Draft Shropshire Mental Health Needs Assessment

February 2018

Contents

Executive Summary

The Shropshire Mental Health Needs Assessment seeks to identify and describe the patterns of mental health problems for adults within Shropshire, identify inequalities in mental health (including access to services) and to determine the priorities for the most effective use of resources to inform whether the content and configuration of existing services is appropriate for our population.

Ensuring our population has good mental and emotional health is important as it impacts on all aspects of people's lives, including links with good physical health, social participation, ability to cope with the normal stresses of life, developing personal relationships, education, training and ability to fulfil potential in employment opportunities.

Managing a positive state of mental wellbeing is associated with a range of positive social outcomes such as educational success, wealth, employment, self-awareness and acceptance of others. There is however, no evidence that these social outcomes alone can improve mental wellbeing. Conversely, there is evidence that negative social factors such as educational failure, poverty, unemployment and fear of others can be both a cause and an outcome of a mental health problem.

Programmes to promote good emotion health and address mental ill health can be targeted throughout the course of life, from pregnancy and maternity (supporting conditions such as antenatal/postnatal depression), childhood and teenage years (where the majority of mental health problems are first identified) through to adulthood (which otherwise could impact on a person's social circumstances) and older age.

The findings of this Health Needs Assessment suggest that in general, the population mental health of people within Shropshire is better that the averages reported in the West Midlands and England. There are however, still many people across our communities where inequality creates different abilities to access appropriate support and engage within their community as a result of their social, physical and economic environment, which can make them more susceptible to mental health problems.

The following recommendations have been produced based on a combination of epidemiological analysis of mental health quantitative service data and from qualitative feedback from the experiences of service users and service providers.

Recommendations

1. **Develop and implement a Mental Health Strategy**: Using the findings of this Health Needs Assessment and ensuring clear links with supporting existing strategies including for dementia, suicide prevention, children and young people and carers.

2. **Better identification and recording of mental ill health**: Data collection across services on issues, characteristics and demographics of clients (particularly with emerging ethnic or migrant populations)

3. **Data sharing between organisations to improve client experience**: Essential information for analysis of risks, understanding needs, service review and promoting equity for clients across different services and for better targeting of care and prevention programmes

4. **Timely access to mental health services based on need**: Feedback from service users indicators identified access to services can be slow and complicated

5. **Raised awareness of and access to support networks that signpost services**: Improved communication to communities and between health & social care services of the range of mental health services and support organisations and how to access them (which may also include links with primary care via Social Prescribing Advisors & Community Care Co-Ordinators)

6. **Frequent service user consultation**: Providers to seek feedback from clients who contact or use mental health service and support networks to review, learn & better respond to changes in community mental health needs

7. **Consistent professional training of frontline staff**: For those working across health, social care, the voluntary sector and other services that are most likely to work with people with mental health needs to promote mental wellbeing to the public and among themselves. This would include upskilling of volunteers & support for carers to empower them to have conversations to support mental health & wellbeing.

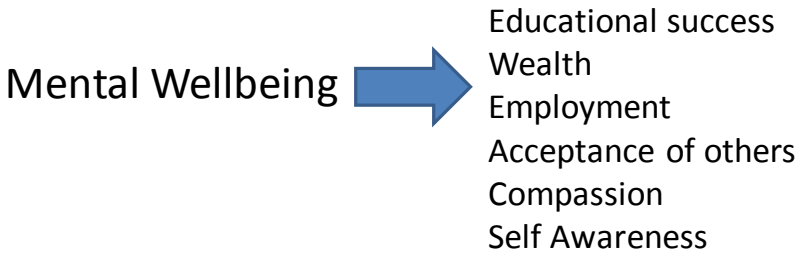
Preface: What is Mental Health?

The term mental health is used to describe a spectrum from mental health problems, conditions, illnesses and disorders through to mental wellbeing or positive mental health[1].

Mental or emotional wellbeing is used to define positive mental health and although is currently not diagnosable, includes the key components of;

- *Feeling good*: a subjective measure such as happiness and life satisfaction and;
- *Functioning well*: including a wide range of psychological wellbeing factors such as self-acceptance, personal growth, positive relations with others, autonomy, purpose in life and ability to ascertain control over one's environment

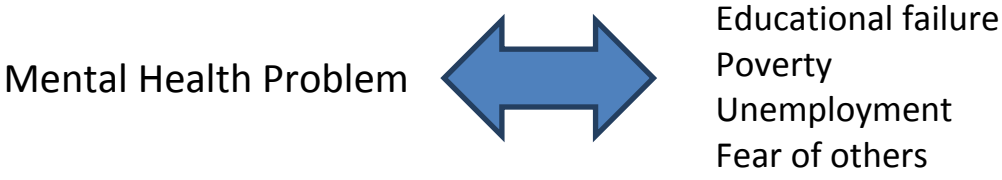
Managing a state of mental wellbeing is associated with a number of positive social outcomes as summarised in the diagram below. It is noted however, there is no evidence to suggest these positive social outcomes have a reciprocal impact on developing mental wellbeing.



Conversely the term mental health problem is used to define poor mental health and negative mental health states which includes the components of;

- *Mental disorder*: an identified mental health problem which can either meet the criteria for psychiatric diagnosis or is recognised but falls short of the diagnostic criteria threshold
- *Common mental health problems*: such as anxiety and depression
- *Severe mental health problems*: which include schizophrenia, bipolar disorder and various behavioural disorders

Having a mental health problem can lead to a number of negative social outcomes. There is evidence that these negative social or environmental factors can also lead to mental health problems, as summarised in the diagram below.



[1] Faculty of Public Health (2016). Better mental health for all: a public health approach to mental health improvement. Available at: http://www.fph.org.uk/better_mental_health_for_all

Introduction

Ensuring our population has good mental and emotional health is important as it impacts on all aspects of people's lives, including links with good physical health, social participation, ability to cope with the normal stresses of life, developing personal relationships, education, training and ability to fulfil potential in employment opportunities. It is also a key component in nurturing resilient communities and can therefore be seen as the responsibility of individuals, families, friends, employers and the wider community to enable people to develop and maintain good mental health.

Mental Health care practice has been in a state of change for the past 30 years. It has moved from a system of long term care and hospitalisation to one predominantly of integration and community care. Care is provided by multidisciplinary teams in people's homes and in the community with access to specialist hospitals for acute admissions and residential units for longer term care. Attitudes, diagnoses, treatment and care have all changed and improved.

Despite this, the majority of mental ill health problems still go unrecognised and untreated (McManus et al, 2009[2]). People with mental health problems are more likely to experience physical health problems, smoke, be overweight, use drugs and drink alcohol to excess, have a disrupted education, be unemployed, take time off work, fall into poverty and be over-represented in the criminal justice system. Mental health is the cause of 40% of new disability benefit claims each year in the UK[3] and 70% of people with severe mental health problems are economically inactive and on disability benefit (compared to 30% of the general population).

A recent study commissioned by the West Midlands Combined Authority[4] (2017) identified that poor mental health has a financial cost in the West Midlands of over £12billion per year (equivalent to £3,000 per person living in the region) comprised of cost of health and social care, employment costs (through loss of output in the local economy, sickness absence and unemployment) and estimated adverse human costs from reduced wellbeing and quality of life. This has significant implications for the Shropshire economy given that at least one if four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time (equating to one in five women and one in eight men)[5].

There is much evidence of inequality for the development of mental health problems, particular between people from different socio-economic groups, genders, ages and ethnicities. Although in recent times there has been greater awareness to address these inequalities across society, it is recognised that there are still many groups who have different abilities to access support and to engage within their community as a result of their social, physical and economic environment. This can make some people more susceptible to mental health problems.

[2] McManus, S., Meltzer, H., Brugha, T., Bebbington, P. and Jenkins, R. (eds.) (2009) Adult psychiatric morbidity in England, 2007. Leeds: NHS Information Centre for health and social care.

[3] Singh, S. (February 2014). Mental Health and Work: United Kingdom Paris: Organisation for Economic Co-operation and Development. Available at: http://www.oecd.org/els/mental-health-and-work-united-kingdom-9789264204997-en.htm

[4] Mental Health in the West Midlands Combined Authority. A report for the West Midlands Health Commission. January 2017. K. Newbigging and M. Parsonage. Available at: http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/news-events/2017/mental-health-in-the-west-midlands-combined-authority.pdf

[5] Adult Psychiatric Morbidity Survey 2014. Available at: http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf

Mental Health during the course of Life

Starting Well

- Mental health problems often begin early in life with over half of these problems being established by age 14 and 75% by age 24 years[6]. Therefore, there is a crucial role that family relationships can play during formative years to mould the infant's brain in a way which affects health throughout their life.
- Perinatal mental health illness during pregnancy and during the first year after birth affects up to 20% of women and covers a wide range of conditions (including antenatal depression, anxiety, perinatal obsessive compulsive disorder, postpartum psychosis and post-traumatic stress disorder). If left untreated it can have a significant and long lasting effects on the women and her family.

Living Well

- During adulthood, mental health problems can impact upon an individual's ability to maintain employment, housing and secure family relationships.

Ageing Well

- Depression in older people affects up to 25% of the population and up to 40% of people in Care Homes.
- Dementia affects 1 in 5 of people over the age of 80 years, which is of even greater risk in an ageing population.

Risk Factors for Children and Young People

The risk factors for poorer mental health outcomes for children and young people include having a learning disability, being a looked after child, being homeless or sleeping rough, parental unemployment and lone parenthood[7]. An additional predictor of adult mental (and physical) health relates to adverse childhood experiences, which includes abusive or neglectful parenting, drug or alcohol misuse, parental mental illness, divorce, bereavement and bullying[8].

Within Shropshire, there is an estimated 4,000 children and young people with a mental health problem with the most common being conduct disorders, emotional disorders and hyperkinetic (ADHD) disorders.

A large proportion of children and young people with mental health needs are usually seen in universal services provided by practitioners who are not mental health specialists (such as GPs, health visitors or school nurses). For specialist support, Shropshire children can be referred to CAMHS (Child and Adolescent Mental Health Services) or to the range of services provided by the recently commissioned 0 to 25 year Emotional Health and Wellbeing Service (see Section 9 for further details).

---

[6] Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62 (6) pp. 593-602. doi:10.1001/archpsyc.62.6.593.

[7] H. Green, A. McGinnity, H. Meltzer, T. Ford and R. Goodman, "Mental Health of Children and Young People in Great Britain 2004," Office for National Statistics, London, 2005.

[8] Bell, M.A., Ashton, K., Hughe.s, K., Ford, K., Bishop, J. and Paranjothy. (2015). Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population. Wales: Public Health Wales.

Risk Factors for Adults

There are a wide range of risk factors in adulthood of mental ill health, which can include individual, social and cultural factors. These are presented in the table below.

Table a1: Additional risk factors associated with mental ill health

Individual factors	▪ Grief and bereavement ▪ Loneliness and isolation ▪ Anxiety and stress ▪ Relationship difficulties ▪ Carer responsibilities ▪ Alcohol and substance misuse
Social factors	▪ Low socio-economic status ▪ Lack of support networks ▪ Homelessness ▪ Stigma and discrimination
Community and cultural factors	▪ Language barriers ▪ Refugee status

Evidence has also identified that people with long term chronic conditions (such as cardiovascular disease and diabetes) are two to three times more likely than the general population to experience mental health problems such as depression or anxiety[9]. In addition, women are more likely than men to be treated for mental health problems (29% vs 17%)[10].

When considering specific types of mental disorder, the following risk factors were identified from the most recent Adult Psychiatric Morbidity Survey (2014).

Table a2: Risk factors identified from responses to the Adult Psychiatric Morbidity Survey (2014) by type of mental disorder

Common Mental Health Disorder	▪ Aged between 16 to 24 years and between 45 to 54 years (females) ▪ Living alone and aged under 60 years ▪ Separated of divorced ▪ Economically inactive (receipt of employment and support allowance), unemployed or financial difficulties ▪ Smoker ▪ Female gender ▪ Comorbidity with chronic physical conditions
Probable Psychotic Disorder	▪ Economically inactive (receipt of employment and support allowance) or Unemployed ▪ Aged between 35 and 44 years ▪ Black ethnicity and male ▪ Living alone *Risk factors identified in previous APMS surveys (2000/2007)* ▪ Low educational attainment ▪ Living in rental accommodation ▪ Living in an urban area ▪ Living as a single person family unit or lone parent ▪ Separated or divorced

[9] C. Naylor, M. Parsonage, D. McDaid, M. Knapp, M. Fossey and A. Galea, "Long-term conditions and mental health: The cost of co-morbidities," The Kings Fund, London, 2012.

[10] Office for National Statistics, "Better Or Worse: A Follow-Up Study Of The Mental Health Of Adults In Great Britain," The Stationary Office, London, 2003.

National Policy Context

In 2011, the Government released its mental health strategy No Health without Mental Health[11], a cross-government all age mental health outcomes strategy. The strategy set out clear, shared objectives for mental health including improvement in the outcomes, physical health and experience of care of people with mental health problems, and a reduction in avoidable harm and stigma. In January 2014, the Government launched Closing the Gap: Priorities for Essential Change in Mental Health[12], which identified 25 aspects of mental health provision where the Government, health and social care commissioners and providers and other organisations can work together to improve outcomes for people living with mental ill health.

Commissioners for mental health services have been working towards Payment by Results since 2011 (where providers of treatment are paid for each patient seen or treated, taking into account the complexity of care needs). The currency in which it will achieve this is through Clusters. A cluster is a global description of a group of people with similar characteristics as identified from a holistic assessment and rated using the mental health clustering tool (MHCT). Within the clustering tool there is a decision tree which shows there are three main trunks of clusters, Non-psychotic, psychotic and organic, from which the cluster sit underneath.

Whilst Mental Health may be ahead of game in respect of moving away from acute and long term based care and improvements have been made in mental health provision and follow-up, inequalities persist in access to good quality services. In addition there has not been the same level of infrastructure to develop data collection and payment by results as physical health care. Although government policy prioritises parity of esteem between physical and mental health, there is a general lack of progress and on some levels a misunderstanding of what will work towards achieving parity of esteem. Physical health targets have been applied to mental health which on paper would support parity of esteem but on the contrary perpetuate the lack of parity.

For example, crisis care has a four hour target to match the A&E 4 hour wait target; this grossly misses the prioritisation process that occurs in an A&E department, so if a person requires immediate attention and resuscitation they don't have to wait 4 hours, they are treated immediately. The question this raises is whether a mental health crisis can ever be considered life threatening? To which the answer is yes, but is a 4 hour response acceptable?

There is no equivalent prioritisation for urgent care in mental health. Another misunderstanding leading to maintaining a lack of parity is the IAPT (Improving Access to Psychological Therapies) target of 6 and 18 weeks to treatment, the latter of which is a secondary care waiting time target although IAPT is a primary care service. It also important that a broader supporting focus is able to support mental health need to take into consideration the links with individual, social, community and economic factors which may not always be associated with physical health issues.

In March 2015, NHS England established an Independent Mental Health Taskforce to develop a five year strategy for mental health (*The Five Year Forward View for Mental Health*[13]) which was published in February 2016. The strategy includes 57 recommendations which require cross government action and multi sector collaboration with themes of;

- Commissioning for prevention and quality

[11] Department of Health, "No health without mental health: a cross-government mental health outcomes strategy for people of all ages," Stationary Office, London, 2011.
[12] Department of Health, "Closing the Gap: Priorities for essential change in mental health," Stationary Office, London, 2014.
[13] The Five Year Forward View for Mental Health. NHS England (Feb 2016). Available at: www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

- Good quality care for all, seven days a week
- Innovation and research to drive change
- Strengthening the workforce
- Transparency and data revolution
- Incentives, levers and payments
- Fair regulation and inspection

The Five Year Forward View for Mental Health also sets a target to reduce suicides by 10% nationally by 2020, with every local area to have a multi-agency suicide prevention plan in place. Shropshire established a Suicide Prevention Partnership Network of stakeholders who work, support or are interested in supporting the reduction and prevention of self-harm and suicide across the Local Authority areas of Shropshire and Telford & Wrekin. During 2016/17, the Network produced a Joint Suicide Prevention Strategy which referenced local data and guidance from the Department of Health's national suicide prevention strategy *Preventing Suicide in England*[14]. In addition, guidance from the Local Government Association[15] suggested a number of questions we should be asking to help inform the development of a local Action Plan

It is recognised that these policy developments must be set within a wide context of changes across public services, the impact of austerity measures on Local Authority budgets and alterations to eligibility criteria which are likely to impact on access to services and the range of support available.

Purpose of the Shropshire Adult Mental Health Needs Assessment

The purpose of this health needs assessment is to describe the patterns of mental health problems for adults within Shropshire, identify inequalities in mental health (including access to services) and to determine the priorities for the most effective use of resources to inform whether the content and configuration of existing services is appropriate for our population.

It is intended that the findings from the health needs assessment will serve as the building blocks in assisting the Shropshire Mental Health Partnership Board to produce a Shropshire Mental Health Strategy.

Adult mental health has been selected as the primary focus for the needs assessment as there has already been a great deal of work locally to establish the mental health needs of children and young people, undertaken for the commissioning of a 0 to 25 Emotional Health and Wellbeing service which was established in 2017. It is however, recognised that there may be some overlap in service provision for those accessing mental health services and are aged between 18 and 25 years.

Methodology

A combination of literature reviews, desk based research, epidemiology, service user and provider perspectives have been used to collate evidence for this assessment. It is produced under guidance from a dedicated steering group comprised of representatives from Shropshire Public Health, Shropshire CCG, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, the charity and voluntary sector and the Commissioning Support Unit. Progress has been reported to and overseen by the Shropshire Mental Health Partnership Board.

The scoping criteria to be assessed within the needs assessment are outlined as follows;

Inclusion:

[14] Preventing suicide in England. A cross government outcomes strategy to save lives (2012). Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf
[15] Suicide prevention: a guide for local authorities. (2016). Available at: www.local.gov.uk/sites/default/files/documents/1.37_Suicide%20prevention%20WEB.pdf

- Analysis of the epidemiology of adult mental health problems in Shropshire
- Use of local and national qualitative information related to diagnosis and access to mental health services
- Use of quantitative information from adult service users who currently access or who have accessed mental health services in Shropshire
- Consideration of co-morbidity of mental and physical health issues
- Mental health illness due to psychoactive substance misuse

Exclusion:

- Children and young people aged under 18 years
- People with learning disabilities
- Adults where the primary diagnosis is related to autism and conditions such as ADHD
- Alzheimer's and dementia as a dementia strategy was developed in 2017[16]
- Carers as an All Age Carers Strategy for Shropshire was developed in 2017[17]

It is recommended that any outcomes as a result of this Needs Assessment make reference to the work area Strategies mentioned above to ensure appropriate links and consistency between pathways (including links to community sector provision, other public sector organisations and wider economic considerations).

It is acknowledged there is a cross over in age ranges, for example the Early Interventions in Psychosis team work with children from aged 14, in addition there has been a separate piece of work regarding commissioning an Emotional and Wellbeing service for 0-25 year olds. To avoid duplication, this document will focus on adult mental health and make reference where appropriate to the findings and evidence already collated on mental health services with children and young people services rather than attempt to 'reinvent the wheel'.

Service user and provider perspectives

Service user and provider insight for adult mental health services was undertaken between June and August 2017 in partnership with Shropshire Council's Business Design Team. The approach taken involved the use of qualitative, contextual, semi-structured/unstructured one-to-one interviews and a separate topic guide for users of mental health services and for providers of these services.

A request was sent out via the Shropshire Mental Health Forum for any providers that would be interested in taking part in the project, both to be interviewed and to assist in recruiting service users. Nine providers were recruited who subsequently identified 19 service users.

Interviews with service users were conducted at the organisation/group they were attending. All were fully informed about the project and all were required to sign a Consent Form for their story to be included in this research. Assurances were given that their contributions would remain anonymous. Conversations lasted approximately 45-60 minutes. All information was then synthesised thematically in order to analyse. Full details of the final report *An Insight into Mental Health Needs in Shropshire for Shropshire Council's Mental Health Needs Assessment* can be seen in Appendix 1 of this Needs Assessment.

[16] Shropshire CCG and Shropshire Council: Dementia Strategy 2017 - 2020

[17] Shropshire Together All Age Carers Strategy for Shropshire 2017 - 2021. Available at: https://shropshire.gov.uk/committee-services/documents/s14383/7%20Appendix%20A%20All%20ages%20Carers%20strategy%20final%20version%202017-21.pdf

Section 1: Shropshire Profile Demographics

This section provides a summary of the populations and people within Shropshire, including the community and environmental factors which influence mental health outcomes.

Population

Shropshire is a large county in the West Midlands, with a population of around 313,400 people (ONS, 2016[18]). It consists of mainly white British ethnicity. The population pyramids in Figures 1.1 and 1.2 highlight the fact that the county has an aging population, with a large proportion of the population being aged between 40 and 69 years. More than 40% people are aged over 50 years and like many rural areas, Shropshire is expecting to experience an increase in the proportion of population of people who are aged 65 and over. Based on mid-year estimates from 2013, slightly more than a fifth of the county's population is under the age of 19 years.

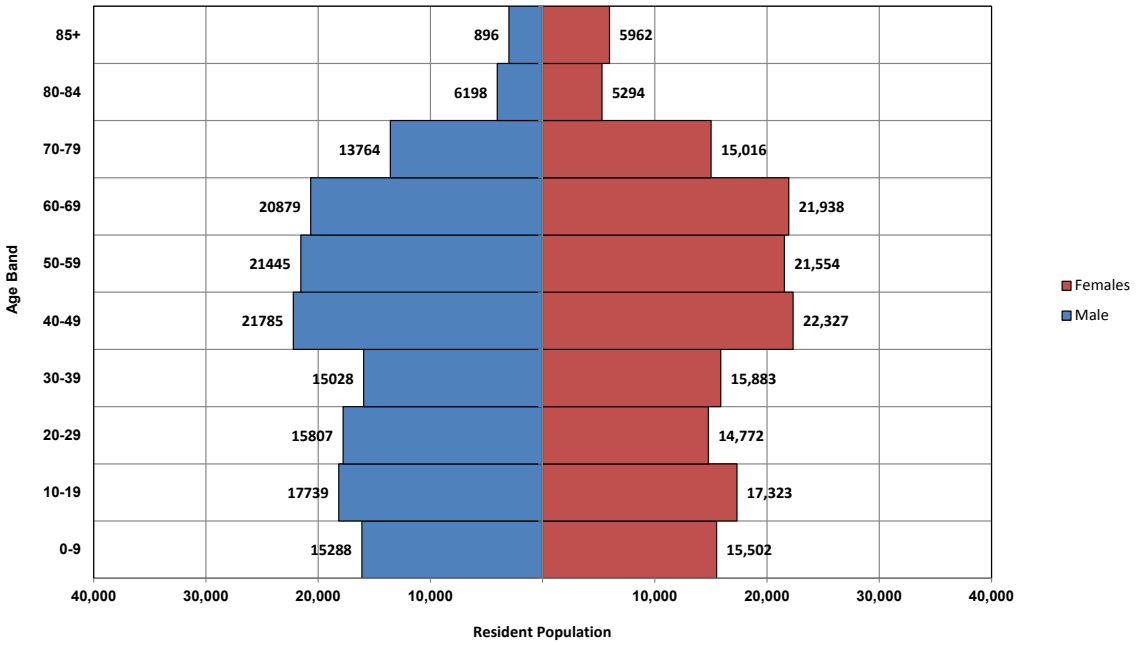
Overall the county is fairly affluent – however there are areas of deprivation and factors of rural sparsity which create issues with access to services. Shropshire supports a low wage economy with reliance on jobs in low paid sectors such as agriculture, tourism, and food and drink. More than 80% of jobs are in the private sector.

Shropshire's geography is an important consideration - it covers a large area of 1,235 square miles, of which only approximately 6% comprises suburban and rural development and continuous urban land. The geography of Shropshire is diverse. The southern and western parts of the county are generally more remote and self-contained.

The landscape provides the backdrop for the market towns as key focal points for communities, businesses, leisure and tourism. Shropshire is entirely inland and its borders also have importance for the people living at the edges of the county – as people may have historic, family or work connections with the bordering areas of Mid Wales, Cheshire, Staffordshire, Telford and Wrekin and onto the West Midlands, Worcestershire and Herefordshire. Shropshire's rural geography and many borders with neighbouring authorities have been highlighted in previous stakeholder consultations as key challenges for accessing services and treatment.

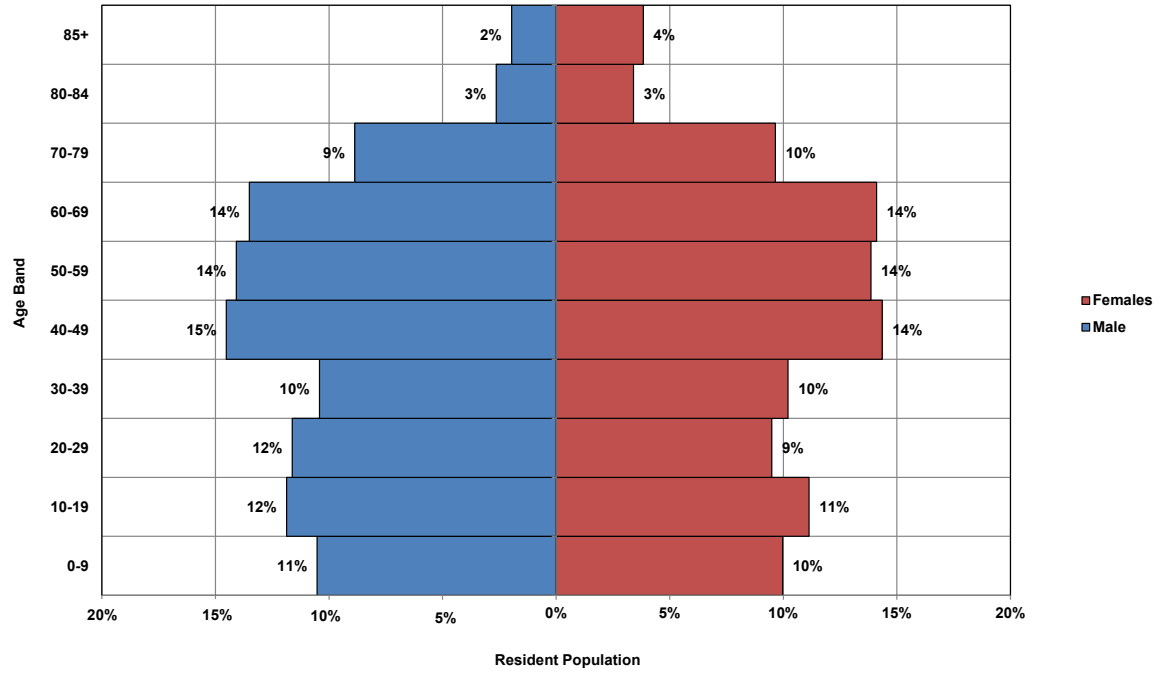
[18] Labour Market Profile – Shropshire. NOMIS Official labour market statistics 2016. Available at: https://www.nomisweb.co.uk/reports/lmp/la/1946157170/report.aspx?town=shropshire#tabrespop

Figure 1.1. Population pyramid showing estimated population of males and females in Shropshire by age group



Source: Revised Mid-Year Population Estimates, ONS, 2013

Figure 1.2. Population pyramid showing proportion of population of males and females in Shropshire by age group



Source: Revised Mid-Year Population Estimates, ONS, 2013

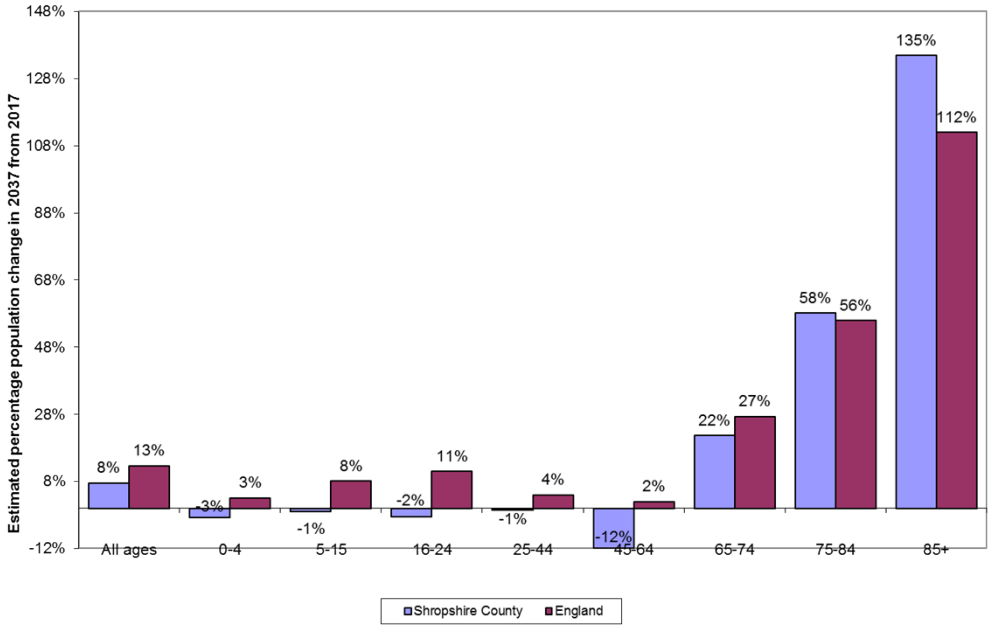
Population Projections (2017 to 2037)

Long-term subnational population projections are an indication of the future trends in population by age and sex over the next 25 years. They are trend-based projections, which mean assumptions for future levels of births, deaths and migration are based on observed levels mainly over the previous five years. They show what the population will be if recent trends continue.

Figure 1.3 shows the projected populations for Shropshire County and England in 2037 compared to populations in 2017. It demonstrates a considerable increase in projected populations for people aged 65 years and above for both Shropshire and England. It can be seen however, that Shropshire is projected to have surpassed growth of those aged 75 years and above compared to England, including 135% additional residents aged over 85 years in 2037 compared to 2017. This has significant implications on the future planning of care and preventative measures related to older age (such as increased risk of frailty and cognitive decline).

In contrast, the projections indicate a decrease in the Shropshire population aged under 64 years with lower growth compared to England.

Figure 1.3: Projected Shropshire County populations by age 2017-2037



Source: Population Projections Unit, ONS. Crown copyright 2014.

Ethnicity

Shropshire has a small ethnic minority population compared to the national average, with a relatively even distribution residing between urban and rural areas.

Table 1.1 identifies that white British residents represent 95.4% of the Shropshire population. It is noted that "other Western European" and "other Eastern European" make up a third of the "Other" ethnicity category.

Table 1.1: Ethnicity profile in Shropshire

	White British	White Other	Mixed/Multiple Ethnic Group	Asian/Asian British	Black/African/ Caribbean/ Black British	Other
Number	292,119	3,892	2,595	1,183	735	5,605
%	95.4%	1.3%	0.8%	0.4%	0.2%	1.8%

Source: NOMIS official labour market statistics - CT0010 - Ethnic group (write-in responses). ONS 2011 Census

Economy and Employment

Shropshire has a high economic activity rate amongst the 16-64 population, and given comparatively low levels of unemployment as well, employment levels are high for this age group. However, given the high proportion of the population past retirement age, the economic activity rate of those aged 16 years and over population is much closer to the national rate.

Between July 2016 and June 2017, 80.5% of working age people in Shropshire were economically active (n= 155,900 people) in employment or self-employed. This is higher than the West Midlands average of 76% and for Great Britain at 78%[19]. There were a greater proportion of economically active males during this time period in Shropshire (85%) compared to females (76%).

The Shropshire labour force is comparatively well qualified, at least compared to the West Midlands, but supports fewer professionals, whilst more work in elementary occupations or as process, plant and machine operatives. Shropshire also supports an above average number of people working in skilled trades occupations.

Shropshire supports a primarily small-business economy, with more than nine out of ten enterprises employing fewer than ten people. Self-employment is high, and significant numbers work from home/run businesses from home. There are comparatively few large employers, and employment is largely concentrated in the county town of Shrewsbury, and the main market towns of Oswestry, Market Drayton, Whitchurch, Bridgnorth and Ludlow.

Key sectors include health, education, retail and manufacturing. Shropshire is under-represented in private sector services such as professional, scientific and technical, and finance and insurance. The mix of sectors in Shropshire contributes to comparatively low workplace wages and to low levels of productivity (GVA generation).

Despite comparatively low workplace wages, resident wages are closer to the national average, with many high earners commuting out of the county for work. Generally, Shropshire is an affluent location, with low levels of deprivation and minimal unemployment. However, like other places, there are pockets of deprivation in Shropshire, where unemployment is higher and incomes lower.

Deprivation

The Index of Multiple Deprivation 2015 (IMD 2015) is a nationally recognised measure of deprivation at the small area level. The IMD 2015 combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. This allows each area to be ranked relative to one another according to their level of deprivation. It is an important tool for identifying the most disadvantaged areas in England and can be used locally to help prioritise services and resources to help tackle health inequalities and social exclusion.

The IMD 2015 is based on small geographic areas known as Lower Super Output Areas (LSOAs). The Office for National Statistics defines a LSOA as a small geographic area containing between 1000 and 3000 people and between 400 to 1200 households. There are 32,844 LSOAs in England.

The IMD 2015 combines all seven broad domains:

- Income deprivation
- Employment deprivation
- Health deprivation and disability
- Education, skills and training deprivation
- Barriers to housing and services

[19] Labour Market Profile. NOMIS (2018). Available at: https://www.nomisweb.co.uk/reports/lmp/la/1946157170/report.aspx?town=shropshire#tabrespop

- Living environment deprivation
- Crime

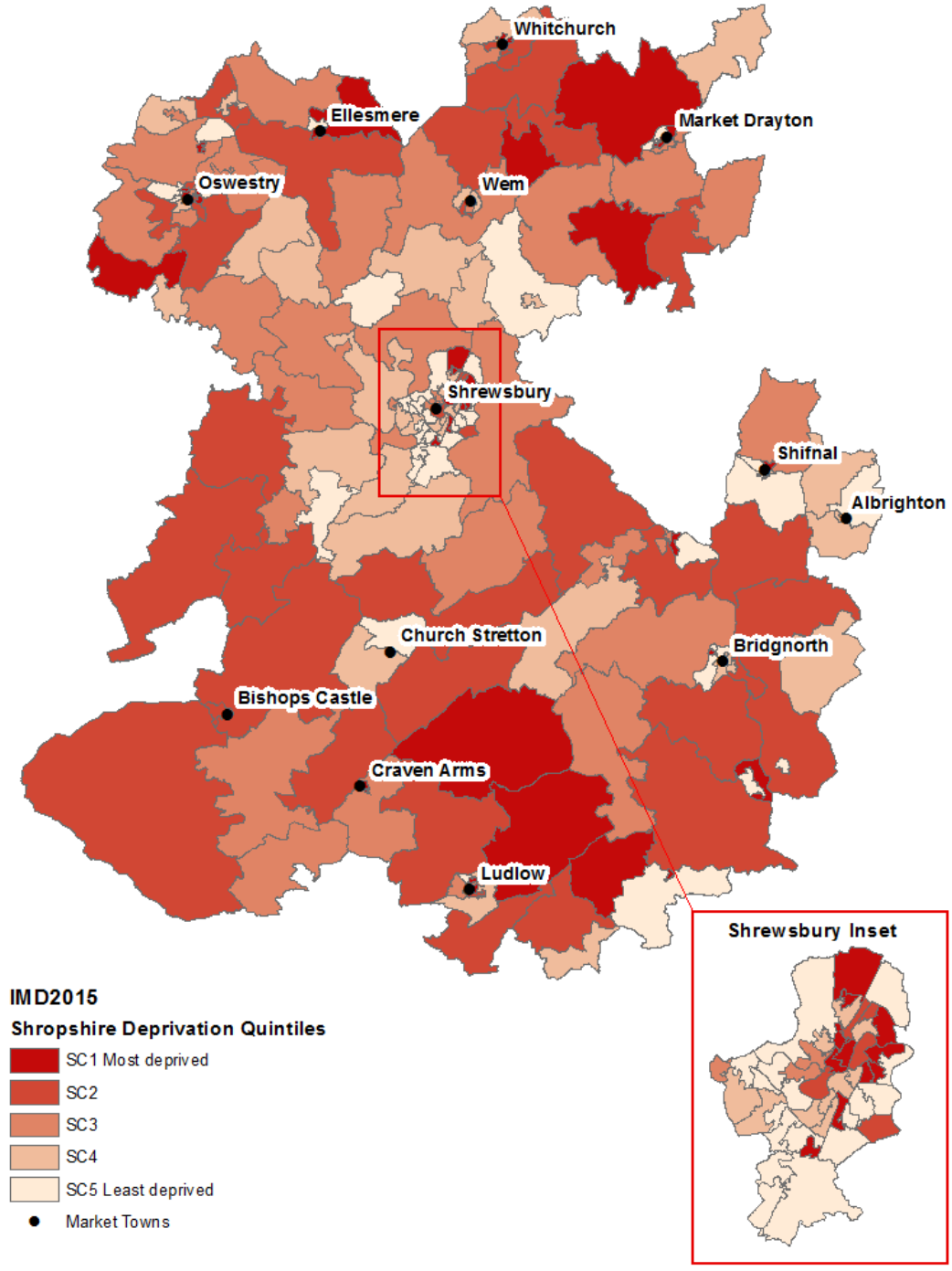
Overall, Shropshire is a relatively affluent area and is ranked the 107th most deprived county out of 152 upper-tier local authorities in England.

There are 193 LSOAs in Shropshire which are based on the boundaries from the most recent 2011 Census. There are nine LSOAs in Shropshire which fall within the 20% most deprived in England and these are located with urban areas of the county. The five most deprived areas are located within the electoral divisions of Harlescott (Shrewsbury), Monkmoor (Shrewsbury), Ludlow East (Ludlow), Oswestry South (Oswestry) and Meole/Bayston Hill, Column and Sutton (the LSOA crosses two electoral divisions in the wider Shrewsbury area).

To get a more accurate picture of local deprivation, Shropshire has been split into five quintiles. This has been done by ranking the IMD score for all LSOAs in Shropshire from one (most deprived) to 193 (least deprived) and then equally dividing the number of LSOAs to provide five categories.

Figure 1.4 shows deprivation as distributed in local quintiles in Shropshire. The LSOAs displayed in the darkest shade are the areas with the highest deprivation rank and those displayed in the lightest shade are the least deprived. The most deprived areas are generally situated around the major settlements in Shropshire, including Shrewsbury and Market Drayton.

Figure 1.4. Index of Multiple Deprivation 2015 in Shropshire County: Local Quintiles



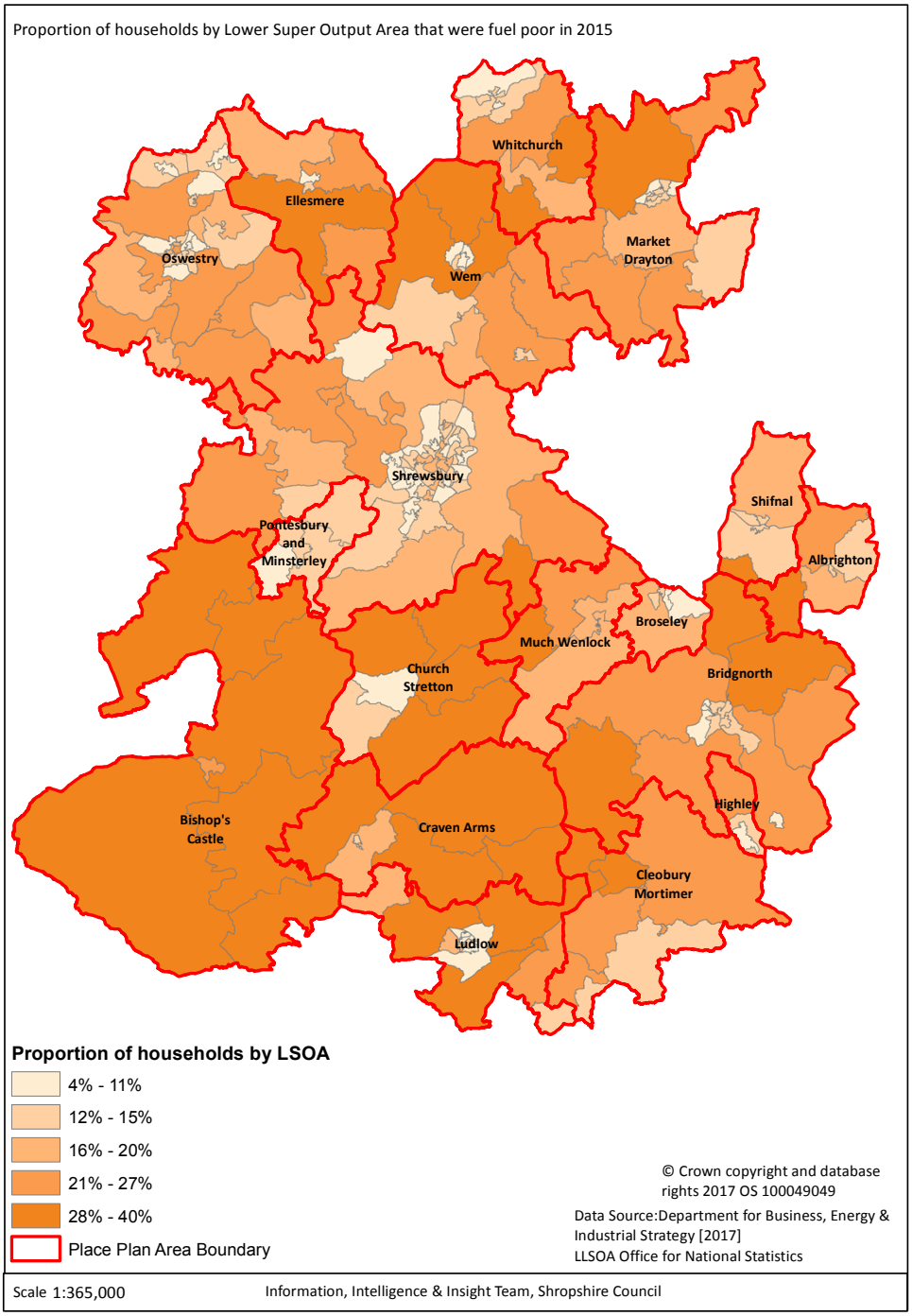
Source: IMD 2015, Community & Local Government and SOA Boundaries, Office of National Statistics 2011

Another factor associated with deprivation is that of fuel poverty where a household is defined as unable to afford to keep the home adequately heated due to;

- required fuel costs above the national average and;
- if they to spend that amount, the household would be left with a residual income below the poverty line

The following geographic place plan map identifies that the areas with the greatest proportion of reported fuel poverty in 2015 were Bishops Castle, Ellesmere, Whitchurch, Craven Arms and Church Stretton.

Figure 1.5. Proportion of households in fuel poverty (2015) in Shropshire County



Office for National Statistics: Measuring Wellbeing and Life Satisfaction

The ONS statistical bulletin Personal well-being in the UK: July 2016 to June 2017[20] provides estimates of personal wellbeing in the UK, based on findings from the April 2012 to March 2015, Annual Population Survey Personal Wellbeing 3-year National Statistics dataset.

ONS uses four survey questions to measure personal well-being. People are asked to respond to the questions on a scale from 0 to 10 where 0 is 'not at all' and 10 is 'completely'. The four questions are:

1. "Overall, how satisfied are you with your life nowadays?"
2. "Overall, to what extent do you feel the things you do in your life are worthwhile?"
3. "Overall, how happy did you feel yesterday?"
4. "Overall, how anxious did you feel yesterday?"

ONS first added these questions to the Annual Population Survey (APS), in April 2011 and more recently within a range of other population surveys[21].

Table 1.2 identifies that although people in the West Midlands felt less satisfied with their lives in England overall, Shropshire people reported greater life satisfaction than both regional and national averages.

Table 1.2: Results of question "How satisfied are you with your life nowadays?" April 2012 to March 2015

	Per cent in each category on 11 point scale:		
	Lower Satisfaction	Higher Satisfaction	Average (mean) rating
Area names	Scale: 0-6	Scale: 7-10	
England	21.53	78.48	7.52
West Midlands	22.37	77.63	7.48
Shropshire	19.65	80.35	7.67

Source: April 2012 to March 2015, Annual Population Survey Personal Well-being 3-year National Statistics dataset, ONS. For more information on the 3-year

A similar pattern is show in table 1.3 for the answers to the question around how worthwhile people felt the things they did in their lives were as with overall life satisfaction. Overall in the West Midlands a lower proportion of people felt the things they did in their lives were worthwhile, compared to Shropshire which had a higher reported worthwhile average compared to both regional and national responses.

Table 1.3: Results of question "Overall, to what extent do you feel the things you do in your life are worthwhile?" April 2012 to March 2015

Per cent in each category on 11 point scale:	Average (mean) rating

[20] Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/july2016tojune2017

[21] Surveys using the 4 ONS personal wellbeing questions as of Feb 2015 (ONS, 2016). Available at: http://webarchive.nationalarchives.gov.uk/20160105170340/http://www.ons.gov.uk/ons/guide-method/method-quality/specific/social-and-welfare-methodology/subjective-wellbeing-survey-user-guide/index.html

Area names	Lower Worthwhile 0-6	Higher Worthwhile 7-10	
England	18.23	81.77	7.75
West Midlands	19.23	80.77	7.68
Shropshire	15.18	84.82	7.88

Source: April 2012 to March 2015, Annual Population Survey Personal Well-being 3-year National Statistics dataset, ONS. For more information on the 3-year

A higher proportion of people in Shropshire rated their feeling of happiness higher than in England and the West Midlands overall.

Table 1.4: Results of question "Overall, how happy did you feel yesterday?" April 2012 to March 2015

	Per cent in each category on 11 point scale:		
Area names	Lower Happiness 0-6	Higher Happiness 7-10	Average (mean) rating
England	27.15	72.85	7.37
West Midlands	27.66	72.35	7.35
Shropshire	24.18	75.81	7.54

Source: April 2012 to March 2015, Annual Population Survey Personal Well-being 3-year National Statistics dataset, ONS. For more information on the 3-year

The fourth question identifies a more positive response to have a lower point on the scale, with a lower proportion having experience anxiety. Again Shropshire shows a better overall average scale score of 2.79 compared to 2.93 average for England.

Table 1.5: Results of question "Overall, how anxious did you feel yesterday?" April 2012 to March 2015

	Per cent in each category on 11 point scale:		
Area names	Lower Anxiety 0-5	Higher Anxiety 6-10	Average (mean) rating
England	79.93	20.08	2.93
West Midlands	81.84	18.17	2.70
Shropshire	82.66	17.34	2.79

Source: April 2012 to March 2015, Annual Population Survey Personal Well-being 3-year National Statistics dataset, ONS. For more information on the 3-year

Wider Determinants of Health and Wellbeing

As identified within the Adult Psychiatric Morbidity Survey, there are a number of wider factors associated with increased risk of mental ill health. In addition to the factors already discussed above, these include;

It is useful to consider these wider determinants which can be used as proxies to identify the "hidden population" of poor mental health (i.e. those who are currently not in contact with health services for a mental health condition). The place plan maps over the next few pages highlight the density of locations where each of these factors are most prevalent across Shropshire.

Summary of Wider Determinant Mapping

When the various risk maps are overlaid, there are 7 locations which commonly display the highest proportions of risk factors. As such it may be assumed these locations may be at a greater risk of *hidden* mental health problems;

- Highley
- Ludlow
- Market Drayton
- Shrewsbury
- Oswestry
- Wem
- Whitchurch

It is noted however, as proxy measures are being considered it does not necessarily mean that living in these locations increases risk of developing a mental health problem nor can it be established if the social circumstance/wider determinant risk factors are experienced as a result of a mental health condition.

Social housing/rented accommodation

The following maps (figures 1.6 and 1.7) identify that the greatest proportion of social housing with registered social landlord properties are located in Shifnal, Broseley, Highley, Ludlow and Oswestry. The highest proportion of rental properties are within Shifnal, Albrighton, Broseley, Much Wenlock and Craven Arms.

Figure 1.6. Registered social landlord properties per 1,000 dwelling by Place Plan Area in Shropshire County

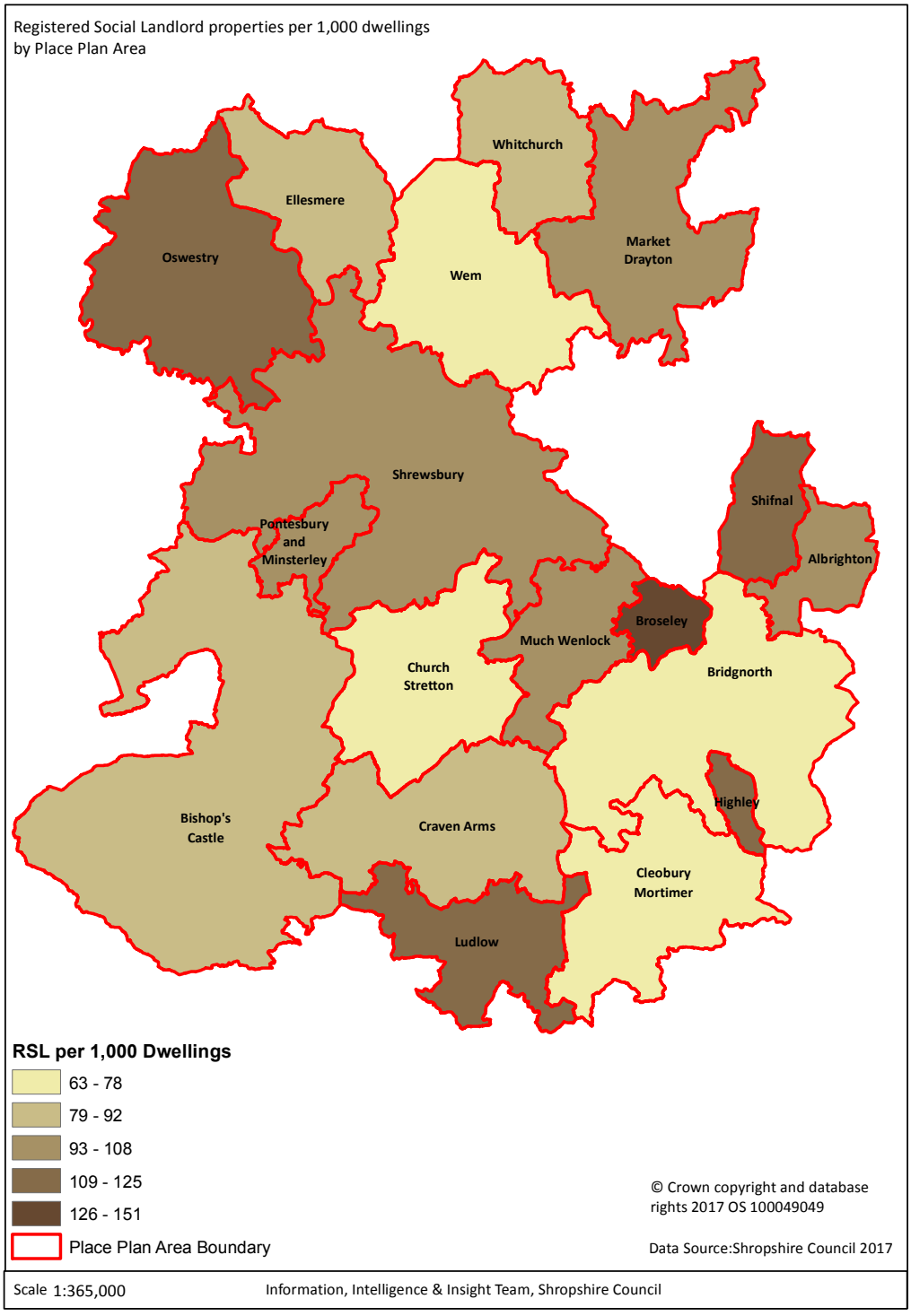
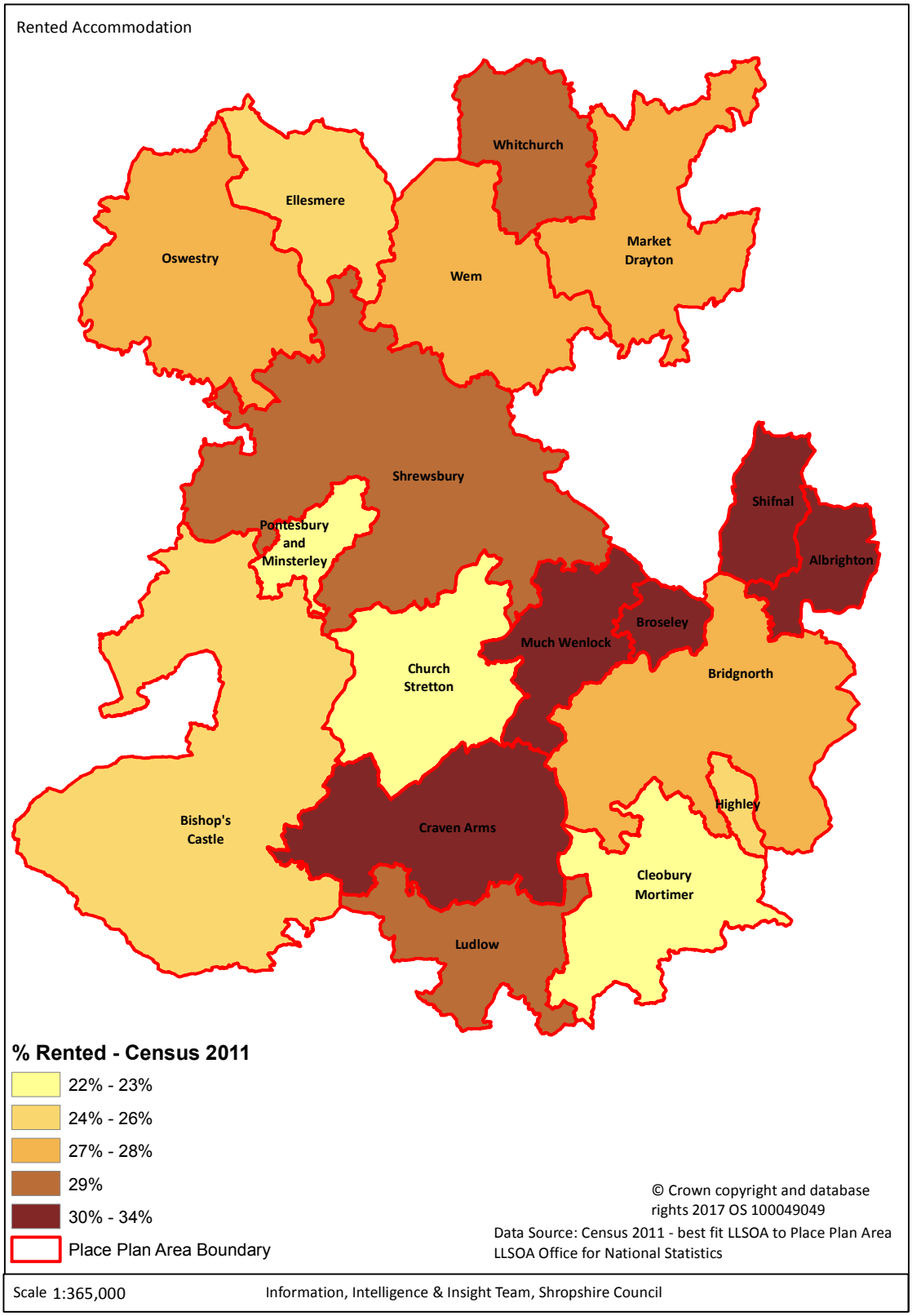


Figure 1.7. Proportion of rented accommodation in Shropshire County based on 2011 Census findings



Living alone

The locations with the highest densities of people aged over 65 years living alone are Albrighton, Much Wenlock, Church Stretton, Ludlow, Ellesmere and Wem. For people aged under 65 years, the greatest density of people living alone are in Sherwsbury, Ludlow and Whitchurch.

Figure 1.9. Proportion of one person households with a person aged 65+ years in Shropshire County based on 2011 Census findings

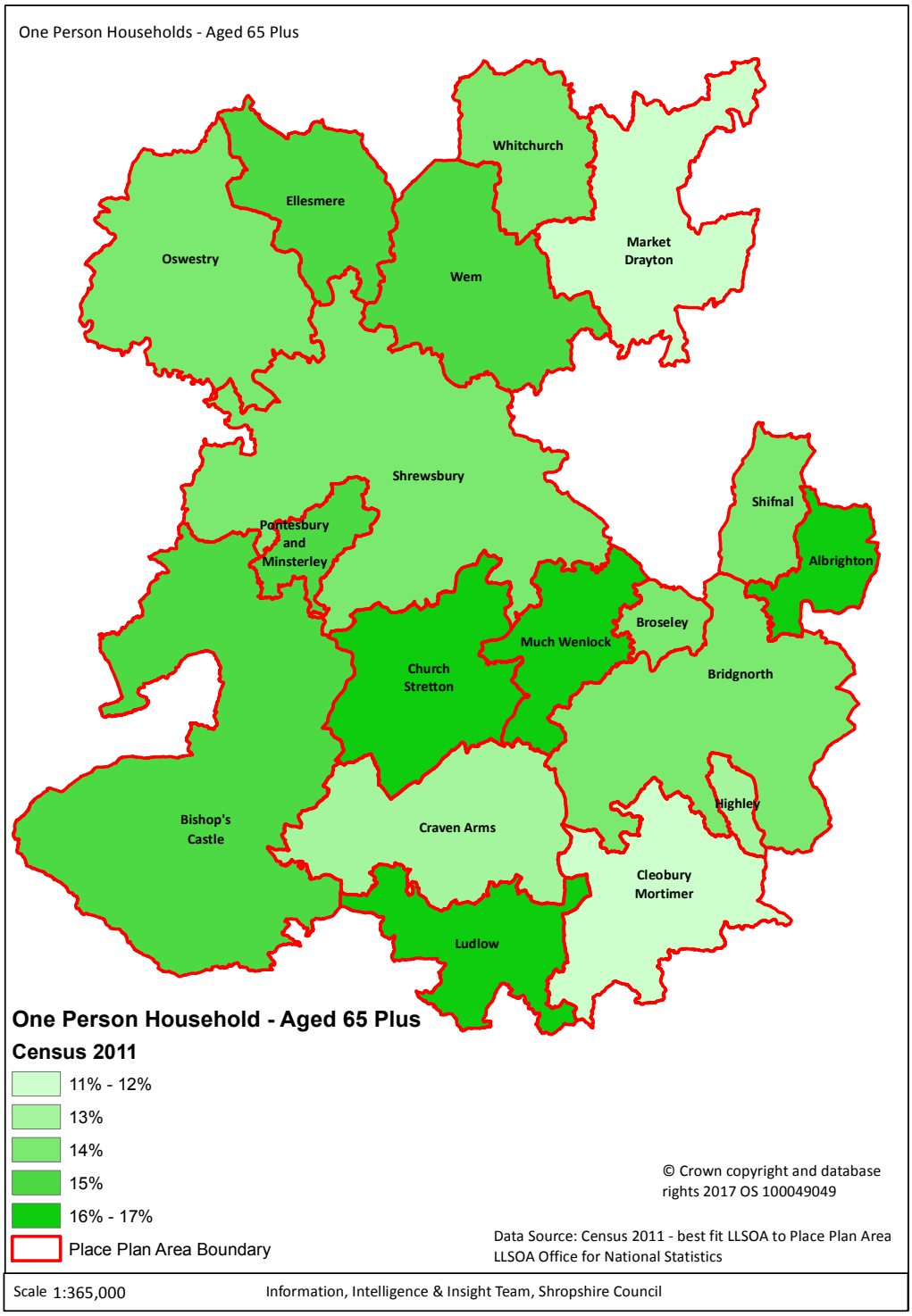
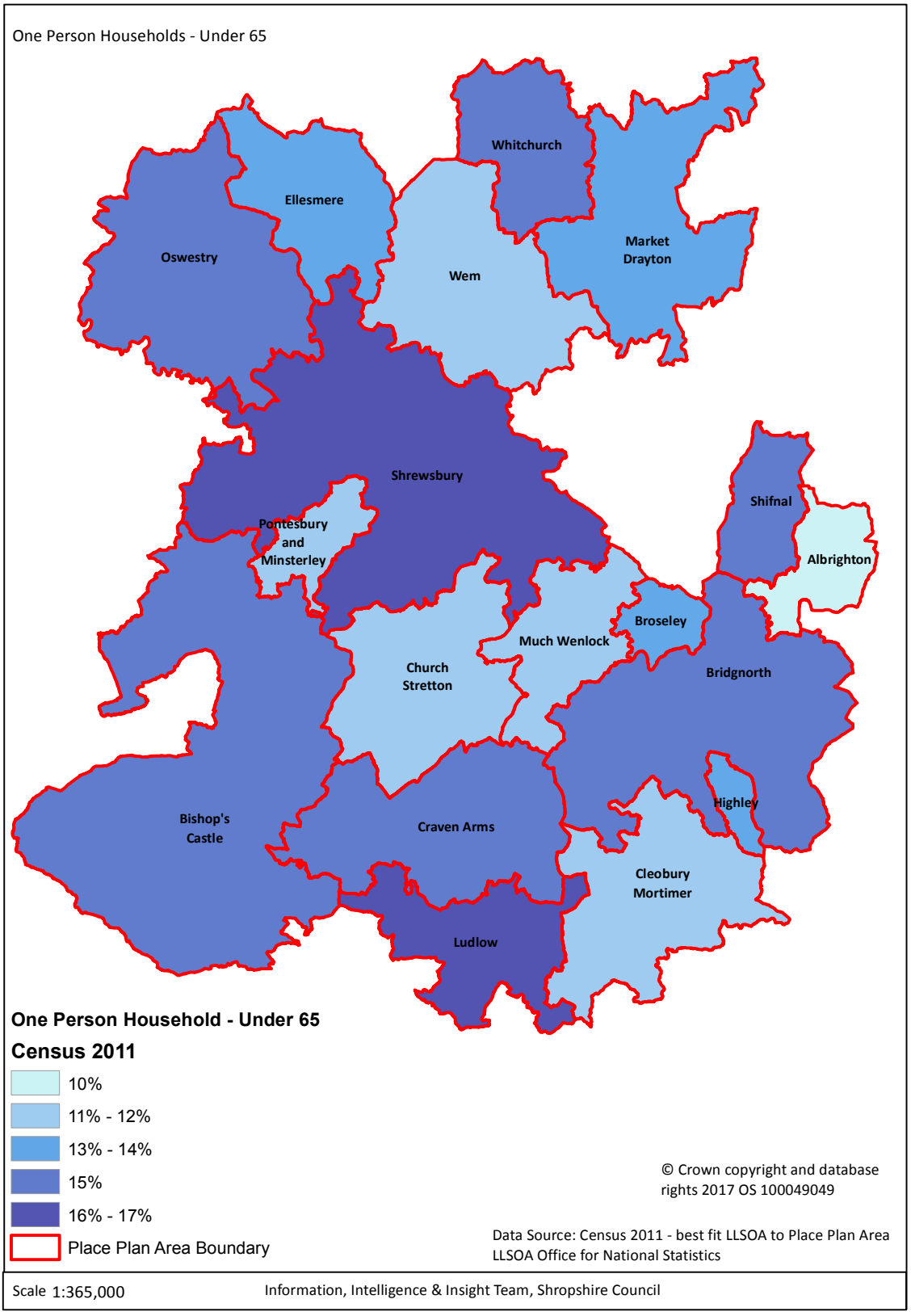


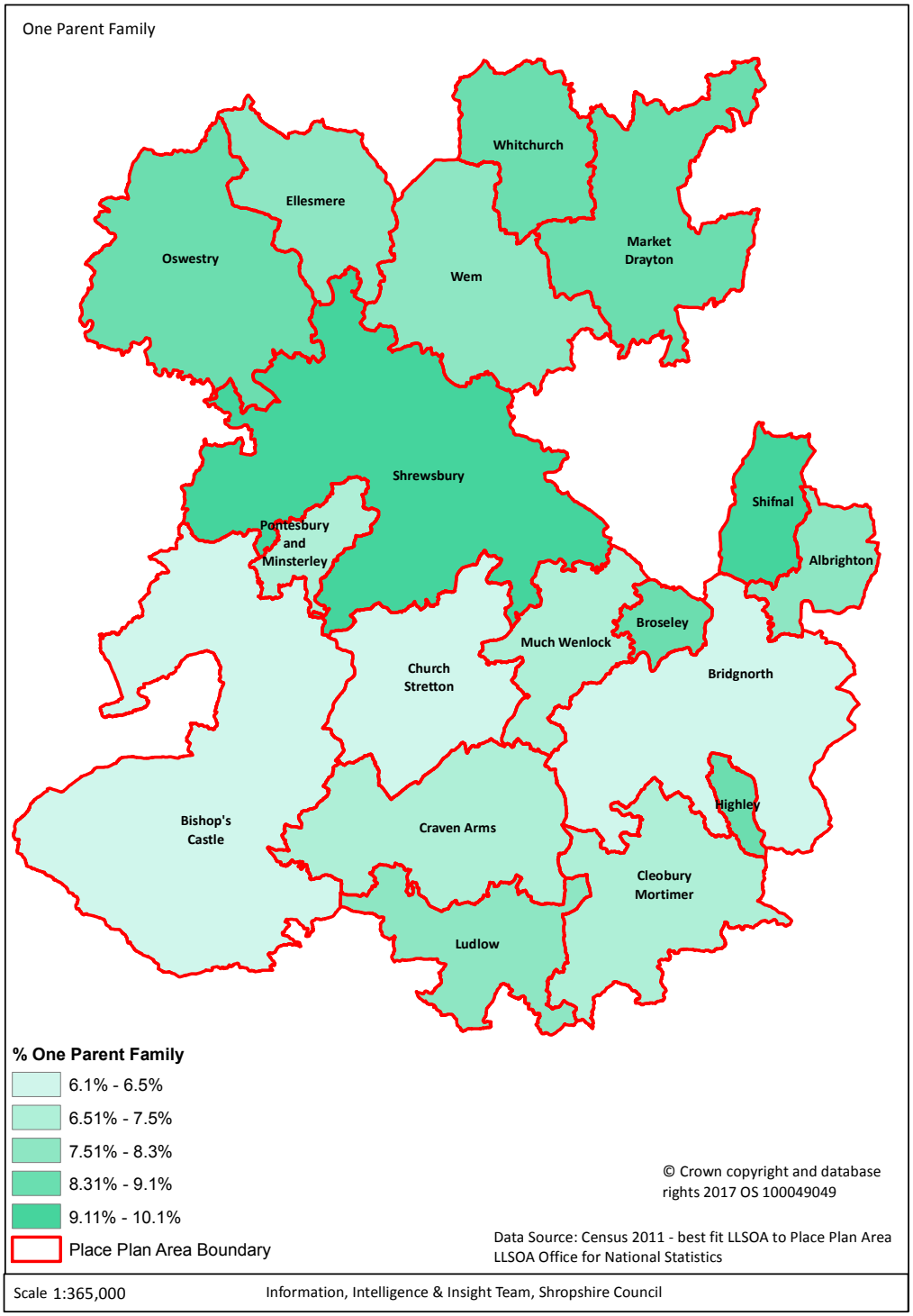
Figure 1.10 Proportion of one person households with a person aged less than 65 years in Shropshire County based on 2011 Census findings



Single Parent Family Households

The highest density of single parent family households are located in Shrewsbury, Shifnal, Market Drayton, Whitchurch and Highley.

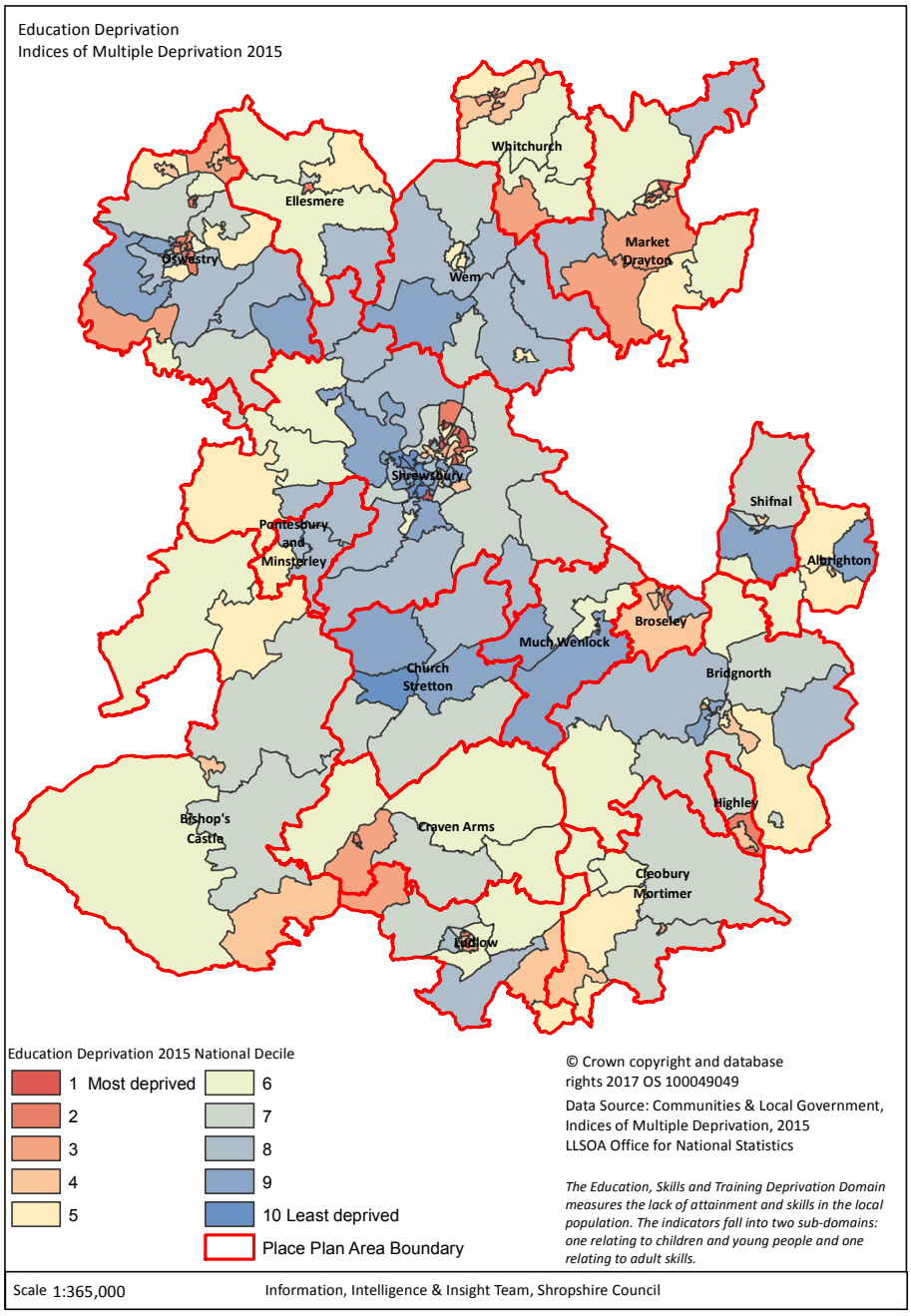
Figure 1.11. Proportion of one parent family households in Shropshire County based on 2011 Census findings



Education (all age)

The following map identifies the locations where the greatest deprivation of education attainment is recorded (based on key stages 2 and 4 outcomes, secondary school absence, post 16 years in education, entry to further education, adult skills and English language proficiency. It is seen that Market Drayton and Highley have the greatest density of poorer education outcomes although there are smaller level ward level localities also.

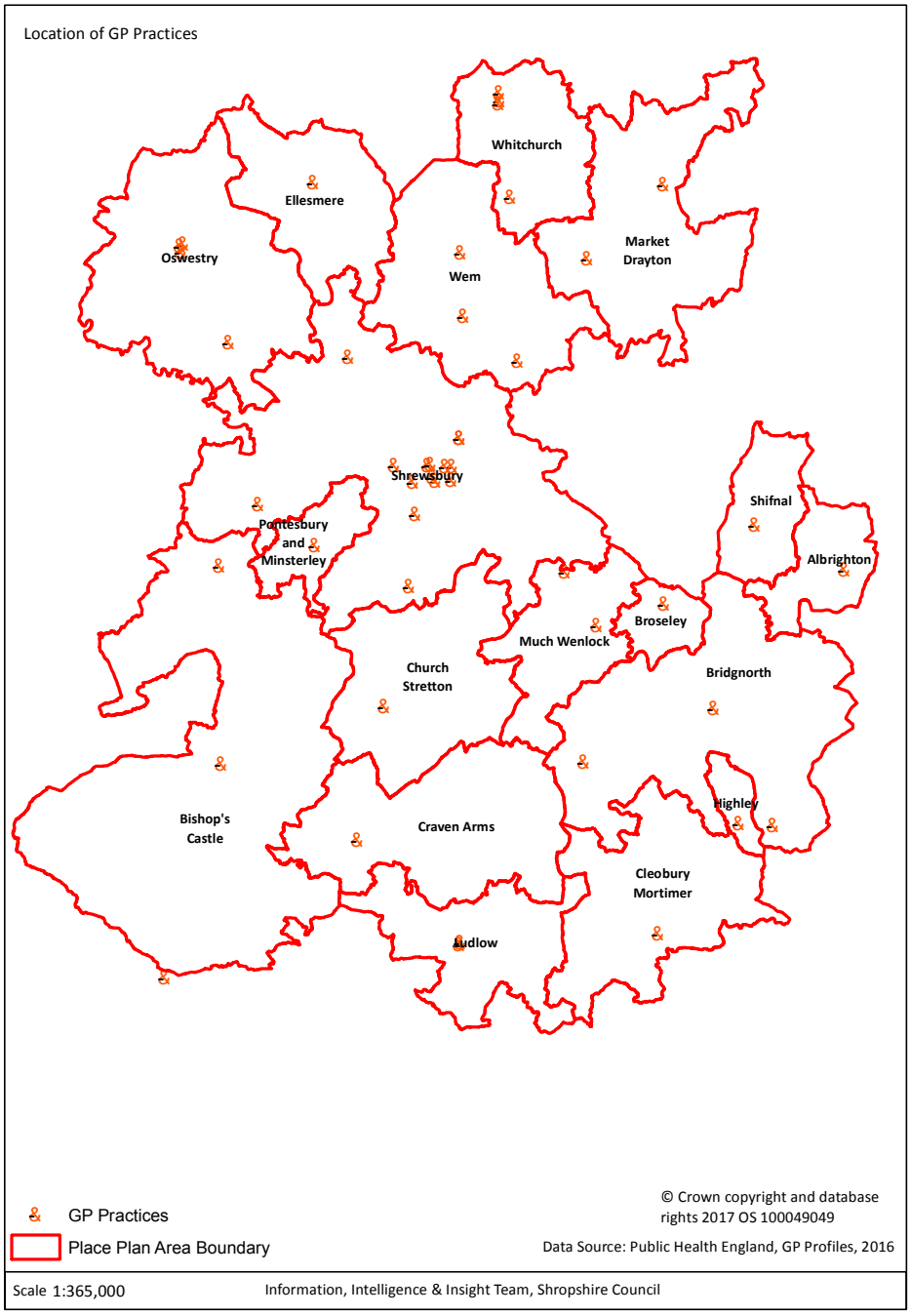
Figure 1.12. Education deprivation based on Indices of Multiple Deprivation (2015) in Shropshire County



Access to Services

Although currently it has not been possible to produce a single map with all health and social care services plotted, the following map provides an overview of GP locations across Shropshire. This is important (particularly in larger rural areas) as demonstrates a combination of population size against need but also highlights where some of the rural challenges of accessing primary care services will be.

Figure 1.13. Location of GP practices in Shropshire County



Section 2: Common mental health disorders

Common mental health problems relate to care clusters 1 to 7

Common mental health conditions (CMDs) comprise of different types of depression, anxiety and specific phobias which cause emotional distress, interfere with daily function and are often associated with physical and social problems (Goldberg and Huxley, 1992) but do not usually affect insight or cognition.

- Depressive Episodes: low mood and loss of interest and enjoyment in ordinary things and experiences
- Anxiety disorder: panic disorders, phobias, obsessive compulsive disorder and generalised anxiety disorder (GAD)

CMDs can result in physical impairment and both anxiety and depression often remain undiagnosed (Kessler et al, 2002) where individuals may not seek nor receive treatment. If left untreated, CMDs are more likely to lead to longer term physical, social and occupational disability and premature mortality (Zivin et al, 2015). Although, CMDs are less disabling compared to major psychiatric disorders, there is a higher prevalence of CMDs which in turn leads to a greater cumulative cost to society.

Chapter Summary

Generally, the mental health of people in Shropshire is better than the England average in terms of comparable rates of anxiety, depression, phobias, obsessive compulsive disorder and eating disorders.

The rates of CMD in Shropshire are significantly higher for women in comparison to men with a peak rate in the 25 to 44 year old range. This is in contrast to the younger peak age for CMD in men of 15 to 24 years. Deprivation in a common association with the localities with highest prevalence of CMDs (however, it cannot be ascertained if this directly cause or effect of a mental health problem).

It is often challenging to identify the true rate of mental health problems in the wider population and as such the findings of the latest Adult Psychiatric Morbidity Survey (2014) have been applied to the Shropshire population demographics (by age and gender). When this is applied, the highest rates of Common Mental Disorder (CMD's) in Shropshire relate to mixed anxiety and depression diagnosis.

Referral rates and the rate of people who enter into the Shropshire IAPT service are consistently lower compared to the England average which potentially could cause a gap between the numbers of those requiring an intervention and those receiving treatment. Once people have accessed the IAPT service however, a higher proportion of people complete treatment and move onto recovery compared to the England average and a similar proportion as to the national average achieve reliable improvement.

Findings from the Adult Psychiatric Morbidity Survey (2014)

National surveys of adult psychiatric morbidity were carried out in 1993, 2000, 2007 and 2014[22] to monitor mental illness and treatment with a large representative sample of the household population interviewed (including 7,500 aged 16 years or more and those who do not access services). Evidence from the Adult Psychiatric Morbidity Survey 2014 identifies a range of known associations with CMDs including;

[22] Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England. Available at: http://content.digital.nhs.uk/catalogue/PUB21748

- Poverty
- Unemployment
- Being female
- Social isolation (adults under 60 years who live alone)
- Ethnicity (particularly black women)
- People in receipt of benefits
- People who smoke cigarettes

Key messages from the survey;

- Nationally there has been a slight but steady increase in the proportion of women with CMD symptoms since 2000, however this proportion has been stable amongst men. The increase in prevalence has been mostly seen at the more severe end of the CMD scale.
- There have been increases in CMD amongst late midlife mid-life men and women aged 55 to 64 years since the previous survey in 2007 and increases in young women aged 16 to 24 years.
- CMD symptoms are about three times more common in women aged 16 to 24 years (26.0%) compared to men (9.1%).
- Most people with an identified CMD reported by the Clinical Interview Schedule Revised (CIS-R) also perceived themselves to have a CMD. This is different to most of the other disorders assessed by the Adult Psychiatric Morbidity Survey.

CMD prevalence in Shropshire

Chart 2.1 displays the England rates for common mental disorders as identified within the Adult Psychiatric Morbidity Survey (2014) for males and females by age group. Chart 2.2 applies these rates to the mid year population estimates in Shropshire to provide estimated local prevalence.

Chart 2.2 suggests that prevalence of aggregated CMDs is consistently higher across all age groups for females compared to males. The greatest prevalence of CMD's are women aged 45 to 54 years and 55 to 54 years. Shropshire male prevalence remains at a similar number between the ages of 25 to 64 years where it is almost double that of males aged 16 to 24 years and males aged over 65 years. It estimated that in total there are 42,673 people with a common mental disorder in Shropshire (26,324 females and 16,348 males).

Chart 2.1: CMD reported in the past week by age and sex (APMS, 2014)

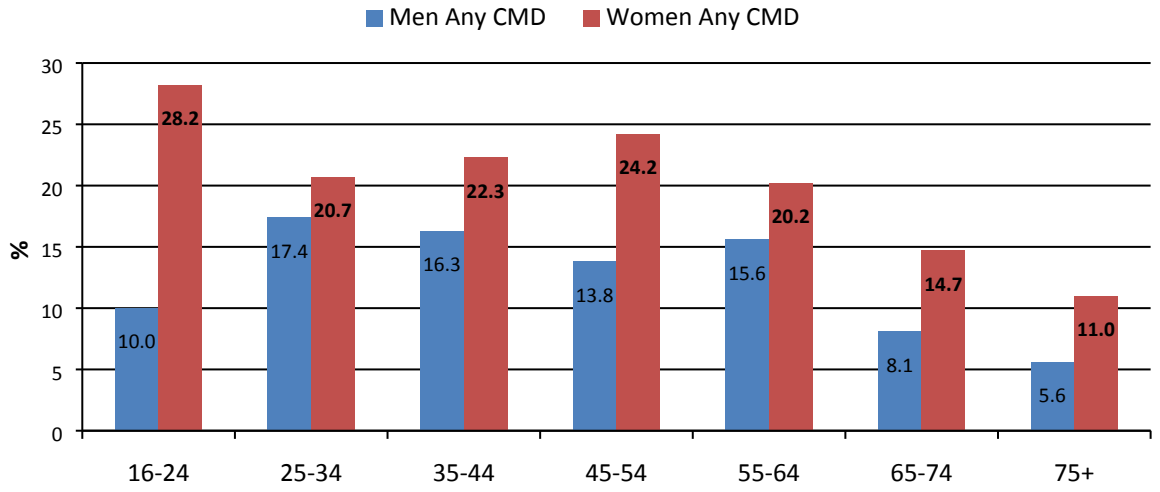


Chart 2.2: Estimated number of Common Mental Disorders for Shropshire males and females by age band, based on 2016 mid year population and rates identified in the APMS Survey

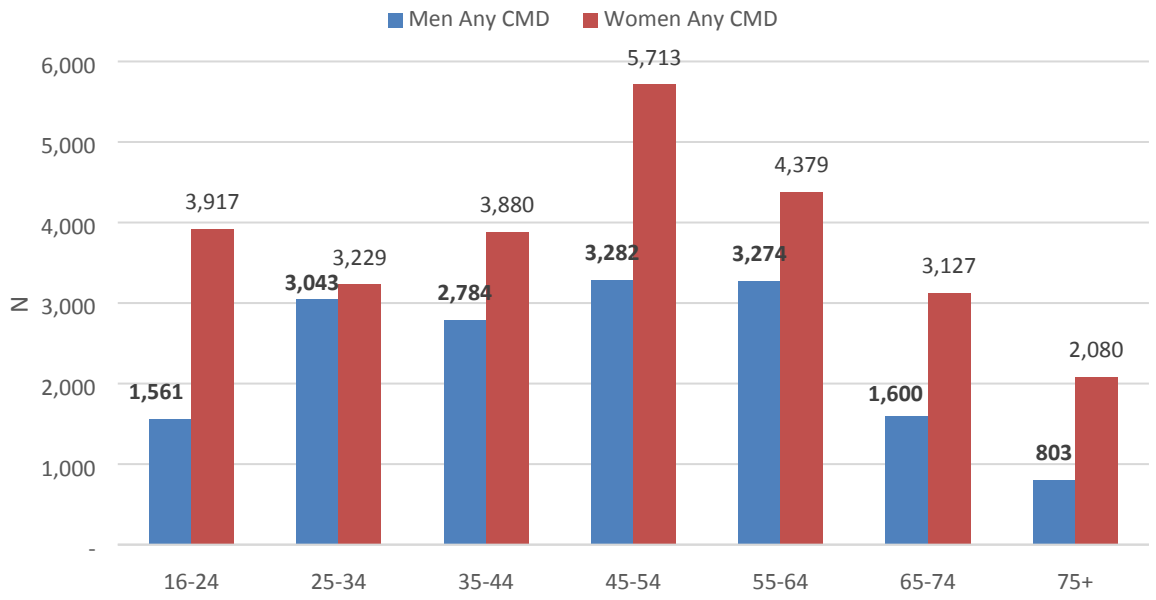


Chart 2.3 outlines the rates of specific CMDs for females as identified in the APMS (2014), where mixed anxiety/depression and general anxiety disorders are the most reported. When applied to the Shropshire 2016 mid year population (Chart 2.4), it can be seen that mixed anxiety and depression have the greatest reported prevalence across each group, with the highest seen in women aged 45 to 54 years.

Chart 2.3: CMD reported by Women the past week by age (APMS, 2014)

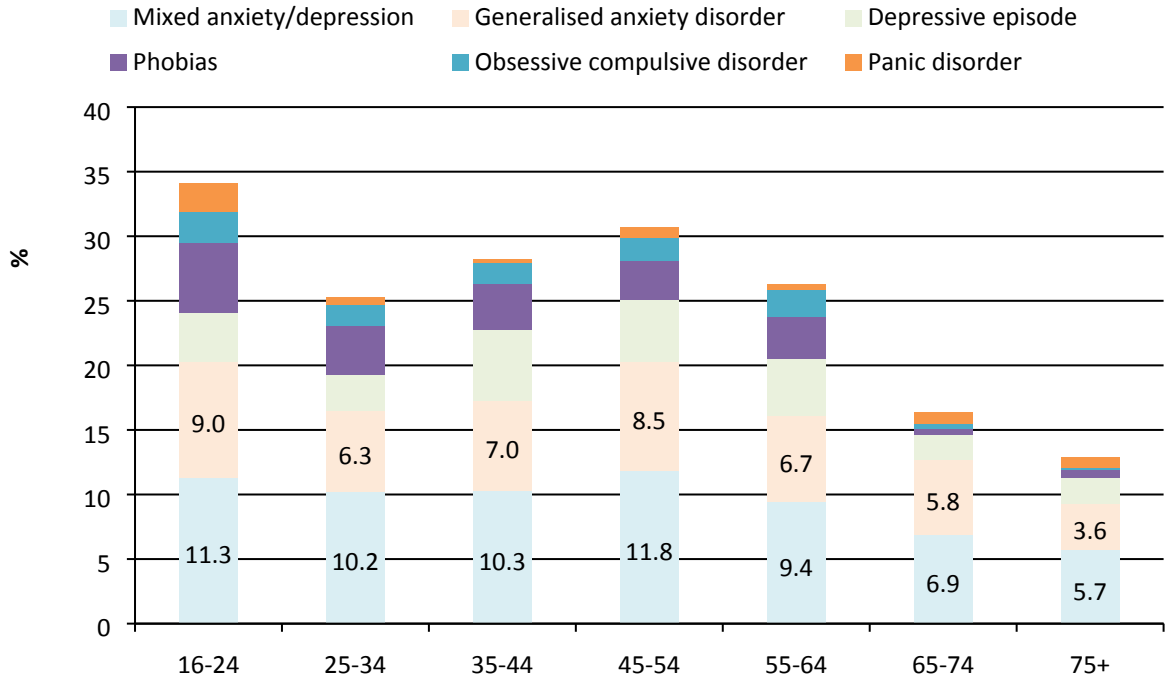
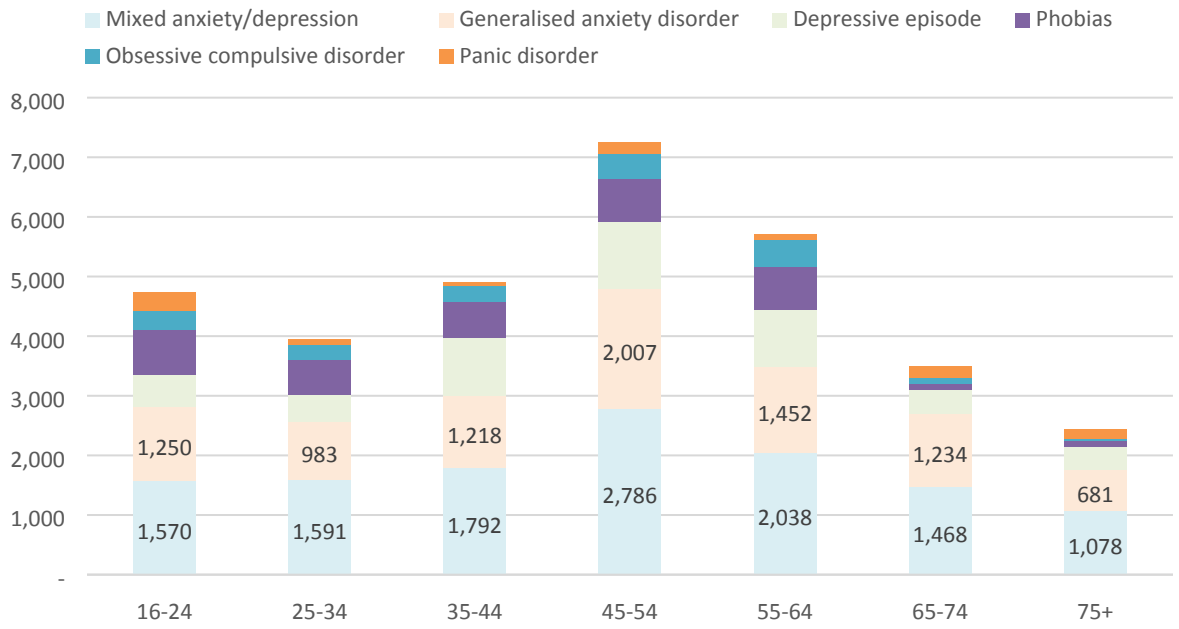


Chart 2.4: Estimated number of CMDs reported by Females the past week by age, based on mid year population rates (2016)



When the same process is applied to males, Chart 2.5 suggests the rates of mixed anxiety and depression are relatively consistent for those aged under 65 years. Chart 2.6 shows the estimated numbers of Shropshire males with specific CMDs and identifies confirms that mixed anxiety and depression are the most prevalent conditions.

Chart 2.5: CMD reported by Males the past week by age (APMS, 2014)

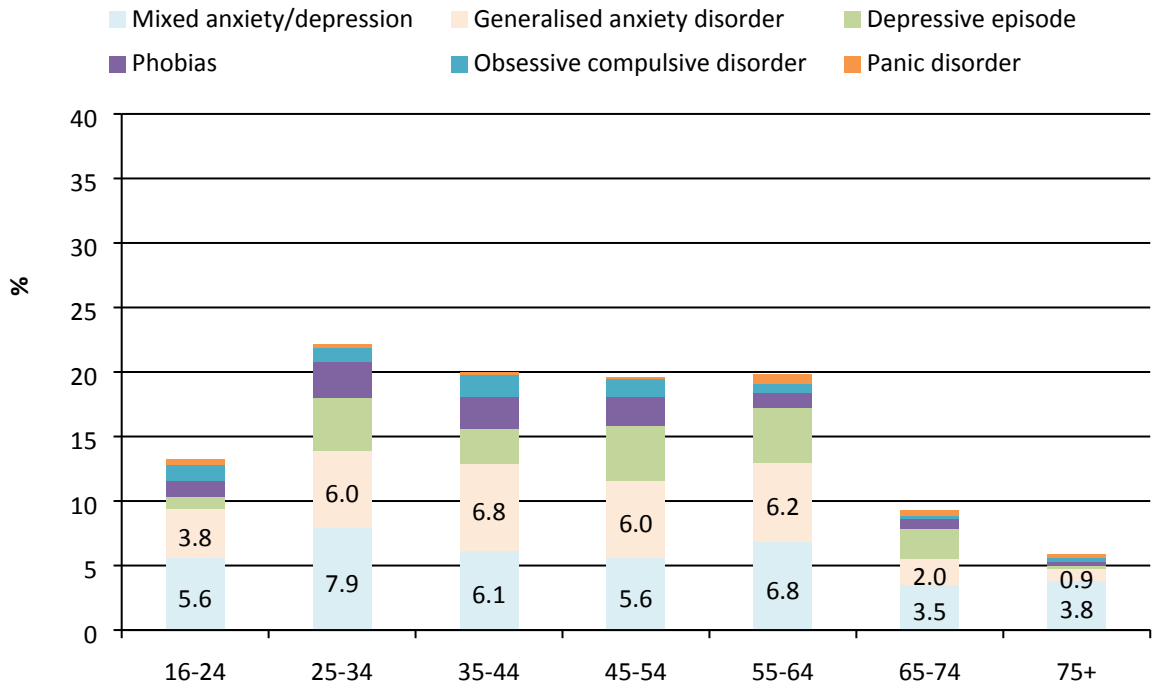
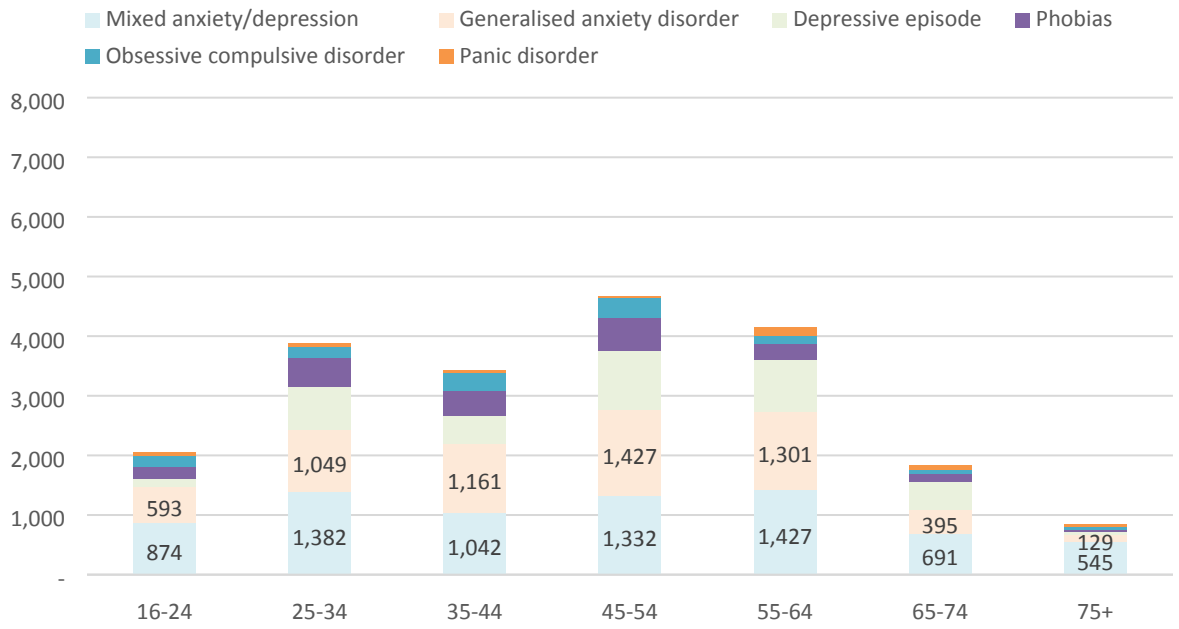


Chart 2.6: Estimated number of CMDs reported by Males the past week by age, based on mid year population rates (2016)



Comparison of Shropshire male and female CMD prevalence

When comparing the male and female prevalence in the following Charts (Charts 2.7a to f), it can also be seen that across all conditions there is a difference in prevalence across the ages and gender. For anxiety and depressive conditions, the greatest prevalence for both males and females is for those aged between 45 and 54 years, however males aged 25 to 34 years and 55 to 64 years have a higher prevalence of mixed anxiety/depression compared to the other male age groups for this condition.

Females aged 16 to 24 years have the highest prevalence of panic disorders with a secondary peak at 45 to 54 years and over 65 years. In comparison males have a peak of panic disorders at 55 to 64 years.

Female obsessive compulsive disorders peak between 45 and 64 years wheras males peak at 45 to 54 years.

Chart 2.7a: Mixed anxiety/depression

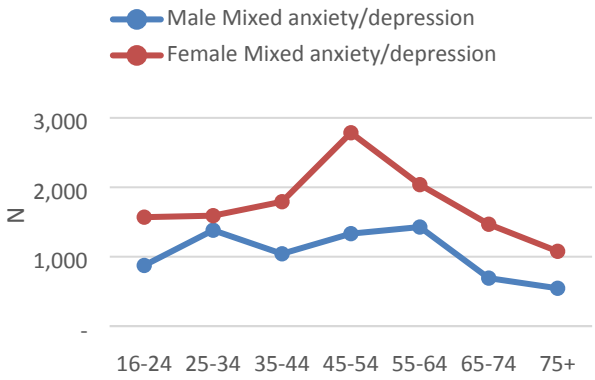
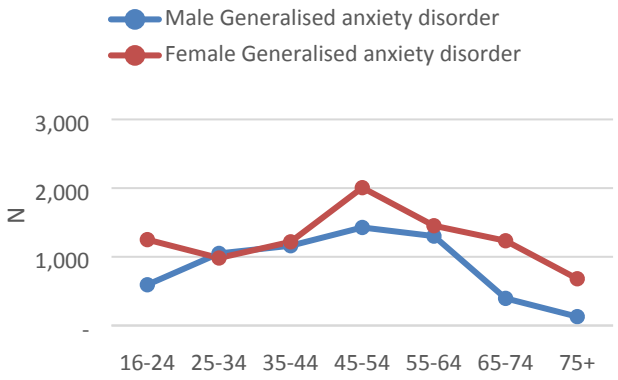
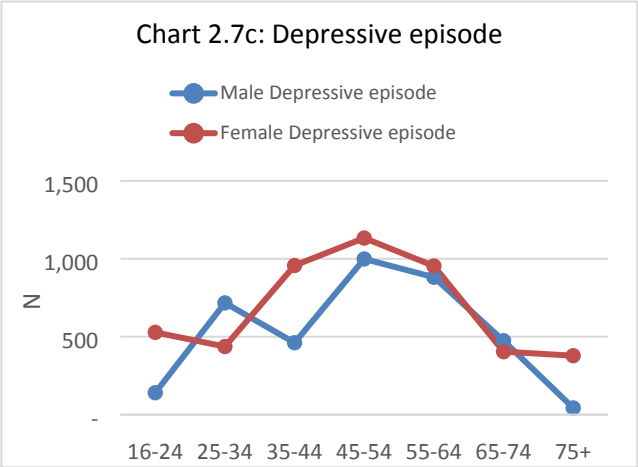
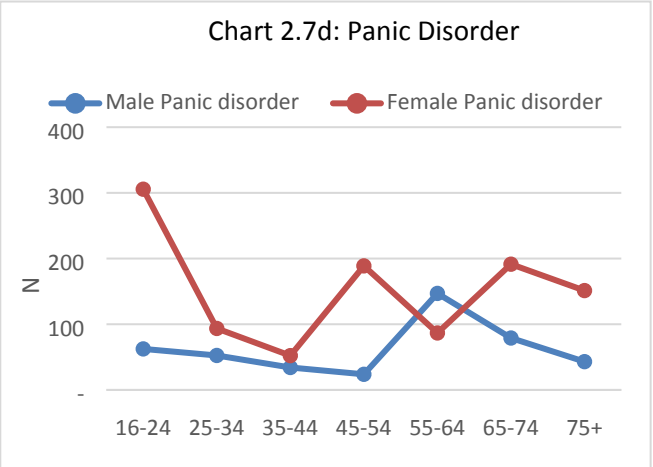
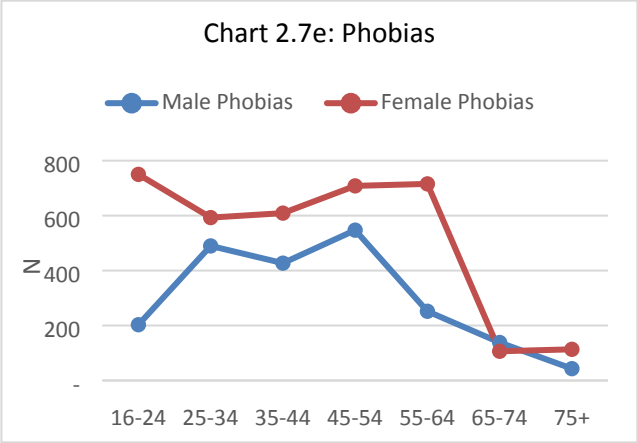


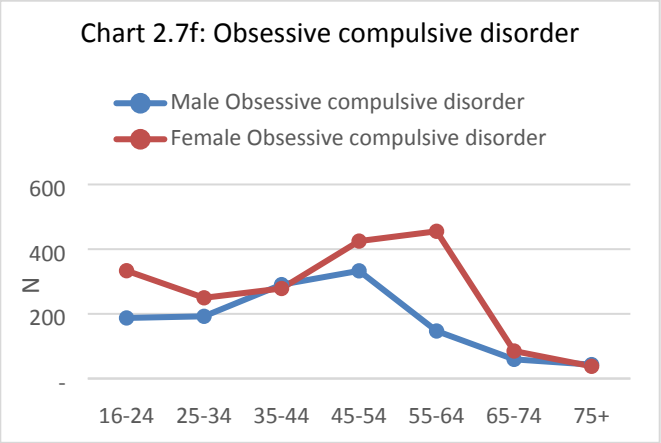
Chart 2.7b: Generalised anxiety disorder











Public Health England Fingertips Data

The Public Health England (PHE) health profiles utilise data provided from across health and social care services in England to provide summary indicators on a wide range of themes to support commissioining, production of Joint Strategic Needs Assessments, improve health and wellbeing and reduce inequalities. The profiles provide ability to browse indicators at different geographical levels and benchmark against the England average.

The table on the following page provides a summary of the key themes relevant to Mental Health taken from the PHE Fingertips data and compares how Shropshire is performing in comparison to the West Midlands and England averages (based on latest data available).

The PHE Fingertips data can be accessed via: https://fingertips.phe.org.uk

CMD outcomes for Shropshire (Public Health England Fingertips Data)

The following table outlines how Shropshire compares to the England average benchmarks for a number of factors related to common mental disorders.

Table 2.1:

Shropshire performing better than the England average	Shropshire performing worse than the England average	Shropshire performing similar to the England average
1. Mixed anxiety and depressive disorder: estimated % of population aged 16-74 • 2012: Shropshire at 6.6% (n= 14,809) was below the England (8.9%) and West Midlands averages (8.8%) 2. Generalised anxiety disorder: estimated % of population aged 16-74 • 2012: Shropshire at 2.8% (n=6,242) was below the England (4.5%) and West Midlands (3.6%) averages 3. Depressive episode: estimated % of population aged 16-74 • 2012: Shropshire at 1.28% (n=2,894) was below the England (2.5%) and West Midlands (1.7%) averages 4. All phobias: estimated % of population aged 16-74 • 2012: Shropshire at 1.08% (n=2,437) was below the England (1.8%) and West Midlands averages (1.5%) 5. Obsessive compulsive disorder: estimated % of population aged 16-74	1. Depression recorded prevalence (QOF): % of practice register aged 18+ • Increasing prevalence of depression in those aged 18+ between 2012/13 (6.0%) to 2016/17 (9.9%, n=24,470) • Shropshire was significantly higher than both the England average of 9.1% and similar to the West Midlands at 9.8% 2. Depression recorded incidence (QOF): % of practice register aged 18+ • Shropshire has an increasing incidence of depression in those aged 18+ each year from 2012/13 (1.1%) to 2016/17 (1.6%, n=3,965), this is above the England average however, follows a similar time trend line • An overall increasing trend indicating a growing local issue	1. Self-reported well-being: % of people with a low happiness score • 2015-16 the Shropshire percentage was similar to both the England and West Midlands averages with an overall decreasing trend 2. Self-reported well-being: % of people with a high anxiety score • 2015-16 the Shropshire percentage was similar to both the England and West Midlands averages • There was a significant increase in the Shropshire percentage between 2014-15 to 2015-16 indicating an improving trend 3. Estimated prevalence of common mental health disorders % of population aged 16-74 • Shropshire estimated percentage was 10.3% and below the estimated England average of 15.6%. 4. Depression and anxiety among social care users: % of social care users • 2013/14 the Shropshire percentage

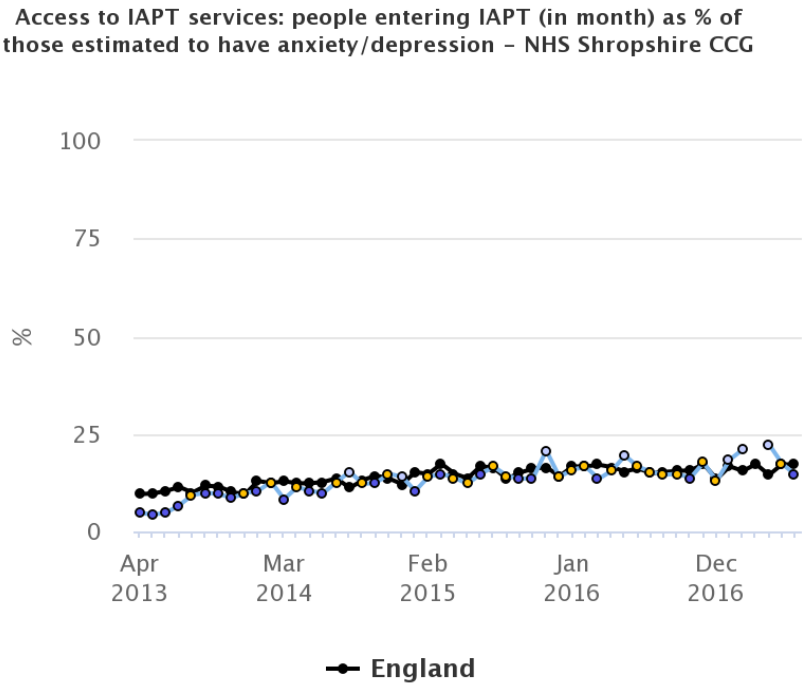
• 2012: Shropshire was below the England and West Midlands averages at 0.12% (n=263) 6. Panic disorder: estimated % of population aged 16-74 • 2012: Shropshire at 0.65% (n=1,454) was below the England (1.1%) and West Midlands averages (0.9%) 7. Eating disorder: estimated % of population aged 16 or more • 2012: Shropshire at 6.5% (n=14,755) was below the England (6.7%) and West Midlands averages (6.5%) 8. Admissions for depression: directly standardised rate per 100,000 population aged 15+ • 2009-10 and 2011-12 indicate that Shropshire was significantly lower (20.9%) than either the England average of 32.1% or the West Midland average of 32.5%. 9. Long-term mental health problems (GP patient survey): % of respondents aged 18+ • Shropshire CCG respondents aged 18+ was significantly lower (4.1%) than the England average of 5.2% or the West Midlands average of 5.4% • An overall increasing trend indicating a growing local issue		was higher than England 59.7% compared to 52.8%

Improving Access to Psychological Therapies (IAPT)

Improving Access to Psychological Therapies (IAPT) is an NHS programme that offers interventions approved by the National Institute for Health and Care Excellence (NICE) for treating people with depression and anxiety disorders. Patients can either self-refer to the depression and anxiety service or can be referred via their GP/other services.

Chart 2.8 below plots the proportion of people estimated to have anxiety/depression who entered IAPT services in the recorded month. It can be seen there is variation around the national average however, there has been an increasing trend of access between April 2013 and June 2017 which is similar to the national trend.

Chart 2.8



Referrals into the IAPT service for adults over 18 years have been consistently lower in Shropshire compared to the national average since 2013/14 Q2 (latest local rate of 484 per 100,000 population compared to 807 per 100,000 in England).

It is recognised that not everyone who is referred to IAPT enters treatment however, since 2013/14 Q2, the Shropshire rate of people entering treatment has been consistently lower than the England average (as per Chart 2.9 below).

Chart 2.9

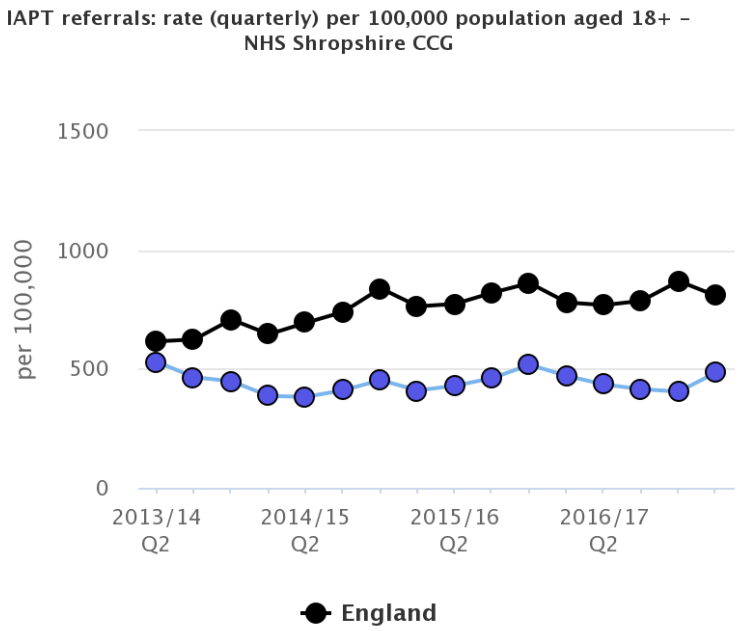


Chart 2.10 plots the proportion of referrals that have finished a course of treatment that waited less than 6 weeks for their first treatment (a standard measure of waiting time). It can be seen that since May 2015, there has been a higher proportion of people who waited less than 6 weeks for treatment compared to the national average (indicating less waiting time on average in Shropshire compared to the national average).

Chart 2.10

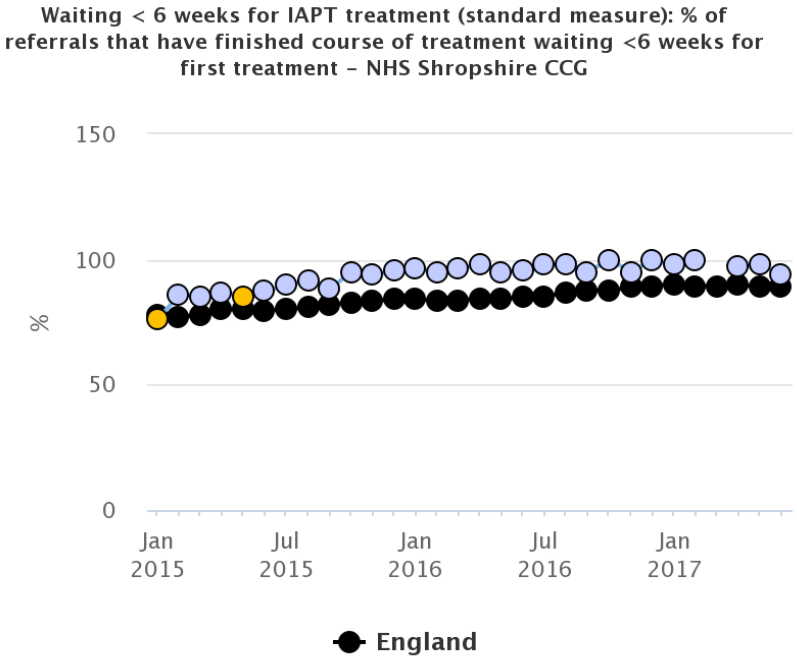
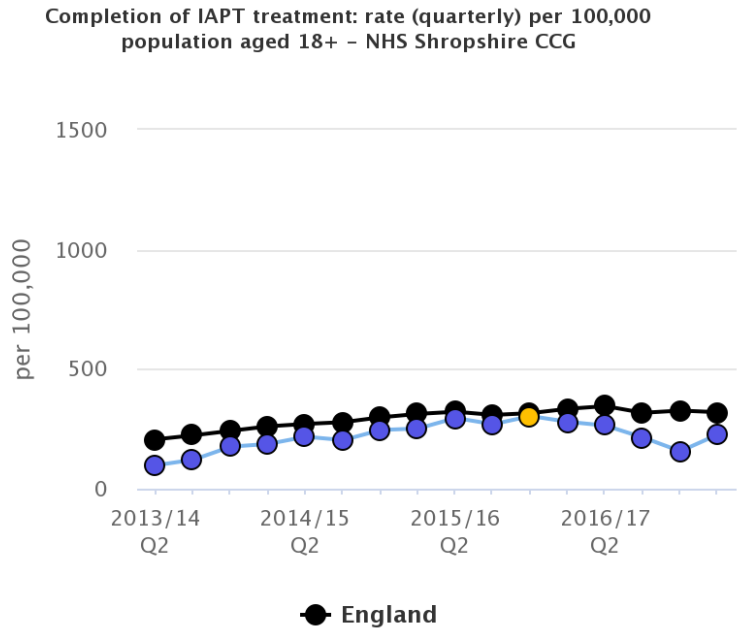


Chart 2.11 identifies that 226 per 100,000 population over 18 years (n=575) completed IAPT treatment during 2017/18 Q1. This is lower than the national average rate of 320 per 100,000 population and has been consistently below the England average for each quarter between 2013/14 to 2017/18 (with the exception of 2015/16 Q4 where a similar rate was recorded).

Chart 2.11



Since June 2015 the proportion of people who have completed their treatment and are moving to recovery has been similar or higher compared to the national average (see chart 2.12 below).

Chart 2.12

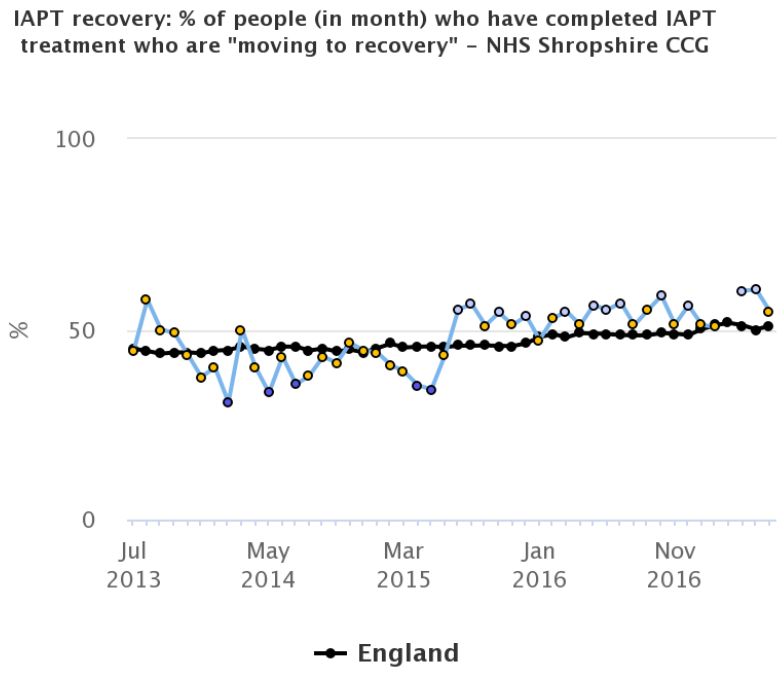
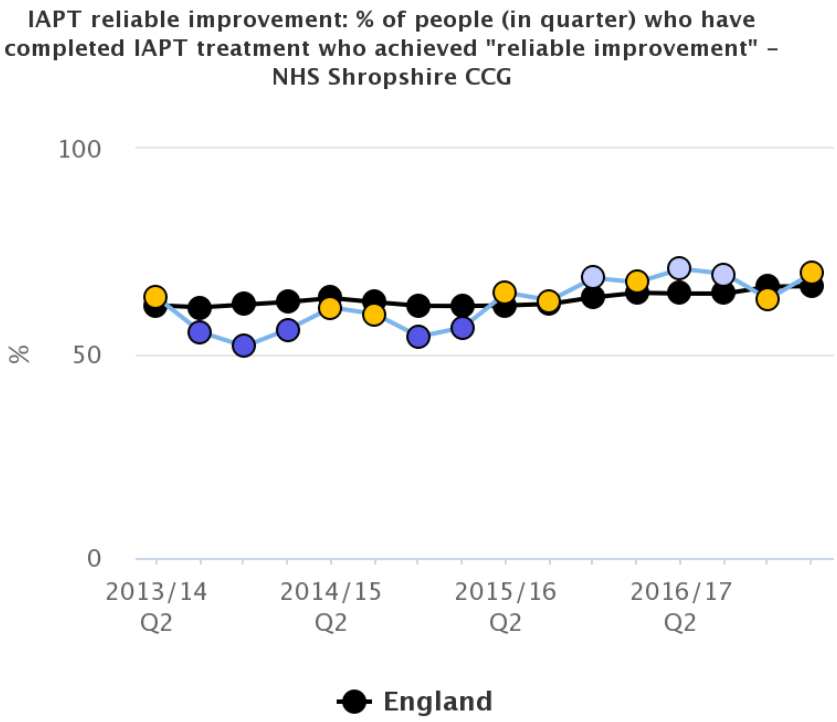


Chart 2.13 shows that 69.6% (n=400) of people who have completed their course of treatment and achieved “reliable improvement” in 2017/18, which is similar to the England average of 66.4%. It can also be seen that since 2015/16 Q2, this proportion has been similar or higher than the national average.

Chart 2.13


IAPT reliable improvement: % of people (in quarter) who have completed IAPT treatment who achieved "reliable improvement" – NHS Shropshire CCG
100
%
50
0
2013/14 Q2
2014/15 Q2
2015/16 Q2
2016/17 Q2
England

Demographics by Cluster

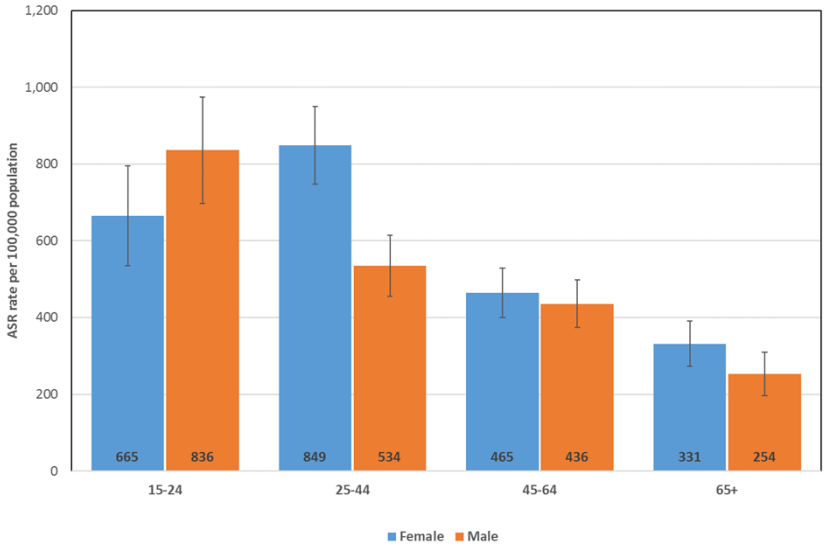
The following section provides a summary of CMD themes for Shropshire based on data from the South Staffordshire and Shropshire Healthcare NHS Foundation Trust (February 2016 to February 2017).

Non Psychotic illness - mild, moderate, severe

Age and Gender:

- There were significantly higher rates for women compared to men in this group.
- Between the genders, there were significantly higher rates for females in the age band 25-44 but no significant difference across all the other age bands.
- Although there were higher rates for females aged 25-44, this was similar to age band 15-24 but significantly higher than age bands 45+.
- There were significantly higher rates of males in the 15-24 age band compared to all the other age bands.

Chart 2.14: Non-psychotic – mild, moderate, severe: by age and gender
Age standardised rates per 100,000 population

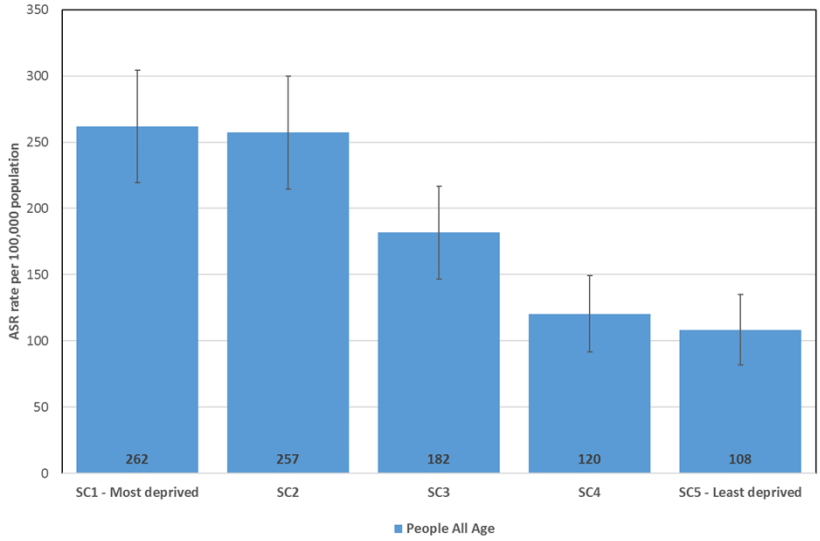


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

- Chart 2.15 overleaf shows that for all age, all gender there were significantly higher rates of people from the most deprived areas; quintile 1 and 2, compared to all the other quintiles
- The most deprived quintile is significantly higher than the least.

Chart 2.15: Non-psychotic – mild, moderate, severe: all age, all gender by deprivation
Age standardised rates per 100,000 population

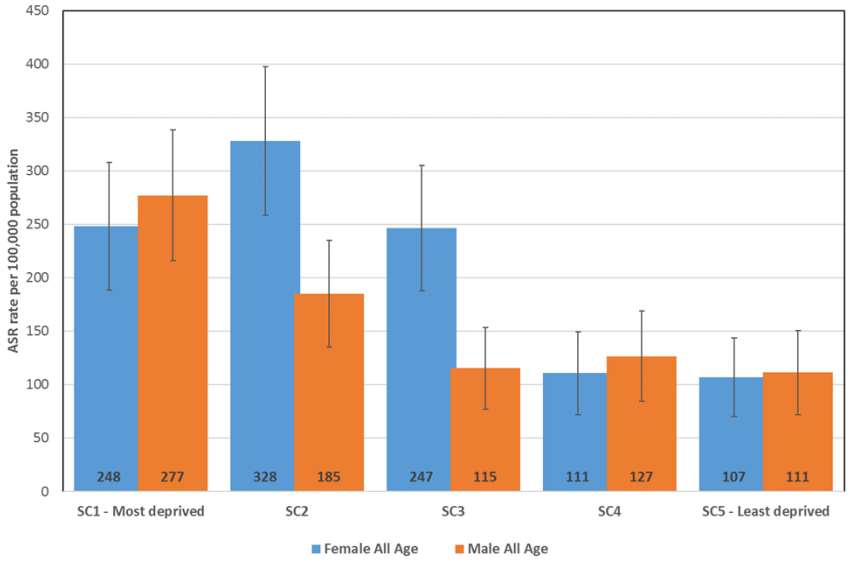


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Chart 2.16 shows the comparison between the genders across all the deprivation quintiles.

- There were significantly higher rates of females compared to males in the more deprived quintiles SC2 and SC3, but the remaining quintiles were similar.
- Female rates were similar between the most deprived quintiles SC1-SC3; with the highest rate in SC2 but were significantly higher than the least deprived quintiles SC4-SC5.
- The pattern was similar for males with the highest rates from SC1 and SC2 being similar but SC1 being significantly higher than the least deprived quintiles SC3-SC5.

Chart 2.16: Non-psychotic – mild, moderate, severe: all age by gender by deprivation
Age standardised rates per 100,000 population

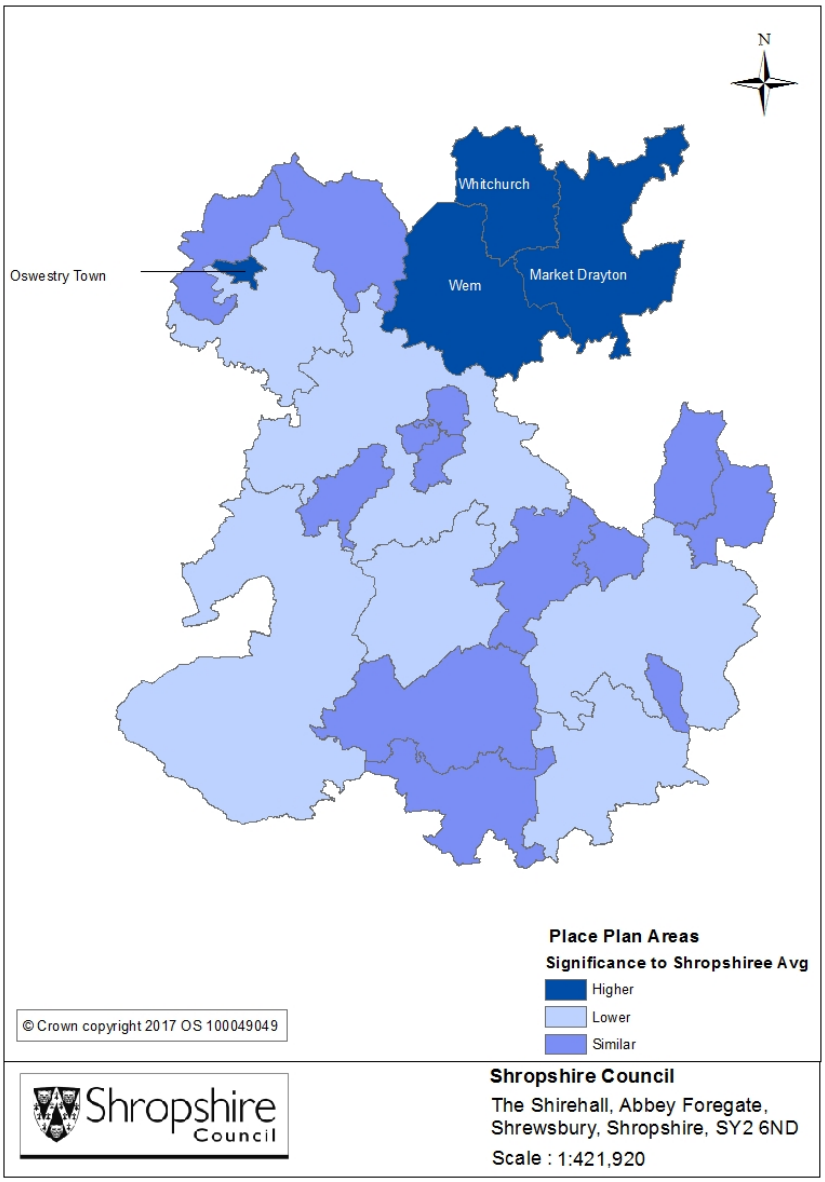


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Rurality:
There were similar rate of people from rural and town areas but significantly lower rates of people from urban areas for all age all gender.

Place Plan:
Highlighted in dark blue are the place plan areas that were significantly higher than the Shropshire average for non-psychotic – mild, moderate and severe cases and these were: Oswestry Town, Wem, Whitchurch and Market Drayton.

Map 1: Non-psychotic – mild, moderate, severe: all age all gender by place plan
Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT)

Section 3: Severe and enduring mental illness

A mental health crisis often means an individual feels unable to cope or be in control of a situation. There may be feelings of emotional distress and high levels of anxiety where some individuals cannot cope with day-to-day life or work and could include thoughts about suicide, self-harm or hallucinations and hearing voices.

Chapter Summary

Rates of severe mental illness are lower compared to Common Mental Disorders however, the impact can be more complex. This chapter focuses on the themes of severe but non psychotic mental ill health, psychotic mental illness and psychotic crisis.

In Shropshire there are significantly higher rates of women with non psychotic but severe and complex mental ill health, with a peak identified in the 15 to 24 year group. Shropshire GP registers have a lower prevalence of recorded severe mental illness compared to the England average.

There are similar rates of men and women with ongoing psychotic episodes, however, the peak female rate is for those aged 45 to 64 years compared to males with a younger range between 15 to 44 years. The incidence of new cases of psychosis is significantly lower than the England average.

Men have a higher rate of psychotic crisis with no significant differences between the age bands.

There are strong associations between the areas with the highest rates of severe mental illness and living in the most deprived locations (except for those who had experienced a first episode of psychosis where the least deprived areas had a higher association).

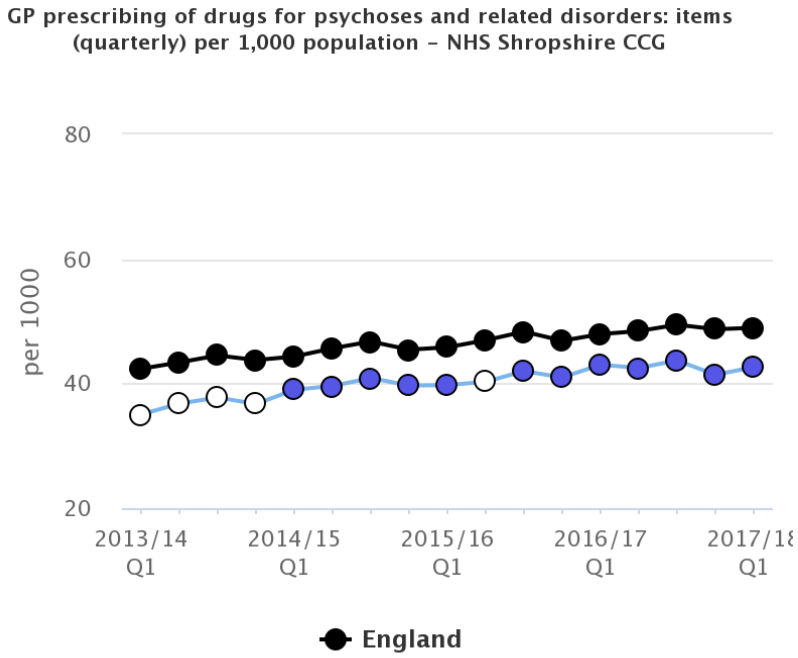
3.1 Severe and complex mental illness

The PHE Health Profiles identify the following trends for people with severe mental illness.

1. The estimated prevalence of psychotic disorder in people aged over 16 years in Shropshire is 0.36% (n=1,409) based on 2012 data

2. The rate of GP prescriptions of drugs for psychoses and related disorders has been consistently lower in Shropshire compared to the national average between 2014/15 Q1 and 2017/18 Q1 (as seen in Chart 3.1.1 below). Latest data (2017/18 Q1) indicates 42.6 per 1,000 population (n=12,931) in Shropshire have been prescribed psychoses drugs compared to 48.9 per 1,000 in England.

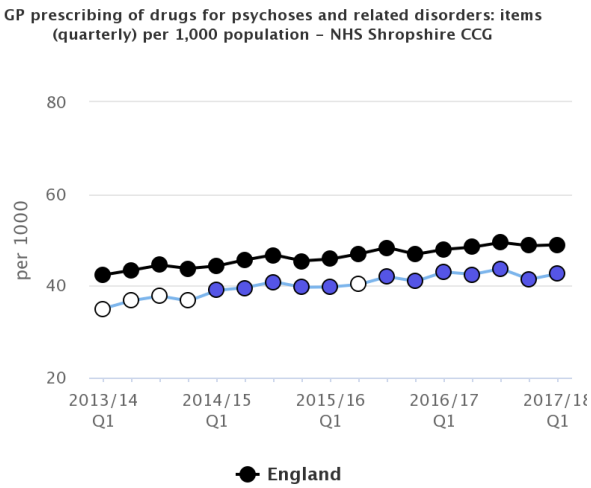
Chart 3.1.1



Severe and complex mental health outcomes for Shropshire (PHE Fingertips Data)

The following table outlines how Shropshire compares to the England average benchmarks for a number of factors related to severe and complex mental health outcomes.

Table 3.1.1: Severe and complex mental health outcomes

Shropshire performing better than the England average	Shropshire performing worse than the England average	Shropshire performing similar to the England average
1. The proportion of practice registers with recorded severe mental illness prevalence (QoF) for all ages, is consistently lower in Shropshire compared to the England average (shown in Chart 3.1.2 below). **Chart 3.1.2**  2. Shropshire has a significantly higher proportion of people with long term conditions who feel they have had enough support from local services in the last 6 months (65.5%) compared to the England average of 63.1% and the West Midlands average of 63.8%. 3. Since 2016/17 Q4, the rate of people in Shropshire subject to the Mental Health Act has been lower than the national average. In 2017/18 Q1 the local rate was 9.8 per 100,000 (n=25) population compared 38.4 per 100,000 for England.	1. Latest data from 2011 identifies that Shropshire had a significantly higher percentage of the population (18.6%) with a long-term health problem or disability compared to the England average of 17.6%. Shropshire is however, lower than the West Midlands average of 19%	1. 16.3 per 100,000 population (n=911) estimated incidence for new cases of psychosis in Shropshire which is statistically similar to the England average of 18.1 per 100,000 population 2. The proportion of mental health service users who were inpatients in a psychiatric hospital in Shropshire has been consistently similar to the national average between 2016/17 Q2 and 2017/18 Q1. The latest reporting period indicates 1.7% (n=25) of mental health service users are in hospital in Shropshire compared to 1.8 nationally

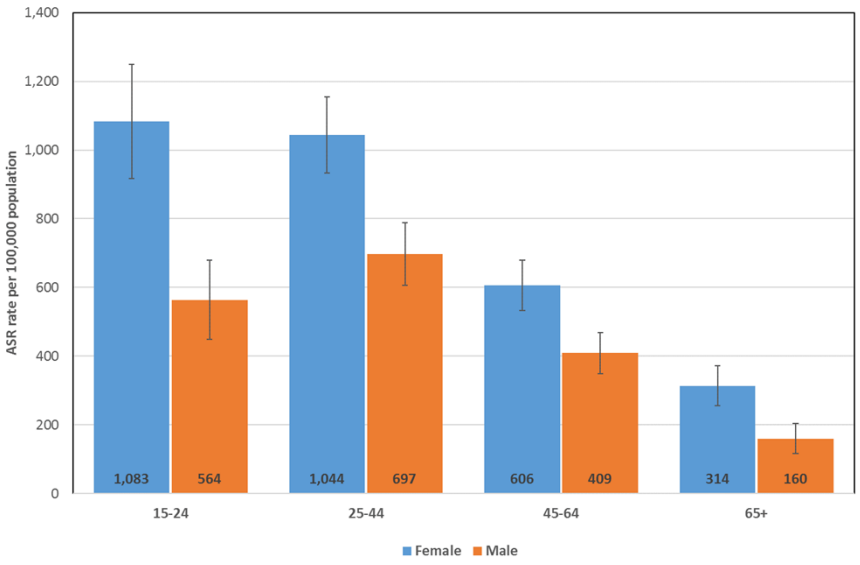
Findings from South Staffordshire and Shropshire Healthcare NHS Foundation Trust Intelligence Report (2017):

Non psychotic – very severe and complex disorders

Age and Gender:

- There were significantly higher rates of women compared to men with non-psychotic but severe and complex mental health illness.
- Between the genders, there were significantly higher rates of females compared to males across all the age bands with the highest rate in the 15-24 age band, which was similar to the 25-44 age band but was significantly higher than the 45+ age bands.
- The highest rates of males was in the 25-44 age band which was similar to the 15-24 age band but significantly higher than those in the 45+ age bands.

Chart 3.2.1: Non-psychotic – very severe and complex: by age and gender: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

Chart 3.2.2 shows the rate of deprivation for all age all gender is significantly higher for those from the most deprived quintile compared to all the other quintiles.

- The rates were similar between the genders across all the quintiles except SC3, which had a significantly higher rate of females to males.
- Female rates were highest from the most deprived area but similar to quintile 3 and significantly higher than those from the least deprived areas.
- Male rates were significantly higher for those from the most deprived quintile compared to all the other quintiles (Chart 3.2.3).

Chart 3.2.2: Non-psychotic – very severe and complex: all age all gender by deprivation: Age standardised rates per 100,000 population

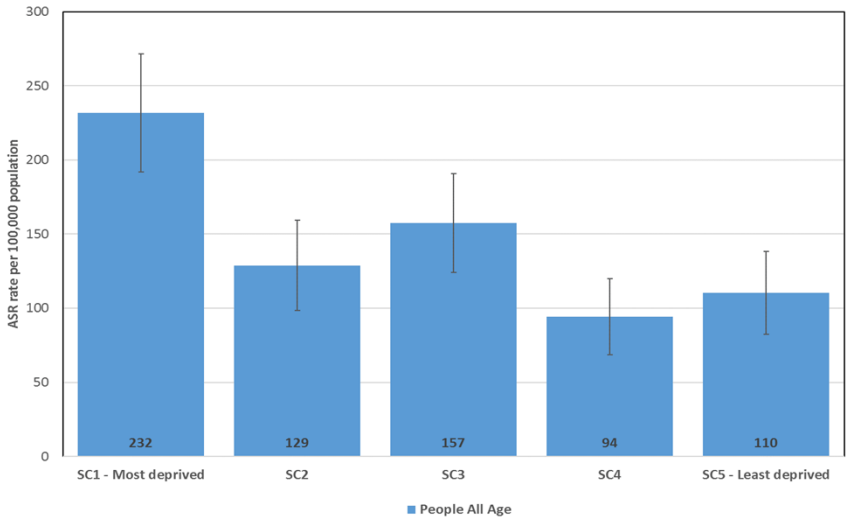
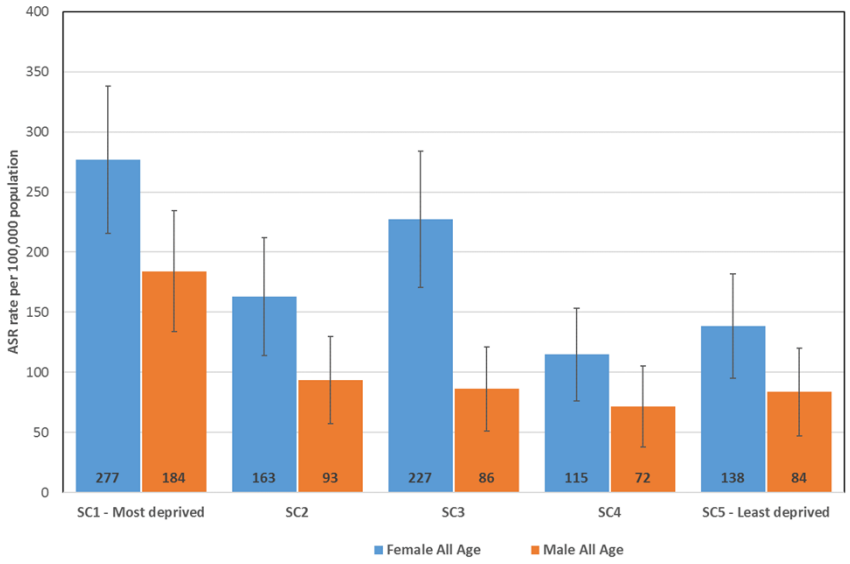


Chart 3.2.3: Non-psychotic – very severe and complex: all age and gender by deprivation: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

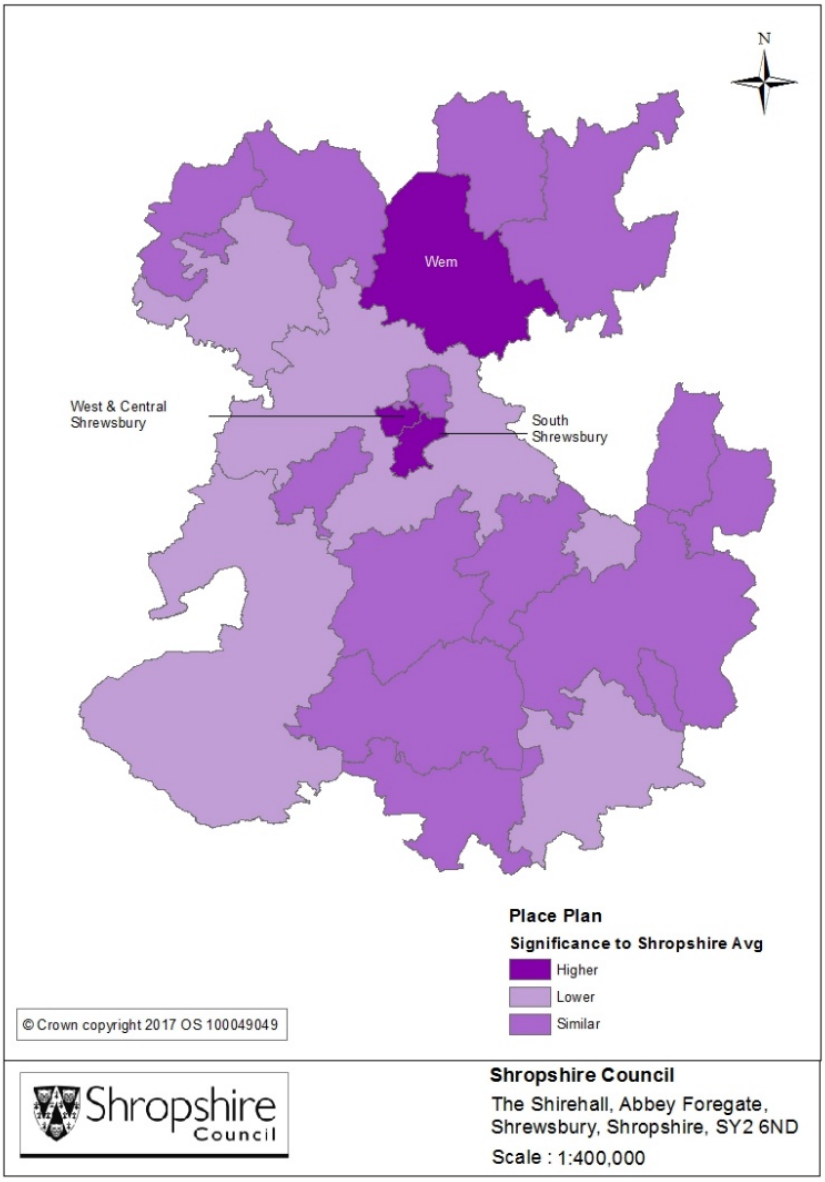
Rurality:

There were significantly higher rates of people from town areas compared to either rural or urban area, which were similar for all age and gender.

Place Plan:

Highlighted in the map overleaf, the dark purple are the place plan areas that were significantly higher than the Shropshire average for non-psychotic – very severe and complex cases and these were: Wem, West & Central Shrewsbury and South Shrewsbury.

Map *3.2.1:* Non-psychotic – very severe and complex: all age all gender by place plan
Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

3.3 Psychotic Disorders

Psychotic disorders produce disturbances in thinking and perception that are severe enough to distort perceptions of reality. They include schizophrenia and affective psychosis.

Although psychotic illness is relatively uncommon there is a resulting high level of service and societal cost. The World Health Organisation calculates that the burden and human suffering associated with psychosis at the family level is only exceeded by dementia and quadriplegia. Research undertaken within the Adult Morbidity Survey identifies that people with a psychotic illness who live in the community have low rates of employment and when employed, are often in poorly paid and less secure jobs.

Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014

The key findings from the Adult Morbidity Survey 2014 (AMS) found the following common characteristic associations for people with a psychotic disorder;

- Higher rates in black men compared to men from other ethnic groups
- Economically inactive
- Receipt of benefits (claimants of Employment and Support Allowance)
- People who live alone (social isolation)

Key messages from the APMS on a national level include;

- Prevalence of psychotic disorder in the past year: less than 1 adult in 100 was identified with a psychotic disorder (0.7% in 2014)
- Prevalence of psychotic disorder in the past year by age and sex: No difference in rate was found between men and women (0.5% men and 0.6% women).
- In both men and women the highest prevalence was in those aged 35 to 44 years

Chart 3.3.1 identifies the estimated numbers of diagnosed psychotic disorders by age group, based on the application of national rates from respondents of the APMS (2014) and applied to the Shropshire mid year population estimates.

The numbers are small compared to common mental disorders with an estimated 1,299 psychotic disorders in Shropshire (548 for males and 742 for females). Chart 3.1 shows the peaks for both males and females are for ages 35 to 44 years and 55 to 64 years, with female numbers being slightly higher than males for those aged 16 to 35 years and aged 55 or more.

Due to the difficulties often associated with missing data where confirmation through SCAN interview was not undertaken in assessment. (SCAN is a set of instruments and manuals aimed at assessing, measuring and classifying psychopathology and behaviour associated with the major psychiatric disorders in adult life.)

Chart 3.3.2 identifies the estimated numbers of Shropshire people by age who are classified as having a probable psychotic disorder. This has been calculated in the same manner as Chart 3.1 using mid year population estimates and APMS rates. The Chart shows that although male prevalence peaks are the same as in Chart 3.1, the female peak is clearly defined for the 45 to 54 year old group.

Chart 3.3.1: Estimated number of Psychotic disorders in the past year based on mid year populations (2016) for Shropshire males and females by age and rates in the APMS (2014)

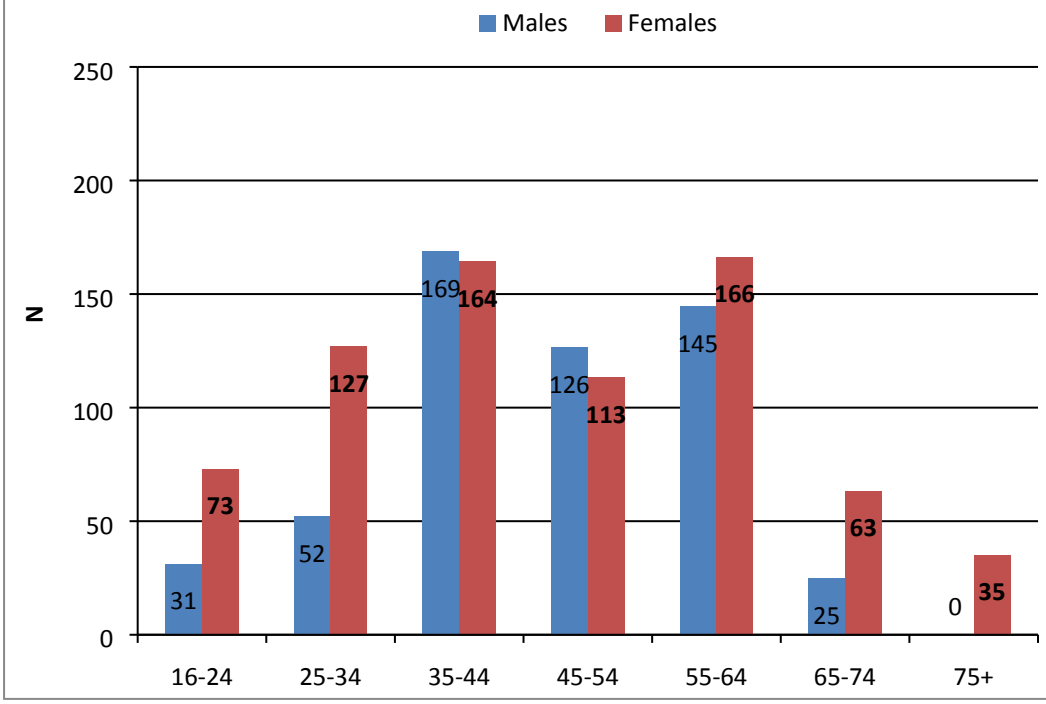
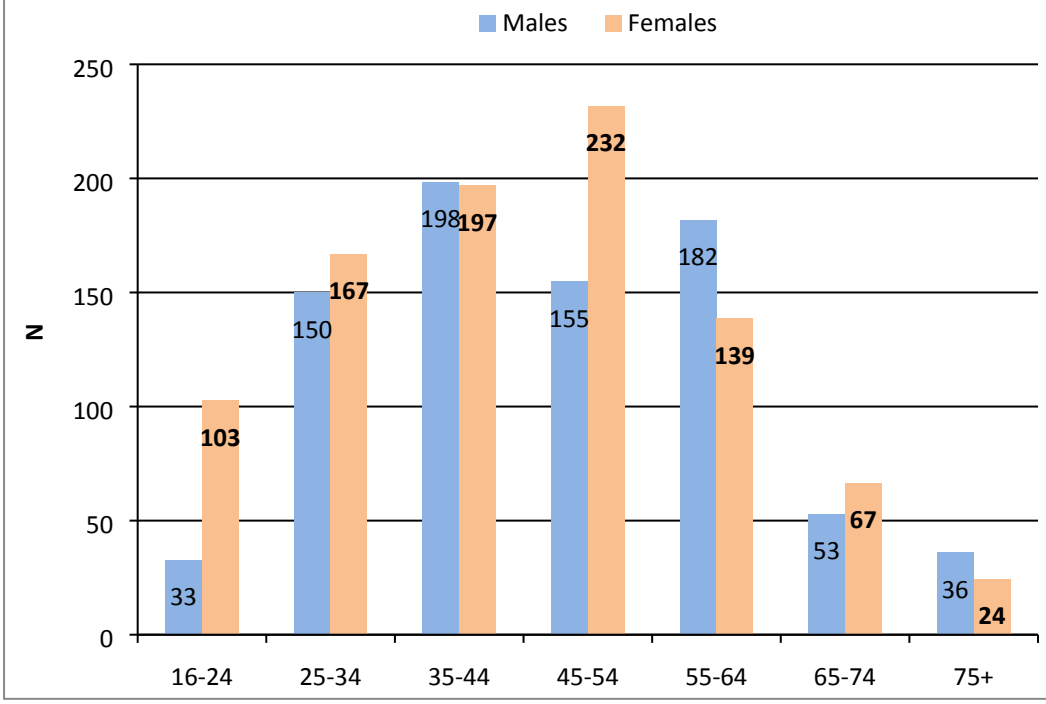


Chart 3.3.2: Estimated number of Probable Psychotic disorders in the past year based on mid year populations (2016) for Shropshire males and females by age and rates in the APMS (2014)



Public Health England Health Profile for Shropshire

Key messages from the Health Profiles indicate the following trends. Note there were no areas on the Profile where Shropshire was recorded as performing worse than the national average;

Shropshire performing similar to the England average
1. Social care mental health clients receiving services: rate per 100,000 population ▪ 2012-13 to 2013-14 Shropshire rates were significantly below both the England average and the West Midlands average. ▪ Shropshire rate in 2013-14 was 108 compared to the England average of 384 and the West Midlands rate of 247. ▪ Both the Shropshire County and England trends were decreasing **2.** Schizophrenia emergency admissions: rate per 100,000 population aged 18+: ▪ 2011-12 were significantly lower than either the England or West Midlands averages. ▪ 2009-10-2011-12 the England rate (57) increased at a higher rate compared to Shropshire at 37 3. New cases of psychosis: estimated incidence rate per 100,000-population aged 16-64 ▪ 2011 synthetic data: Shropshire rates (16.3) were significantly lower than either the England average of 24.2 or the West Midlands average of 25

Findings from Shropshire County Mental Health Services Intelligence Report (Feb 2016 – Feb 2017)

In this section 4 groups of psychosis were defined;

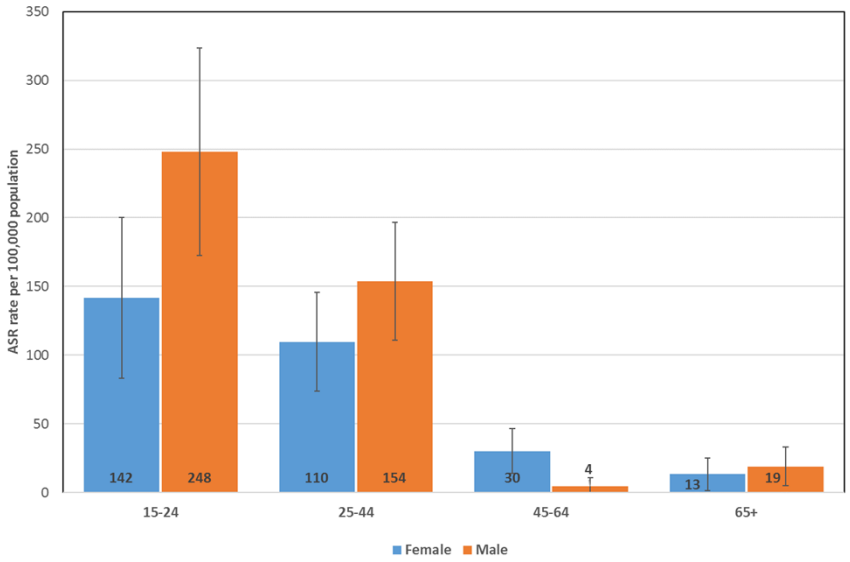
- Group 1: psychosis 1st episode
- Group 2: psychosis ongoing or recurrent
- Group 3: psychotic crisis
- Group 4: very severe engagement

Group 1: psychosis 1st episode

Age and Gender:

- There were similar rates between males and females for all ages and across all the age bands except for those aged 45-64 where there were significantly higher rates of females to males.
- For both males and females, rates were higher in 15-24 age band but were similar to those aged 25-44 but significantly higher than those aged 45+.

Chart 3.3.3: Psychosis - 1st episode: by age and gender: Age standardised rates per 100,000 population

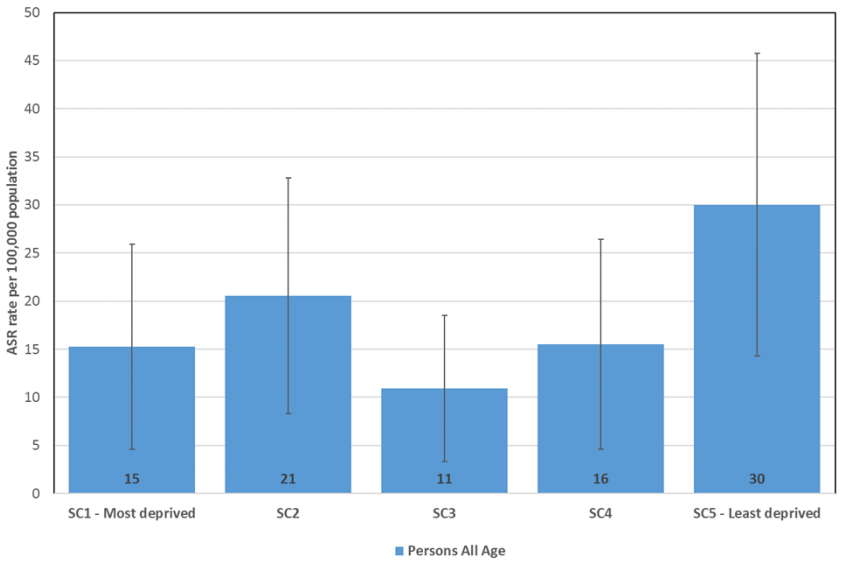


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

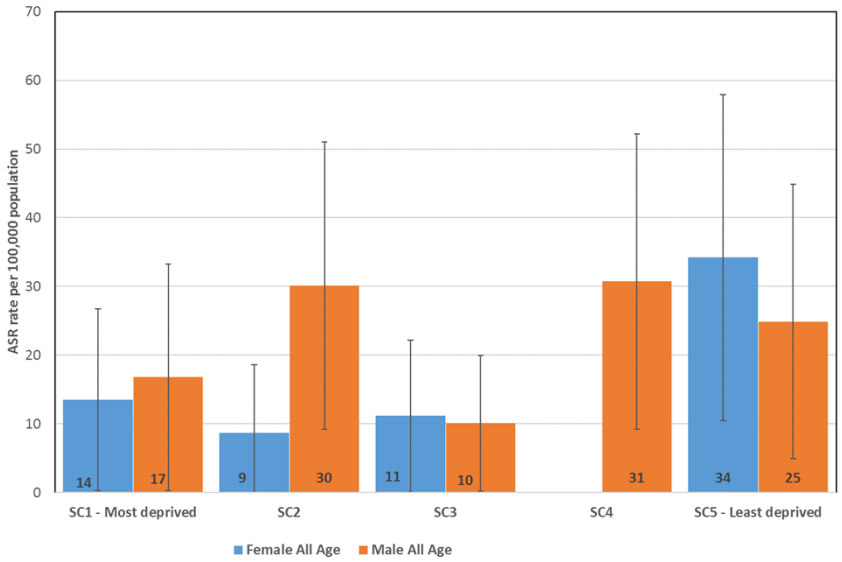
- Chart 3.3.4 shows that by all age all gender there were higher rates of people from the least deprived quintile but that the rates were statistically similar across all the deprivation quintiles.
- Chart 3.3.5 shows that where a rate was recorded, rates were higher for females from the least deprived area but were statistically similar across all the deprivation quintiles
- Rates were higher for males from both the second and fourth quintiles but were again statistically similar across all the quintiles.

Chart 3.3.4: Psychosis - 1st episode: All age all gender by deprivation: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Chart 3.3.5: Psychosis - 1st episode: All age and gender by deprivation: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

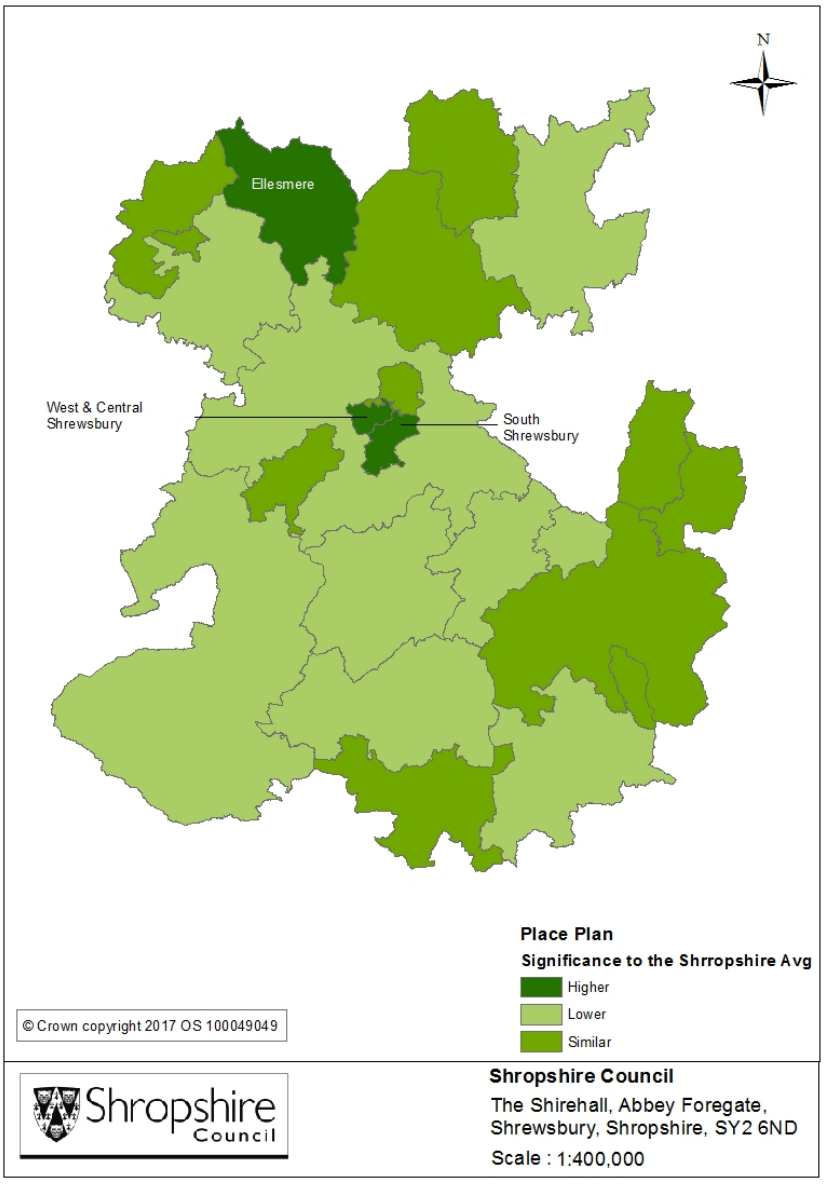
Rurality:

For all age all genders, there were similar rates from rural and town areas but significantly lower rates from urban areas.

Place Plan

Highlighted in dark green are the place plan areas that were significantly higher than the Shropshire average for Psychosis - 1st episode cases and these were: Ellesmere, West & Central Shrewsbury and South Shrewsbury.

Map 2.*3.1*: Psychosis - 1st episode: all age all gender by place plan
Age standardised rates per 100,000 population



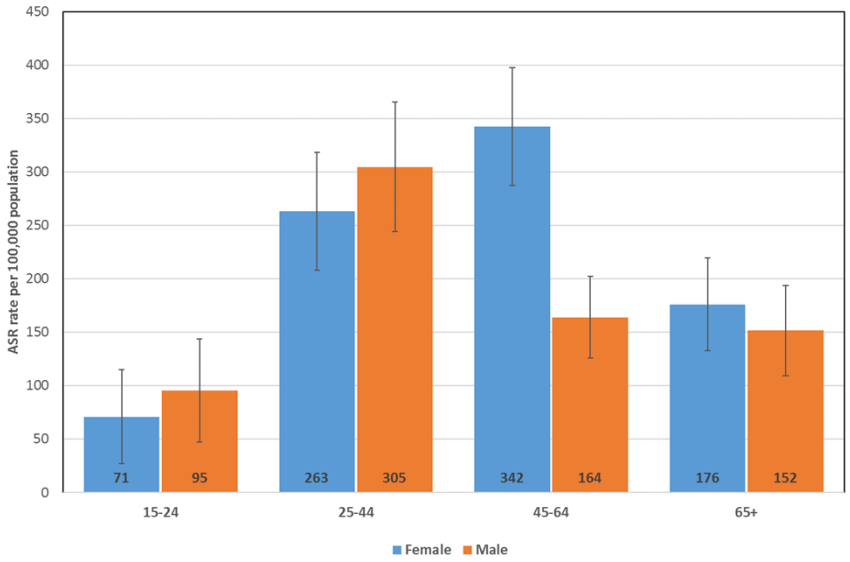
Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Group 2: psychosis ongoing or recurrent

Age and Gender:

- Overall, there were higher rates of females to males but this was not significant.
- There were similar rates between the genders across all the age bands except for those aged 45-64 which had significantly higher rates of females compared to males.
- Figure 12 shows that there were higher rates for females in the 45-64 age band, which was similar to those aged 25-44 but significantly higher than those from the remaining age bands.
- There were significantly higher rates for males aged 25-44 compared to all the other age bands.

Chart 3.3.6Psychosis - ongoing or recurrent: by age and gender: Age standardised rates per 100,000 population

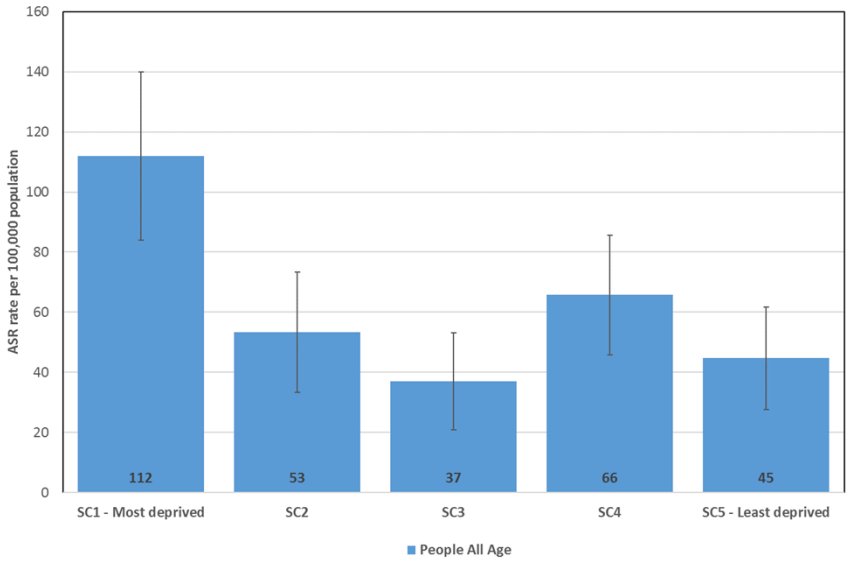


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

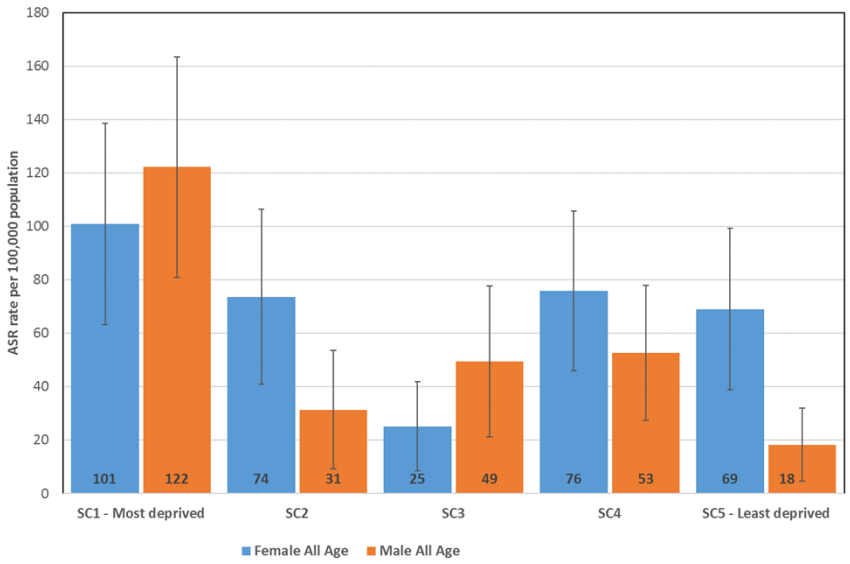
- For all age all genders, the highest rates were from the most deprived quintile and were similar to quintile 3 but was significantly higher than the remaining quintiles.
- Chart 3.3.7 shows higher rates of females from the most deprived quintile but was similar to all the remaining quintiles except quintile 3, which is significantly lower.
- There were significantly higher rates for males from the most deprived quintile compared to all the other quintiles.

Chart 3.3.7: Psychosis - ongoing or recurrent: all age all gender by deprivation: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Chart 3.3.8: Psychosis - ongoing or recurrent: all age and gender by deprivation: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

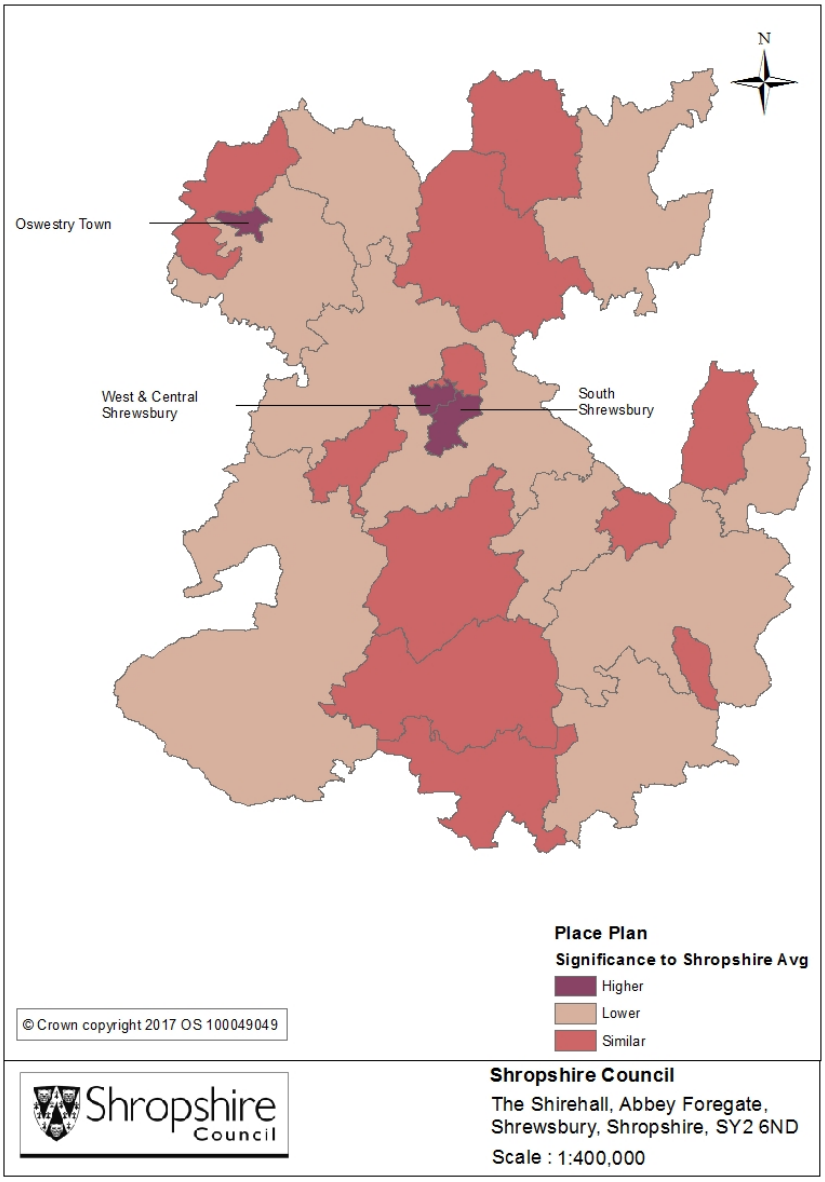
Rurality:

There were higher rates of people from towns but there was no significant difference between the areas.

Place Plan:

Highlighted in dark mauve are the place plan areas that were significantly higher than the Shropshire average for Psychosis - ongoing or recurrent cases and these were: Oswestry Town, West & Central Shrewsbury and South Shrewsbury.

Map *3.3.2*: Psychosis - ongoing or recurrent: all age all gender by place plan: Age standardised rates per 100,000 population



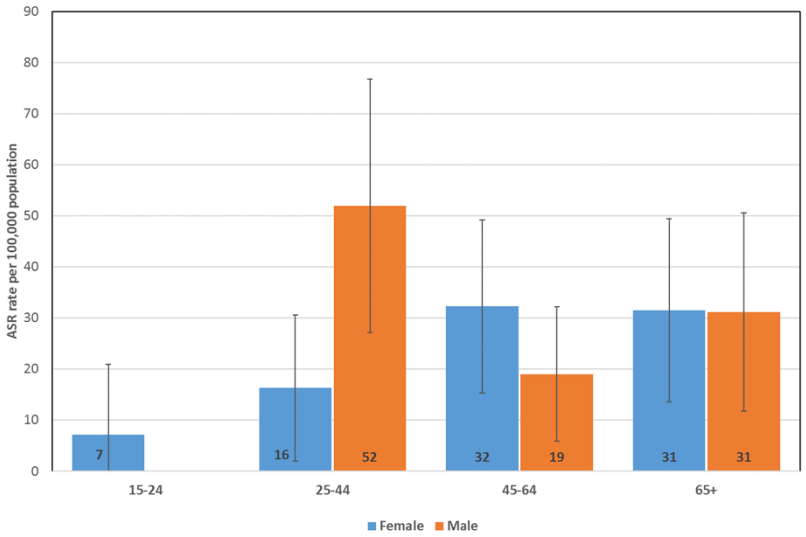
Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Group 3: Psychotic crisis

Age and Gender:

- Overall, there were higher rates of males to females but this was not significant.
- Chart 3.3.9 shows that where a rate was recorded, the rates were similar between the genders across all the age bands and rates were similar between each age band for each gender.

Chart 3.3.9: Psychosis - psychotic crisis: by age and gender: Age standardised rates per 100,000 population

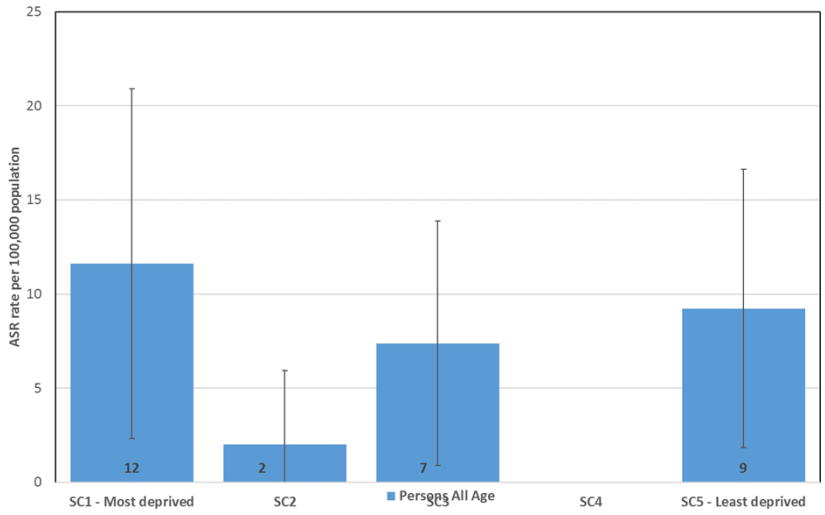


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

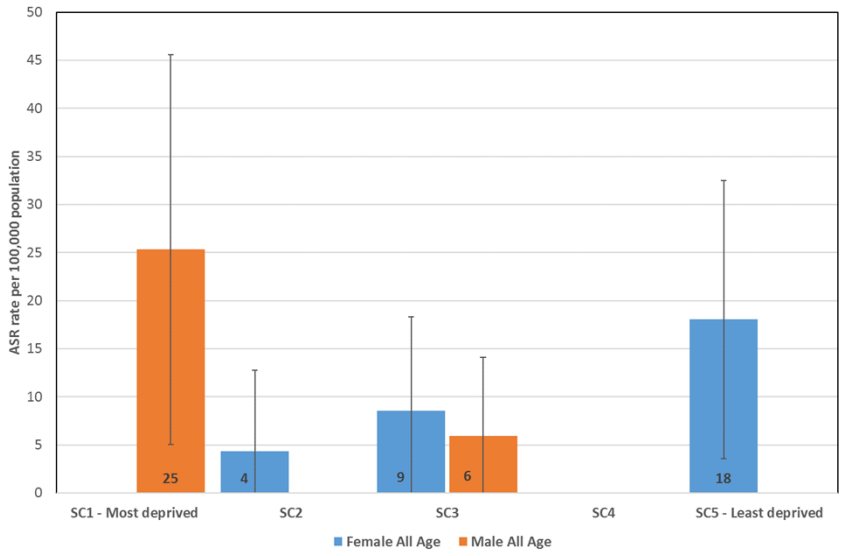
- Chart 3.3.10 shows that where a rate was recorded, a higher rate of people from the most deprived quintile; however, this was not significant.
- Chart 3.3.11 shows that rates were similar between the genders across all the quintiles
- There were higher rates of females from the least deprived quintile but this was not significant whilst there were higher rates of males from the most deprived quintile but this was similar to all the other quintiles.

Chart 3.3.10: Psychotic crisis: all age all gender: by deprivation
Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Chart 3.3.11: Psychotic crisis: all age and gender by deprivation
Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

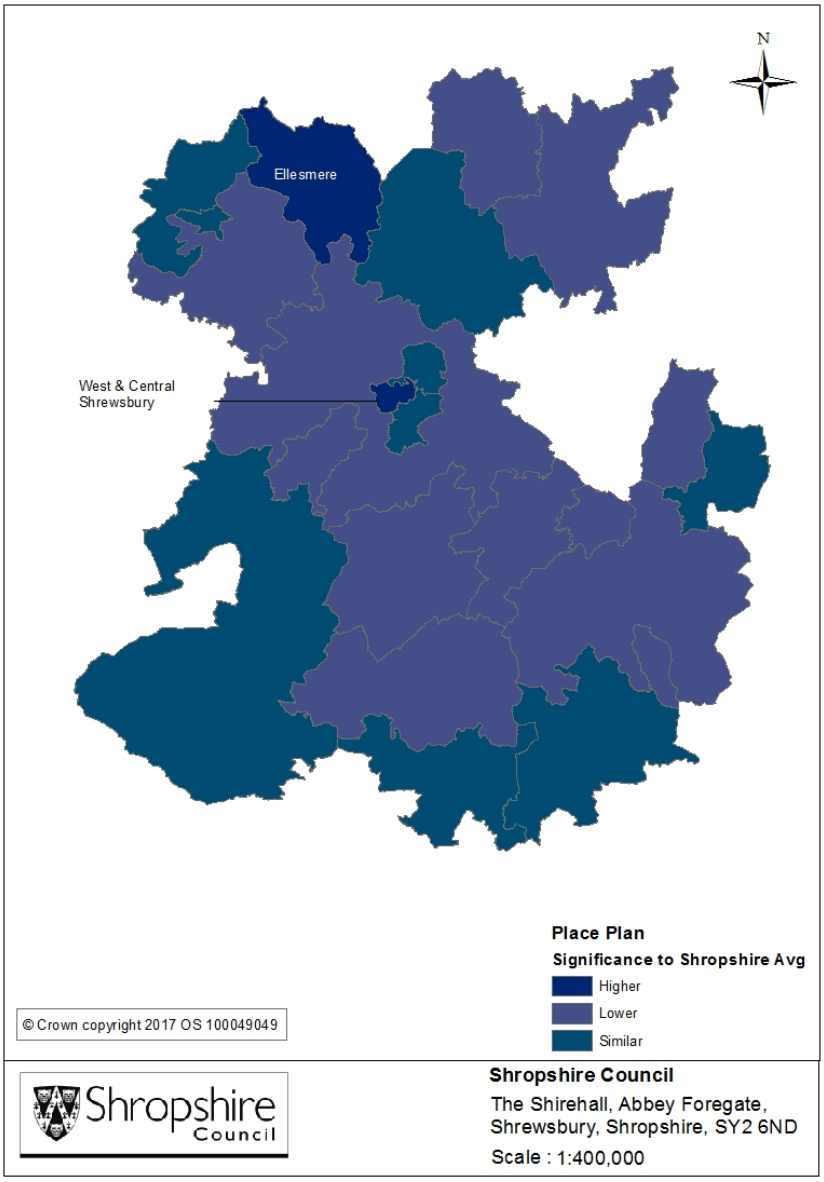
Rurality:

Rates for urban areas were nil but were similar between rural and town areas.

Place Plan:

Highlighted in dark blue are the place plan areas that were significantly higher than the Shropshire average for Psychotic crisis cases and these were: Ellesmere Town and West & Central Shrewsbury.

Map *3.3.3*: Psychotic crisis: all age all gender: by place plan
Age standardised rates per 100,000 population



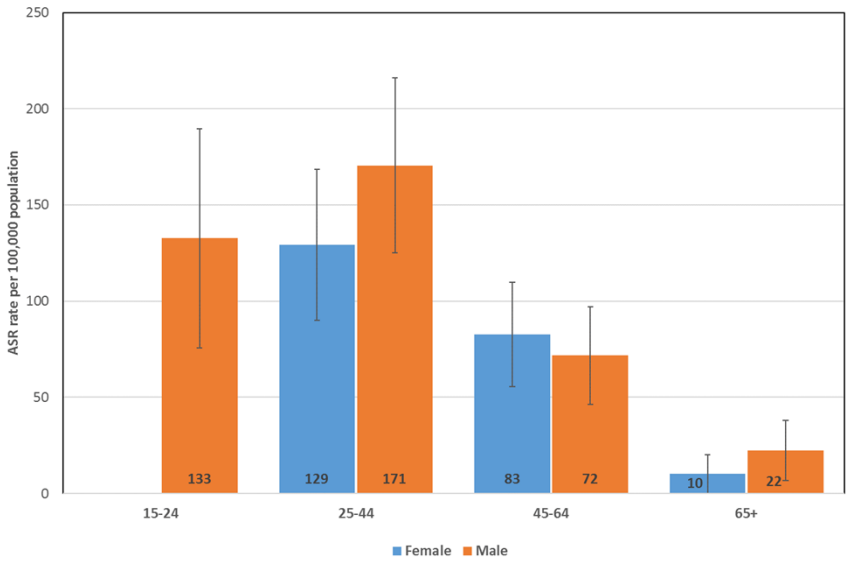
Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Group 4: Psychosis with very severe engagement

Age and Gender:

- For all age all gender, there were higher rates for males compared to females but this was not significant.
- Rates between the genders across all the age bands were similar except for 15-24 year olds where there was a nil count for females.
- Figure 18 shows that where a rate was recorded, the highest rate for females was in the 25-44 age band and was similar to the 45-64 year age band but was significantly higher than the 65+-age band.
- There was a similar pattern for males: the highest rate being in the 25-44 age band and similar to those aged 15-24 but significantly higher than those aged 45+.

Chart 3.3.12: Psychosis - very severe engagement: by age and gender
Age standardised rates per 100,000 population



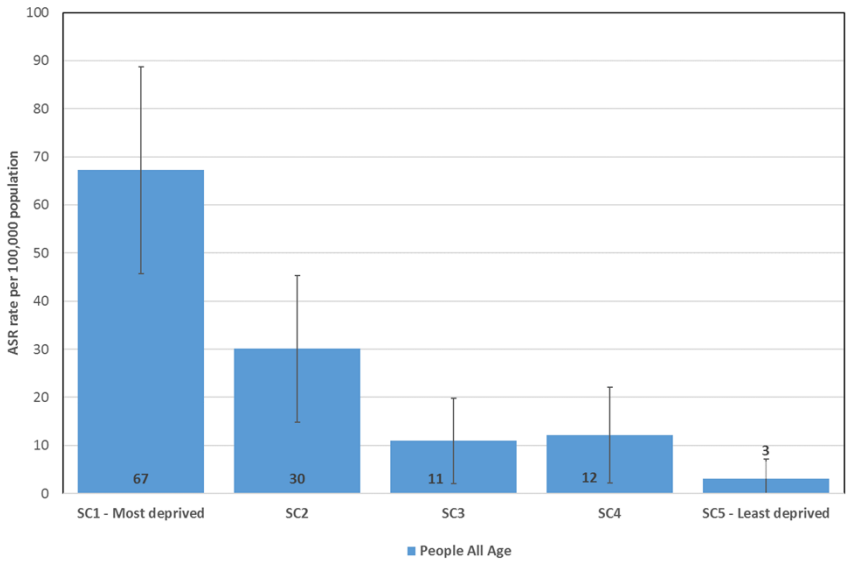
Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

- For all age, all gender there was a significantly higher rate of people from the most deprived quintile compared to all the other quintiles (figure 19).
- Chart 3.3.13 shows that where a rate was recorded, there was no significant difference between the genders; however there were higher female rates from the most deprived quintile which was similar to SC2 but was significantly higher than the lesser deprived area SC4.
- There were higher rates of males from the most deprived quintile, which was similar to SC3 but significantly higher than the lesser deprived quintiles SC4-SC5.

Chart 3.3.13: Psychosis - very severe engagement: all age all gender by deprivation

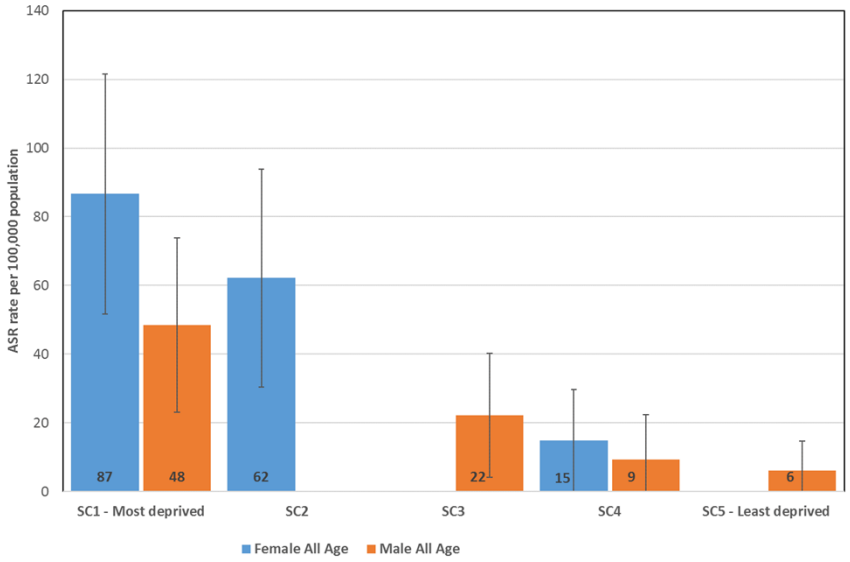
Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Chart 3.3.14: Psychosis - very severe engagement: all age and gender by deprivation

Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Rurality:

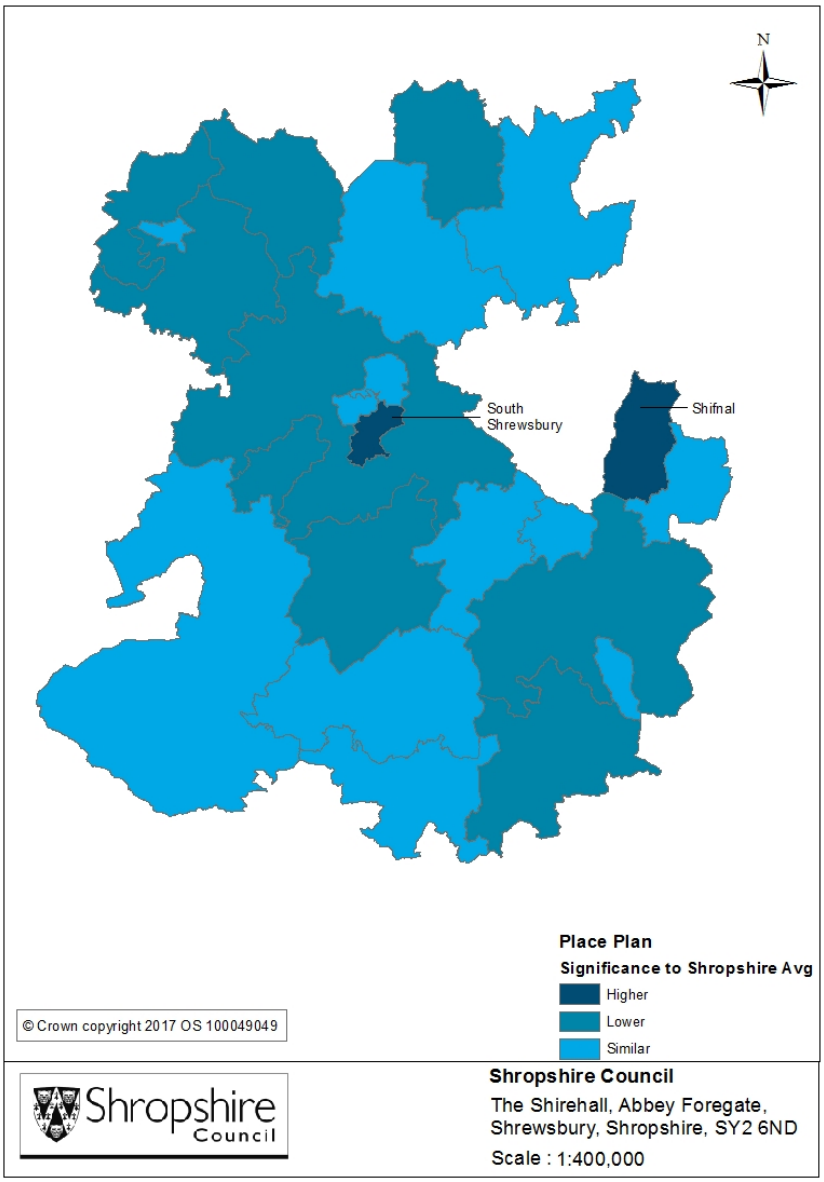
There was a higher rate of people from town areas but this was similar to both rural and urban areas.

Place Plan:

Highlighted in dark blue are the place plan areas that are significantly higher than the Shropshire average for Psychosis - very severe engagement cases and these are: South Shrewsbury and Shifnal.

Map 3.3.4: Psychosis - very severe engagement: all age all gender by place plan

Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Section 4: Crisis, Self-Harm and Suicide

Crisis

A mental health crisis is where a person feels unable to cope or be in control of a situation and associated with extreme emotional distress or anxiety, inability to cope with day-to-day life or has thoughts about suicide, self-harm or experience hallucinations.

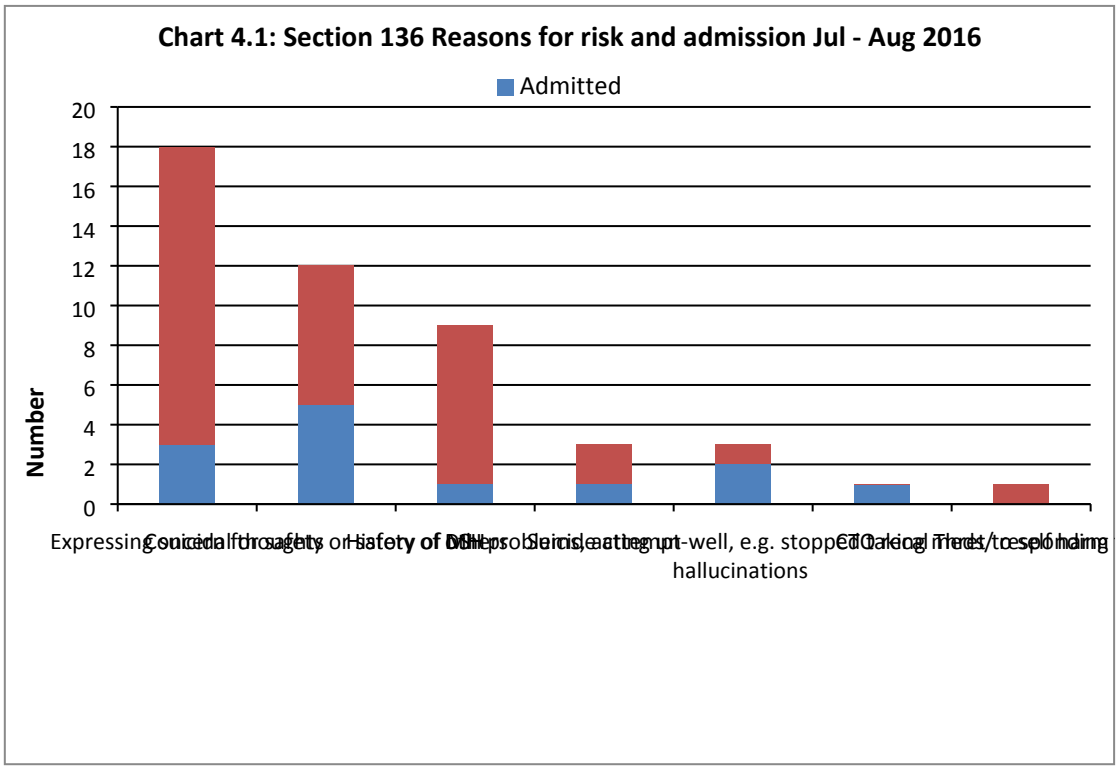
Section 136

A section 136 refers to an emergency power within the Mental Health Act which allows an individual to be taken to a place of safety from a public place, if a police officer considers that individual to be suffering from mental illness and in need of immediate care. A place of safety could be a person's home, a hospital or a police station. Rates of Section 136 in Shropshire have been reported locally as being high.

Within Shropshire there has been 1 Section 136 Suite with another opening recently in 2018. Chart 4.1 below shows the findings of an audit of activity during July and August 2016 identified the following reasons why people were identified under a Section 136 and whether they were admitted to the suite or not.

It can be seen that;

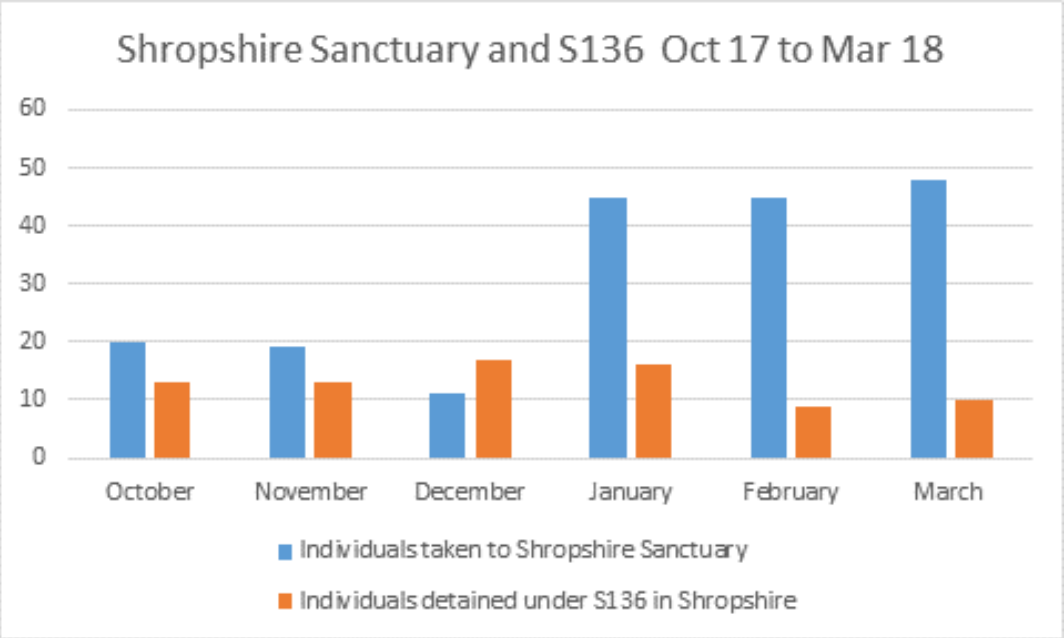
- 47 people were identified under a Section 136 during July and August 2016 with 13 being admitted to the Suite
- Suicidal thoughts were the most frequent reason for use of Section 136 but most likely to not be admitted to the Suite
- The primary reason for admittance to the Suite is where there was concern for the safety of the individual or for others



Shropshire Sanctuary

During 2016/17 Shropshire MIND and Shropshire CCG (and in partnership with West Mercia police and a range of other mental health providers) developed a sanctuary model of care in order to provide an alternative location to Section 136 for people in crisis/mental distress during after-hours. The Shropshire Sanctuary is based at Observer House in Shrewsbury and provides a safe, calm, welcoming and reassuring environment that is responsive to support individuals to relieve mental distress, anxiety and associated issues. Following a visit to the Shropshire Sanctuary, a follow up contact is attempted where appropriate to provide a "check up".

Use of the Shropshire Sanctuary has increased significantly since January 2018 and is helping to manage demand on the Section 136 Suite. In March 2018, there were 10 attendance for Section 136 and 48 for the Shropshire Sanctuary. At least half of the reason for visits were related to suicidal thoughts.



The latest qualitative feedback from the Shropshire Sanctuary indicates there has been increasing footfall, with more people being supported by the Sanctuary in the first seven days of January 2018 than the whole of the previous month. This equates to an average of 2 people per shift, with an average of 3 to 5 hours stay.

[23] J. Randall, N. Nickel and I. Colman, "Contagion from Peer Suicidal Behavior in a Representative Sample of American Adolescents," *Journal of Affective Disorders,* vol. 186, pp. 219-225, 2015.
[24] P. Qin, E. Agerbo and P. Mortensen, "Suicide Risk in Relation to Family History of Completed Suicide and Psychiatric Disorders: A Nested Case-control Study Based on Longitudinal Registers," *The Lancet,* vol. 170, pp. 1126-1130, 2002.
[25] S. Nilsson, C. Feodor, R. Hjorthoj, A. Erlangsen and M. Nordentoft, "Suicide and Unintentional Injury Mortality among Homeless People: A Danish Nationwide Register-based Cohort Study," European Journal of Public Health, vol. 24, pp. 50-56, 2013.
[26] A. Milner, A. Page and A. Lamontagne, "Long-Term Unemployment and Suicide: A Systematic Review and Meta-Analysis," *PLOS One,* vol. 8, 2014.

Suicide

Research has found evidence for risk of suicide increases with history of suicide or self-harm among close friends or family[2324] , alcohol or substance misuse[25], unemployment[26], male gender[27] and schizophrenia spectrum disorders[28].

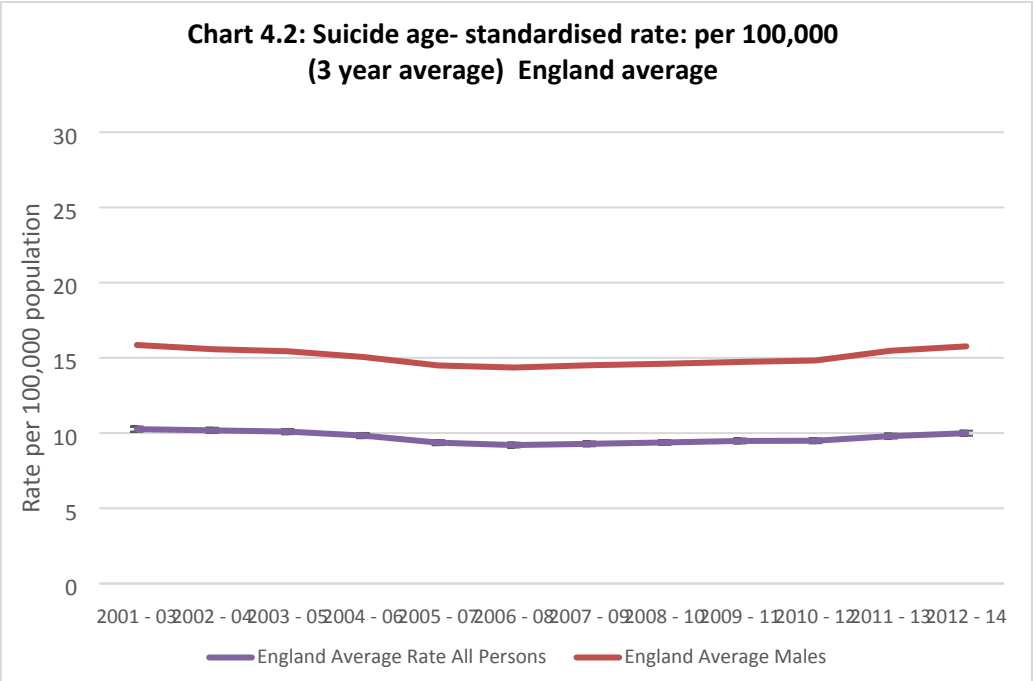
Every day in England around 13 people take their own lives and the effects can reach into every community and have a devastating impact on families, friends, colleagues and others. It is the leading cause of premature mortality in men younger than 50 years and those who are bereaved by suicide are at three times the risk of making a suicide attempt themselves.

Suicide risk reflects the wider inequalities as there are marked differences in suicide rates according to people's social and economic circumstances, with those in poorer communities more likely to be affected.

National data on suicide identifies the following key themes;

- In 2014 in England there were 4,882 deaths registered as a result of suicide.
- The rate has remained similar since 2001 and is currently at 10.1 per 100,000 people (2013 – 15).
- Men are significantly higher risk with 3 out of 4 suicides being completed by men, with the greatest risk in those aged 45 to 49 years.
- There is a secondary peak in suicides for men aged over 75 years which is attributed to those affected by bereavement, loneliness and chronic illness
- There has been an increasing trend in recent years of female suicides
- Greater risk of suicide is associated for people with a history of self-harm, mental ill health, substance misuse and time spent in prison.
- Additional key risks include access to means, chronic illness and occupation (particularly medical, vets, farmers and those in lowest skilled occupations such as males in labourer or construction roles).
- Suicide rates for children and young people are low in England, with a total of 145 suicides between 2014 and 2015. Those in their late teens are at greatest risk, with 70% being male in this period.
- Reasons identified for the young people that committed suicide include bereavement by the suicide of a friend or family member, a chronic health problem such as asthma or acne, academic stress, bullying and social isolation.

[27] Department of Health, "Preventing suicide in England: Two years on. Second annual report on the cross-government outcomes strategy to save lives.," The Stationary Office, London, 2015.
[28] K. Hor and M. Taylor, "Suicide and Schizophrenia: A Systematic Review of Rates and Risk Factors," vol. 24.4S, 2010.

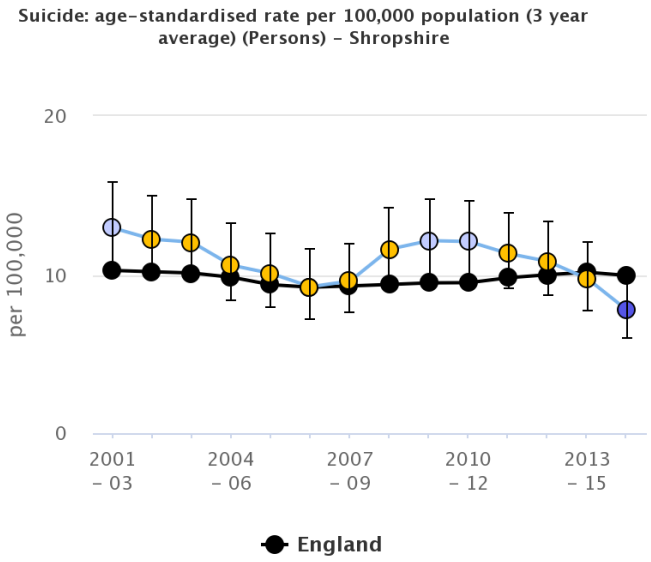


Application to Shropshire

Between 2013 and 2015 there were 131 deaths recorded as suicide across Shropshire and Telford and Wrekin (both LA areas which share a Coroner service). Of these, 100 were men and 31 were female.

Chart 4.3 (below) compares the age standardised rate of suicide for Shropshire compared to the England average, based on 3 year average data (due to small numbers). It can be seen that following an increase above the England rate in 2010-12, the local suicide rate has consistently been reducing to the latest data point for 2013-15 where it is now significantly lower compared to the national average.

Chart 4.3



Data from the Public Health England Health Profile identified the following trends of the age standardised suicide rate for Shropshire;

- Suicide rate in Shropshire declined in the period 2011-13 to 2013-15.
- The Shropshire rate (9.7 per 100,000 people) was similar in 2013-15 to both the England rate of 10.2 per 100,000 and the West Midlands rate of 10.3 per 100,000

An audit of Coroner inquests for deaths by suicide or expected suicide between 2014 and 2016 identified the following themes;

- 95 suicides across Shropshire and Telford and Wrekin
- 54 (57%) of these suicides took place within a Shropshire postcode
- 72% of suicides were male (n=69) and 28% female (n=27). The table below provides a summary of suicide by gender by location of death.

Suicide - by gender 2014 -2015 for T&W and Shropshire

Row Labels	Shropshire	T&W	Grand Total
Female	16	11	27
Male	38	30	68
Grand Total	54	41	95

Suicide Prevention in Shropshire

A Shropshire and Telford and Wrekin joint Suicide Prevention Strategy (2017 to 2020) was ratified in May 2017 and is currently being implemented through the creation of a Shropshire Partnership Action Group (with stakeholders representing health, social care, the voluntary and community sector as well as organisations that have regular interaction with high risk groups). The Strategy seeks to;

- Reduce suicide in Shropshire through early identification and intervention for people at risk
- Provide the best support for people affected by suicide and ensure they are connected to the services which can most meet their needs
- Promote clear pathways and signposting to the various sources of support for people experiencing crisis and who may be either self-harming or considering suicide
- Equip all services who may interact with people at greater risk of self-harm or suicide with the knowledge and confidence to recognise systems of risk and approaches to intervention.

As of December 2017, the Shropshire Suicide Prevention Action Group (a multi-agency partnership) agreed the formation of 6 work streams with dedicated operational teams to be established and progress actions to achieve the outcomes of the Strategy. The work streams are as follows;

Work-streams	Purpose
Communications and Media	▪ To develop and implement a Communications Strategy for the Shropshire Action Plan in order to raise awareness across the county and encourage participation with the agenda. ▪ To work with the media to reduce stigma, reduce the risk of imitation following a suicide death and information as to how to access local support services if writing a related story.
Access to support, Prevention and Care Plans	▪ To reduce the risk of suicide in high risk groups through the use of targeted programmes. ▪ To identify and promote the access points/services that can provide support for people who self-harm/are at risk of suicide/are in crisis or bereaved by suicide. ▪ To ensure clear pathways exist and are communicated between different agencies (including education, primary care, probation etc). ▪ To ensure continuity for access to appropriate support is built into other care pathways

	(such as depression) following discharge. ▪ To establish pathways that monitor parity of care between mental, physical health and long term conditions. ▪ To review support available and communication pathways for Carers of vulnerable people that are at risk of suicide. ▪ To ensure Care Plans are used and provided for people identified at risk in an appropriately timed manner for the situation (e.g. immediate plans for those presenting in crisis). Specific links to be made with perinatal mental health and older people.
Using Information and Data	▪ To identify what types of data will best inform impact of activity and how the partnership group can share relevant information. ▪ To consider whether the group can influence the collection of information that may better inform our actions (e.g. coding systems for deliberate self-harm in A&E).
Self-Harm	▪ To identify how we can best work with partners to identify people who deliberately self-harm, appropriate sharing of information and how to ensure they can access support.
Engaging post Suicide	▪ To provide a package of care for people who have been affected by a suicide death which establishes a consistent message as to the different types of support available, what will be happening as part of the post suicide process and can provide a link into/between these services.
Training	▪ To provide suicide awareness and self-harm training for all staff with a public facing role in order to identify warning signs and understand how to refer to appropriate support agencies. ▪ Suicide post-vention training to be provided to all people who are most likely to interact with bereaved people following a suicide death. ▪ To promote good emotional wellbeing and mental health first aid within workplaces and organisations across Shropshire.

Self-Harm

Self-harm, whether involving intentional self-poisoning or self-injury, is the most important risk factor for death by suicide, even though many people who self-harm do not intend to take their own life. People who frequently present to hospital following self-harm are a particularly vulnerable group.

While most people who self-harm do not die by suicide, the strong link between self-harm and suicide make this a matter of concern. Evidence as reported by Public Health England has found that;

- There are around 200,000 episodes of self-harm that present to hospital services each year nationally
- The true scale of the problem is not known as many people who self-harm do not attend A&E or seek help from health or other services
- Roughly 50% of people who die by suicide have a history of self-harm, in many cases with an episode shortly before death
- Around 15% of those who die by suicide have carried out an act of self-harm leading to presentation at hospital in the year before their death

Data from the PHE Health Profiles for Shropshire has identified for Emergency hospital Admissions for intentional self-harm;

- The rate has increased in the 3-year period 2012-13 to 2014-15
- Shropshire rates in 2014-15 (176) are similar to both the England rate of 191.4 and the West Midlands rate of 191

Shropshire demographics of self-harm

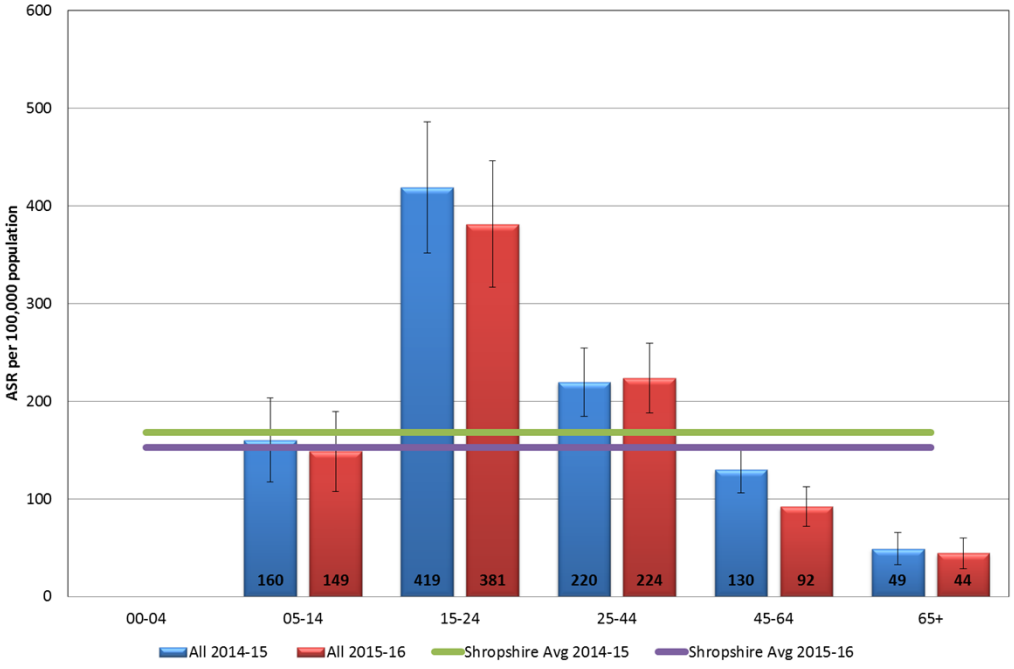
Local analysis from the Shropshire Emergency Self-harm Admissions 2014-15 & 2015-16 report (Shropshire Council, 2017) identified the following trends;

1. The top 10 self-harm hospital admissions by diagnosis in the reporting time period (which comprised over 85% of all diagnosed self-harm admissions) were;
    i. Open wound of forearm
    ii. Open wound of wrist and hand
    iii. Poisoning by hormones and their synthetic substitutes and antagonists, not elsewhere classified
    iv. Poisoning by nonopioid analgesics, antipyretics and antirheumatics
    v. Poisoning by narcotics and psychodysleptics [hallucinogens]
    vi. Poisoning by antiepileptic, sedative-hypnotic and antiparkinsonism drugs
    vii. Poisoning by psychotropic drugs, not elsewhere classified
    viii. Poisoning by drugs primarily affecting the autonomic nervous system
    ix. Poisoning by primarily systemic and haematological agents, not elsewhere classified
    x. Poisoning by diuretics and other and unspecified drugs, medicaments and biological substances

2. There were no significant differences between the proportions of people admitted for self-harm between 2014-15 (437 admissions, 53%) and 2015-16 (387 admissions, 46.9%).

3. In both years there was a higher rate of females admitted for self-harm (a rate of 203 per 100,000 people in 14/15 and 191 per 100,000 people in 15/16) compared to males (rate of 134 per 100,000 people in 14/15 and 117 per 100,000 in 15/16). There were no significant differences between the years for each gender.
4. Chart 4.4 shows the rate of admissions by year and age band. There were significantly higher rates of admissions in both years for those aged 15-24 followed by those aged 25-44 both of which were significantly higher than the Shropshire average. Rates were similar between the years in all age bands.

Chart 4.4: Age standardised rate (per 100,000 population) of all self-harm admissions by year and age band



Source: SUS Hospital admissions data extracted by CSU 2014-15 – 2015-16

5. A significantly higher rate of females compared to males was admitted from age bands 05-14 and 15-24 in both years; however rates were similar for each gender, across both years in each age band (table 1).

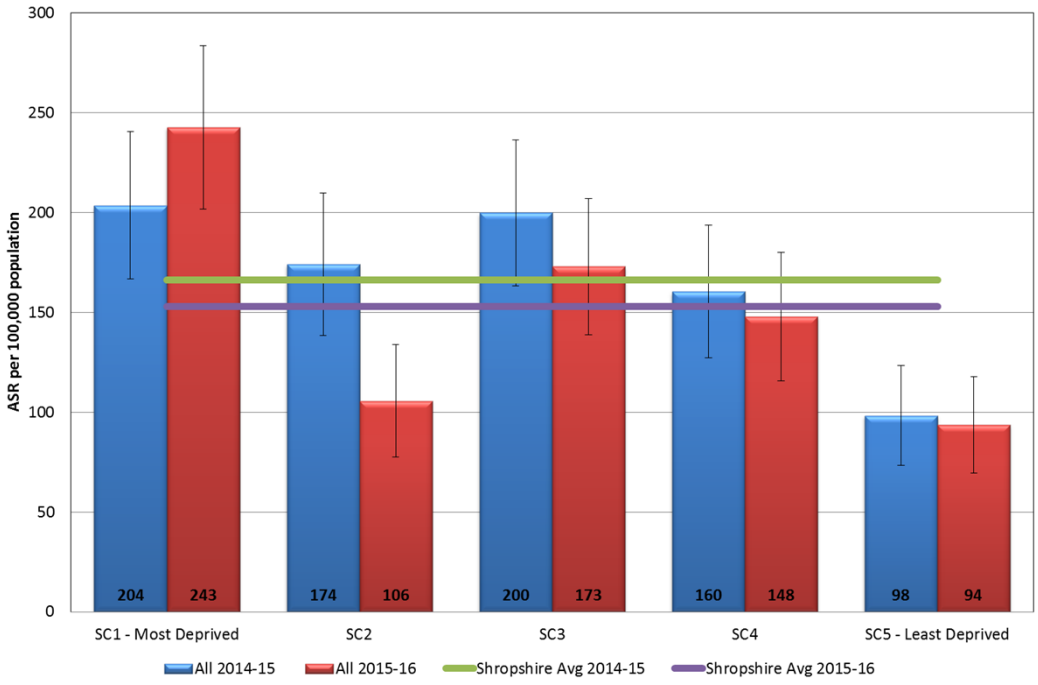
Table 4.1: Age standardised rate (per 100,000 population) of all self-harm admissions 2014-15 – 2015-16 by age band and gender

	95% confidence interval											
Age	Male 2014-15	LLC	UCL	Female 2014-15	LLC	UCL	Male 2015-	LLC	UCL	Female 2015-16	LCL	UCL
00-04	0	0	0	0	0	0	0	0	0	0	0	0
05-14	35	7	64	286	205	367	36	7	64	262	185	340
15-24	273	198	348	580	465	694	192	128	256	593	475	710
25-44	224	175	274	213	164	262	226	176	276	221	171	272
45-64	119	87	151	141	105	176	83	56	110	101	71	130
65+	42	20	64	55	31	79	49	24	74	42	21	63

Source: SUS Hospital admissions data extracted by CSU 2014-15 – 2015-16

6. There were significantly higher admissions rates of people from the most deprived quintile compared to the least in both years and were above the Shropshire average in both years.

Chart 4.5: Age standardised rate (per 100,000 population) of deprivation by year – all age all gender 2014-15 – 2015-16



Source: SUS Hospital admissions data extracted by CSU 2014-15 – 2015-16

7. In 2014-15 there were similar rates between the genders across all the quintiles except for quintile 2 which had a significantly higher rate of admissions for females compared to males. This pattern was similar in 2015-16 except for a significantly higher rate of admissions for females compared to males from the least deprived quintile.

8. In both years a significantly higher rate of self-harm admissions was for people from urban areas compared to rural areas, but both were similar to town areas.

9. Whitchurch, was significantly higher than the Shropshire average for all age, gender and diagnosis self-harm (as shown in Map 1 and table 3). In individual years: Shrewsbury North East and Oswestry Town were significantly higher than the Shropshire average in both 2014-15 and 2015-16 and Whitchurch was also significantly higher in 2014-15. Rates between the years across all the place plan areas were all similar.

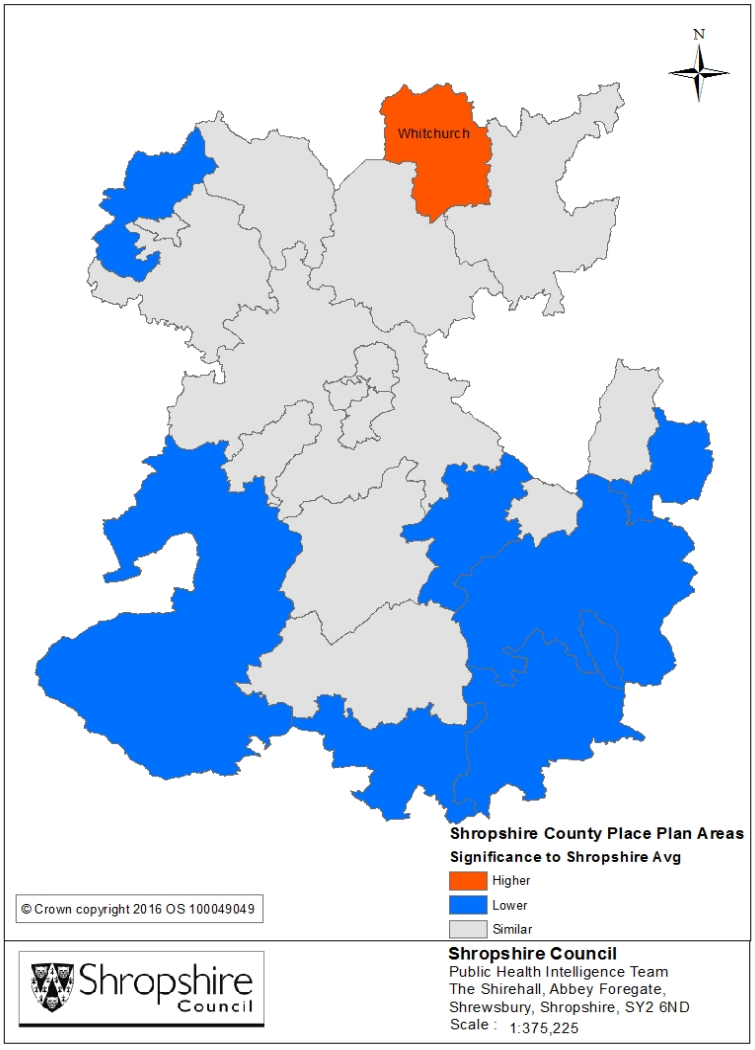
Table 4.2: All age, gender and diagnosis significance to Shropshire average : Age standardised rate by place plan map – 2014-15 & 2015-16

Place Plan Area	Albrighton	Bishop's Castle	Bridgnorth	Broseley	Church Stretton	Cleobury Mortimer	Craven Arms	Ellesmere	Highley	Ludlow	Market Drayton	Much Wenlock	North East Shrewsbury	North Oswestry	Oswestry Town	Pontesbury and Minsterley	Shifnal	Shrewsbury Rural	South & East Oswestry	South Shrewsbury	Wem	West and Central Shrewsbury	Whitchurch
Significance to Shropshire average: age standardised rate per 100,000 population	67	93	79	162	150	79	248	149	31	75	179	68	199	59	195	250	106	187	167	202	167	208	260

Lower | Similar | Higher

Source: SUS Hospital admissions data extracted by CSU 2014-15 & 2015-16

Map 4.3: All age, gender and diagnosis significance to Shropshire average: Age standardised rate by place plan map – 2014-15 & 2015-16

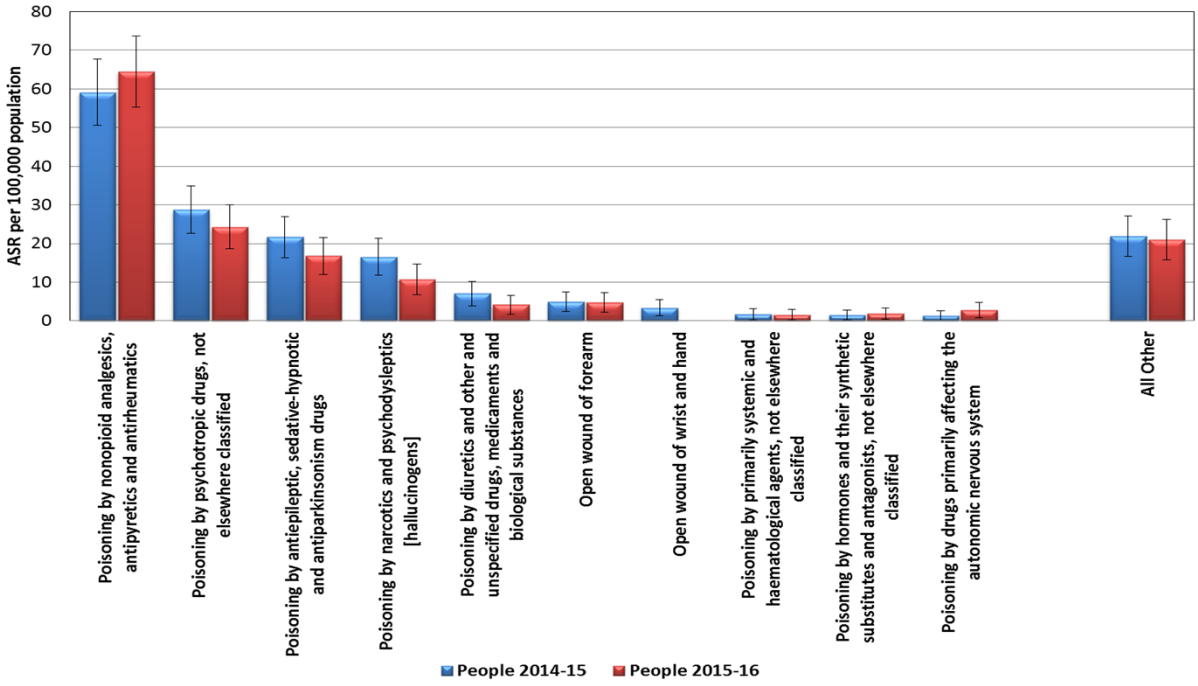


Source: SUS Hospital admissions data extracted by CSU 2014-15 & 2015-16

10. There were significantly higher rates of self-harm admissions were for *poisoning by nonopioid analgesics, antipyretics and antirheumatics* in both years and rates between the years were similar across the diagnosis headings (as seen in Chart 4.6).

11. In 2014-15 there were significantly higher rates of self-harm admissions for females compared to males for *poisoning by nonopioid analgesics, antipyretics and antirheumatics* and *open wound forearm*; the remaining diagnosis headings were all similar. In 2015-16 the pattern was similar between the genders across all the diagnosis headings except for a significantly higher rate of females admitted for *poisoning by nonopioid analgesics, antipyretics and antirheumatics* (table 4). Rates were similar across all the diagnosis headings between each year for each gender.

Figure 4.6: Age standardised rate (per 100,000 population) of all self-harm admissions 2014-15 – 2015-16 by diagnosis by year



Source: SUS Hospital admissions data extracted by CSU 2014-15 – 2015-16

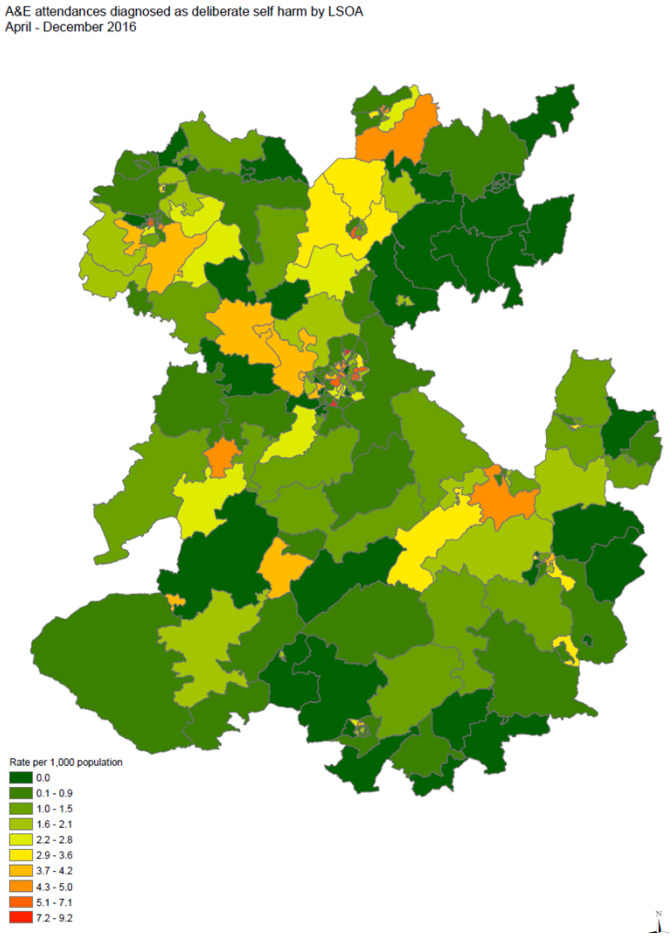
Table 1.3 Age standardised rate (per 100,000 population) of all self-harm admissions 2014-15 – 2015-16 by diagnosis by year and gender

	95% Confidence Interval											
ICD10 Description Heading	**Male 2014-15**	**LLC**	**UCL**	**Female 2014-15**	**LLC**	**UCL**	**Male 2015-16**	**LLC**	**UCL**	**Female 2015-16**	**LLC**	**UCL**
Poisoning by nonopioid analgesics, antipyretics and antirheumatics	41	31	51	78	64	92	46	35	57	84	69	100
Poisoning by psychotropic drugs, not elsewhere classified	25	17	33	33	23	42	17	11	24	31	22	41
Poisoning by antiepileptic, sedative-hypnotic and antiparkinsonism drugs	20	12	27	23	15	31	13	7	19	20	13	27
Poisoning by narcotics and psychodysleptics [hallucinogens]	18	11	25	15	9	22	10	5	16	11	6	17
Poisoning by diuretics and other and unspecified drugs, medicaments and biological substances	5	2	9	9	4	14	3	0	6	5	1	9
Open wound of forearm	1	0	2	9	4	14	2	0	4	8	3	12
Open wound of wrist and hand	3	0	6	4	1	7	0	0	0	0	0	0
Poisoning by primarily systemic and haematological agents, not elsewhere	3	0	5	1	0	2	1	0	2	3	0	5
Poisoning by hormones and their synthetic substitutes and antagonists, not elsewhere	1	0	2	2	0	5	1	0	3	3	0	5
Poisoning by drugs primarily affecting the autonomic nervous system	1	0	4	1	0	3	5	1	8	1	0	3

Source: SUS Hospital admissions data extracted by CSU 2014-15 – 2015-16

The following map shows the usual residence of attenders for self-harm admissions (diagnosed as deliberate self-harm) at a rate per 1,000 population. The anonymised postcodes were then mapped in order to assess links with deprivation. The findings indicate that the highest rate of self-harm hospital attendances (8.1 per 1,000) came from the 10% most deprived communities and displays a step reduction as deprivation reduces.

Map 4.2: A&E attendances from deliberate self-harm in Shropshire



2015 IMD Decile	Rate per 1,000 population Q1-Q3 2016/17
10% most deprived	8.1
10-20% most deprived	4.7
20-30% most deprived	2.9
30-40% most deprived	1.7
40-50% most deprived	1.4
40-50% least deprived	1.8
30-40% least deprived	1.7
20-30% least deprived	0.8
10-20% least deprived	0.7
10% least deprived	0.5

Section 5: Mental Health and Substance Misuse – Dual Diagnosis

Substance misuse can often be seen as *usual* rather than the *exception* among people with severe mental health problems and the relationship between the two is complex. People with mental health problems can be more sensitive to the effects of modest amounts of substances due to the psycho-biological vulnerability that underlies their psychiatric disorder.

The combination of substance misuse and mental health issues in an individual is commonly referred to as "dual diagnosis", though in most circumstances there are more than just these two issues.

The majority of people in substance misuse services are likely to experience problems with their mental health. National research found 70% of drug users and 86% of alcohol users in treatment have mental health problems. In suicides of people experiencing mental health problems, 54% also have a history of problems with drugs and alcohol.

Research has also found people with drug/alcohol dependency who demonstrate mental health conditions are not always able to access the help they need. Reasons for this vary, from the level of mental health distress not great enough to warrant specialist services, to exclusion of support from mental health services due to their substance misuse. A number of reports and guidance, including clinical guidance from the National Institute of Clinical Excellence (NICE) promote better care co-ordination and support for this client group. Despite this, dual diagnosis and co-occurring drug/alcohol and mental health conditions has remained a challenging area, with many people falling through the delivery gaps.

Public Health England (PHE) have published guidance to compliment the NHS Five Year Forward View for Mental Health to support improved care for those with co-existing mental health and drug/alcohol dependency issues. *Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers (PHE, 2017)* provides a framework to support implementing change to support better care co-ordination. The guidance covers all age groups, all substances and all types of mental health conditions. It also promotes commissioners and providers of mental health and substance misuse services to have joint responsibility for meeting the needs of people with co-occurring conditions. Experts by experience and their carers should also be involved in the commissioning of evidence-based services.

The principles of this guidance are;

- **Everyone's Job** – All service providers (including homeless and wider social care teams) and commissioners have responsibility to work together to achieve shared solutions to meet the needs of this cohort.
- **No Wrong Door** – Treatment for any co-occurring condition is available through every contact point, all services have an open door policy for co-occurring conditions.
- **Understanding local need** – All partnerships should have a good understanding of need and be able to project likely future demands.
- **Using the evidence base** – All services should be commissioned using the evidence base

PHE have also developed a data tool Co-occurring substance misuse and mental health issues profiling tool to support this area of work. The tool supports an intelligence driven approach to supporting need, benchmarking areas against both regional and national trend against a number of indicators. The tool also measures the quality of the data used and whether there is any significant change in the direction of travel from previous years.

Alcohol Consumption

Alcohol misuse or *hazardous drinking* is a pattern of alcohol consumption carrying risks of physical and psychological harm to the individual and may include alcohol dependence.

The Adult Psychiatric Morbidity Survey (2014) identified the prevalence of harmful drinking in England for adults to be 16.6%. Levels of hazardous drinking have declined in men over the past 15 years (36.8% in 2000 among 16 to 74 year olds to 27.9% in 2014) and has remained stable in women. However, although hazardous drinking has become less common in 16 to 24 year olds (reducing from 6.2% in 2007 to 4.2% in 2014) it has become more common in 55 to 64 year olds (increasing from 1.4% in 2007 to 2.8% in 2014).

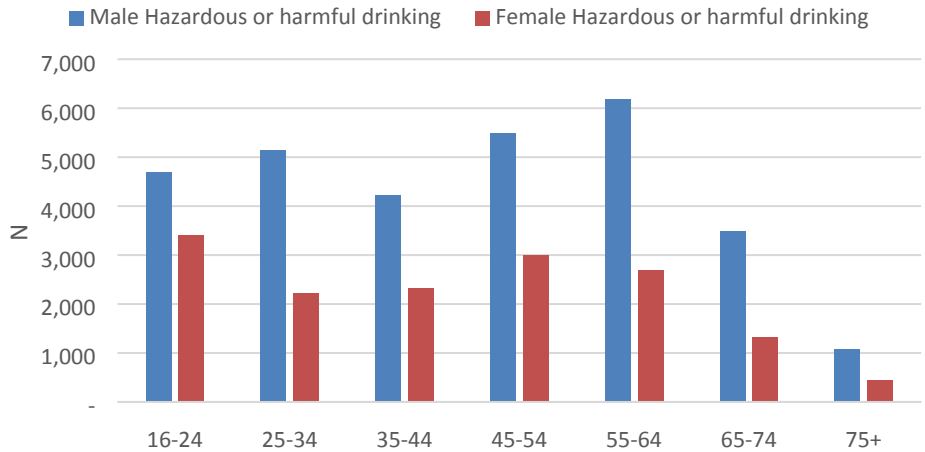
The survey identifies higher risk factors for alcohol misuse as;

- White British men and women
- Adults under 60 years of age living alone
- People in receipt of Employment and Support Allowance (ESA)

In addition to the above, a quarter of adults with probable alcohol dependence (an AUDIT score of over 20) were receiving treatment and services for a mental or emotional problem. Of this group, 6.1% were taking medication to treat substance misuse and 6.3% were in substance misuse counselling.

Chart 5.1 uses the mid year population estimates (2016) against the APMS (2014) rates for harmful and hazardous drinking. It can be seen that if Shropshire rates were similar to the national rates, there would be consistently more males at each group who misuse alcohol. The peak age for males in Shropshire is 55 to 64 years compared to females who peak at 16 to 24 years.

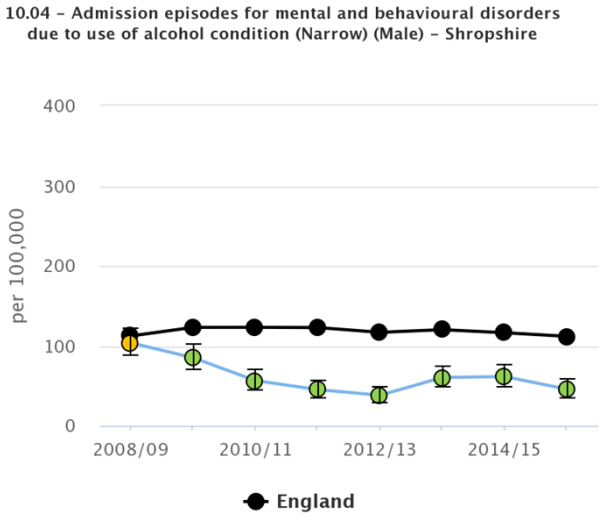
Chart 5.1: Estimated population in Shropshire with reported hazardous or harmful drinking behaviour in the past year (numbers)

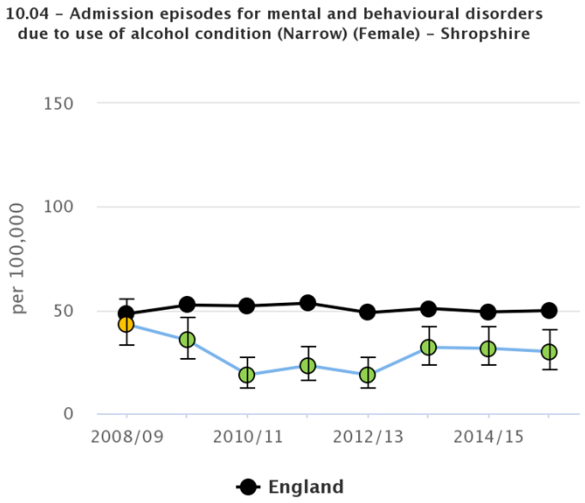


The Charts below display the rate of hospital admissions per 100,000 for mental and behaviour disorders due to the use of alcohol for males and females (PHE Local Alcohol Profiles for England, 2018). Although the male admission rates both locally and nationally are higher than female admissions, the Shropshire rates are significantly lower compared to the England averages;

- 45.5 per 100,000 for Shropshire males compared to 111.6 per 100,000 England average in 2015/16
- 29.9 per 100,000 for Shropshire females compared to 49.7 per 100,000 for England average in 2015/16

Chart 5.2





Drug misuse

Chart 5.3 uses the mid year population estimates (2016) against the APMS (2014) rates for drug dependence in the past year by age and gender. In total there is an estimated 9,705 Shropshire people who have any drug dependence. It can also be seen that if Shropshire rates were similar to the national rates, cannabis is reported to be the highest used dependent drug for males at each age group, followed by cocaine (highest usage in the 16 to 34 years group) and heroin/methadone (most common in the 25 to 44 year group). Male drug dependence reduces with increasing age from 11.8% in ages 16 to 24 years compared to 0.3% in males aged over 75 years.

Chart 5.3: Estimated male population in Shropshire with reported drug dependence

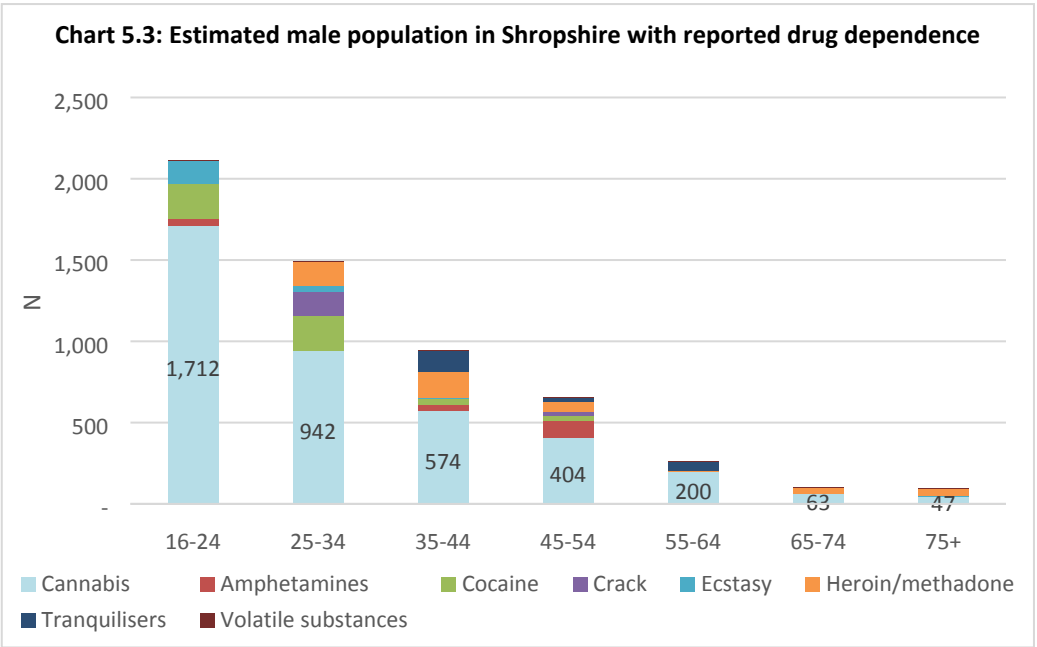
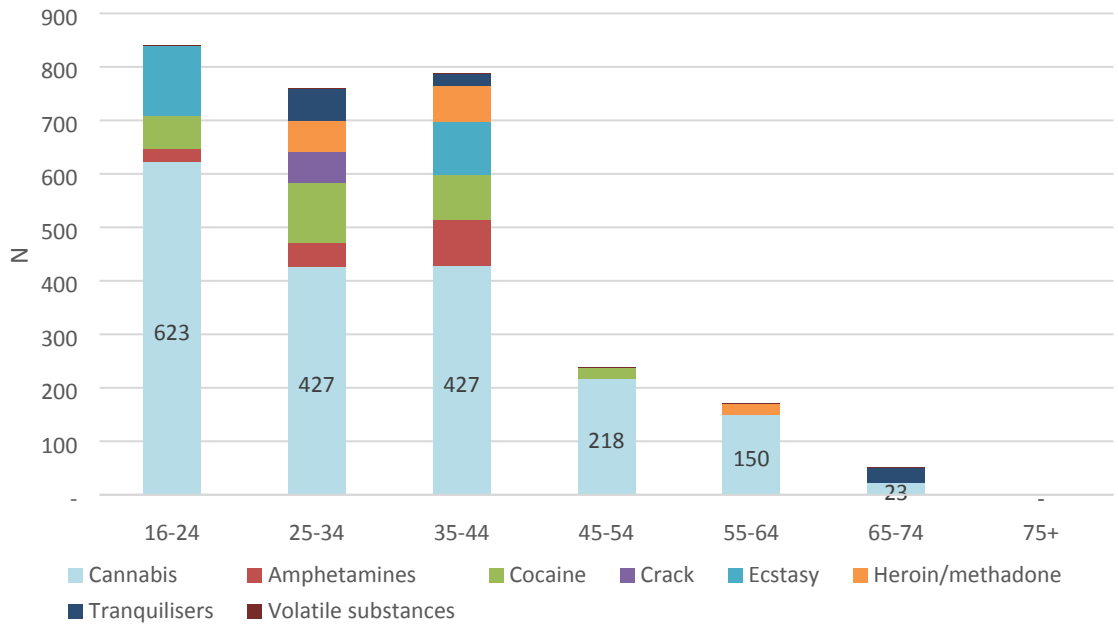


Chart 5.4 considers the same information for Shropshire females where cannabis is also the highest reported dependent drug followed by cocaine and ecstasy. The estimated numbers of dependency are roughly half that of males (except for ecstasy use which has a secondary peak use for females aged 35 to 44 years after those aged 16 to 24 years). For both males and females, dependence is most likely to be related to cannabis only.

Chart 5.4: Estimated female population in Shropshire with reported drug dependence



Adults receiving substance misuse and mental health treatment

Information from the latest JSNA provides information on the number of people who entered treatment in 2016-2017 and received care from a mental health services for issues other than substance misuse (tables 5.1 and 5.2).

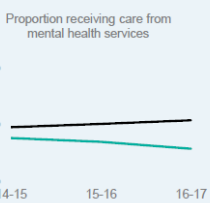
There were 38 (11%) new presentations for Shropshire alcohol misuse services during 2016/17 who were also receiving mental health treatment. This is below the England average of 21%. There was no local difference between the proportions of males or females accessing services (both at 11%), whereas nationally there is a greater proportion of females.

Table 5.1: Alcohol

Local National

Adults who entered treatment in 2016-17 and received care from a mental health service for reasons other than substance treatment

	Local n	Proportion of new presentations	Proportion by gender M	Proportion by gender F	National n	Proportion of new presentations	Proportion by gender M	Proportion by gender F
Receiving care from mental health services	38	11%	11%	11%	11,035	21%	19%	24%
Incomplete data	11	3%	2%	5%	3,905	7%	7%	8%



Please note the proportion of new presentations does not include those clients with a missing/incomplete dual diagnosis status.

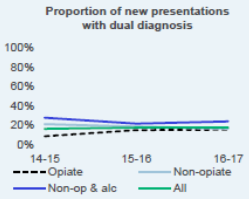
It can be seen in Table 5.2 that 51 people (17%) of all new presentations to drug misuse services in Shropshire during 2016/17 were also receiving mental health services (for a reason other than substance misuse). This is below the national average of 24%.

For each drug misuse category there is a greater proportion of Shropshire females being treated who also access mental health services which is consistent with the national data during this time period.

Table 5.2: Drugs

Adults who entered treatment in 2016-17 and received care from a mental health service for reasons other than substance misuse

	Local		Proportion by gender		National		Proportion by gender	
	n	Proportion of new presentations*	M	F	n	Proportion of new presentations*	M	F
Opiate	25	15%	13%	22%	8,846	22%	20%	27%
Non-opiate	12	16%	15%	27%	3,771	25%	23%	32%
Non-opiate and alcohol	14	24%	18%	50%	4,948	29%	26%	38%
All	51	17%	15%	28%	17,565	24%	22%	31%
Incomplete data								



** The proportion of new presentations does not include those clients with a missing/incomplete dual diagnosis status. There were 8 clients locally with a missing/incomplete status.*

Young people In Treatment (ages 10 to 18 years)

Information on young people is made available in the same format, however, in the JSNA for Young People in 2016/17 however, there were no young people identified as having a mental health need in young people's services. It is recognised locally there is an issue with the current referral pathways and this is a piece of work currently under review.

In the previous reporting period, 2015/16, the proportion of young people accessing substance misuse treatment in Shropshire with an identified mental health problem was higher (26%, n=9) than the England average (19%). The same proportion of 26% in Shropshire were identified as being involved with self-harm (n=9) compared with 17% of those entering treatment nationally. It is recognised however, that the small numbers involved make statistical differences between the local and national rates harder to identify.

Because of associated vulnerabilities such as mental health and self-harm, it is important that the pathways between treatment services and other specialist services such as child mental health services and children's social care work effectively so that those young people who are in a vulnerable situation can be protected from further escalation of substance misuse and the associated harms that that can cause.

Section 6: Co-morbidity in Mental and Physical Illness

The Kings Fund estimate that over four million people in England with a long term physical health problems also have a mental health problem[29] and that the risk factors for physical and mental health problems commonly overlap. The effect of social and environmental determinants on physical health can have a significant influence on resilience[30], which explains why the physical health of people with severe and enduring mental illness is often poor[31].

People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people[32], with two-thirds of these deaths from avoidable physical illnesses such as heart disease and cancer. This may be explained due to roughly half of all tobacco being consumed by people with a mental health problem and demonstrates a clear inequality. In addition, there are often difficulties for people with mental health problems to access physical healthcare support and people with long term illnesses suffer more complications if they also develop mental health problems, with depression increasing the risk of non-compliance with treatment programmes.

Conversely, mental wellbeing and resilience are protective factors for physical health as they reduce the prevalence of risky behaviours such as heavy drinking, illegal drug use, smoking and unhealthy food choices which are often used as coping and management mechanisms in the absence of other support. As such there is a sound argument towards achieving parity of esteem for mental health to be given equal priority to physical health.

Mental and Physical Health in Shropshire

Currently there is no readily available data to accurately quantify the numbers of people within Shropshire with both a long term illness and mental health problem and so estimates from the Adult Psychiatric Morbidity Survey (2014) have been applied.

According to the Adult Psychiatric Morbidity Survey, just over a quarter (27.7%) reported having at least one the following chronic conditions (in order of highest prevalence);

- High blood pressure (most common)
- Asthma
- Diabetes
- Cancer

The survey identified an association between common mental disorders and chronic physical conditions, with 37.6% of those with a more severe CMD symptom reporting a chronic physical condition compared to 25.3% of those with no or few symptoms of CMD.

[29] Naylor, C., Galea, A., Parsonage, M., McDaid, D., Knapp, M. and Fossey, M. (2012). Long-term conditions and mental health; the cost of co-morbidities. London: The Kings Fund/Centre for Mental Health.
[30] Faculty of Public Health (2016). Better mental health for all: a public health approach to mental health improvement. Available at: http://www.fph.org.uk/better_mental_health_for_all
[31] Barry S. Okena,B, Chaminea,I., Wakelandc, W. (2015). A systems approach to stress, stressors and resilience in humans. 44–154. P.150.
[32] NHS England (2016). The Five Year Forward View for Mental Health

Evidence has also found that the presence of self-reported diagnosed asthma and high blood pressure is associated with a wide range of different mental disorders including depression, anxiety disorders and phobias.

Table 6.1 applies the national rates of common mental disorders by chronic physical health to Shropshire adults. It can be seen that non-specified common mental disorders are the highest prevalent disorder associated which each long term health condition followed by anxiety disorder.

Table 6.1: Estimated number of Shropshire adults with co-morbidity chronic conditions and common mental disorder

Psychiatric disorders	All Adults in Shropshire (estimate)	Cancer	Diabetes	Asthma	High blood pressure
Generalized anxiety disorder	15,423	1,220	1,198	1,237	1,399
Obsessive-compulsive disorder	3,398	83	342	265	577
Depression	8,626	337	791	826	1,136
Phobia	6,274	120	373	558	1,016
Panic disorder	1,568	-	161	123	92
CMD Not otherwise specified	20,390	3,096	1,629	2,004	1,715

Section 7: Service User Feedback

Shropshire Council's Business Design Team were commissioned to undertake a research project between May and July 2017 to understand the mental health issues, trends, services provided and any gaps in service relating to mental health across Shropshire. This was achieved through undertaking 1 to 1 interviews (with the use of topic guides) to identify the opinions, thoughts and feelings expressed by service users and providers of mental health services in Shropshire.

A request was sent out via the Shropshire Mental Health Partnership Forum for any providers that would be interested in taking part in the project, both to be interviewed and to assist in recruiting service users. In total there were 19 clients (16 women and 3 men, age range estimate from early 20s to late 60s but mostly older people).

The interviewed service users were all from across the Shropshire area, all of whom have recently come into contact with Mental Health Services in Shropshire with some having long-term conditions that have meant many years of service use, being out of work and struggling to live independent lives. Conditions included anxiety/depression, eating disorders, bipolar, and psychosis, with some placed under a Section 136 and several having attempted suicide.

Nine provider organisations agreed to participate and were interviewed which included a mix of drop-in centres, counselling services, employment services, charities and advice and advocacy services. These organisations were;

1. Citizens Advice Bureaux
2. Confide Counselling Service
3. Designs in Mind (Oswestry)
4. Enable
5. Rethink -Shropshire Carers Group
6. Samaritans (Shrewsbury)
7. Shropshire Mind
8. SIAS - Shropshire Independent Advisory Service
9. Talking Point

In addition a paper survey was produced and shared for those who wanted to participate in the project but for whatever reason felt unable to speak with the interviewers directly. Initially there were 10 questionnaires which were completed and returned, however a further 15 men completed the survey in October 2017 with assistance from Shropshire MIND.

The key findings from these interviews are summarised below.

Overarching Themes

- Access to local mental health services is lengthy and complicated
- Users reported a good service once they found the right support
- Building relationships with professionals is very important to achieve positive outcomes
- Consistency in how support is provided needed to achieve positive outcomes
- Those with stronger family support generally achieve more positive outcomes supporting towards recovery (if can recognise signs before crisis)
- Peer support was identified as one of the most supportive ways of managing conditions along with counselling and medication
- Significant emerging trend of more younger people asking for help

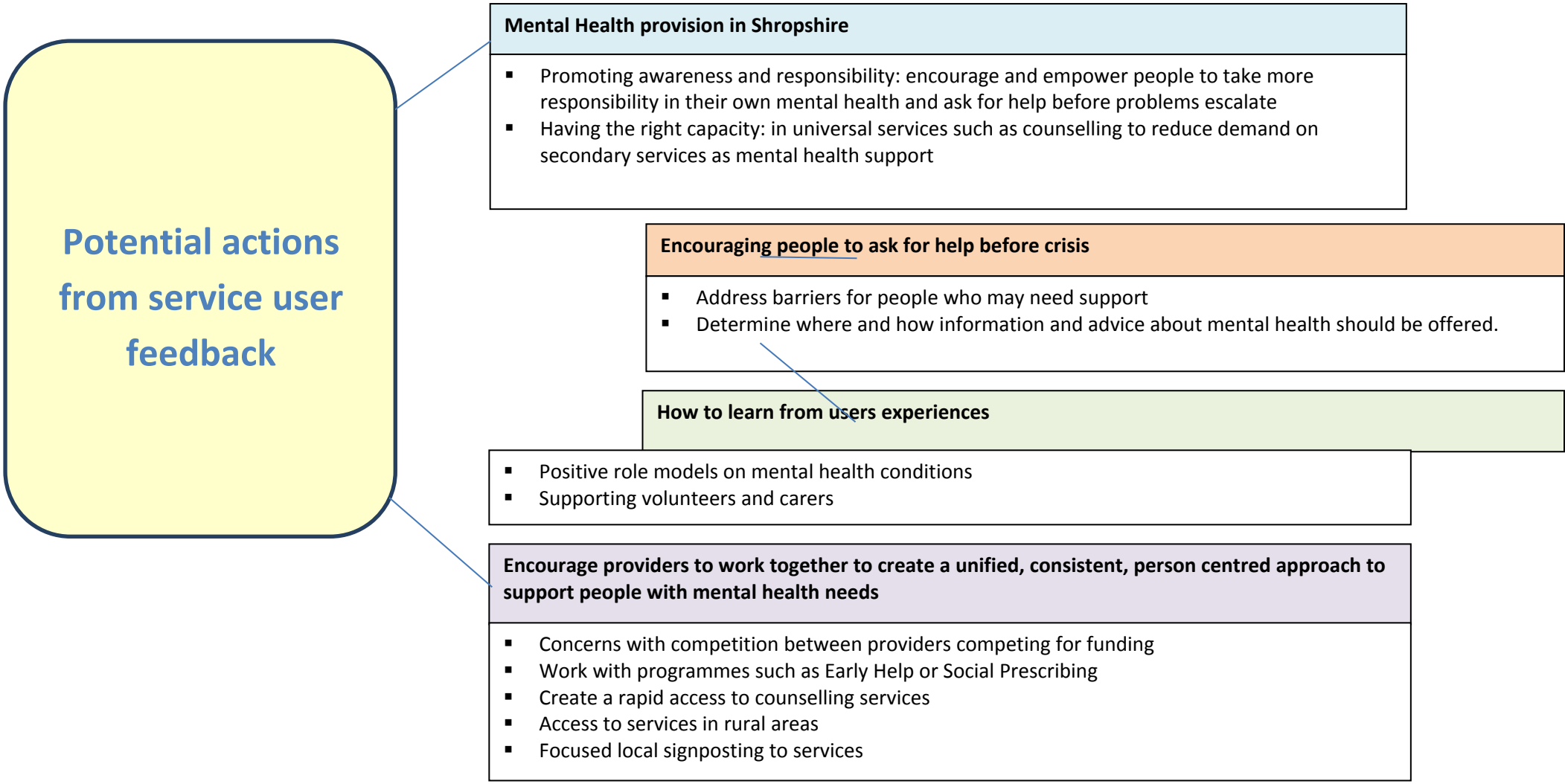
- Complexity of life (wider social problems) main contributing factor to mental wellbeing. For men this included gambling and debt. For women this included relationship problems and issues with abuse.

Emerging Trends

- Key reasons why people seek mental health help include Relationship difficulties, Problems at work, Bereavement, Financial (debt, gambling), Abuse, Addiction, Trauma/life events, Childhood trauma
- Trend of increasing older people seeking support - isolation and bereavement, dementia and Alzheimer's
- Children and young people are increasingly seeking mental health services for anxiety and depression from pressures at school, bullying, social media and abuse
- Isolation is a contributing factor not just of older people but amongst single parents (especially in rural locations) and those who work from home
- Increasing number of people from Caring professions seeking help for mental health issues (including teachers, medical professionals and police)

Potential Improvements identified by service users and providers

- Community Mental Health Team (CMHT) staff could shadow each other so that a wider range of experience could be learnt and share good practice across teams
- Those at a strategic level would benefit from shadowing 'ground level' staff and talking to service users
- Concerns raised by service users included the age and experience of some staff, who service users felt might be too young to really be able to empathise with their situation
- Counselling should be more tailored to individual needs rather than one size fits all approach (wider selection of counselling types)
- GPs should have more training in mental health issues
- A mental health specialist at every GP surgery who knows what support is available both formally and through the community
- Mental health service providers should attend at GP group sessions
- Service users wanted to ensure that all areas were served with mental health support services and that it should not just be a Shrewsbury centric service
- More drop in centres (Although a mixed review of their effectiveness was given) for more immediate support as well as being a regular place of safety for people who like to build relationships and have consistency in their support
- People wanted a faster, and less complicated way to access mental health services, with a central place that people can go to find information and advice
- Review individual circumstances not just the mental health issues as support to resolve wider social issues may assist with the mental health condition
- Shropshire needs a lean, joined up service, and that any strategy needs to have core principles that keep the person at its heart
- Importance of providing support services for mental health issues in the work place (felt there is currently a gap) - potential in working with the private sector to develop a model of support


Potential actions from service user feedback
Mental Health provision in Shropshire
Promoting awareness and responsibility: encourage and empower people to take more responsibility in their own mental health and ask for help before problems escalate
Having the right capacity: in universal services such as counselling to reduce demand on secondary services as mental health support
Encouraging people to ask for help before crisis
Address barriers for people who may need support
Determine where and how information and advice about mental health should be offered.
How to learn from users experiences
Positive role models on mental health conditions
Supporting volunteers and carers
Encourage providers to work together to create a unified, consistent, person centred approach to support people with mental health needs
Concerns with competition between providers competing for funding
Work with programmes such as Early Help or Social Prescribing
Create a rapid access to counselling services
Access to services in rural areas
Focused local signposting to services

Section 8: Commissioned Mental Health services in Shropshire

South Staffordshire and Shropshire NHS Foundation Trust (SSSFT) are commissioned to provide mental health and learning disabilities services to Shropshire patients and residents.

These services include the areas of;

i. Adult and older people's Mental Health Services
ii. Emotional Health and Wellbeing (for 0-25 year olds)
iii. Community Adult learning Disabilities
iv. Improving Access to Psychological Therapies

Adult and Older People's mental health services[33]

SSSFT are continuing to implement a service change in Shropshire called Community Remodelling which has moved service delivery away from traditional team based services to one of a pathway approach. In order for this to happen there needed to be a point of access, called Access, which provides triage for people and identifies which pathway they would be best suited to (as summarised in the table below);

Non-Psychosis Pathway (Care Clusters 1-7)	Provides assessment and evidence based time limited interventions for people who have complex mental health difficulties that are significantly impacting on daily life. *This would include mood disorders, anxiety disorders, trauma related conditions, and other severe emotional difficulties.*
Psychosis Team (Care Clusters 10 – 17)	Early intervention and services for people who may perceive or interpret reality in a different way from others, which may include having experiences of hearing or seeing things that others don't seem to, experiencing tastes, smells and sensations that have no apparent cause or holding beliefs that no one else seems to share even though logic and evidence may suggest other explanations. These thoughts and experiences may make it difficult to think clearly and can be distressing especially if they lead to feelings that others may want to cause harm.
Complex Care and Intensive Life Skills Team (Care Cluster 8)	Working with people who have complex mental health difficulties based on a personality disorder that is impacting on their ability to; regulate their emotions, maintain relationships (both within their own life but also with professionals and are often at high risk of harm to themselves. This pathway offers a structured approach to support the person to engage and learn to work with the distressing thoughts and feelings to achieve their goals.
Memory Service and Dementia Team (Care Clusters 18-21)	Provides assessment of people who are experiencing memory problems who may have Dementia and also a service to those who have a diagnosis of Dementia who require a routine review. The pathway also provides interventions to those diagnosed and/or their families /carers with specialised, intensive input from the team to help to remain in their home environment. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will also be supported through this pathway.
Crisis Resolution and Home Treatment	Urgent care pathways to help support people at home during a mental health crisis working with Psychiatry Liaison and the Rapid Assessment Intervention and

[33] A summary of the commissioned and community services provided by SSSFT is included within Tables 1 & 2

Team (CRHT)	Discharge team (RAID), based in the local accident and emergency departments of The Royal Shrewsbury Hospital in Shropshire and Princess Royal Hospital.

The pathways allow a more patient centred model with interventions and therapies being brought to the patient rather than them being referred internally to a different team. The intention is that under the pathways model the patient will receive more timely specialist interventions that have been clinically effective for their diagnosis and situation.

The Access team are available 24/7, the calls are answered by non-clinicians but they have direct access to clinicians between 8am-8pm Monday – Friday, outside of these hours they have clinical input from the crisis team. The Access team manage all requests for help including;

- General advice
- Arrangement new referrals including urgent referrals
- Arrangement of a Mental Health Act assessment
- To speak to clinician's about patients

Once a patient has been telephone triaged by Access they are picked up by the east or west administration hubs; east covering Market Drayton, Bridgnorth and Telford and west covering the rest Oswestry, Whitchurch, Shrewsbury and Ludlow, their assessment would generally take place locally to them.

Currently there is not a separate professional's line to phone. If a GP is seeking advice or to speak to a clinician about a new patient then the ACCESS number is the one to use. If a patient is open to the mental health team and the GP would like to speak to the patient's clinician about ongoing management concerns or to ask advice then the appropriate east or west admin hub would be phoned.

Emotional Health and Wellbeing Service (EHWB)

SSSFT won the tender for the new Child and Adolescent Mental Health Services (CAMHS) which is named the Emotional Health Wellbeing Service. The EHWB has a variety of options to help families, children and young people where their mental health and emotional wellbeing may need some extra support or help.

SSSFT are the lead provider of the EHWB service and deliver the CAMHS/NHS element of services including a community based mental health services (early intervention through to specialist treatment and crisis resolution for young people with mental health problems). The EHWB service is also delivered in partnership with The Children's Society, Kooth and Healios, with a range of support available includes online forums with peer support and trained counsellors, online CBT (Cognitive Behavioural Therapy) service, drop in sessions for young people and their families, specialist assessment and support via mental health practitioners including crisis care management.

The Children's Society	A national charity that runs local services in Shropshire to help children and young people when they are at their most vulnerable. This service delivers health promotion, prevention and early help and support as well as working with young people to aid transition/sign posting to other services or resources. Drop in' sessions are also being provided in Shrewsbury every Thursday 1pm-6pm at Palmers Coffee Shop, Belmont Church, Claremont Street. This drop in is open for children, parents and professionals. Other drop ins will be opening soon.

Kooth	A 24 hour available online support service which can be accessed anonymously via phone, tablet, laptop or PC and offers peer support, self-help material and gives children and young people access to live forums. Professional councillors for live online chats are available Monday to Friday 12pm to 10pm and weekends/bank holidays between 6pm and 10pm. Anyone aged 11-25, living in Shropshire and Telford & Wrekin, can register to access this service without referral.
Healios	An online psychological therapy service delivered by qualified practitioners and is available between 8am and 9pm, 7 days a week.

There were over 660 young people on the waiting list across Shropshire, Telford and Wrekin in January 2017 so the partnership was asked to begin work on addressing the waiting list in preparation for the contract commencing 1st May 2017.

As of September 2017 there were less than 50 people on the waiting list and all have been actioned and allocated to case workers.

The vision and specification for the EHWB service is a significant change to what was before and implementing the new service is a change in culture. The main focus of work is on implementing the IT infrastructure, moving from paper records to an electronic patient record. This is fundamental in order to operate across the partnership and be able to develop an effective single point of access.

The IT infrastructure is due to be complete at the end of October. Work will commence on the single point of access in autumn. Until then the referral process has not changed and it is still via COMPASS.

Adult Learning Disability Services

There is redesign of learning disabilities services underway and is expected to be out for consultation in autumn.

Improving Access to Psychological Therapies

A redesign of psychological therapies is underway and options appraisal on delivery models will be completed in October 2017.

The map on the following page displays the geographic location of the SSSFT Community Mental Health Services in Shropshire. Further details of access to specific services provided at each location are described in Tables 8.1 and 8.2.

Map 8.1: Locations of Mental Health Community locations across Shropshire

Mental Health Community Locations across Shropshire
13 views
SHARE

West Locality

- 71 Salop Road, Oswestry, SY11 2NQ
- Thomas Savin Close, Off Gobowen Road,...
- Redwoods Centre, Somerby Drive, Shrew...
- 28 Corve Street, Ludlow, SY8 1DA
- Severn Fields Health Village, Sundorne R...

East Locality

- Fuller House, Hall Court Way, Telford, TF...
- Market Drayton Cottage Hospital, Shrops...
- Northgate House, Bridgnorth, WV16 4EN

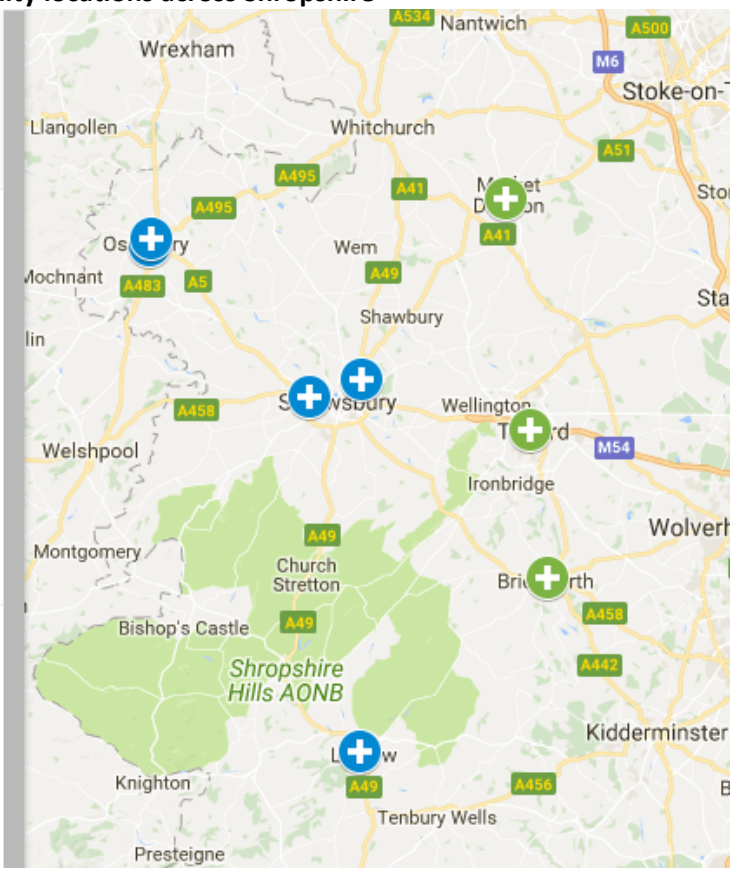


Table 8.1: Summary of South Staffordshire and Shropshire NHS Foundation Trust Commissioned services in Shropshire

Service area	Emotional Health and Wellbeing Service (0-25)	Adult Learning Disabilities	Improving Access to Psychological Therapies	Adult and Older people's Mental health Services
Contact	Is via COMPASS 0345 6789021 Web: http://mentalhealth.sssft.nhs.uk/322-corporate-content/0-to-25	Tel: 01743 211210 Mytton Oak Royal Shrewsbury Hospital(North) Shrewsbury SY3 8XQ	0300 123 6020	Is via ACCESS Tel: 0300 124 0365 Fax: 0300 3033425 Email: access.shropshire@sssft.nhs.uk The Redwoods Centre, Somersby Drive, Shrewsbury, SY3 8DS
Services	• Drop-ins (Shrewsbury and Wellington) • Kooth: Anonymous online counselling, peer support, self-help and forums via www.kooth.com • Healios. Evidence based psychological interventions delivered online. Access to this is via a face to-face assessment. • SSSFT – more traditional CAMHS element, mental health, neuro-development and learning disabilities	• Psychiatry • Learning Disability Nurses • Psychology • Occupational Therapy • Speech and Language	• Therapies include • CBT • Counselling, • EMDR (eye movement desensitisation and reprocessing), • ACT (acceptance and commitment therapy, • IPT (interpersonal psychotherapy • Wellbeing courses that can be delivered in person, by telephone, via email and in a group setting.	• New Referrals • Crisis • Mental Health Act Assessments • Advice • Speak to Clinician (new patient) West Admin Hub – 0300 303 4326 East Admin Hub – 0300 303 1601 • Speak to clinician about ongoing management of a patient already open to services.

Table 8.2: Summary of South Staffordshire and Shropshire NHS Foundation Trust Community services provided in Shropshire

Location site name	Name of services provided at location (If more than one type of service is provided at a location, list each service type in a separate row)	Brief description of team/ward and services provided (150 words max) OR provide link to document on Trust Website	Name, address and postcode for each service (Include name and contact details for community or inpatient service manager)	Main phone number for service
25 Corve Street	Memory Service and Dementia West Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Alison Marpole, 25 Corve Street, Ludlow, Shropshire, SY8 1DA alison.marpole@sssft.nhs.uk	0300 303 3426
25 Corve Street	MH Non-Psychosis West Shrops	"This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attacks and obsessive-compulsive disorder and trauma experiences across the West Shropshire locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a spoke for this pathway with the main hub being based in Severnfields, Shrewsbury.	Carrie Spafford, 25 Corve Street, Ludlow, Shropshire, SY8 1DA carrie.spafford@sssft.nhs.uk	0300 303 3426

25 Corve Street	MH Psychosis West Shrops	This service provides specialist intervention for people with more complex mental health problems across West Shropshire. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a spoke with the main hub for this service being Severn Fields, Shrewsbury.	Rob Fry, 25 Corve Street, Ludlow, Shropshire, SY8 1DA rob.fry@sssft.nhs.uk	0300 303 3426
71 Salop Road	MH Non-Psychosis West Shrops	This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attaches and obsessive-compulsive disorder and trauma experiences across the West Shropshire locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a spoke for this pathway with the main hub being based in Severnfields, Shrewsbury.	Carrie Spafford, 71 Salop Road, Oswestry, Shropshire, SY11 2NQ carrie.spafford@sssft.nhs.uk	0300 303 3426
71 Salop Road	MH Psychosis West Shrops	This service provides specialist intervention for people with more complex mental health problems across West Shropshire. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a spoke with the main hub for this service being Severn Fields, Shrewsbury.	Rob Fry, 71 Salop Road, Oswestry, Shropshire, SY11 2NQ rob.fry@sssft.nhs.uk	0300 303 3426

71 Salop Road	Memory Service and Dementia West Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Alison Marpole, 71 Salop Road Oswestry, Shropshire SY11 2NQ alison.marpole@sssft.nhs.uk	0300 303 3426
Hall Court	Memory Service and Dementia East Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Sarah Broadbent, Hall Park Way, Telford, Shropshire, TF3 4NF sarah.broadbent@sssft.nhs.uk	0300 303 1601
Hall Court	MH Non-Psychosis East Shrops	This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attaches and obsessive-compulsive disorder and trauma experiences across the East Shropshire and Telford and Wrekin locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. Hall Court is the main hub for this pathway across the	Helen McIntyre, Hall Park Way, Telford, Shropshire, TF3 4NF helen.mcintyre@sssft.nhs.uk	0300 303 1601

		locality.		
Hall Court	MH Psychosis East Shrops	This service provides specialist intervention for people with more complex mental health problems across East Shropshire and Telford and Wrekin. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is the main hub for this service.	Kerry Endsor, Hall Park Way, Telford, Shropshire, TF3 4NF kerry.endsor@sssft.nhs.uk	0300 303 1601
Hall Court	Intensive Life Skills Shropshire	This service is for people who experience a fractured sense of self, have difficulties managing their emotions and tolerating distress. They may be self-harming in a number of ways that are potentially life threatening and experiencing on-going suicidality. They will have difficulties that stretch beyond their internal experiences in terms of difficulty forming and maintaining good attachments, occupying themselves in a way that is satisfying and may gamble, be sexually promiscuous and/or misuse drugs or alcohol. The model of care is a team approach, using structured clinical care, DBT and Mentalisation work to support service users to develop life skills that will support them.	Kerry Endsor, Hall Park Way, Telford, Shropshire, TF3 4NF kerry.endsor@sssft.nhs.uk	0300 303 1601
Hall Court	IAPT Telford & Wrekin	The Wellbeing service in Telford and Wrekin are a 16+ service who encourage self-referral to access a range of NICE approved treatment options for low mood and/or anxiety disorders.	Lucy Cotterill lucy.cotterill@sssft.nhs.uk St. Hall Park Way, Telford, Shropshire, TF3 4NF	01952 457415
Hall Court	CRHT Telford & Wrekin	Crisis Resolution and Home Treatment teams focus on delivering care to acutely mentally unwell people in the community. They: • Respond quickly to and assess people who appear to be suffering from a MH related crisis • Support people with identified moderate to severe MH problems to stay at home where it is likely that without that support they would need psychiatric hospital care • Gate-keep all admissions to general adult and older adult psychiatric beds to ensure that they are used according to need • Work with certain people admitted to hospital to try and facilitate discharge at the earliest and safest opportunity.	Maryan Davies, Hall Court, Hall Park Way, Telford, TF3 4NF maryan.davies@sssft.nhs.uk	01952 741880

Market Drayton Day Centre	Memory Service and Dementia East Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Sarah Broadbent, Shropshire Street, Market Drayton, Shropshire, TF9 3DQ sarah.broadbent@sssft.nhs.uk	0300 303 1601
Market Drayton Day Centre	MH Non-Psychosis East Shrops	This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attaches and obsessive-compulsive disorder and trauma experiences across the East Shropshire and Telford and Wrekin locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. Hall Court is the main hub for this pathway across the locality.	Helen McIntyre, Shropshire Street, Market Drayton, Shropshire, TF9 3DQ helen.mcintyre@sssft.nhs.uk	0300 303 1601
Market Drayton Day Centre	MH Psychosis East Shrops	This service provides specialist intervention for people with more complex mental health problems across East Staffordshire. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is the main hub for this service.	Sam Kearns, Shropshire Street, Market Drayton, Shropshire, TF9 3DQ sam.kearns@sssft.nhs.uk	0300 303 1601

Northgate Health Centre	Memory Service and Dementia East Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Sarah Broadbent, Northgate, Bridgnorth, WV16 4EN sarah.broadbent@sssft.nhs.uk	0300 303 1601
Northgate Health Centre	MH Non-Psychosis East Shrops	This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attacks and obsessive-compulsive disorder and trauma experiences across the East Shropshire and Telford and Wrekin locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a spoke with the main hub being Hall Court, Telford	Helen McIntyre, Northgate Health centre , Bridgnorth, WV16 4EN helen.McIntyre@sssft.nhs.uk	0300 303 1601
Northgate Health Centre	MH Psychosis East Shrops	This service provides specialist intervention for people with more complex mental health problems across East Shropshire and Telford and Wrekin. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a hub with the main hub being Hall Court, Telford for this service.	Kerry Endsor, Northgate Health centre, Bridgnorth, WV16 4EN kerry.endsor@sssft.nhs.uk	0300 303 1601

Oswestry Primary Care Centre	IAPT	Providing CBT, counselling, EMDR and other NICE Guidance recommended psychological therapy interventions for patients with low mood, stress or anxiety problems. Service covers the whole of Shropshire county and uses various community venues including, but not limited to, GP surgeries.	Anne O'Shea, Thomas Savin Close, Off Gobowen Road, Oswestry, Shropshire, SY11 1HS anne.oshea@sssft.nhs.uk	0300 123 6020
Severn Fields Health Village (Ground Floor)	MH Non-Psychosis West Shrops	This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attaches and obsessive-compulsive disorder and trauma experiences across the West Shropshire locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This is the main hub for this pathway and locality	Carrie Spafford, Sundorne Road, Shrewsbury, Shropshire, SY1 4RQ carrie.spafford@sssft.nhs.uk	0300 3033426
Severn Fields Health Village (Ground Floor)	MH Psychosis West Shrops	This service provides specialist intervention for people with more complex mental health problems across West Shropshire. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is the main hub for this service.	Rob Fry, Sundorne Road, Shrewsbury, Shropshire, SY1 4RQ rob.fry@sssft.nhs.uk	0300 3033426
Severn Fields Health Village (Ground Floor)	Intensive Life Skills Shropshire	This service is for people who experience a fractured sense of self, have difficulties managing their emotions and tolerating distress. They may be self-harming in a number of ways that are potentially life threatening and experiencing on-going suicidality. They will have difficulties that stretch beyond their internal experiences in terms of difficulty forming and maintaining good attachments, occupying themselves in a way that is satisfying and may gamble, be sexually promiscuous and/or misuse drugs or alcohol. The model of care is a team approach, using structured clinical care, DBT and Mentalisation work to support service users to develop life skills that will support them. .	Kerry Endsor, Sundorne Road, Shrewsbury, Shropshire, SY1 4RQ kerry.endsor@sssft.nhs.uk	0300 3033426

Severn Fields Health Village (Ground Floor)	Memory Service and Dementia West Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Alison Marpole, Sundorne Road, Shrewsbury, Shropshire, SY1 4RQ Alison.marpole@sssft.nhs.uk	0300 3033426
Severn Fields Health Village (Ground Floor)	IAPT	Providing CBT, counselling, EMDR and other NICE Guidance recommended psychological therapy interventions for patients with low mood, stress or anxiety problems. Service covers the whole of Shropshire county and uses various community venues including, but not limited to, GP surgeries.	Anne O'Shea, Sundorne Road, Shrewsbury, Shropshire, SY1 4RQ anne.oshea@sssft.nhs.uk	0300 123 6020
The Redwoods Centre	CRHT Shropshire	Crisis Resolution and Home Treatment teams focus on delivering care to acutely mentally unwell people in the community. They • Respond quickly to and assess people who appear to be suffering from a MH related crisis • Support people with identified moderate to severe MH problems to stay at home where it is likely that without that support they would need psychiatric hospital care • Gate-keep all admissions to general adult and older adult psychiatric beds to ensure that they are used according to need • Work with certain people admitted to hospital to try and facilitate discharge at the earliest and safest opportunity.	Dave Wilkinson, The Redwoods Centre, Somerby Drive, Bicton Heath, Shrewsbury, SY3 8DS dave.wilkinson@sssft.nhs.uk	01743 210050

The Redwoods Centre	Access Shropshire	Providing a single point of contact for enquiries and referrals 24/7 for the mental health pathways Psychosis, Non-Psychosis, Intensive Life Skills and Dementia and Memory Services. The single point of access manages all requests for help, including: - Urgent and non-urgent referrals, including self-referrals - Booking and rebooking of appointments - Providing facilitated guidance, advice and information including signposting to other services - Gathering all relevant information and documentation in preparation for the assessment appointment	Colin Gittins, Redwoods Centre, Somerby Drive, Shrewbury, SY3 8DS colin.gittins@sssft.nhs.uk	0300 124 0365

Additional Services:

Shropshire Sanctuary

As discussed in a previous Chapter, the Shropshire Sanctuary provides an alternative location to Section 136 for people in crisis/mental distress. The service is provided by Shropshire MIND in conjunction with other partners (including West Mercia Police) and is commissioned by Shropshire CCG to provide an out of hours service. As of January 2018, Telford CCG has also contributed funding for 3 months (until 31st March 2018) to provide the service for 18 hours a day and covering the whole of the Shropshire and Telford areas. There is ambition that funding to continue the longer opening hours will be made available from April 2018.

The wider voluntary and community organisations in Shropshire which provide service to help people manage and improve mental wellbeing are described in Table 8.3 (on the following page).

Table 8.3: Summary of Voluntary and Community Sector organisations supporting wellbeing and mental health in Shropshire

Focus	Organisation	Contact
Advocacy	Age UK	3 Mardol Gardens, Shrewsbury SY1 1PR 01743 233 123 Enquiries@ageukstw.org.uk
	SIAS (Shropshire Independent Advocacy Service	The Redwoods Centre, Somerby Drive, Shrewsbury SY3 8DS 01743 361702 enquiries@siasonline.org
	PCAS (Peer Counselling and Advocacy Service)	2 The Old Railway Station, Oswald Rd, Oswestry SY11 1RE 01691 658008 info@shropshire-pcas.co.uk
	POhWER (Independent Mental Capacity Advocacy)	0300 456 2370
Autism	A4U	The Autism Hub, Louise House, Roman Road, Shrewsbury, SY3 9JN 01743 539 201
Bereavement	Cruse	The Roy Fletcher Centre 12-17 Cross Hill, Shrewsbury 0 0845 606 6812 Shropshiretelford&wrekin@cruse.org.uk
Counselling	Confide	The Roy Fletcher Centre 12-17 Cross Hill, Shrewsbury 0 01743 351319 enquiries@confide.org.uk
	Green Oak	Unit B, Silkmoor, New Street, Frankwell, Shrewsbury SY3 8LN 01743 340880 info@greenoakfoundation.co.uk
Disability	Disability Network	Info@shropshire-disability.net
Domestic Abuse / Violence	Shropshire Domestic Abuse Service	0300 303 1191 http://www.shropshirehousing.org.uk/domesticviolence
	West Mercia Women's Aid	0800 7831359
Ex-service people	Walking with the Wounded	01263 863900 info@wwtw.org.uk

	Combat Stress	0800 138 1619 Text 07537 404 719 helpline@combatstress.org.uk
Homelessness	The Ark	10 Castle Foregate, Shrewsbury SY1 2DJ 01743 363305 ark@shrewsburyark.co.uk
Mental Health	Mind	Observer House, Holywell street Shrewsbury SY2 6BL 01743 368647
Money problems / debt	StepChange	0800 138 1111
	Citizens Advice Bureau	0344 499 1100
	Barnabas	01743 364101 barnabascommunityprojects@gmail.com
Older Men	Men in Sheds	Louise House Roman Road, Shrewsbury SY3 9JN 07833204273
Older People	Age UK	3 Mardol Gardens, Shrewsbury SY1 1PR 01743 233 123 enquiries@ageukstw.org.uk
Self-harm	Sapphire	07946 061 463
Rape and Sexual Abuse	Axis	Fletcher House, Coleham Head, Shrewsbury SY3 7BH 01743 357777
	The Glade	0808 178 2058 info@theglade.org.uk
People with suicidal thoughts and people in need of emotional support	Samaritans	Swan House, Coleham Head, Shrewsbury SY3 7BH Helpline Local phone 01743 369696 Helpline Freephcall 116123 Helpline Email jo@samaritans.org Helpline Text 07725 90 90 90Office Voicemail 0772 467 1122 Office Email enquiries@shrewsburysamaritans.org.uk