Suffolk County Council

Public Health & Communities

# Mental health in working age adults

## Part of the Suffolk mental health needs assessment

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Suffolk County Council Public Health & Communities

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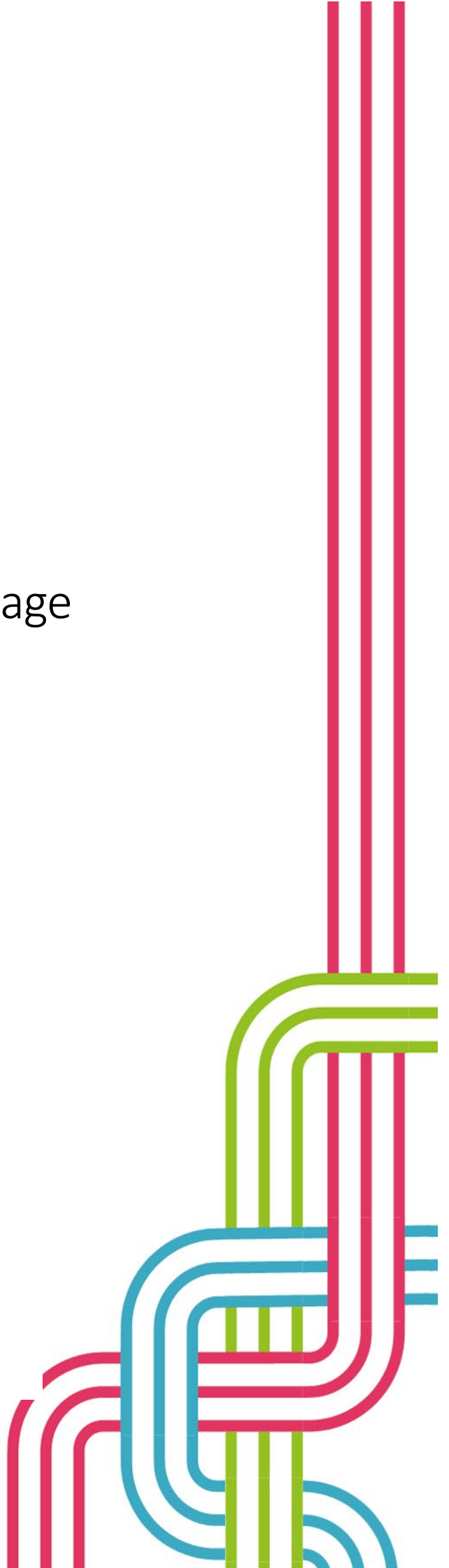


# Contents

# Five key points

1. Nationally, common mental health problems (CMHPs) lead to reduced income and employment, which entrenches poverty and increases the risk of mental health problems (See section below on Overview of common mental health problems)
2. In 2021-22, 13.2% (n=87,437) people aged 18 and over in Suffolk had a recorded diagnosis of depression, the highest prevalence in the East of England, and statistically significantly higher than England as a whole (12.7%) (See section below on Depression)
3. Most people (96-97%) from the Integrated Care Board (ICB) areas that cover Suffolk who were referred to talking therapies in 2021-22 started treatment within 6 weeks. (See section below on Prevention and treatment of common mental health problems)
4. 7,365 people in Suffolk are on the mental health register for schizophrenia, bipolar affective disorder, and other psychoses (2021-22) (See section below on Overview (SMI))
5. In 2020-21, 13.0% (n=262) of people in Suffolk (aged 18 to 69) who were in contact with secondary mental health services and on the Care Plan Approach, were in paid employment. This was statistically significantly better than England (9.0%) (See section below on Enhanced rehabilitation, recovery, and secure care)

# Context

## Type of report

This report is part of a mental health needs assessment in the Suffolk Joint Strategic Needs Assessment. "A health needs assessment is a systematic approach to understanding the needs of a population that can be used as part of the commissioning process to ensure that the most effective support is provided for those in greatest need"[1].

## Background - geography

The report covers the Suffolk County Council geography.

Clinical Commissioning Groups (CCGs) ceased to exist on 1 July 2022, when Integrated Care Boards (ICBs) were legally established. "Sub-ICB areas" match the geography of CCGs for data analysis. Suffolk is covered by two ICBs: Suffolk and North East Essex (West Suffolk and Ipswich and East Suffolk CCGs or sub-ICB areas), and Norfolk and Waveney (ICB or CCG). These areas are different sizes in terms of geography and population (March 2023)[2]:

- 1,088,258 Norfolk and Waveney CCG/ICB
- 1,058,560 Suffolk and North East Essex ICB
- 422,283 Ipswich & East Suffolk CCG/sub-ICB
- 265,688 West Suffolk CCG/sub-ICB

Where possible, health information on the Waveney part of Suffolk (including Lowestoft) is given at Primary Care Network (PCN) level. PCNs are groups of GP practices that cover smaller areas than an ICB or CCG.

Note: East Suffolk Lower Tier Local Authority (LTLA) includes the Lowestoft and Waveney area, which is in the Norfolk and Waveney ICB.

# Introduction

This report considers prevalence and treatment of common mental health conditions and severe mental illness (SMI) in people of typical working age (aged 18 to 64).

Opportunities to promote healthy behaviours, prevent mental ill health and develop community resilience are covered in **Mental health: environmental factors** and **Mental health: population factors**. For example, low educational attainment, material disadvantage and unemployment affect mental health and wellbeing. Cost-effective interventions such as cognitive behavioural therapy (CBT) and mindfulness exist to promote and protect employee mental health[3].

The Mental Health Services Data Set is incomplete – variation between CCGs or over time may be "due to variations in levels of mental illness, service provision or due to data quality limitations"[4].

## Other age groups

Around half (46.4%) adult mental health disorders start in childhood (by age 14)[5]. These conditions are covered in the **children and young people** chapter of this needs assessment. Where appropriate, NICE guidance is age specific (for example treatment for eating disorders) and differing treatments and approaches may be recommended for the adult population[6].

Some content in the current chapter will be relevant to all adults; specific older age considerations are set out in the chapter on **mental health in older people**.

# Common mental health problems

## Overview of common mental health problems

"Common mental health problem" (CMHP) is a term used by NICE[7]. The prevalence of common mental health problems (CMHPs) is influenced by social determinants of health. Poor and disadvantaged people suffer disproportionately more CMHPs. For example, the more debt people have, the more likely they are to have some form of mental health disorder. CMHPs lead to reduced income and employment, which entrench poverty and increase the risk of mental ill health. High rates of CMHPs are associated with low educational attainment [8,9]. These factors are considered in more detail in **Mental health: environmental factors** and **Mental health: population factors**.

Common mental health problems include:[10]

- agoraphobia
- body dysmorphic disorder (BDD)
- depression
- generalised anxiety disorder
- health anxiety (hypochondriasis)
- mixed depression and anxiety
- obsessive-compulsive disorder (OCD)
- panic disorder
- Post-traumatic Stress Disorder (PTSD)

- social anxiety disorder
- specific phobias (such as heights, flying, spiders etc.).

Common mental health conditions cause distress and interfere with normal everyday life. Parenting, caring, going to work and socialising can all suffer. The large numbers of people experiencing these conditions at any one time has a significant impact and cost to society[11].

It was estimated that 91,887 people aged 16 and over in Suffolk could have a common mental disorder in 2017. This was 14.8% of the population, statistically significantly lower (better) than England (16.9%)[12]. Other estimates suggest 80-90,000 people in Suffolk might have a common mental disorder in 2024[11,13]. These now appear likely to be under-estimates, as in 2021-22, 13.2% (n=87,437) people aged 18 and over in Suffolk had a recorded diagnosis of depression[12].

## Depression

Depression is a mental health disorder characterised by persistent low mood and a loss of interest and enjoyment in ordinary things. A range of emotional, physical, and behavioural symptoms are likely such as sleep disturbance, change in appetite, loss of energy, poor concentration, low feelings of self-worth and thoughts of suicide. Depressive episodes can range from mild to severe[14].

In 2021-22, 13.2% (n=87,437) people aged 18 and over in Suffolk had a recorded diagnosis of depression, the highest prevalence in the East of England, and statistically significantly higher than England as a whole (12.7%)[12]. These figures are lower than national estimates that "around 1 in 6 (16%) adults aged 16 years and over reported moderate to severe depressive symptoms" in autumn 2022, higher than before the pandemic (10% July 2019 to March 2020)[15].

8,370 people in Suffolk aged 18 and over were newly diagnosed with depression in 2021-22. The incidence rate of 1.3% was statistically significantly lower than England (1.5%), and similar to the East of England as a whole (1.3%)[12].

Suffolk primary care network (PCN) areas with prevalence of depression statistically significantly higher than England: Sudbury, Lowestoft, South Waveney, Barrack Lane and Ivry Street, East Suffolk (Table 1).

*Table 1: Depression: QOF prevalence (patients aged 18 and over), Suffolk PCNs (descending order of prevalence), 2021-22*[16]

| Area Name | Value | Count | Denominator | Recent Trend | Compared to England |
|---|---|---|---|---|---|
| **England** | 12.7 | | | Increasing | |
| **Suffolk PCNs** | 13.4 | 83,147 | 622,741 | Cannot be calculated | Higher |
| **Sudbury PCN** | 18.4 | 5,225 | 28,465 | Increasing | Higher |
| **Lowestoft PCN** | 15.8 | 10,142 | 64,263 | Increasing | Higher |
| **South Waveney PCN** | 14.4 | 6,464 | 44,991 | Increasing | Higher |
| **Barrack Lane & Ivry Street PCN** | 14.2 | 3,606 | 25,443 | Increasing | Higher |
| **East Suffolk PCN** | 13.8 | 17,144 | 124,386 | Increasing | Higher |
| **Haverhill PCN** | 13.1 | 3,575 | 27,361 | Increasing | Similar |
| **East Ipswich PCN** | 13.0 | 3,658 | 28,072 | Increasing | Similar |
| **WGGL PCN** | 12.7 | 2,609 | 20,589 | Increasing | Similar |
| **North East Ipswich PCN** | 12.5 | 3,935 | 31,370 | Increasing | Similar |
| **Forest Heath PCN** | 12.5 | 7,430 | 59,573 | Increasing | Similar |

| Area Name | Value | Count | Denominator | Recent Trend | Compared to England |
|---|---|---|---|---|---|
| **Blackbourne PCN** | 12.4 | 3,067 | 24,770 | Increasing | Similar |
| **Orwell PCN** | 12.1 | 2,586 | 21,338 | Increasing | Similar |
| **Bury St Edmunds PCN** | 11.8 | 6,245 | 52,768 | Increasing | Lower |
| **South Rural PCN** | 10.9 | 4,982 | 45,765 | Increasing | Lower |
| **North East Coastal PCN** | 10.5 | 2,479 | 23,587 | Increasing | Lower |

*Source: Fingertips: National GP profiles*[16]

### Generalised anxiety disorder (GAD)

An anxiety disorder characterised by excessive worry about many different things and difficulty controlling that worry. This is often accompanied by restlessness, difficulties with concentration, irritability, muscular tension and disturbed sleep [17,18].

In 2021-22, the following referrals (rounded to 5) were received to NHS talking therapies for GAD in the CCG/ICB areas that cover Suffolk[19] (note the areas have populations of different sizes – see Background - geography):

- 3,310 Ipswich & East Suffolk CCG
- 1,835 West Suffolk CCG
- 4,215 Norfolk & Waveney ICB

### Social anxiety disorder (social phobia)

A persistent and overwhelming fear of a social situation, such as shopping or speaking on the phone which impacts on a person's ability to function effectively in aspects of their daily life. People with social anxiety will fear doing or saying something that will lead to being judged by others and being embarrassed or humiliated. Feared situations are avoided or endured with intense distress [20,21].

In 2021-22, the following referrals (rounded to 5) were received to NHS talking therapies for social phobias in the CCG/ICB areas that cover Suffolk[19] (note the areas have populations of different sizes – see Background - geography):

- 150 Ipswich & East Suffolk CCG
- 95 West Suffolk CCG
- 935 Norfolk & Waveney ICB

### Panic disorder

People with panic disorder experience repeated and unexpected attacks of intense anxiety. There is a marked fear of future attacks, and this can result in avoidance of situations that may provoke a panic attack. Symptoms include a feeling of overwhelming fear and apprehension often accompanied by physical symptoms such as nausea, sweating, heart palpitations and trembling [17,22].

In 2021-22, the following referrals (rounded to 5) were received to NHS talking therapies for Panic disorder (episodic paroxysmal anxiety) in the CCG/ICB areas that cover Suffolk[19] (note the areas have populations of different sizes – see Background - geography):

- 170 Ipswich & East Suffolk CCG
- 110 West Suffolk CCG
- 545 Norfolk & Waveney ICB

### Agoraphobia

Characterised by fear or avoidance of specific situations or activities that the person fears will trigger panic-like symptoms, or be difficult or embarrassing to escape from, or where help may not be available. Specific feared situations can include leaving the house, being in open or crowded places, or using public transport [23].

In 2021-22, the following referrals (rounded to 5) were received to NHS talking therapies for agoraphobia in the CCG/ICB areas that cover Suffolk[19] (note the areas have populations of different sizes – see Background - geography):

- 125 Ipswich & East Suffolk CCG
- 85 West Suffolk CCG
- 610 Norfolk & Waveney ICB

### Obsessive-compulsive disorder (OCD)

An anxiety condition characterised by the presence of either obsessions (repetitive, intrusive and unwanted thoughts, images or urges) or compulsions (repetitive behaviours or mental acts that a person feels driven to perform), or both [24].

In 2021-22, the following referrals (rounded to 5) were received to NHS talking therapies for OCD in the CCG/ICB areas that cover Suffolk[19] (note the areas have populations of different sizes – see Background - geography):

- 195 Ipswich & East Suffolk CCG
- 110 West Suffolk CCG
- 650 Norfolk & Waveney ICB

### Specific phobia

An overwhelming and debilitating fear of an object, place, situation, feeling or animal. This can include a fear of heights, flying, particular animals, seeing blood or receiving an injection. Phobias can have a significant impact on day to day life and cause significant distress [25].

In 2021-22, the following referrals (rounded to 5) were received to NHS talking therapies for specific (isolated) phobias in the CCG/ICB areas that cover Suffolk[19] (note the areas have populations of different sizes – see Background - geography):

- 75 Ipswich & East Suffolk CCG
- 40 West Suffolk CCG
- 235 Norfolk & Waveney ICB

### Post-traumatic stress disorder (PTSD)

Psychological and physical signs and symptoms that can develop in response to threatening or distressing events, such as physical, sexual, or emotional abuse, severe accidents, disasters, and military action (see also the Suffolk **Veterans' mental health assessment, 2021**). Typical features of PTSD include repeated and intrusive distressing memories that can cause a feeling of 'reliving or re-experiencing' the trauma. PTSD is often comorbid with other mental health conditions such as depression [11,26].

In 2021-22, the following referrals (rounded to 5) were received to NHS talking therapies for specific (isolated) phobias in the CCG/ICB areas that cover Suffolk[19] (note the areas have populations of different sizes – see Background - geography):

- 315 Ipswich & East Suffolk CCG
- 215 West Suffolk CCG
- 1,435 Norfolk & Waveney ICB

### Health anxiety (hypochondriasis)

A central feature is a persistent preoccupation with the possibility that the person has, or will have, a serious physical health problem. Normal or commonplace physical symptoms are often interpreted as abnormal and distressing, or as indicators of serious illness.

In 2021-22, the following referrals (rounded to 5) were received to NHS talking therapies for hypochondriacal disorders in the CCG/ICB areas that cover Suffolk[19] (note the areas have populations of different sizes – see Background - geography):

- 80 Ipswich & East Suffolk CCG
- 70 West Suffolk CCG
- 335 Norfolk & Waveney ICB

## Prevention and treatment of common mental health problems

Prevention and treatment of CMHPs should follow the stepped model of care, where the most effective yet least resource intensive form of support is provided in the first instance[14].

General population-level support measures should be considered as part of the stepped care approach[27]. These should focus on enhancing community assets to prevent poor mental health and promote healthy behaviours. This may include providing support around:

- housing
- relationships
- access to education
- employment
- discrimination
- welfare rights
- carer support
- crime

Developing social capital through community engagement can help to build resilience and increase a sense of belonging which is beneficial to adult wellbeing [9,28].

At the initial steps of the model, primary care workers should be alert to the presenting symptoms of CMHPs and have a clear understanding of the best practice protocols they can put in place and the onward referral routes available [10]. This includes social prescribing to community resources such as volunteering opportunities, physical activity programmes and befriending services [29]. This form of prescribing is likely to increase confidence, build social networks and develop self-efficacy [29,30]. Medication should not routinely be prescribed at the lower steps for recent onset mild to moderate CMHPs, although NICE guidelines are clear about the risks and exceptions do apply [7,14].

At the higher steps of the model, NHS talking therapies for anxiety and depression[31] (known until 2023 as Improving Access to Psychological Therapies (IAPT) services [10]), to which people can self-refer, should provide treatment for conditions including:

- agoraphobia
- body dysmorphic disorder

- depression
- generalised anxiety disorder
- health anxiety
- mixed depression and anxiety
- obsessive-compulsive disorder (OCD)
- panic disorder
- post-traumatic stress disorder (PTSD)
- social anxiety disorder
- specific phobias (such as heights, flying, spiders etc.).

NHS talking therapies provide evidence-based treatment at a level appropriate to an individual's condition. In 2021-22, over a million (1.24 million) referrals accessed IAPT services, with over half (50.2%) moving to recovery (according to a range of clinical measures which monitor symptom frequency and severity) [19].

For mild to moderate CMHPs the following interventions should be available [7,14]:

- individual facilitated self-help based on the principles of cognitive behavioural therapy (CBT)
- computerised CBT
- structured group physical activity programmes
- group-based peer support (self-help) programmes (for those who also have a chronic physical health condition)
- non-directive counselling for depression delivered at home (for women during pregnancy or the postnatal period)

People who present with more severe CMHPs, or who fail to respond to the above treatments, should be offered one of a range of more intense psychological therapies (such as face to face CBT or couples' therapy), or a suitable medication, or both [7,14]. As mentioned previously, social factors contributing to the depression should also be addressed [9,29].

Whilst CMHPs respond well to evidence based interventions, there is a known high level of relapse. Services should ensure that relapse prevention approaches are included in treatment episodes as identified by the condition-specific NICE guidance [7].

The Five Year Forward View for Mental Health[32] and subsequent implementation guidance[33], including the NHS long term plan[34] set out new ambitions for the delivery of services for CMHPs (Table 2):

- At least 25% of people with CMHPs should access appropriate services each year. In June 2019 (the most recent month for which data was available at health geographies covering Suffolk) West Suffolk CCG and Ipswich and East Suffolk CCG were statistically significantly better (higher) than England, Norfolk and Waveney ICB was statistically significantly worse (lower).[12]
- 75% of people referred to IAPT services should start treatment within 6 weeks. Significance was not calculated, sub-national figures not available to one decimal place. All areas (Suffolk health areas and England) appear to have reached the target. [19]
- 95% of people referred to IAPT services should start treatment within 18 weeks. Significance was not calculated, sub-national figures not available to one decimal place. All areas (Suffolk health areas and England) appear to have reached the target. [35]

- 50% of people entering IAPT treatments should achieve clinical recovery. Significance was not calculated, sub-national figures not available to one decimal place. All areas (Suffolk health areas and England) appear to have reached the target. [19]
- in relation to post-traumatic stress disorder in veterans, all NHS-commissioned mental health providers will have armed forces champions and a specific named clinician with an expertise in military trauma. Norfolk and Suffolk Foundation Trust (NSFT) services include: Veterans Integrated Service, veterans high intensity service, and Op COURAGE. NSFT has Veteran Aware accreditation (with veterans champions and a dedicated Armed Forces and Veterans Practitioner).

The number of people entering IAPT as a percentage of people estimated to have anxiety or depression (Table 2) is statistically significantly lower (worse) in Norfolk and Waveney, and statistically significantly higher (better) than England in West Suffolk and in Ipswich and East Suffolk sub-ICB areas.

*Table 2: Performance measures for services for common mental illness, Suffolk health areas*[12,19,35]

| Measure | Period | Target | England | Ipswich & East Suffolk | West Suffolk | Norfolk & Waveney |
|---|---|---|---|---|---|---|
| **Number of people entering IAPT as a percentage of people estimated to have anxiety or depression** | June 2019 | 25% or more | **18.8%** | 21.6% | 20.6% | 15.5% |
| **Percentage of people referred to IAPT services starting treatment within 6 weeks** | 2021-22 | 75% | **91.1%** | 96% | 96% | 97% |
| **Percentage of people referred to IAPT services starting treatment within 18 weeks** | Quarter 3, 2022-23 | 95% | **98.1%** | 100% | 100% | 100% |
| **Percentage of people referred to IAPT services achieving clinical recovery** | 2021-22 | 50% | **50.2%** | 52% | 52% | 55% |

*Source: Fingertips, Annual report on the use of IAPT services, Mental Health Five Year Forward View Dashboard*[12,19,35]

## Risk and protective factors of common mental health problems

Risk and protective factors are considered in more detail in **Mental health: environmental** and **Mental health: population factors**.

An overview of risk factors for mental ill health[12] (using the latest data available in June 2023), shows Suffolk as a whole performs similar to, or better than, England for most indicators, including: prevalence of overweight in reception and year 6, children in relative low income, Employment and Support Allowance claimants, crime deprivation and admissions for alcohol-related conditions. However, for example, Suffolk has a higher percentage of people in fuel poverty (14.5%, compared to 13.2% for England and for the East of England).

Factors protecting against mental ill health[12] include (healthy) life expectancy, percentage of people in employment and sports club membership. Suffolk is better than England for most of these indicators (latest data, June 2023), however Suffolk performs statistically significantly worse than

England on school readiness (children achieving a good level of development at the end of Reception) and social isolation (percentage of adult carers who have as much contact as they would like).

## Service performance

*Table 3: Adult mental health: NHS Talking Therapies, for depression and anxiety (formerly IAPT services), Quarter 3 2022-23*[35]

| Indicator | Ipswich & East Suffolk sub-ICB | West Suffolk sub-ICB | Norfolk & Waveney ICB | England |
|---|---|---|---|---|
| **Access: number of people entering NHS funded treatment during reporting period** | 2,965 | 1,705 | 6,705 | **297,843** |
| **% of all referrals that are for older people 65** | 8.4% | 9.4% | 8.6% | **6.1%** |
| **Recovery rate: % of people that attended at least 2 treatment contacts and are moving to recovery** | 51.0% | 54.0% | 51.0% | **49.2%** |
| **Recovery rate for Black, Asian, or Minority Ethnic groups** | 56.0% | 55.0% | 47.0% | **47.4%** |
| **% of people receiving first treatment appointment within 6 weeks of referral** | 97.0% | 98.0% | 95.0% | **89.3%** |

*Source: Mental Health Five Year Forward View Dashboard*[35]

*Table 4: Talking therapies services, 2021-22*[19]

| Area | Referrals received | Referrals accessing services | Referrals finishing treatment | Recovery rate (%) |
|---|---|---|---|---|
| **Ipswich & East Suffolk CCG** | 17,180 | 11,645 | 4,090 | 52 |
| **West Suffolk CCG** | 9,520 | 6,330 | 2,500 | 52 |
| **Norfolk & Waveney CCG** | 34,660 | 23,435 | 9,875 | 55 |
| **England** | **1,812,596** | **1,244,386** | **664,087** | **50.2** |

*Source: Annual report on the use of IAPT services*[19]

Depression is "often a chronic disease, yet treatment is often episodic and short-lived", so there is national monitoring of reviews. Performance across Suffolk as a whole was similar to England (Table 5).

*Table 5: Newly diagnosed patients with depression (aged 18 and over) who had a review 10-56 days after diagnosis (denominator incl. PCAs), Suffolk PCNs, 2021-22*[16]

| Area Name | Value | Count | Denominator | Recent Trend (statistical significance) | Compared to England (statistical comparison) |
|---|---|---|---|---|---|
| **England** | **54.9** | | | **Decreasing** | |
| **Suffolk PCNs combined** | **53.7** | **4,298** | **8,011** | **Cannot be calculated** | **Similar** |
| **Barrack Lane & Ivry Street PCN** | 49.1 | 134 | 273 | No significant change | Similar |
| **Blackbourne PCN** | 63.5 | 235 | 370 | No significant change | Higher |
| **Bury St Edmunds PCN** | 45.4 | 243 | 535 | Decreasing | Lower |
| **East Ipswich PCN** | 60.6 | 172 | 284 | No significant change | Similar |
| **East Suffolk PCN** | 61.6 | 1,027 | 1,666 | Decreasing | Higher |
| **Forest Heath PCN** | 57.8 | 323 | 559 | Decreasing | Similar |
| **Haverhill PCN** | 22.4 | 98 | 437 | Decreasing | Lower |
| **Lowestoft PCN** | 52.3 | 524 | 1,002 | Decreasing | Similar |
| **North East Coastal PCN** | 64.0 | 135 | 211 | No significant change | Similar |
| **North East Ipswich PCN** | 62.1 | 265 | 427 | No significant change | Similar |
| **Orwell PCN** | 12.2 | 44 | 360 | Decreasing | Lower |
| **South Rural PCN** | 62.6 | 300 | 479 | Decreasing | Higher |
| **South Waveney PCN** | 46.9 | 309 | 659 | Decreasing | Lower |
| **Sudbury PCN** | 68.7 | 345 | 502 | Increasing | Higher |
| **WGGL PCN** | 58.3 | 144 | 247 | No significant change | Similar |

*Source: Fingertips: National GP profiles*[16]

In 2022, 83% respondents to the GP patient survey from Suffolk & North East Essex ICB (the figure for Norfolk and Waveney ICB was also 83%) felt that, during their last general practice appointment, the healthcare professional recognised and/or understood any mental health needs that they might have had (definitely or to some extent), similar to England (81%), and excluding responses from patients who selected "I did not have any mental health needs". In 2022, most Suffolk PCNs were statistically similar to England, although Blackbourne, Bury St Edmunds, and South Rural were statistically significantly better, and Haverhill was statistically significantly worse (Table 6).

Healthwatch Suffolk's survey of satisfaction with GP services in 2022 reported "a significant amount of variation in people's experiences", 22% of 303 young people aged over 16 rated their experience of mental health support from their GP as very poor (one star), and only 12% rated the support five star (very good). Their feedback service gives Wellbeing Suffolk 3.5 stars based on 97 reviews (July 2023) – 16 reviews were published between 1 January and 28 June 2023, 14 gave five stars (with a five specifically mentioning peer support), one review was three stars (comments about waiting 6 weeks, and changing staff) and one was four stars [36].

*Table 6: Percentage of patients agreeing their mental health needs were recognised and understood by Suffolk PCN, GP patient surveys, 2022 & 2023*[37]

| PCN | 2023 | 2023 compared to England | 2022 | 2022 compared to England |
|---|---|---|---|---|
| **Barrack Lane & Ivry St** | | | 77% | Similar |
| **Blackbourne** | | | 91% | Higher (better) |
| **Bury St Edmunds** | | | 92% | Higher (better) |
| **Cardinal Medical Practice** | | | Not available | |
| **Deben Health** | | | 86% | Similar |
| **East Ipswich** | | | 83% | Similar |
| **East Suffolk** | | | 84% | Similar |
| **Forest Heath** | | | 84% | Similar |
| **Haverhill** | | | 70% | Lower (worse) |
| **Lowestoft** | | | 80% | Similar |
| **North East Coastal** | | | 85% | Similar |
| **North East Ipswich** | | | 77% | Similar |
| **Orwell** | | | 89% | Similar |
| **South Rural** | | | 89% | Higher (better) |
| **South Waveney** | | | 80% | Similar |
| **Sudbury** | | | 91% | Similar |
| **WGGL** | | | 81% | Similar |
| **England** | | | 81% | Not applicable |

*Source: GP patient surveys*[37]

## Evidence and further information

- NHS Talking Therapies, for anxiety and depression (formerly known as the IAPT programme): priorities for development and a range of links to service standards and workforce requirements.
- NICE: Common mental health problems: identifies common mental health disorders in people aged 18 and over in primary care and the principles for treatment and referral. From this pathway it is possible to access specific guidance on depression, generalised anxiety, PTSD, OCD, social anxiety, and panic disorder.
- PHE: Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill Health: evidence on promoting good mental health, including addressing bullying in children, providing debt advice to protect mental health, and addressing loneliness to protect the mental health of older people.
- For a detailed consideration of available metrics relating to adult common mental health conditions, see the Fingertips common mental health disorders profile[38].
- The Adult Psychiatric Morbidity Survey 2014[11] provides further data at a national and regional level on prevalence of specific common mental health conditions and psychoses by age, gender and other demographic analyses.
- NHS Digital produces reports from the IAPT Dataset[39] and the Mental Health Services Dataset[40]. These provide a source of information on CMHPs treated by primary and specialist care services.

# Integrating physical and mental health

The relationship between physical and mental health is complex. There are high rates of mental ill health among people with long-term physical conditions (LTC) and within this group the associated

healthcare costs are 45% higher. It has been estimated that nationally 46% of people with a mental health condition have a LTC and 30% of people with LTC have mental ill health[41].

There is likely to be a two-way causal relationship; people with LTC are two to three times more likely to experience mental ill health than the general population [42]. Co-existing mental ill health can lead to:[9]

- increased hospitalisation rates - patients with chronic lung disease spend twice as long in hospital if they also have poor mental health.
- increased outpatient service use - diabetes sufferers with poor mental health access double the amount of outpatient services as those with diabetes alone.
- less effective self-management - poor mental health means that people with heart disease or other long-term conditions are less likely to look after their physical health, take medication as intended and attend medical appointments.

Physical and mental health conditions should be supported in an integrated way across all aspects of the health system, from public health and prevention initiatives to the care provided by GPs, hospitals and the social care sector [41]. Cost-effective interventions which protect the mental health of people with long term conditions are available [43].

## Medically unexplained symptoms

It has been estimated that more than a quarter of primary care patients in England have unexplained chronic pain, irritable bowel syndrome, or chronic fatigue[9,44]. Persistent physical medically unexplained symptoms (MUS) are often managed with limited psychological support. Without appropriate treatment, outcomes for many patients with MUS are poor [9].

Appropriate multi-disciplinary services for people with MUS should be commissioned in primary care, community, day services, A&E departments, and inpatient facilities. This will enable people to access the services most appropriate for them, resulting in improved outcomes for patients and substantial cost-savings for the healthcare system [9].

In 2023, Suffolk Public Health and Communities published local analysis of hospital admissions for fibromyalgia, medically unexplained symptoms and similar conditions (categorised in hospital records under "undifferentiated somatoform disorder"). Rates of admission for F45: any somatoform disorder were "very low (< 10 for each LTLA)" so had to be suppressed.

## Evidence and further information

The following documents and supporting materials are useful sources of further information on this topic:

- King's Fund: Bringing together physical and mental health: integration of physical and mental health assessments, treatments, care pathways and services.
- Institute for Public Policy Research: Patients in control: why people with long-term conditions must be empowered: overview of self-management and peer support in long term conditions.
- PHE: Wellbeing in mental health: applying All Our Health: examples to help healthcare professionals make interventions to promote physical health and wellbeing in mental health.

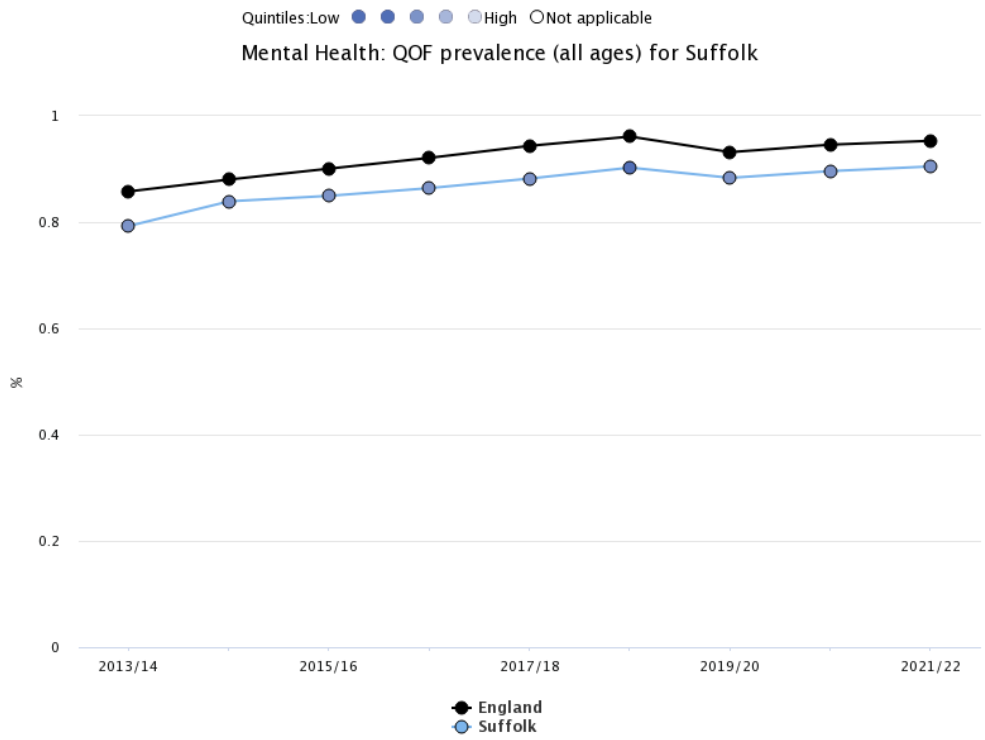
# Severe mental illness (SMI)

## Overview (SMI)

Severe mental illness (SMI) includes schizophrenia, bipolar disorder and psychoses [45].

In 2021-22, 7,365 patients were on Suffolk GP practice SMI registers, 0.90% of the population, statistically significantly lower than England (0.95%). The mental health register includes patients with schizophrenia, bipolar affective disorder, and other psychoses. There has been no significant change over time (Figure 1) [12].

*Figure 1: Percentage of patients on mental health (SMI) registers, Suffolk compared to England, 2013/14 - 21-22*[12]




*Source: OHID. Mental Health and Wellbeing JSNA*

There are well established NICE standards and guidelines for SMI which cover a wide range of conditions:

- Psychosis and Schizophrenia in adults: Prevention and management (2014): sets out the evidence base for the recognition and management of psychosis and schizophrenia in adults at each stage in the pathway from early recognition and treatment, through to rehabilitation and recovery and primary care continuing care. Recommends checking for coexisting ill health and providing support for family members and carers.
- NICE Bipolar assessment and management (2014): recognising, assessing, and treating bipolar disorder (formerly known as manic depression) in children, young people, and adults. It aims to improve access to treatment and quality of life in people with bipolar disorder.
- Depression in adults (updated June 2022): describes the presentation and impact of depression and the range of social, psychological, medication and other interventions. Suicidal ideation is more common in people with severe depression and in some cases people will experience psychotic symptoms [46].

- NICE Personality disorders overview: standards and guidelines stressing that early recognition and rapid access to biopsychosocial effective care provides the best outcomes. However, the commissioning and implementation of these services is more variable than for comparable physical health conditions [9]. Variation is seen in the duration of untreated mental health illness, access to full, rather than just partial, effective interventions and in levels of resourcing. The national policy and plans seek to transform this pattern of care [9].

## Models of care (SMI)

The Five year Forward View for mental health[32] set out principles, models of care and timescales for implementation of services to deliver improved benefits for people's mental, social and physical health, and major economic value to the wider health and social care system. This included:

- early intervention for first episode psychosis
- rapid access to urgent and emergency care when in crisis
- coordinated case management, rehabilitation, and recovery for on-going needs
- enhanced secure care when risk is high
- physical health care to reduce the 20 year premature mortality gap
- suicide prevention
- recovery to social inclusion, stable housing, and employment

Community-based mental health services should support people with mental health conditions in their journey from referral to longer term recovery. The NHS Long term plan "new community-based offer will include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use. This includes maintaining and developing new services for people who have the most complex needs and proactive work to address racial disparities"[34]. Local areas should "move towards a new place-based, multidisciplinary service across health and social care aligned with primary care networks"[47]. There is a "focus on people whose needs are deemed too severe for Improving Access to Psychological Therapies (IAPT) services but not severe enough to meet secondary care "thresholds", including, for example, eating disorders and complex mental health difficulties associated with a diagnosis of "personality disorder""[47].

Services should help people achieve and maintain recovery by providing:[9]

- rapid referral for assessment and secondary care treatment and support where required
- enhanced primary care step-down support to maintain recovery following discharge from secondary mental health services
- rapid access to care to enable service users to step-up their care as required, or self-refer for re-assessment
- routinely record & publish patient and carer experience and outcome measures

Suffolk performs better than England for outcome measures for severe mental illness (Table 7).

*Table 7: SMI measures, Suffolk compared to England and region*

| Indicator Name | Time period | Suffolk count | Suffolk | Suffolk compared to England | England | Suffolk compared to East of England | East of England |
|---|---|---|---|---|---|---|---|
| **Premature mortality in adults with severe mental illness (SMI) (Persons, 18-74 years)** | 2018-20 | 1,235 | 71.1 | Better | 103.6 | Better | 89.8 |
| **Excess under 75 mortality rate in adults with severe mental illness (SMI) (Persons, 18-74 years)** | 2018-20 | n/a | 414.0 | Similar | 389.9 | Similar | 388.8 |
| **The percentage of the population who are in contact with secondary mental health services and on the Care Plan Approach, that are in paid employment (aged 18 to 69)** | 2020-21 | 262 | 13.0 | Better | 9.0 | Similar | 15.0 |
| **Gap in the employment rate for those who are in contact with secondary mental health services (aged 18 to 69) and on the Care Plan Approach, and the overall employment rate** | 2020-21 | n/a | 62.4 | Better | 66.1 | Similar | 61.9 |
| **Adults in contact with secondary mental health services who live in stable and appropriate accommodation: Persons (18-69 years)** | 2020-21 | | 70 | Better | 58 | Better | 61 |
| **Adults in contact with secondary mental health services who live in stable and appropriate accommodation: Male (18-69 years)** | 2020-21 | | 69 | Better | 56 | Better | 60 |
| **Adults in contact with secondary mental health services who live in stable and appropriate accommodation: Female (18-69 years)** | 2020-21 | | 71 | Better | 59 | Better | 61 |

*Source: Fingertips*

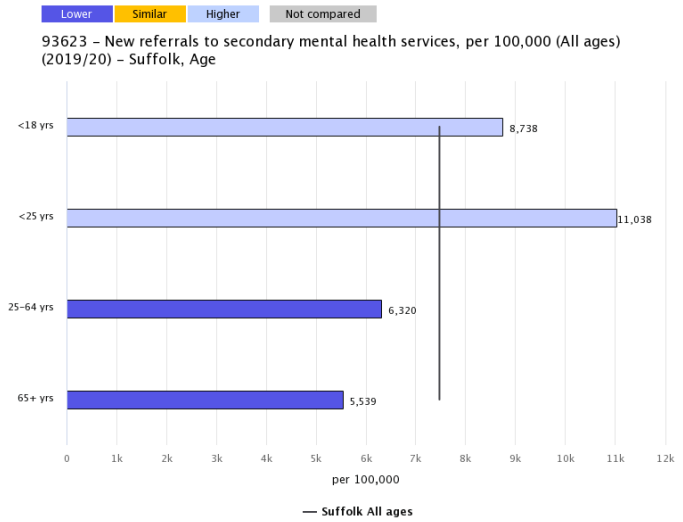
## Secondary mental health services

55,265 new referrals to secondary mental health services were made in 2019-20 in Suffolk. Directly standardised rates of referrals (all ages) were statistically significantly higher than England (6,897 per 100,000) for each of the health areas serving Suffolk:[12]

- 7,112 per 100,000 Ipswich & East Suffolk CCG
- 7,467 per 100,000 West Suffolk CCG
- 8,390 per 100,000 Norfolk & Waveney CCG

Although the highest number of referrals in Suffolk were for people aged 25-64, the highest rates per 100,000 were in people aged under 25 or under 18. The rates for these age bands were higher than Suffolk overall and also higher than England rates (Figure 2, Table 8).

*Figure 2: New referrals to secondary mental health services, per 100,000, by age band, Suffolk, 2019-20*[12]



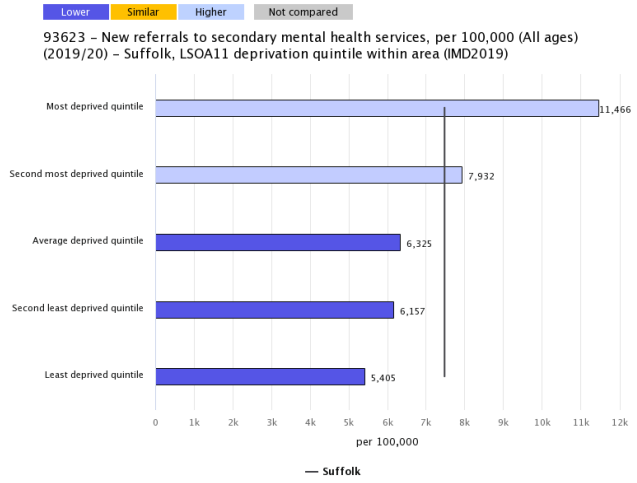

*Source: OHID. Mental Health and Wellbeing JSNA*

*Table 8: New referrals to secondary mental health services by age band, Suffolk, 2019-20*[12]

| | Suffolk count | Suffolk rate per 100,000 | England rate per 100,000 |
|---|---|---|---|
| **Aged under 18 years** | 13,195 | 8,738 | 6,977 |
| **Aged under 25 years** | 21,590 | 11,038 | 8,132 |
| **25-64 years old** | 23,460 | 6,320 | 6,309 |
| **Aged 65 years and over** | 10,210 | 5,539 | 6,754 |
| **All ages** | **55,265** | **7,465** | **6,897** |

In 2019-20, people in the most deprived 40% of areas in Suffolk had a higher rate of referrals to secondary mental health services than less deprived areas of Suffolk, Suffolk overall, and England. Less deprived areas and areas of average deprivation have lower rates of new referrals to services than Suffolk overall and England (Figure 3).

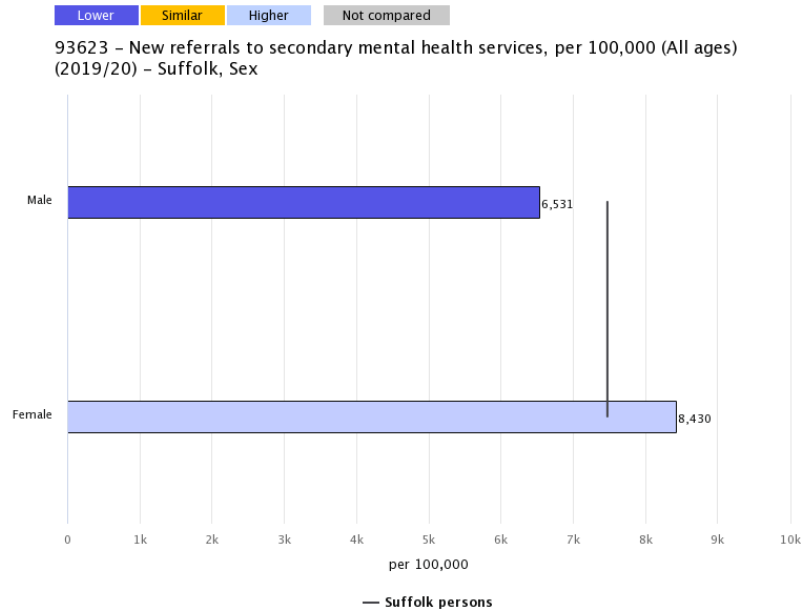
*Figure 3: New referrals to secondary mental health services, per 100,000, by areas of deprivation in Suffolk, 2019-20*[12]




*Source: OHID. Mental Health and Wellbeing JSNA*

Women (8,430 new referrals per 100,000) were more likely to be referred to secondary mental health services than men (6,531 new referrals per 100,000) in Suffolk in 2019-20. The rate for females was higher than Suffolk overall, and higher than the England rate (Figure 4).

*Figure 4: New referrals to secondary mental health services, per 100,000, by sex, Suffolk, 2019-20*[12]




*Source: OHID. Mental Health and Wellbeing JSNA*

## Early intervention in psychosis (EIP)

EIP services are multidisciplinary community mental health services that provide treatment and support to people experiencing or at high risk of developing psychosis, typically for a three year period [48]. EIP services have a strong ethos of hope and whole-team commitment to enabling recovery through the provision of individually tailored, evidence-based interventions and support to service users and their families/carers [9].

The short and longer-term economic benefits of EIP services are significant [9,48]. The net cost savings (reported in 2019) per person after the first four years is £7,972, with a further £6,780 saving per person in the next four to 10 years if full EIP provisions are provided. Over a 10-year period this would result in £15 of costs saved for every £1 invested in EIP services. The majority of these cost savings can be attributed to:

- the reduction in use of crisis and inpatient services,
- improved employment outcomes,
- the reduction in risk of future hospitalisation as a result of improved management and reduced risk of relapse.

*Table 9: Referrals on Early Intervention for Psychosis (EIP) pathway 2021-22, count, health areas covering Suffolk*[49]

| Measure | Ipswich & East Suffolk CCG | West Suffolk CCG | Norfolk & Waveney CCG | England |
|---|---|---|---|---|
| **Number of referrals on EIP pathway (10f)** | 220 | 125 | 725 | |
| **Crude rate of referrals on Early Intervention for Psychosis (EIP) pathway per 100,000 population** | 54 | 54 | 70 | **108.9** |
| **Number of referrals that entered treatment (10a)** | 45 | 25 | 230 | |
| **Crude rate of referrals on Early Intervention for Psychosis (EIP) pathway that entered treatment per 100,000 population (10g)** | 10 | 12 | 22 | **24.7** |

*Table 10: Current records of health checks for patients with psychosis, health areas covering Suffolk 2021-22*[16]

| Area | Alcohol consumption (%) | Alcohol consumption record compared to England | Lipid profile (%) | Lipid profile record compared to England | Blood glucose or HbA1c (%) | Blood glucose record compared to England |
|---|---|---|---|---|---|---|
| **Ipswich and East Suffolk CCG** | 79.0 | Higher | 74.2 | Higher | 76.0 | Higher |
| **West Suffolk CCG** | 67.0 | Similar | 67.1 | Higher | 69.6 | Higher |
| **Norfolk and Waveney CCG** | 55.0 | Lower | 58.1 | Lower | 56.9 | Lower |
| **England** | **63.2** | | **60.7** | | **60.1** | |

## Enhanced rehabilitation, recovery, and secure care

For people with continuing and rehabilitation needs, there are a range of service models with the emphasis on 24/7 community-based recovery-focussed care. These aim to prevent avoidable admissions, support recovery for people who have longer-term SMI, to be available in the least restrictive setting and as close to home as possible. Secure (or 'forensic') mental health services provide accommodation, treatment, and support for people with SMI who pose a risk to themselves and at times, the public.

NHS England set objectives to improve the quality of community-based mental health provision in 2016[32]. Some of these can be reported at ICB and sub-ICB level.

At least 60% of people with first episode psychosis start treatment with a NICE-recommended package of care with a EIP service within two weeks of referral. In 2021-22, 70% of referrals on the Early Intervention for Psychosis pathway in England waited two weeks or less for treatment. Significance has not been calculated, but the percentages for Suffolk areas are:

- 88% Ipswich and East Suffolk
- 85% West Suffolk
- 81% Norfolk and Waveney

"Employment and health form a virtuous circle: suitable work can be good for your health, and good health means that you are more likely to be employed" [32]. In 2021-22, in Suffolk, 12% of adults in contact with secondary mental health services were in paid employment, compared to 6% in England and 11% in the East of England (significance not calculated) [50]. In 2020-21 13% (n=262) were in paid employment, statistically significantly better than England (9%) (Table 7). The NHS Long Term Plan had set a target that, in Q3 2022-23 33,000 people would access Individual Placement and Support (IPS), which enables people with SMI to find and retain employment [9,34]. Actual figures for Q3 2022-23 (cumulative for the year) were:[35]

- 19,915 England
- 110 Ipswich and East Suffolk CCG/ sub-ICB
- 70 West Suffolk CCG/ sub-ICB
- 80 Norfolk and Waveney ICB

60% of services will achieve Level 3 NICE concordance by 2020-21 [51]. In 2021-22, none of the Early Intervention in Psychosis (EIP) services commissioned by Suffolk and North East Essex reached level 3 (100% reached level 2), while a third (33.3%) of EIP services in Norfolk and Waveney met level 3 (100% reached level 2) [35].

## Use of the Mental Health Act (MHA)

The NHS aims to ensure that use of the Mental Health Act is closely monitored and, through the provision of earlier intervention, to reduce the rates of detention. Plans should include specific actions to reduce avoidable Mental Health Act detentions and targeted work should be undertaken to reduce the current over-representation from disadvantaged groups in acute and forensic care. [9]

The Mental Health Services Data Set is incomplete – variation between CCGs or over time may be "due to variations in levels of mental illness, service provision or due to data quality limitations"[4].

In 2021-22, the three health areas covering Suffolk had statistically significantly lower rates of detentions under the Mental Health Act compared to all CCGs in England (Table 11).

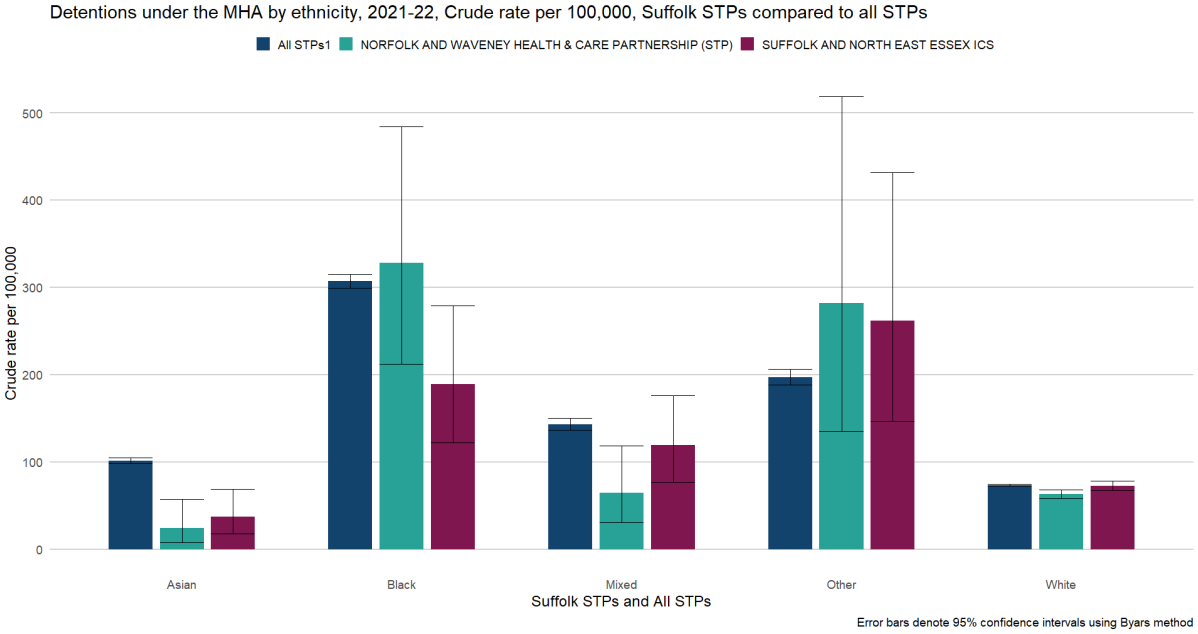
*Table 11: Detentions under the Mental Health Act, 2021-22, NHS areas serving Suffolk*

| Area | Number of detentions | Crude rate per 100,000 population | Statistical comparison with all CCGs |
|---|---|---|---|
| **IPSWICH AND EAST SUFFOLK CCG** | 320 | 77.7 | Significantly lower |
| **WEST SUFFOLK CCG** | 175 | 75.9 | Significantly lower |
| **NORFOLK AND WAVENEY CCG** | 760 | 73.6 | Significantly lower |
| **All England CCGs** | **51,128** | **90.4** | **n/a** |

*Source: Mental Health Act Statistics*[52]

In England, known rates of detentions under the Mental Health Act (MHA) were statistically significantly higher for people in the "Black or Black British" ethnic group compared to other ethnic groups in 2021-22. Known rates of detention for people in this group were statistically significantly similar to England for Norfolk and Waveney STP (N&W), but statistically significantly lower in Suffolk and North East Essex (SNEE) (Figure 5). Smaller numbers mean greater statistical uncertainty, so some differences for other ethnic groups are not statistically significant.

*Figure 5: Detentions under the MHA by ethnicity, 2021-22, crude rate per 100,000, Suffolk STP/ ICB areas compared to all STP/ICB areas*[52]



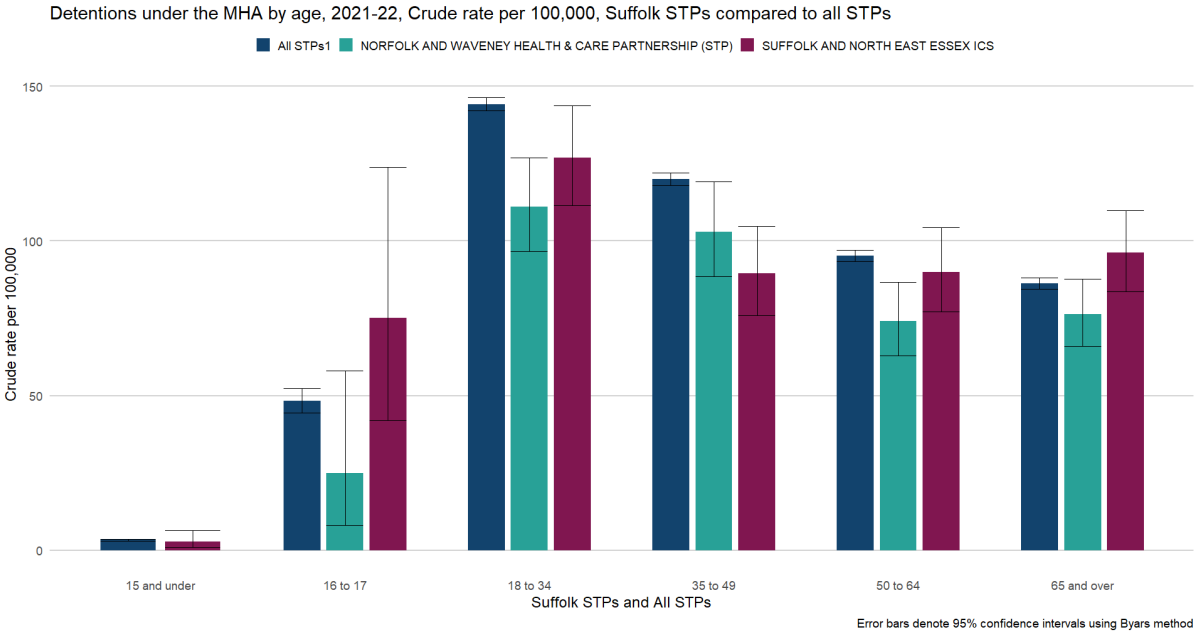

*Source: NHS. Mental Health Act Statistics, Annual Figures, 2021-22*
*Note: STP (Sustainability and Transformation Plan) areas cover the same geography as ICBs*

The England rate for male detentions under the MHA was statistically significantly higher than females (94 per 100,000 compared to 86), in Suffolk the difference between sexes was not statistically significant:

- Norfolk and Waveney: 75 per 100,000 for men compared to 73 per 100,000 for women, both rates statistically significantly lower than England
- Suffolk and North East Essex: 79 per 100,000 for men (statistically significantly lower than England) compared to 86 per 100,000 for women (similar to England)

Detention rates usually decline with age [52]. In England rates drop statistically significantly between each age band from 18-34 to 35-49 to 50-64 to 65 and over. In Suffolk and North East Essex, rates drop statistically significantly from band 18-34 to ages 35-49, but the confidence intervals overlap for 35-49 and older age bands. In Norfolk and Waveney rates in the 35-49 age band are statistically similar to the 18-34 band; 50-64 and 65 and over bands are not statistically significantly different (Figure 6).

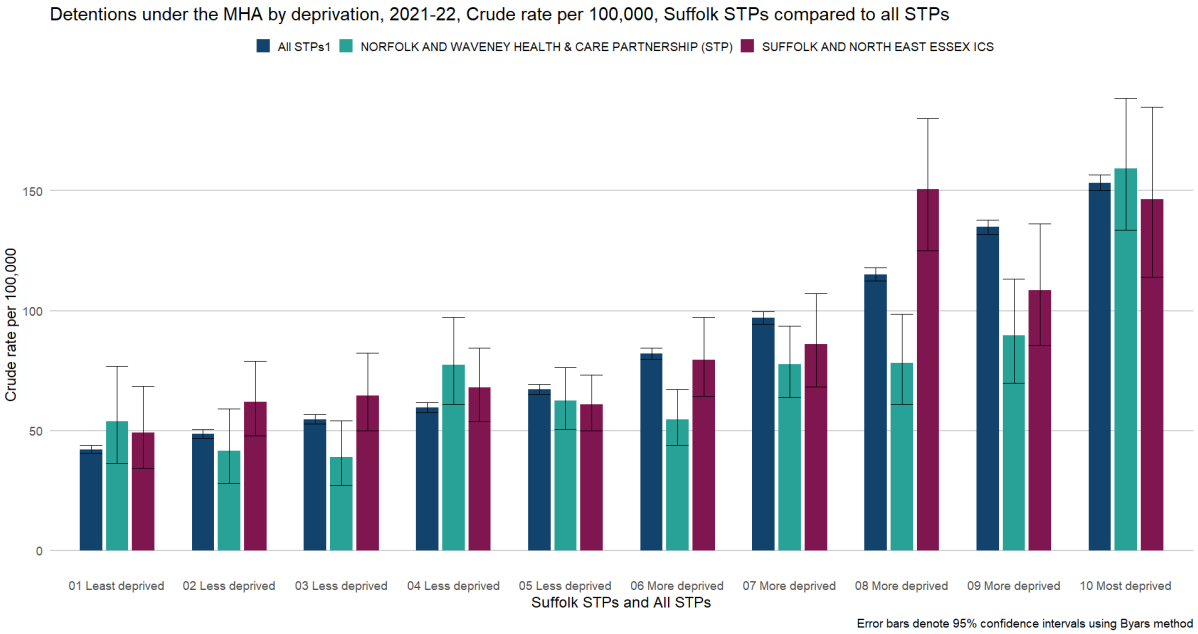
*Figure 6: Detentions under the MHA by age, 2021-22, crude rate per 100,000, Suffolk STPs compared to all STPs*[52]




*Source: NHS. Mental Health Act Statistics, Annual Figures, 2021-22*

People who live in areas of greater relative deprivation are also more likely to be detained under the Mental Health Act[52], although variation is more noticeable at national level (Figure 7).

*Figure 7: Detentions under the MHA by deprivation decile, 2021-22, crude rate per 100,000, Suffolk STPs compared to all STPs*[52]




*Source: NHS. Mental Health Act Statistics, Annual Figures, 2021-22*

## Urgent, emergency, and acute mental health care

Urgent, emergency, and acute mental health care is provided by a range of teams and services:

### Crisis response and home treatment teams

Based in a community setting, these services aim to assess and manage all patients in a mental health crisis and those also being considered for acute hospital admission. They offer intensive home treatment rather than hospital admission if safe and feasible. They also work to facilitate early discharge from hospital where possible and appropriate [9].

### Mental health liaison services

Situated in general hospitals, for example in the emergency department or in-patient wards, these services aim to provide psychiatric assessment and treatment to patients who may be experiencing distress whilst in hospital. They provide a valuable interface between mental and physical health. There is evidence that medical patients have a high rate of psychiatric disorders but can respond positively to psychological or drug treatments. Psychiatric liaison teams are helpful in detecting these psychiatric disorders, such as depression or anxiety, and improving patient outcomes [9].

### Acute inpatient services

Providing treatment when a person's mental health condition cannot be managed in the community, and where the situation is so severe that specialist care is required in a safe and therapeutic space. Admissions should be purposeful, integrated with other services, open and transparent, and as local and short as possible [9].

The NHS Mental Health Implementation Plan[51] set out a target that "By 2023/24: The therapeutic offer from inpatient mental health services will be improved by increasing investment in interventions and activities, resulting in better patient outcomes and experience in hospital. This will contribute to a reduction in length of stay for all services to the current national average of 32 days (or fewer) in adult acute inpatient mental health settings".

In 2021-22, health areas serving Suffolk had higher percentages of adult and older adult acute admissions for patients who had contact with mental health services in the prior year than England (significance not calculated) (Table 2).

*Table 12: Admissions relating to mental ill health, CCG areas covering Suffolk, 2021-22[49]*

| Area | Admissions to NHS funded secondary mental health, learning disabilities and autism inpatient services (count) | People in contact with NHS funded secondary mental health, learning disabilities and autism services admitted as an inpatient (percentage) | Adult and older acute admissions (count) | Percentage of adult and older adult acute admissions for patients with contact in the prior year with mental health services, in the reporting period |
|---|---|---|---|---|
| **Ipswich and East Suffolk CCG** | 555 | 4% | 470 | 87% |
| **West Suffolk CCG** | 395 | 4% | 330 | 89% |
| **Norfolk and Waveney CCG** | 1,420 | 3% | 1,020 | 92% |
| **England** | **109,900** | **2.98%** | **67,359** | **85%** |

*Source: Mental Health Bulletin[49]*

Across England, people are routinely sent out of area for acute care due to a lack of bed capacity. Delays in the transfer of care are a major issue in mental health providers, with a lack of housing and capacity in community mental service as the main causes [9].

Although there are limitations with the data, Table 13 gives a snapshot of performance for quarter 3 in 2022-23, as well as the full (financial) year. The 24 month percentage change for Quarter 3 (2022-23) with each indicator was better (lower) for each area, except Ipswich and East Suffolk sub-ICB (no change in number of placements started, increase in the total number of inappropriate out of area bed stays).

*Table 13: Inappropriate out of area placements (rounded counts), 2022-23, sub-ICB areas covering Suffolk*[35,53]

| Area | Total number of inappropriate Out of Area bed days Q3 | Total number of inappropriate Out of Area bed days 2022-23 | Number of inappropriate Mental Health Out of Area Placements started in the period Q3 | Number of inappropriate Mental Health Out of Area Placements started in 2022-23 |
|---|---|---|---|---|
| **Ipswich and East Suffolk sub-ICB** | 130 | 620 | 5 | 10 |
| **West Suffolk sub-ICB** | 65 | 355 | 5 | 15 |
| **Norfolk and Waveney ICB** | 1,165 | 3,560 | 20 | 85 |
| **England (incomplete)** | **56,305** | **207,470** | **1,075** | **4,395** |

*Source: Mental Health Five Year Forward View Dashboard, Out of Area Placements in Mental Health Services*[35,53]

The NHS mental health implementation plan[51] set out the following crisis care and liaison goals. By 2023-24, there will be 100% coverage of 24/7 age-appropriate crisis care, via NHS 111, including:

- 24/7 Crisis Resolution Home Treatment (CRHT) functions for adults, operating in line with best practice by 2020-21 and maintaining coverage to 2023/24
- 24/7 provision for children and young people that combines crisis assessment, brief response and intensive home treatment functions
  A range of complementary and alternative crisis services to A&E and admission (including in VCSE/local authority-provided services) within all local mental health crisis pathways
- A programme for mental health and ambulances, including mental health transport vehicles, training for ambulance staff and the introduction of nurses and other mental health professionals in Integrated Urgent Care Clinical Assessment Services
- All general hospitals will have mental health liaison services, with 70% meeting the 'core 24' standard for adults and older adults.

## Evidence and further information (SMI)

The following documents and supporting materials are useful sources of further information on this topic:

- Care Quality Commission: Right Here Right Now: review of the quality, safety and effectiveness of care provided to those experiencing a mental health crisis.
- Centre for Mental Health: IPS Resources: collection of materials brought together from the IPS Centres of Excellence to help services develop IPS supported employment or vocational services.
- Commission on Acute Adult Psychiatric Care: Old Problems, New Solutions (2016): describes the problems with finding care beds or receiving good home treatment and points to the

improvements that can be made. It gives examples where people are being well cared for in good services.

- JCPMH: Rehabilitation services for people with complex mental health needs: the commissioning of good quality mental health interventions and services for people with complex and longer-term illness to support them in their recovery.
- NICE/NHS England: Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance: guidance on establishing, developing, and maintaining urgent and emergency liaison mental health services for adults and older adults in emergency departments (EDs) and general hospital wards. The appendices provide examples of successful implementation and useful resources to share learning.
- NICE/NHS England: Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance: provides support to local commissioners and providers in implementing the standard. An information pack accompanies this publication to provide commissioners and providers with helpful resources to support implementation.
- NICE: Transition between inpatient mental health settings and community or care home settings: covers the period before, during and after a person is admitted to, and discharged from, a mental health hospital.

## Reducing premature mortality (SMI)

### Suicide and self-harm

In 2019-21, 208 suicides were recorded in Suffolk. The rate, 10.4 per 100,000, is statistically similar to England (10.4 per 100,000) [12]. The suicide rate is statistically significantly higher for men (15.1 per 100,000) than women (6.0 per 100,000).

NHS 111 will be the point of access for people experiencing mental health crisis, and alternative forms of support for those in crisis will be increased (including non-medical alternatives to A&E and alternatives to inpatient admission. Families and staff who are bereaved by suicide will also have access to support. [34]

People under the care of mental health services have been identified as a high risk group for suicide and self-harm [9]. For a more detailed overview of what can be done for people who present with significant risk or safety issues, please see suicide and self-harm in **Mental health: population factors**, and the suicide audit.

### Severe mental illness and poor physical health

On average, people with SMI die 15-20 years earlier than the general population and have almost five times higher death rate for ages under 75 than the general population. Two thirds of people with serious mental health illness will die prematurely from preventable illnesses. Cancer, cardiovascular disease, liver disease and respiratory disease accounted for around 60% of all deaths of adults with SMI before the COVID-19 pandemic [54].

SMI can create “a toxic interaction between poor mental health, consequential unhealthy lifestyles, obesogenic and diabetogenic antipsychotic treatments, and social disadvantage” in early adulthood, putting people with SMI on a path towards poor future health at a much earlier age than the general population [54]. Key factors contributing to worse health outcomes for people with SMI include:[54]

- high rates of smoking, poor nutrition, and limited physical exercise (see **Mental health: population factors**)
- lack of support to use available health information and advice or to take up tests and interventions that reduce the risk of preventable health conditions
- negative effect on physical health of medication such as antipsychotics
- lack of robust commissioned pathways across primary and secondary care
- gaps in training among primary care clinicians
- lack of confidence across the workforce to deliver physical health checks to people with SMI
- lack of integration between primary care, specialist physical health and community mental health services

The NHS Mental Health implementation Plan[51] has set a national target to increase the number of people with SMI receiving physical health checks (alcohol, blood glucose, blood lipid, blood pressure, BMI weight, smoking) to 390,000 in England in 2023/24. At the end of 2022-23, the number of people with SMI who received the full checks were:[55]

- 313,022 England
- 33,129 East of England
- 5,233 Norfolk and Waveney sub-ICB
- 1,911 Ipswich and East Suffolk sub-ICB
- 875 West Suffolk sub-ICB

An analysis of the counts suggests that West Suffolk (66.9%) and Ipswich and East Suffolk (75.1%) completed a statistically significantly higher percentage of checks than England (58.5%), while the percentage completed in Norfolk and Waveney was statistically significantly lower (55.2%).

### Evidence and further information (SMI)

The following documents and supporting materials are useful sources of further information on this topic:

Academy of Medical Royal Colleges: Improving the physical health of adults with severe mental illness: essential actions: recommends practical ways to improve physical healthcare services for people with psychoses and those on antipsychotic medications.

Department of Health: Improving the physical health of people with mental health problems: Actions for mental health nurses: draws on the available evidence to improve the monitoring of and reduction of the risk factors that have a detrimental effect on people's physical health and ultimately reduce health inequalities.

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