



Annual Public Health Report 2014

Mental Health and Wellbeing in Kingston



THE ROYAL BOROUGH OF
KINGSTON
UPON THAMES



Contents

Authors and Contributors	2
Introduction	5
1. Improving Mental Wellbeing	9
1.0 Overview	10
1.1 How Individuals can Improve their Mental Wellbeing.....	12
1.2 Promoting Purpose through Learning, Art and Volunteering.....	15
1.3 Ensuring Safe Communities for Mental Wellbeing	18
1.4 Addressing Social Isolation, Loneliness and Discrimination	22
1.5 Building Resilient Communities through Community Engagement.....	26
2. Better Environment for Mental Health	37
2.0 Overview	39
2.1 Housing.....	40
2.2 Active Travel	43
2.3 Green Spaces	47
2.4 Planning.....	49
2.5 Work and Income.....	52
3. Parenthood, Children and Mental Health	61
3.0 Overview	63
3.1 Mental Health of Pregnant Women and Parents	64
3.2 Prevention and Early Intervention in Children and Young People	69
3.3 Child and Adolescent Mental Health Services.....	78
4. Adults and Mental Illness	87
4.0 Overview	89
4.1 Stigma	90
4.2 Mental Illness in Adults and Mental Health Services.....	93
4.3 Dementia and Mental Illness in Older Age	113
4.4 Self Harm.....	119
4.5 Suicide.....	122
4.6 Carers.....	125
5. Physical Health, Lifestyles and Mental Health.....	131
5.0 Overview	133
5.1 Long Term Physical Conditions.....	134
5.2 Alcohol and Drugs.....	141
5.3 Smoking.....	144
5.4 Physical Activity.....	147
5.5 Healthy Weight and Healthy Eating.....	151
5.6 Sexual Health	156
6. Profiles	161
6.1 Mental Health Profile.....	162
6.2 Demography.....	185
Abbreviations and Glossary	204
Statistical Annex.....	211

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Key Messages

- Mental wellbeing is having a positive state of mind, feeling safe and able to cope and having a sense of connection with other people. Good mental wellbeing results in a range of better health outcomes.
- The Council and local partners can undertake a range of actions which will support individuals and communities in taking steps to improve their mental wellbeing.
- Mental illnesses make up nearly a quarter of the total burden of ill health. They affect one in four people each year, and one in six people at any point in time.
- The stigma around mental illness causes a great deal of distress, can stop people seeking treatment, may impede recovery and affect someone's chances of being in work. Action must be taken to eliminate stigma and discrimination against people with mental illness.
- Intervening effectively when children and adolescents are starting to develop mental health problems could prevent between a quarter and a half of adult mental illness so these interventions should be prioritised.
- One in five older people and two in five living in care homes suffer from depression which can go undiagnosed and untreated. The number of people with dementia in Kingston is estimated at 1,600 and our communities need to become dementia friendly places.
- A transformation in the way people with mental illness are treated and cared for is needed and the voluntary sector will be an important part of this change. Carers need to be well supported so that they are able to sustain their input.
- Mental health and physical health are closely intertwined. People with mental illnesses often have poor physical health and can die early. Much of this can be prevented by addressing smoking, alcohol use, diet and exercise.
- People with long term physical illnesses are at high risk of also developing mental health problems and these co-exist in an estimated 12,000 people in Kingston. Health and care professionals must be alert to this and ensure both are effectively treated.

Introduction

Dr Jonathan Hildebrand – Director of Public Health, Kingston Council

For my eighth report on the health of Kingston people I have focused on mental health and wellbeing. Defining mental wellbeing can be challenging. I have used the definition contained in the Department of Health publication *Confident Communities, Brighter Futures* which is that 'wellbeing is a positive state of mind and body, feeling safe and able to cope and having a sense of connection with people, communities and the wider environment'.

There are many definitions of mental health, which frequently overlap with definitions of wellbeing. To take one example, the World Health Organisation describes mental health as 'a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community'.

Taking action to improve wellbeing is in line with national policy. At the time of finalising this report the Chief Medical Officer has questioned the usage of 'mental wellbeing' in her Annual Report and it is likely that this will stimulate an ongoing debate.

To further complicate matters, there are many terms used to describe when someone does not have good mental health. These include mental health problems, mental illness and mental disorder. All of these refer to a number of specific medical conditions that people can be diagnosed as having including anxiety, depression and schizophrenia.

This report examines a range of factors that impact on wellbeing, looks at the interplay between physical and mental health and looks at mental health issues across the life course from birth to older age.

Section 1 of the report focuses on wellbeing. Improving wellbeing has a range of benefits including better physical health, a healthier lifestyle and a longer life expectancy. A number of factors have been shown to be crucial to wellbeing and these include feeling connected to others, being physically active, being safe and secure and having a sense of purpose, which often comes from employment, paid or otherwise.

The Council, working with partners, can take a range of actions to support people in being able to achieve these.

Chapter 1.5 focuses on the importance of community resilience in maintaining wellbeing and gives a range of examples of local work which is addressing this issue in Kingston. These include the refugee time bank, the community development for health course and the participatory needs assessment in Malden Manor. The impact of the environment on wellbeing is discussed in section 2 which looks at housing, active travel, green spaces and the planning process. Local achievements are described, including the Better Homes Programme, the increase in cycling rates, and the Green Flag awards given to three Kingston parks.

As with many Public Health issues, intervening early in childhood can have lifelong positive effects. Many people's mental health problems begin in childhood or adolescence so these are crucial times to intervene. This report looks in detail at these times of life in section 3. Chapter 3.2 describes the importance of supporting good parenting skills, developing children's social and emotional skills and intervening early if children develop mental health problems. Positive developments in these areas have included an increase in the availability of schools based mental health promotion activities and the introduction of a team of Health Link Workers for local secondary schools. There have been issues regarding aspects of Child and Adolescent Mental Health Services (CAMHS) provision, which were reported in my Annual Report for 2011/12. It is good to report that the Tier two service is being re-launched, as well as a new single point of access to CAMHS, and it is recommended that there is ongoing monitoring to provide assurance that the issues have been resolved.

The complex interplay between physical and mental health is discussed in section 5. People with mental health problems can suffer from unhealthy lifestyles and this can impact on their general health. To take one example, people with mental health problems are 50% more likely to be smokers than the general population, which is one of the main reasons why they tend to die at an earlier age. The medication that some people with mental health problems are prescribed can impact on their health by causing weight gain. Helping people with mental health problems to stop smoking and manage their weight should be prioritised. A positive local development is the 'Good Energy Club' which supports people with mental health problems to be more active.

Conversely, people can make changes to their lifestyle that improves their mental health. Undertaking physical activity improves symptoms of anxiety and depression. This underlines the importance of encouraging active travel and having green spaces that are accessible to all.

People with long term physical conditions such as heart disease or diabetes are two to three times more likely to have mental health problems (often depression or anxiety) than the general population. This equates to around 12,000 people in Kingston. Having a mental health problem can worsen the severity of a long term condition. To take just one example, patients with cardiovascular disease and depression have 50% more acute exacerbations per year than patients who do not have depression. In addition there is a major impact in terms of costs, with people with long term conditions who also have mental health problems having 45% more spent on their healthcare. Local actions that are being taken to address the mental health needs of people with long term conditions are discussed in Chapter 5.1.

The impact of mental illness is huge. As highlighted in the Government's strategy, No Health Without Mental Health:

- One in every six adults has a mental health problem at any one time
- At least one in four people will experience mental health problems in any one year
- Mental ill health is the largest single cause of disability in the United Kingdom
- Across England these illnesses cost £105 billion

People with mental health problems also suffer from the stigma associated with these illnesses. This is so severe that 70% of mental health service users felt the need to conceal their illness, 25% reported receiving either verbal or physical abuse and 50% reported being shunned by others. These figures should shame us all and highlight the importance of actually delivering parity of esteem with physical health conditions. The lack of parity is also illustrated by the relatively small proportion of the NHS budget that is spent on mental health and the levels of under treatment of mental health problems, some of which is due to people's fear of divulging their symptoms to health professionals, which returns us to the negative impact of stigma, which is covered in Chapter 4.1.

Chapter 4.2 describes mental ill health amongst adults in Kingston. The main conditions are discussed as are the range of services available to assist recovery. The commissioning vision of having most people with mental ill health cared for in primary care, with voluntary sector support and mental health specialist input being reserved for people with new, complex or unstable mental illness is described. This will require a shift from the way mental health care is currently provided. The Mental Health Mandate for Kingston set out local commissioning principles and values and was approved by Kingston's Health and Wellbeing Board and the work that will be undertaken to change mental health services must adhere to the Mandate at all times.

Mental health problems in older people are discussed in Chapter 4.3. What Kingston is doing in response to the national policy on Improving Care for People with Dementia is described and there is a discussion on depression in older people, which is estimated to affect 5,650 people locally, is often not diagnosed, and even when diagnosed is often not treated appropriately.

Unpaid carers, often family or friends, undertake a huge proportion of the care provided to people with mental health problems. It is estimated that 25% of carers nationally care for people with mental health problems. Chapter 4.6 details some of the support that is available locally.

There are a range of other chapters in the report that discuss support for parents with mental health problems, income, work and mental health, self harm and suicide.

The mental health section of the report concludes with a detailed mental health profile which presents a wide variety of information on mental health including wider determinants, risk factors and the extent of mental health problems in Kingston. It is of interest that some of the information provided indicates that Kingston residents have a higher level of contact with specialist mental health services than might be expected, and that the utilisation of acute inpatient beds is considerably higher than the national average. This adds extra evidence to the need to implement the commissioning vision so that more people with mental health problems are safely treated and recover in the community.

I hope that the information provided in this report is acted upon and the recommendations implemented so as to improve mental health outcomes for people in Kingston. The six shared national objectives to improve outcomes as set out in No Health Without Mental Health are also fully relevant in Kingston:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

The update on progress against recommendations from the last report that focused on older people can be found on the Council's website at:

www.kingston.gov.uk/health_and_wellbeing

whilst I have included a general demography section which provides an update on key Kingston statistics (Chapter 6.2).

I would like to thank all the authors and contributors to the report, especially Helen Raison, Liz Trayhorn, Sundus Hashim and Helen Nation. As always I very much welcome both comments on the report and suggestions for topics for future reports which can be sent to me at **jonathan.hildebrand@kingston.gov.uk**.



JMHildebrand





Section 1

Improving Mental Wellbeing

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Overview

Mental wellbeing is a positive state of mind and body, feeling safe and able to cope, and having a sense of connection with people, communities and the wider environment¹. Mental wellbeing is therefore distinct from mental illness. Someone can have symptoms of a mental illness and still be experiencing good mental wellbeing, just as a person with poor mental wellbeing can have no clinically identifiable mental illness².

The term mental wellbeing has been used in this report instead of the World Health Organisation term 'mental health', although there is ongoing debate about which term is preferred.

The component parts of mental wellbeing are in turn influenced by other factors such as life events, personal resilience and how well we function socially. Social functioning is a reflection of our participation in social networks and we cannot experience wellness to its fullest without help from other people. All these factors are interconnected and all influence mental wellbeing.

Community resilience may help mitigate the negative impacts of inequalities as well as promote personal and community capacity to face other challenges.

Improved mental wellbeing is associated with a range of better outcomes for people of all ages and backgrounds³, from a greater sense of belonging and participation to better physical health and longer life expectancy. Improvements in mental wellbeing can be achieved through a wide range of evidence-based interventions provided for the whole population. There are also actions that individuals can take to improve their own mental wellbeing.

What is the level of mental wellbeing in Kingston?

Participants in the 2014 Kingston Lifestyle Survey scored well on the different aspects of mental wellbeing. When asked a series of questions, the percentage of people who replied some, often or all of the time were as follows:

- 78% were optimistic about the future
- 87% felt useful
- 76% felt relaxed
- 87% felt they were dealing with problems well
- 92% could think clearly
- 93% were able to make up their own mind about things
- 91% felt close to others

More survey details are shown in the Mental Health Profile Chapter 6.1. If this survey is repeated in future years, we will be able to follow the trend in the population's mental wellbeing.

As described in Chapter 3.2, the recent School Health Education Unit Survey found that overall Kingston pupils' reported self esteem levels were higher than the national average but a considerable percentage did not fall within the medium to high self esteem range. For example, 20% of year 9 girls achieved 'low' or 'medium-low' composite self esteem scores. Overall, girls scored lower on self esteem scores than boys. Community resilience may help mitigate the negative impacts of inequalities as well as promote personal and community capacity to face other challenges.

Who is at greater risk of poor mental wellbeing?

Mental wellbeing is affected by a combination of an individual's character, life experiences and interaction within the community, and so needs to be addressed on many fronts. Factors that can affect resilience and a sense of safety and security at individual and community level include high levels of inequality⁴, adverse life events such as violence and abuse^{5,6}, debt, unemployment⁷, poverty, poor housing, homelessness and fuel poverty^{4,8}. Addressing these will improve health and reduce inequalities^{8,9}.

Details of the numbers affected by these factors in Kingston are provided in Chapter 6.1.

The following chapters look at some key areas:

- Chapter 1.1 looks at how individuals can improve their personal mental wellbeing
- Chapter 1.2 looks at promoting purpose and participation
- Chapter 1.3 looks at community safety and mental wellbeing, including the impact of domestic violence on mental wellbeing
- Chapter 1.4 looks at how social isolation and discrimination can both lead to poor mental wellbeing
- Chapter 1.5 looks at building community resilience for mental wellbeing and focuses on vulnerable populations in Kingston

More detail on work to reduce homelessness, improve housing conditions and promote employment is provided in Section 2.

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1.1 How Individuals can Improve their Mental Wellbeing

Liz Trayhorn, Public Health Programme Lead for Mental Health, Kingston Council

Key messages

- Individuals can improve their own mental wellbeing with the 'Five Ways to Wellbeing' (see Box 1)
- The Council's Public Health team plans to train up local practitioners to deliver the Practical Ideas for Happier Living course within the borough to help local residents improve their own mental wellbeing

Introduction

The Foresight Project, which was led by the Government Office for Science in 2008, was set up to identify opportunities and challenges facing the UK over the next 20 years and beyond, and the implications for people's mental development and mental wellbeing¹. As part of this project the New Economics Foundation was commissioned² to identify the mental wellbeing equivalent of "five fruit and vegetables a day" in order to promote public understanding of the factors associated with mental wellbeing, and to engage individuals in improving their own mental wellbeing. Whilst it was noted that the evidence was incomplete, the suggestions arrived at were that people should:

1. Connect with others
2. Be physically active
3. Take notice of the world around you
4. Keep learning new things
5. Give to others

These are collectively known as the 'Five Ways to Wellbeing'. Ideas for how to achieve these are given in Box 1.

Box 1: The Five Ways to Wellbeing

1. Connect... With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.

2. Be active... Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.

3. Take notice... Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.

4. Keep learning... Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you enjoy achieving. Learning new things will make you more confident as well as being fun.

5. Give... Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, as linked to the wider community can be incredibly rewarding and creates connections with the people around you.

Positive psychological interventions actively promote positive emotions, behaviours and cognitions³. An example of this is 'Mindfulness' which is a mind-body based approach that helps people change the way they think and feel about their experiences, especially stressful experiences. Mindfulness exercises or mindfulness-based cognitive therapy (MBCT) are ways of paying attention to the present moment, using techniques like meditation, breathing and yoga. Mindfulness training helps people become more aware of their thoughts and feelings so that instead of being overwhelmed by them, they are better able to manage them. The Mental Health Foundation is promoting Mindfulness to help people reduce their stress⁴.

Online courses are available through www.bemindful.co.uk/learn/about.

Local Action

The Council's Public Health team has been promoting the Five Ways to Wellbeing in a range of ways using the DIY Happiness game⁵, information on its website and holding community talks. It has also recently piloted the 'Practical Ideas for Happier Living' course. This is a two-session training course which helps people learn practical and proactive skills to enhance their mental wellbeing. It is aimed at a general audience and is suitable for adults of all ages and backgrounds. It is intended for people at various different levels of mental wellbeing and appears to be particularly effective for people with lower than average mental wellbeing (although it is not intended as a therapeutic intervention for people suffering with serious mental health problems).

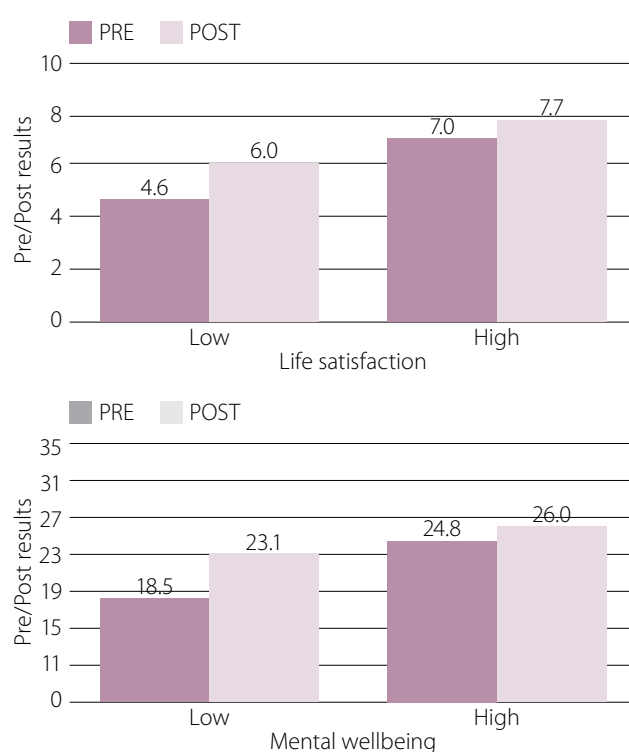


The course was developed by Action for Happiness (AFH) in 2013, in partnership with the Council's Public Health team, and is based on ideas and activities which are underpinned by robust psychological research. During 2013 and 2014 the course has been piloted in different settings, including a Children's Centre (for parents), a Community Centre and a GP practice. These courses were attended by 27 people in total, covering a wide range of ages. The pilot results have been extremely promising, with very good feedback received about the course, plus quantitative evidence showing improvements in people's mental wellbeing after taking the course. Results included:

- 100% of participants rated it as Very Good or Good
- 94% would recommend the course to others
- There was a 29% increase in average Life Satisfaction scores
- Average Mental Wellbeing scores went up from 'better than 40% of UK population' to 'better than 70% of UK population'
- Benefits for Life Satisfaction and Mental Wellbeing were found to be more pronounced for those people with lower initial scores (see Figure 1 below)

There are now plans to train up local practitioners to deliver the Practical Ideas for Happier Living course within the borough to make it more widely available.

Figure 1: Comparing effects on low and high Wellbeing groups



Source: 'Practical Ideas for Happier Living' Questionnaire before and after the course

Recommendations

1. The Five Ways to Wellbeing should influence commissioning and strategic planning across the Council and the Kingston Clinical Commissioning Group, so that the mental wellbeing of the population can be improved
2. Work should be undertaken to increase the awareness of staff working for the Council, other statutory bodies and the third sector of how they can promote the Five Ways to Wellbeing
3. Practical Ideas for Happier Living courses should continue, together with training of local practitioners to deliver these courses
4. Understand better the effectiveness of Mindfulness for different groups and reflect on ways to incorporate it in local activities and programmes

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1.2 Promoting Purpose through Learning, Art and Volunteering

Liz Trayhorn, Public Health Programme Lead for Mental Health, Kingston Council

Key messages

- Wellbeing is strongly associated with a sense of meaning or purpose
- Purpose can be derived from many sources, including learning, volunteering, work and many other activities
- A range of actions are taking place locally to ensure these activities can be accessed and that inequalities are addressed

Introduction

Several studies have shown that mental wellbeing is strongly associated with a sense of meaning or purpose^{1,2}. Good evidence also exists for links between having a sense of purpose and lower levels of depression³ and suicidal feelings⁴.

Purpose can be derived from many sources, including family, friends, community participation in leisure, learning, art, volunteering, work and many other activities.

This chapter explores participation in learning, art and volunteering as a means to increase a sense of purpose and mental wellbeing.

Learning

Education and lifelong learning promote mental wellbeing and resilience and reduce the risk of mental illness⁵. Learning can aid recovery from mental health problems by improved self-esteem, self-efficacy, sense of purpose and hope, competencies and social integration⁶ and it should be noted that people with mental health problems tend, on average, to have fewer qualifications than the general population⁷. Adult learning promotes skills, particularly non-cognitive skills such as confidence, which can have positive effects upon mental wellbeing⁸.

Art

Participation in the arts and creativity can enhance engagement in both individuals and communities, increase positive emotions and provide a sense of purpose. These actions can also help people to connect with a wider sense of meaning and fulfilment, which can increase mental wellbeing⁹.

Volunteering

Volunteering can play a significant part in increasing mental wellbeing. Both the volunteer and the recipient of help can benefit. It can also assist in building self-esteem and promote a sense of purpose and self-worth as well as contributing to forming social networks and reducing isolation.

Volunteering by its very nature encourages the sense that volunteers are 'making a difference' and contributing to their own and others' mental wellbeing^{10,11}.

For older people, volunteering has been shown to be associated not only with improved mental wellbeing but also with living longer¹¹.

Local Picture

Educational attainment is generally good in Kingston schools. At the Early Years Foundation stage, however, there is a 30% gap in children's achievement between those who are materially disadvantaged (measured as those on free school meals) and those who are not¹².

7,005 people accessed adult education in Kingston in the academic year 2013-14. Of these 15.6% were aged between 60 and 70 years and 10% were over 70 years old. Over the last year, 10% of those accessing adult education courses had a disability. This percentage includes people with learning disabilities. The number of people accessing adult education who had mental health problems is not known.

During the year 2013-14, Go Kingston Volunteering (GKV) referred 1,898 potential volunteers to 337 Volunteer Involving Organisations. The majority of these volunteers were women (1,495) compared with 403 men. 846 of the total (45%) were under the age of 25. Whilst older people make up the minority of people registered with GKV, many people volunteer directly with organisations and so are not recorded.

Local Action

Learning

As part of an overall commitment to reduce achievement gaps to enable pupils to make good progress throughout their time in education, Kingston's Children and Young People's plan¹³ includes a target to narrow the gap in attainment and progress between:

- (a) Boys and girls
- (b) Black and minority ethnic pupils and their peers
- (c) Pupils eligible for free school meals and their peers
- (d) Looked after children and their peers

The Council's Adult Education department provides a range of courses including art, design, craft and ceramics, computing, English for speakers of other languages (ESOL), family learning, food, horticulture (gardening and flower arranging), languages, maths and English, music and performing arts, photography, sport and training for work.

The 'Back to Work' course provides basic IT skills, employability and job search skills and support for people aged 19 and over. The 'Steps to Employment' course is free for young people between 16 and 19 who want to gain skills to enable them to find employment, an apprenticeship or progress onto a college course. The course includes practical skills like money management, putting a CV together and interview practice.

Learners on courses with qualifications have progressed to university, further education and in some cases set up their own businesses. The ESOL provision has supported learners into work and into voluntary positions within the community whilst the apprenticeship provision has supported learners into work with a range of local businesses.

'Family learning' courses are informal courses which are run in schools and children's centres. There has been an increase in people with mental health problems accessing these courses.

Alongside these, outreach projects have included:

- A creative writing course for carers at the Noble Centre
- A creative writing course on the Cambridge Road Estate for local people. The learners produced a short book of stories and poems from this six week course and two learners progressed onto a mainstream creative writing course

- An IT course run at Old Malden Library for Korean Elders, who can be isolated from general society
- A finance course at the Fircroft centre which was aimed at learners with mental health problems or learning disabilities

This year the service is working to increase the overall participation of male learners and narrow the achievement gap between Black, Asian and Minority Ethnic (BAME) learners and White learners, between male and female learners and between learners with a disability and those without a disability.

The University of the Third Age runs courses for older people taught by older people. More detail about some community based education projects can be found in Chapter 1.5, which focuses on community resilience.

Art

The Council supports and promotes the development of arts organisations and their activities across the community, for example through its grants and cultural programme. There are a range of creative organisations working in Kingston to develop the arts, offering residents and visitors the opportunity to enjoy events and participate in the cultural life of the borough. One of these organisations is Creative Youth – International Youth Arts Festival¹⁴ who are committed to ensuring that young people, whatever their skills or background, are involved in high quality arts projects. As well as targeting some of the most vulnerable young people in Kingston, it also reaches out to large and diverse audiences by using public spaces, street arts and digital technology in order to reach new audiences.

Mind in Kingston, a mental health charity, holds an annual 'Art and Music for the Mind Festival' for World Mental Health Week at All Saints Church in the Market Place in Kingston. This year there was an art display, bands, including Mid-Siren a service user band, poetry, prose reading and a play performed by the Bridge drop-in drama troupe.

'Picture your Mind' is a photography and health course in Kingston provided by one of the Council's community development workers. Over a period of six weeks participants gain knowledge and skills in photography, meet and interact with other local residents, as well as health professionals, and get to showcase their photography at a public exhibition at the end of the course.



Volunteering

Kingston has a thriving and diverse voluntary and community sector (VCS) that contributes in a wide range of ways to the mental wellbeing of Kingston residents including through encouraging and supporting volunteering. The sector, working with statutory partners, has recently developed a VCS Strategy which includes the aim of building social capital through supporting and growing volunteering as well as through enabling communities to get their voice heard on issues that affect their lives.

Go Kingston Volunteering (GKV) aims to promote and develop volunteering throughout Kingston. Together with Kingston University and Kingston First, GKV hosted a highly successful volunteer speed matching event in February 2014 which gave 20 volunteer involving organisations the opportunity to promote their work and recruit volunteers. In order to support best practice in volunteer management, GKV are working towards a Kingston specific volunteer quality mark that all organisations registered with GKV must adopt.

Half of all people who apply to be a volunteer with GKV have a disability which includes people with mental health problems. Plans for the future include a supported needs project to break down some of the barriers these potential volunteers sometimes face and increase their skills, confidence and self-esteem by introducing them to volunteering.

Kingston University has a volunteering programme which sees around 300 active volunteers involved with 100 volunteering opportunities, contributing around 3,500 hours to the borough each year. The scheme gives volunteers the opportunity to work regularly in schools, voluntary and community groups.

There are various opportunities for different groups of residents to participate in a range of forums and organisations including Kingston Youth Council, the Looked after Children Forum, the Pensioners Forum, the Learning Disabilities Parliament, the Mental

Health Parliament and RISE (Recovery Initiative Social Enterprise) which provides peer support to individuals who are in recovery from alcohol and drug addiction.

The consultation that formed part of a mental wellbeing assessment carried out by the Council's Public Health team in 2013 identified some groups who find it hard to volunteer, including people with low levels of English and people with disabilities. This finding should be addressed.

Recommendations

1. Implement the Voluntary and Community Sector Strategy
2. Evaluate the 'Picture your Mind' course
3. Enable more people with low levels of English and people with disabilities to be able to volunteer

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1.3 Ensuring Safe Communities for Mental Wellbeing

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Key messages

- Crime, violence and abuse all undermine mental wellbeing
- A range of different interventions throughout life can reduce an individual's propensity for violence, lower the chances of those involved in violence being involved again and ensure that those affected by violence get the support they require
- Kingston provides a range of domestic violence advice and support services to domestic violence survivors, a project to support child witnesses, prevention work in schools and a programme in which perpetrators have the opportunity to address their violent behaviour
- Local organisations need to continue to work together to prevent and tackle the abuse of vulnerable people

Introduction

High levels of crime, violence and abuse all undermine mental wellbeing^{1,2,3}. Violent crime in particular is linked to mental health problems including depression, anxiety and post-traumatic stress disorder, suicide, and misuse of drugs and alcohol⁴. A strong negative relationship has been found between rates of violent crime in an area and the mental wellbeing of residents living there⁵. Examples of the impact of abuse, crime and violence include:

- Child abuse has been shown to increase an individual's risk of mental health problems, both as a child and as an adult⁶
- Domestic violence happens in all communities and across all socio-economic groups. It is estimated that during 2012-13, 1.2 million women suffered domestic abuse in England and Wales⁷

- Witnessing domestic violence can have a serious impact on children's safety, health, welfare and future opportunities. At least 750,000 children a year in England and Wales witness domestic violence⁸
- Research in 2007 found that 4% of older people (aged over 65) were subject to abuse in their own homes in the past year which was often perpetrated by members of their own family⁹
- Systematic reviews have shown that both disabled children and adults are at increased risk of violence, and that those with learning disabilities can be particularly vulnerable^{10,11}

Violence shows one of the strongest inequalities gradients, with emergency hospital admission rates for violence being around five times higher in the most deprived communities than in the most affluent. Violence impacts on mental wellbeing and quality of life, prevents people using outdoor space and public transport, inhibits the development of community cohesion and can prevent individuals from going out and participating fully in society¹². For example:

- Young people living in communities affected by gang violence and crime (such as muggings) may constantly fear for their safety in public places.
- Studies have shown that many children with learning disabilities are scared to go out due to fear of being bullied¹³
- Experience and fear of abuse affects the lives of large numbers of adults with disabilities, for example by preventing them from using public transport, going out at night or going to places where they fear abuse may occur¹⁴

Early intervention is the most effective way to tackle the impacts of violence and save costs¹⁵. A range of different interventions throughout life can reduce an individual's propensity for violence, lower the chances of those involved in violence being involved again and ensure that those affected by violence get the support they require:

- Interventions that develop parenting skills and support families can have long lasting violence prevention benefits. More detail on this is provided in Chapter 3.2

- Programmes that develop life and social skills in young people can help protect them from violence by building their social and emotional competencies, teaching conflict avoidance skills and providing broader skills to help them find employment and avoid poverty and crime. More detail on this is provided in Chapter 3.2
- Interventions that work with high risk youth to change their behaviour can be important in preventing future violence. This includes access to psychological therapies which is discussed in Chapter 3.3

Local picture

Kingston is one of the safest boroughs in London¹⁶. Kingston has a lower level of crime than the London average and both the Kingston and London rates have reduced from 2012-13 to 2013-14. In the 2014 'Your Kingston, Your Say' survey (3,181 responses), 92% of Kingston residents felt safe during the day and 60% of respondents feel that safety issues were being tackled effectively¹⁷. More detail on crime rates is provided in Chapter 6.1.

Child Abuse

As of July 2014 there were 118 children subject to child protection plans.

Adult Safeguarding

327 alerts relating to people over the age of 65 in Kingston were raised between April 2012 and March 2013. Of these 69% were investigated further and 47 (21% of those investigated) were found to have some substance. The most common social care need of the adult at risk at the point an alert was raised was mental health, followed by dementia.

Domestic Violence

The Crime Survey for England and Wales found that some 7% of women and 5% of men were estimated to have experienced domestic abuse in the past 12 months. This equates to an estimated 3,724 women and 2,605 men in Kingston¹⁸. Kingston has one of the lowest levels of reported domestic violence in London however research suggests that more affluent residents are less likely to identify what is happening to them as domestic violence, or to report violence to the police¹⁹. The number of domestic incidents and offences in Kingston over a five year period is shown in Table 1.

Table 1: The levels of domestic violence incidents and offences reported to Kingston police

	2008/09*	2009/10	2010/11	2011/12	2012/13
Domestic incidents**	1,435	1,639	1,828	1,715	1,752
Domestic offences***	719	665	611	570	636

Source: Kingston police data

* Data is by financial year, eg April 2008 to March 2009

** All reports of incidents, whether from victims, witnesses or third parties and whether crime related or not, will result in the registration of an incident report by the police

*** An incident is recorded as an offence if it is determined by the police to be a crime as defined by law

In 2013-14 the Kingston 'One Stop Shop' saw 685 female and male victims. In 2012-13 there were 524 contacts to the Council's Children's Social Care department where the concern about the child was recorded as 'Domestic Violence Issues'. This accounted for 33.4% of the total contacts during that period.

Local action

Overall Crime Prevention

Preventing violence is a major priority of the Council and its partners. The priorities for the Safer Kingston Partnership Plan 2014-2017²⁰ were taken from the responses to the 2013 "Your Kingston, Your Say" residents' survey²¹ and include:

- Alcohol misuse
- Antisocial behaviour
- Domestic violence
- Drug misuse
- Sexual offences
- Violence against the person
- Youth crime

Kingston street pastors work to enhance safety and wellbeing in Kingston town centre on Friday and Saturday nights. 65% of volunteers are aged 45 to 64 years and 20% over 65. It has been suggested that the maturity of the street pastors can help to calm aggression and cause people to walk away. Interventions undertaken by street pastors include:

- Removing bottles, glasses or other objects which have the potential to become weapons
- Interrupting conduct that might escalate into antisocial behaviour
- Distracting people from antisocial behaviour through friendly conversation
- Chaperoning vulnerable individuals to protect them from becoming victims of assault or robbery, in particular intoxicated young women who are vulnerable to sexual assault. The street pastor will often stay with them whilst they wait for a cab, bus or friend to take them home



Preventing abuse

The safeguarding of children was discussed in detail in the 2011-12 Annual Public Health Report (pages 238 to 261). For adults, local organisations work together through the Safeguarding Adults Partnership Board to coordinate and prioritise action and deliver services. This includes a strategy and detailed action plan, which is reviewed regularly by the board.

Members of the Kingston Learning Disabilities Parliament have been working with the police regarding keeping people with learning disabilities safe when out in the community and as a result Kingston police have signed the MENCAP 'Stand by Me Police Promise', ten things that the police have agreed to do if someone with a disability ever becomes a victim of a crime²² (see Box 1).

Box 1: Stand By Me Police Promise

1. Make sure that information is available and presented in a suitable form
2. Get better evidence and increase convictions by allowing more time for interviews, particularly where the victim has difficulty communicating
3. Understand how to identify if someone has a learning disability
4. Listen to, respect and involve families, carers and support staff of disabled people
5. Challenge discriminatory attitudes and language among fellow officers
6. Ensure that victims are kept up to date with the progress of the case once they have reported a crime
7. Recognise that disability hate crime is as harmful as other types of hate crime
8. Don't label disability hate crime as antisocial behaviour – identify the crime and deal with it
9. Hold regular beat meetings and ensure they are open to disabled people
10. Display the Stand By Me promises where everyone can see them



A pioneering 'Safe Places Scheme', by and for local people with learning disabilities, was launched in July 2013. This scheme offers a person with a learning disability somewhere to go if they feel unwell, lost or are being bullied or picked on,

or just feel they need help when they are out and about in the community. Safe Place window stickers are issued to shops and other places that sign up to the scheme so that people with learning disabilities looking for help know where to go.

Domestic Violence

The Kingston One Stop Shop for Domestic Violence is a comprehensive weekly walk-in service which offers access to specialist domestic violence advocates and confidential advice. Victims also have the opportunity to report to the police if they wish.

Victim Support provides a domestic and sexual violence support service in Kingston which includes a domestic violence caseworker, independent domestic violence advocate (supporting higher risk victims) and a sexual violence advocate as well as access to highly trained volunteers who can provide emotional support. It also delivers the 'Safer Space' project, which provides one to one and group support to children and young people who have experienced domestic violence at home as well as running prevention and education workshops in local schools.

As part of the MARAC (multi agency risk assessment conferencing) key professionals meet about high risk cases where there is serious risk of harm, and develop an action plan with the specific remit of reducing the level of risk to the victims and their families.

As well as working closely with the police to bring perpetrators to justice, this year the Council is piloting a 32 week perpetrator programme which helps men to end their abusive and controlling behaviour.

This year the Council has set up a Domestic and Sexual Violence Strategic Board to develop and monitor a borough strategy and action plan.

Recommendations

- Develop a borough strategy and action plan to tackle domestic violence
- Support interventions that develop parenting skills and those that develop life and social skills in young people. Also support interventions with high risk young people that result in behaviour change
- All local organisations should fully support the work of both the Safeguarding Adults Partnership Board and the Local Safeguarding Children's Board

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1.4 Addressing Social Isolation, Loneliness and Discrimination

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Key messages

- Active participation in social and community life is associated with mental wellbeing whilst social isolation is an important risk factor for poor mental health
- A key aspect of creating connected communities is to challenge the stigma and discrimination that can result in the exclusion of particular population groups
- There is work by a range of Council departments to increase social connectedness

Introduction

A person's social networks are a key aspect of their mental wellbeing. Active participation in social and community life is associated with mental wellbeing¹ whilst conversely social isolation is an important risk factor for deteriorating mental health and suicide². The development of connected communities is therefore a priority.

The following have been shown to help develop connected communities:

- Preventing social isolation and loneliness
- Developing peer support and enhancing individual and community empowerment
- Improving neighbourhood environments, increasing access to and use of green spaces
- Reducing discrimination against those with mental illness and other stigmatised groups

Information about improving neighbourhoods and increasing access to green spaces is provided in Section 2. More detail on local initiatives to enhance individual and community resilience and empowerment is provided in Chapter 1.5.

Loneliness

Loneliness can occur at any time in life:

- A report by the NSPCC³ published in March 2010 found that in 2008-09 almost 10,000 children were counselled by ChildLine about loneliness. Half this number telephoned about loneliness as their main problem and this tripled in five years from 1,852 in 2003-04 to 5,525 in 2008-09. Children cited reasons for their increased feelings of loneliness, the most common being family relationship problems, issues linked to school, and bullying⁴
- Middle age is a time when key risks for loneliness accumulate, such as retirement, children leaving the family home, divorce and bereavement
- Loneliness is not an inevitable part of old age but is more likely to affect pensioners because of bereavement, ill health and poverty. At the same time, the changing structure of families has affected the degree to which today's elderly people are socially engaged. People living longer and having smaller families and grandchildren not necessarily living nearby all have an impact on the way old age is experienced

Loneliness is a complex problem and so requires a variety of different approaches to be taken:

- Clinical psychologists and psychiatrists can help people who feel lonely by addressing emotional issues that make it hard for them to form relationships or that reinforce their sense of isolation. Talking therapies can help people to develop self-acceptance, making it easier for them to relate to others
- Befriending schemes can help to ease the worst effects of isolation for vulnerable people, and could prevent loneliness from becoming chronic. A study by the Joseph Rowntree Foundation found that befriending schemes were useful in reducing isolation, for example, among people who had spent long periods in mental health institutions and were living independently in the community⁵
- Technology can help to reduce isolation, such as through teleconference projects which can facilitate relationships

- Volunteering helps to reduce loneliness in two ways: someone who is lonely might benefit not only from helping others, but also from being involved in a voluntary scheme where they receive support and help to build their own social network, preventing loneliness from becoming chronic. Volunteering is discussed in more detail in Chapter 1.2
- With respect to loneliness in old age the Campaign to End Loneliness (www.campaigntoendloneliness.org) have created a loneliness toolkit to enable commissioners to better understand, identify and commission interventions for the issue of loneliness in this age group
- Many older people continue to experience discrimination, also known as ageism¹³, which is unfair treatment based on a person's age often related to employment, but also sometimes related to access to health and other services. This can impact on someone's confidence, job prospects, financial situation and quality of life¹⁴. This can also include the way that older people are represented in the media, which can have a wider impact on the public's attitudes.
- Carers can experience stigma and may feel forced to give up work¹⁵

Discrimination

A key aspect of creating sustainable communities is to challenge the stigma and discrimination that can result in the exclusion of particular population groups. Adults with mental health problems are one of the most excluded groups in society and have the lowest employment rate for any of the main groups of disabled people⁶. More information about this is provided in Chapter 4.1.

Other forms of discrimination can also have a negative impact on mental wellbeing:

- Refugees and asylum seekers often experience discrimination⁷
- Victims of racial attacks are almost three times more likely to have depression and almost five times more likely to have psychosis than people reporting no harassment
- Many disabled people report that they continue to experience discrimination daily^{8,9}
- More than half of lesbian, gay and bisexual pupils have been bullied because of their sexuality. While over half of gay pupils had faced verbal abuse, around one in six (16%) had been victims of physical abuse, and almost a quarter (23%) experienced cyberbullying¹⁰
- One in five (19%) lesbian, gay and bisexual employees has experienced verbal bullying from colleagues, customers or service users because of their sexual orientation in the last five years¹¹
- Many prisoners are discriminated against, have poor skills and little experience of employment, few positive social networks and severe housing problems¹²

Social Isolation

Social isolation can be defined as the absence of relationships with family or friends on an individual level and with society on a broader level. The absence or weakness of a person's social network indicates whether the person is socially isolated. Social isolation is harmful to our health; research shows that lacking social connections is as damaging to our health as smoking 15 cigarettes a day¹⁶. Social networks and friendships not only have an impact on reducing the risk of mortality or developing certain diseases, but they also help individuals to recover when they do fall ill. There are a number of population groups at high risk of social isolation. These include:

- People who are disabled; their specific disability can also contribute to social isolation, for example through immobility or sensory impairment
- Social isolation is prevalent amongst older people (half of all people aged over 75 live alone). A 2009 report by Age Concern (now called Staywell) found several factors were associated with being at severe risk of social exclusion including poor health, living in rented accommodation, being a member of a minority ethnic community, having low occupational status and never having been married¹⁷
- People with learning disabilities are amongst the most socially excluded in our society. Very few have jobs, live in their own homes or have choice over who cares for them. Many have few friends outside their families and paid carers^{18,19}

Local Picture

The mental health profile in Chapter 6.1 shows that 20% of people aged 65 to 74 years live alone in Kingston and this percentage increases to 34% among people aged 75 and over. It also provides information about the percentage of social care service users who are socially connected in Kingston. This is 40.7% which is slightly higher than the regional average (39.8%) but lower than the national average (43.2%).

It is very difficult to measure social exclusion, however, levels of hate crime give some indication of the levels of exclusion of some groups. Table 1 below gives figures for Kingston of these crimes over the last two years.

Table 1: Numbers of hate crimes in Kingston, July 2012 to June 2013 and July 2013 to June 2014

	July 2012 to June 2013	July 2013 to June 2014
Racist and religious hate crime	106	123
Homophobic crime	<5	11

Note that 'hate crimes' covers the datasets of: racist and religious hate crime, homophobic crime, antisemitic crime and Islamophobic crime
 Source: Metropolitan Police Crime Figures
www.met.police.uk/crimefigures

Local Action

Adult social care and some voluntary organisations provide day centres, cafés and other opportunities for vulnerable groups to meet. Some examples are given below:

- The Kingston Carers Network (KCN) runs the Young Carers' Project
- St Peter's Church provides a 'Great Feast' for local homeless people providing an opportunity for support and assistance.
- Youth services run a number of groups for young people who may feel isolated:
 - TAG (the Teenage Action Group) for young people on the autistic spectrum
 - FAB (For Any Body) for young people with disabilities
 - Asperger's Syndrome group for 19 to 25 year olds
 - Lesbian, Gay, Bisexual and Transgender (LGBT) youth group

There are a number of resource centres and lunch clubs which provide an opportunity for older people to meet. For people that cannot leave their homes, Stay Well (formerly known as Age Concern Kingston upon Thames) runs the 'In touch' teleconference service. There is also a befriending service run by Alfriston, a day centre for older people in Surbiton.

The new permanent night shelter for homeless people, run by the Joel Community Trust, opened in March 2014. Kingston Churches Action on Homelessness will also be relocating to this site, which will both improve their premises but also create a one stop shop for local homeless people. Those attending the shelter are able to access various training and life skills courses including English classes provided by 'Learn English at Home,' cook and eat courses and maths tuition. Individuals can also take part in therapeutic activities such as conflict resolution, communication skills and anger management. There are also volunteering opportunities for residents and ex-residents.

Following a participatory needs assessment in Malden Manor, the Council's Public Health team has just begun a pilot of the 'U Project' run by the Young Foundation. The aim of this project is to reduce isolation and to increase people's confidence and willingness to get involved in local opportunities such as volunteering. It is envisaged that around 250 local people will be supported to make social connections across cultural, social and generational groups which will lead to an increased sense of belonging and neighbourliness.

Peer support groups can assist in addressing social isolation. Some local examples include:

- Kingston Voluntary Action supported user led self help groups such as the manic depression fellowship and arthritis care
- 'EnhanceAble' (a local charity) provides peer support for parents of children with disabilities
- A pilot project has recently been set up to provide peer support for parents of children with mental health problems

Many voluntary organisations and user groups, including the Kingston Race Equalities Council, Kingston Centre for Independent Living, Mind, KCN, the BME forum²⁰, LGBT forum²¹ and the Learning Disability Parliament, work to reduce discrimination and improve access to services. More information on work undertaken with refugees and asylum seekers is provided in Chapter 1.5.

A recent event on isolation (Together Kingston) identified the need for more work to reduce the high levels of isolation facing marginalised groups, which participants at the event identified as a risk factor to the mental wellbeing of refugees and asylum seekers, older people, people facing socio-economic disadvantage, people living with mental health problems and their carers.

One project developed to help address this is the 'Picture Your Mind' project. This uses photography to bring people together to learn some basic photography skills, receive information on healthy lifestyles and meet new people. Participants were also introduced to more long term engagement opportunities for example the Community Development and Health Course and Mental Health First Aid courses. Two Picture Your Mind courses have taken place (in 2013 and 2014). Places were all offered to people from the vulnerable groups identified at the Together Kingston event.

Kingston Council has identified low current awareness of peer support opportunities available within the borough²². Work has recently begun as part of implementing the Care Act in Kingston to review how to tackle isolation.

A consultation that was undertaken as part of a mental wellbeing assessment carried out by the Council's Public Health team in 2013 identified a lack of access by some BME young people to youth services and concerns about isolated LGBT older people in care.

Recommendations

1. Evaluate the U Project pilot and its impact of the social connectedness of people in the area. Depending on the results of the evaluation investigate ways to expand this to different areas of the borough
2. Investigate opportunities for tackling isolation through the Care Act work stream for prevention, information and advice and ensure that this includes isolated LGBT older people
3. Review the use of youth services by young people from BME communities and investigate options to improve this

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1.5 Building Resilient Communities through Community Engagement

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Key messages

- It is essential for mental wellbeing that individuals and communities have solid inbuilt mechanisms to cope with the stresses of life, are economically secure and fruitful, are able to contribute to positive relationships with others and are able to access appropriate early interventions and universal services at a community level
- The integrated approach to mental health and disadvantaged communities taken through the Joint Health and Wellbeing Strategy offers a great opportunity to embed resilient public mental health in Kingston through developing innovative interventions for reaching and supporting disadvantaged communities
- In order to support and increase sustained community resilience we need to continue to provide opportunities for communities to develop their skills and capacity to deal with the circumstances they face. These need to include increased opportunities for social networks, help for people to link into local communities and community and adult education courses
- These opportunities are crucial to prevent people from becoming marginalised and to support those who are currently experiencing exclusion to positively participate in community life

Introduction

This chapter is focused on community resilience to improve mental health and wellbeing, through community development and empowerment approaches amongst socially excluded and disadvantaged communities living in the Royal Borough of Kingston.

Community resilience

The term 'Community resilience' is gaining increasing currency in examining how communities function, how they can be supported to improve health and wellbeing and how and on what terms they should be best engaged. The term itself is often contested between and within disciplines – for example, in Public Health it is frequently referred to in health protection with reference to climate change, sustainability and flooding¹.

In this chapter, community resilience is referred to as the sustained ability of a community to utilise available resources and assets to withstand, recover, and develop in response to adverse circumstances and vulnerabilities that impact on their health, and particularly on their mental health and wellbeing.

Resilience is considered to be important in the prevention of mental illness and is an important component of many definitions of mental wellbeing. The resilience of individuals and communities has a direct influence on good mental health and wellbeing and being able to cope with the normal stresses of life².

Health inequalities and resilience

Socio-economic inequalities and the degree of disadvantage that people experience is associated with increased risk of developing a mental disorder³. Black and minority ethnic (BME) communities, refugees, asylum seekers and migrants as well as Gypsies and Travellers⁴ are particularly cited in research as experiencing poorer mental health and wellbeing. Inequalities exist for those people who have a mental illness, across the spectrum of disorders, with evidence showing these individuals tend to experience poorer health outcomes, are prone to poorer lifestyle choices and live significantly less years than the general population⁵.

Resilience may help mitigate the negative impacts of these inequalities as well as promote personal and community capacity to face other challenges⁵. Evidence shows that where there are strong community relationships, connections, and buoyant networks of informal support, people are much

more enabled to cope with the pressures of daily life. For example, research into the impact of economic cuts on vulnerable London residents showed that greater social capital (defined as the collective value of a person's social networks) improved community resilience⁶.

Community engagement and development

Community engagement work within communities and improved community involvement can contribute towards happier and healthier communities⁷. Providing residents with better access to information, encouraging residents to get to know their neighbours, encouraging volunteering⁸, working in partnership with them and supporting community leaders are some recommended approaches to reduce dependency, improve resilience, reduce social isolation, and build healthier communities⁹.

Local Picture

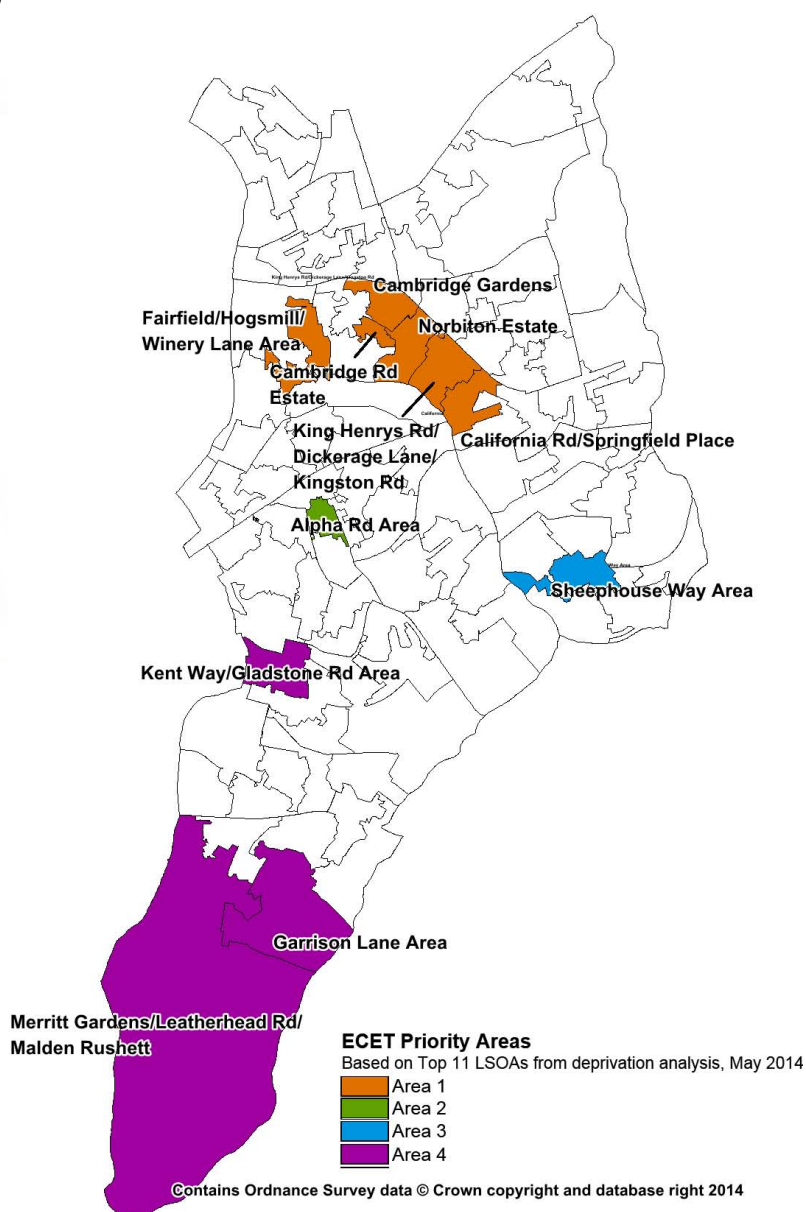
The communities most vulnerable to poor mental wellbeing include people living in areas of disadvantage and some minority groups⁹.

Locality areas of disadvantage

Map 1 shows the four geographical areas of the borough that are the most disadvantaged using a number of nationally and locally available deprivation indicators. These are the main geographical areas of focus for the Equalities and Community Engagement Team (ECET).

Source: Kingston Data based on ONS Index of Multiple Deprivation combined with other indicators

Map 1 Geographical Areas of Focus for the Equalities and Engagement Team



Upon identification of the 11 most deprived Lower Super Output Areas (LSOAs), the four priority areas of focus were identified based on overall rank and geographical/neighbourhood proximity as shown in Map 1 and Table 1:

Table 1: Equalities and community engagement team ranking by Lower Super Output Area

Rank	Lower Super Output Area	Priority Area
1	Cambridge Road Estate	1
2	California Road/Springfield Place Area	1
3	Alpha Road Area	2
4	Norbiton Estate	1
5	King Henrys Road/Dickerage Lane/Kingston Road Area	1
6	Sheephouse Way Area	3
7	Kent Way/Gladstone Road Area	4
8	Garrison Lane Area	4
9	Merritt Gardens/Leatherhead Road/Malden Rushett	4
10	Fairfield/Hogsmill/Winery Lane Area	1
11	Cambridge Gardens	1

Minority groups

There are a number of minority groups who service providers need to work with to provide targeted support due to health inequalities. Some examples of these groups are gypsies and travellers, refugees and asylum seekers and non-English speakers.

Gypsies and travellers

There are a number of English Gypsies and Irish Travellers residing in the borough and we know that the number identified by the census (33 people) is highly likely to be inaccurate. There are three formal sites where English Gypsy communities live, such as the one at Swallow Park in Chessington, where there are 15 pitches where approximately 54 children and adults live, but many Gypsies and Travellers also live in standard homes. Gypsies and Travellers are two separate distinct ethnic minority groups and are known to experience poorer health outcomes than any other ethnic group⁴. Nationally they have been shown to have a reduced life expectancy (12 years less than the general population for women and 20 years less for men), are twice as likely to be depressed, have higher rates of self reported anxiety and also suffer from high suicide rates. Experiences of prejudice and racism are reportedly

significant amongst Gypsy and Traveller communities throughout the UK⁴.

Local research is limited in terms of our knowledge and understanding of Gypsy and Traveller experiences in the borough but anecdotal evidence from community workers working with these communities indicate feelings of stigma, unwillingness to access services, high levels of depression and being disadvantaged¹⁰.

Refugees and asylum seekers

There were 873 clients known to Refugee Action Kingston during 2012-13 but this organisation believes there to be many more people not known to them. A needs assessment carried out in 2008 estimated that there may have been over 2,000 refugees and asylum seekers living in the borough at that time¹¹.

It is known that refugees and asylum seekers experience poorer mental health outcomes than the general population with two thirds having experienced anxiety or depression¹². This can often be attributed to trauma experienced in their home country, exacerbated by trying to make a new life in a new country and culture.

Non-English speakers

Low levels of English cause people to be isolated, face difficulty in fitting into local life and prevent them from supporting their children and other members of their family they care for to lead a full and integrated life within the borough. This can lead to poor mental wellbeing.

There are 25,176 residents aged three years and over who do not speak English as a main language. 3,666 (2%) of residents cannot speak English well or at all according to the 2011 census (although this may be an underestimate). 47% of these residents live in the Maldens and Coombe neighbourhood.

Local Action

The examples set out in this section highlight local action in support of individuals and groups from disadvantaged communities. These include:

- Strategic partnership working
- Community education
- Equipping people with new skills and supporting opportunities to employment
- Supporting communities to define their own needs
- Tailored interventions for specific groups
- Ensuring people have access to the services and facilities they need

Strategic partnership working

Improving the health and wellbeing of socially excluded and disadvantaged communities is one of the four priorities in Kingston's Health and Wellbeing Strategy¹³. One of the key ways that this is being progressed is through community development and empowerment approaches⁷⁹, as well as asset driven work, which can have a transformative effect on individuals, communities and partnerships¹⁴.

The Voluntary and Community Sector Strategy¹⁵ also includes sections dealing with capacity building and community development and a wide range of agencies including local community and voluntary groups are working to support and empower vulnerable communities. Their approaches are based on the premise that in order to help individuals and communities living in vulnerable and pressing circumstances, they must first be helped to help themselves⁷⁹.

In addition, local individuals in communities have responded to their circumstances through setting up community initiatives and volunteering despite finding themselves in difficult personal circumstances¹⁶. Volunteering in this way has personal benefits for those individuals¹⁷. However, their experiences to find and maintain personal resilience can also be used to inspire, as well as inform, service providers on how to best support and tackle issues of disadvantage.

Other examples of strategic partnership work include the work of the Refugee and Migrant Strategy, a co-produced partnership strategy, and the English for Speakers of Other Languages (ESOL) group.



Graduates from the 2013 Community Engagement for Health Course with the former Mayor

Community education

Community Engagement for Health Course

The Equalities and Community Engagement Team (ECET) have delivered a 'Community Engagement for Health Course', accredited by the Open College Network, since 2010. The course recruits local residents who are from, or who have community connections with, socially excluded and disadvantaged communities. The course includes modules on understanding and developing communities, understanding health and wellbeing and empowering communities for change. To date there are 59 graduates of this course. Key outcomes include personal qualifications, new learner-led participation in communities, and Public Health developing close links to those communities through course members. One graduate was recently appointed as a Korean link worker as part of the European Funded 'Empower and Inspire' programme described in this chapter. Recovery Initiative and Social Enterprise (RISE), for people in recovery from alcohol and substance misuse as well as for people with mental illness, was founded by an individual after he graduated from the course.

Some graduate's experiences are cited below:

"When I was in my illness from depression, isolation and alcoholism, I had a hugely negative view of people, as well as the local area and particularly the local community. Through peer support in my recovery and taking a community development course, I have new view of everything around me. This for me is a virtuous circle – the more I engage in our community the better I feel and the more I give in return. I am now confident of my future and my ability to contribute to the future of our community".

Mario Sobczak, course graduate and founder of RISE, Recovery Initiative and Social Enterprise

"I never had the opportunity to study as a school kid because of me being in hospital with asthma and two serious car accidents as a child. So I missed a lot of school. So thank you for giving me the self esteem and confidence to study as an adult."

Course graduate

Neighbourhood management initiatives such as community budgeting

For the past two years, the South of the Borough Neighbourhood has run a community budgeting scheme called 'Your Money You Decide'. This is an example of local communities taking control and action to respond to locally identified needs and is a recommended initiative to improve the wellbeing of communities¹⁸. Local organisations and groups can present initiatives and local people vote on those they wish to be delivered within their community.

“The aim of the scheme is to encourage the local residents to become involved in the decisions that affect them. The process identifies local need and helps to build community resilience.”

Barry Allen, South of the Borough Neighbourhood Manager

One of the initiatives funded by the Your Money You Decide initiative was a literacy class for local Traveller women facilitated by the ECET. This was delivered by Kingston Adult Education’s family learning service in Tolworth Recreation Centre, where the women felt comfortable attending. The outcomes were well evidenced with the women gaining confidence, increasing their literacy skills, integrating with the wider community and gaining opportunities to move on to other initiatives¹⁹.

The Traveller women who took part in the classes previously had either very little or no formal education at all and those who had formal education stated they only received this up to the age of ten.

Some comments from participants were:

“I enjoyed it very much, it did me good”

“It helped because I went with my daughters – my daughters are signed up”

“It has helped my confidence”¹⁹

Also funded by the Your Money You Decide Neighbourhood Management Initiative and facilitated by ECET was a ‘Health Champions’ course, run in Chessington.

“I found the Health Champions course very enlightening. Since the course I volunteer with a couple of local charities and have been able to participate in encouraging healthy eating and regular exercise with young people with learning difficulties and people learning English”.

Kim Bailey, participant in the Health Champions course

Supporting communities to define their own needs

Participatory Assessments of Needs and Assets – Malden Manor Community Project

By involving communities and working with them to understand their assets and needs, the Council and key partners can assist them to help themselves in improving their health and wellbeing.

The Malden Manor Community Project was designed to be research ‘with’ rather than ‘on’ the community. At each stage of the project residents were co-

producers of knowledge and treated as experts of their community. Some community members were trained as community researchers and were equipped with new skills that enabled them to act as research buddies to participants and conduct qualitative interviews.

New technologies were utilised in research including digital photo-diaries recorded by camera and smart phones that documented people’s everyday routines in which they were free to record and explore what was important and significant to them.

After the initial analysis of the data was conducted the key findings were displayed in various locations across the area to check the interpretation of the data. There were a range of prioritisation exercises with a wider range of residents.

“Research on resilience indicates that neighbourhoods with stronger community ties are more able to cope with adversity. It also highlights that those individuals who feel recognised and have opportunities to actively contribute to decisions that impact upon their lives and environment report generally better levels of physical and mental health”.

Dr Carlie Goldsmith, Senior Lecturer at Kingston University and researcher for the Malden Manor Community Project

The wide range of community engagement methods used to carry out the research promoted community links between residents as well as between residents and service providers with positive outcomes such as the increase in use of the local children’s centre.

“Thanks to the information regarding the locality provided by the Project, Kingston University and support offered by ECET, the Centre engaged with some families from Malden Manor area more effectively and this is reflected in the increasing registration numbers (in December 2013: 64.7%, by March 2014: 76.2%) of families who live in the Sheephouse Way Estate.”

Aneta Kubiak, Achieving for Children, Children’s Centres Hub Manager for Maldens and Coombe Locality

The report’s recommendations for tackling social isolation, promoting community cohesion and improving wellbeing include:

- Identifying and supporting key community contacts (local connectors)
- Developing strategies to counter social divisions through developing joint activities that bring different groups in Malden Manor together
- Helping people that struggle with everyday costs by, for example, tackling fuel poverty

Equipping people with new skills and supporting opportunities to employment

Learn English At Home's English for Health project

Learn English at Home (LEAH) is a voluntary organisation that supports Kingston residents who have limited spoken English language ability to attain a level of English needed to communicate their everyday needs and assimilate into the wider community. One to one home tuition is currently (July 2014) provided by 80 trained volunteers going into people's homes. LEAH also provides the English for Health project which provides community classes and social activities with embedded health messages alongside English language provision.



Participants in LEAH's 'English for Health' project enjoying some fun physical activities

"The LEAH 'Learn English and Be Healthy' club provides a weekly platform for people to meet, socialise, learn English, take part in fun physical activities and participate in targeted awareness raising sessions. The mental health sessions have been developed specifically for the client group. All sessions have embedded English for speakers of other languages enabling group participation and understanding. Sessions have included talks by Mind in Kingston, the healthier communities worker at the Council and sessions around stress, anxiety and emotions."

Zoe Hourigan, Health Education Coordinator at LEAH

Getting by and money matters

Kingston's Citizen's Advice Bureau Service (KCABS) runs the Money Talks project which is cited as an example of good practice²⁰. This provides budgeting advice and financial capability learning sessions. The project equips people with basic skills, without which they may face financial hardship or sign up to unsuitable or unaffordable financial agreements. The service targets vulnerable people and those living in areas of disadvantage.



The Money Talks Programme delivers free educational sessions on topics such as credit, debt and budgeting

"KCABS has been working with members of our community to give them the relevant skills to help manage their money better. We understand that a key contributing factor for stress and ill health is worrying about money and that this is increasingly common due to the economic climate. We have found that information about financial literacy boosts people's confidence as well as reducing stress."

Pippa Mackie, Chief Executive, Kingston Citizens Advice, May 2014

Empower and Inspire

Kingston's Empower and Inspire programme led by the ECET won a £240,000 European Union Integration Fund bid in 2013. The programme focuses on community members who are often isolated and vulnerable; particularly women and young people who don't have English as a first language. By improving English language skills, the project gives people independence in accessing health and other services, improves their health, assists integration and develops greater resilience. Empower and Inspire builds on the success of the European Integration Fund programme, again delivered by ECET between 2009 and 2013. The programme also involves the Council's Heritage Service as part of a project to raise the profile of All Saints Church where the Kings of England were originally crowned.

"Understanding and enjoying our local heritage is important to the future of our wonderful Borough because it develops resilience through shared learning between diverse cultures, improves communication and integration and contributes to enhanced health and social wellbeing."

Councillor Kevin Davis, Leader of the Council, Royal Borough of Kingston upon Thames

Refugee Action Kingston (RAK)

Refugee Action Kingston's learning centre is for refugees and asylum seekers and supports them by improving English, providing support to find a job and teaching people life skills such as how to cook healthy food on a budget. RAK now plans to turn the learning centre into a centre for community resilience:

"The Centre for Community Resilience will be a hub where RAK facilitates learning and integration through English for Speakers of Other Languages, Citizenship courses, Into Work sessions, Art workshops, Fitness and Wellbeing Classes, Financial Awareness Sessions, Health Literacy Days and Local News Clubs."

Sanja Djeric Kane, Director of Refugee Action Kingston

RAK also provide a crisis support and advocacy service as well as helping people to deal with essential needs such as getting children a school place and helping people to register with a GP. Refugee Action Kingston's Timebanking project contributes to the 'Five ways to wellbeing' (see Chapter 1.1) and community resilience. The case study (page 35) provides information about how this has been achieved.

Building tailored interventions

Korean link worker

A Korean link worker has been recruited to provide isolated Korean migrants with an opportunity to learn new skills and access information on issues such as mental wellbeing, women's health and local community services and groups. Local Korean volunteers have also been recruited to act as access mentors. The link worker has also supported the development of Korean family support groups such as the one now in operation at the Malden Manor Children's Centre.

Communities Connected

Kingston Voluntary Action's Communities Connected outreach project is aimed at tackling digital exclusion by enabling disadvantaged people to access the internet and computer technology. Training and development are provided in community settings and bespoke internet access for the areas of greatest disadvantage, such as on Cambridge Road Estate, have been installed giving local people free internet access.

RISE

RISE, the Recovery Initiative Social Enterprise, supports community members who are in recovery from drug or alcohol misuse, people who have suffered mental health problems, or people with both issues. RISE provides a service which operates an Asset Based Community Development approach providing all members with the ability to bring their personal strengths, skills and assets to the 'RISE community' skilling up each other as well as service providers on ways of working in a co-productive way.

RISE is made up of several projects including Community Resilience (connecting people together), RISE Unite (supporting migrant community members), Kingston Rise (recovery from substance misuse and mental illness) and the Jasmine Project (a knowledge hub and educational support through the use of volunteer teachers).

"My only community and connections were the people I knew in the drugs community, until I became a member of the RISE community and my life is completely different now. You need to feel a part of something to have an identity."

Member of RISE Community speaking at Kingston University's Community, Identity and Difference event in March 2014

Promoting good mental health through gardening

Once a week, homeless or vulnerably housed people who attend the Great Feast at St Peter's Church go to an allotment in Tolworth for an hours gardening. This is part of a pilot, whereby members of different community groups (Refugee Action Kingston and RISE amongst others) come together to take care of a plot of land.

The intended outcome of these weekly gardening sessions is that people who may normally feel marginalised have increased self confidence, wellbeing and get to connect with others over a shared love of gardening.

Ensure people have access to the services they need

The Community Wellbeing Group brings together nine local groups working to improve mental health outcomes for BME and marginalised groups through awareness raising, influencing mental health commissioning in the borough and offering mental health services. Work that this project supports includes:

- Promoting access to parenting advice and support among BME communities
- Supporting the Centre for Community Development to establish a mental health helpline for Tamil speakers
- Counselling services for refugees and asylum seekers including unaccompanied minors
- Supervision sessions for volunteer counsellors. This has enabled Islamic counselling services to offer an effective service that meets the standards of the British Association for Counselling and Psychotherapy (BACP)
- Khat and mental health sessions – raising awareness and supporting communities to reduce the impact of the use and misuse of the drug on mental health
- Mental health awareness sessions to reduce barriers to mental wellbeing, for example stigma and lack of information about services
- Befriending project to reduce social isolation among older people
- Community English and craft skills classes to reduce social isolation among women and older people from the Korean community
- Increasing levels of physical and social activity. The purchase of a table tennis table for a mental health drop-in group in Cambridge Road Estate has been agreed by the project

Recommendations

1. Ensure the recommendations of the Participatory Assessment of Needs and Assets in Malden Manor are implemented jointly with residents
2. Develop the ECET Localities Strategy and Action Plan based on the four geographical priority areas of disadvantage
3. Deliver the Refugee and Migrant Needs Assessment
4. Develop the co-produced and refreshed Refugee and Migrant Strategy and action plan for 2015-20
5. Deliver a Kingston specific community engagement for health course
6. Commission appropriate services that respond to the needs of socially excluded and disadvantaged communities and evidence improved health outcomes
7. Provide seed grants to build the capacity of small community groups who wish to build community resilience through initiatives and low level support with evidenced outcomes
8. Develop and implement the Voluntary and Community Sector Strategy's Community Development Action Plan providing strategic direction to and support for community development in the borough
9. Support the development of low level interventions available to socially excluded and disadvantaged communities that support social connections and wellbeing such as walking and talking clubs, casserole clubs, luncheon clubs, social gardening initiatives, new skills courses and community health and wellbeing activities

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Case Study:

Refugee Time Bank – 'Our Time'

'Our Time' is a time bank which enables refugees to integrate and contribute to their local community through sharing their personal skills and knowledge.

Members 'deposit' their time by giving practical help and support to others and 'withdraw' time when they need something for themselves. Everyone's time is valued equally, so one hour of time given earns one hour of time credit and an exchange takes place without the need for money or financial recompense.

Refugees and asylum seekers in Kingston are often not familiar with the UK's concept of volunteering whilst others are not allowed to get paid work, but yet wish to contribute to the community.



'Our Time' provides experience in volunteering, opportunities to have skills and contributions recognised and the opportunity to 'give back'. Members act as equal partners in reciprocal relationships and are therefore empowered to facilitate the types of assistance they need instead of having it delivered to them.

As a result of the time bank, members have reported reduced isolation and exclusion. It has increased opportunities to utilise their skills and experiences and learn new skills whilst playing an active, self determining role in their local community all leading to improved health and wellbeing.



Section 2

Better Environment for Mental Health

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Overview

People's wellbeing can be maintained and improved by living in a permanent, safe and good quality home^{1,2,3} and being able to live⁴, work⁵ and take leisure⁶ in a pleasant⁷ environment.

Ensuring access to green spaces⁸, and providing opportunities for physical exercise through encouraging active transport^{9,10,11} within routine activity, also improves a number of aspects of mental health¹² and wellbeing¹³.

The Marmot Review⁴ of health inequalities clearly shows how health and wellbeing is often determined by wider social and economic factors. This chapter looks at a number of these and describes how good housing, natural environments, planning and active transport can impact on people's quality of life, contribute to mental health and wellbeing, and determine how well individuals and communities function and cope with the normal stresses of life.

A foundation of economic security is vitally important to help establish a positive and healthy living environment and good mental health and wellbeing. Work has an important role in promoting mental wellbeing, and is also discussed in this section.

The following chapters cover these themes in more detail:

2.1 Housing

2.2 Active travel

2.3 Green spaces

2.4 Planning

2.5 Work and income

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2.1 Housing

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Justine Rego, Team Leader (Data and Information Management), Kingston Council

Key messages

- Good quality housing^{1,2,3} and a settled home life are important in maintaining good mental health whilst poor housing or the lack of a permanent home can contribute to the development of mental health problems or can make existing mental health problems more difficult to manage.
- Addressing housing need and support is a priority to improve the mental health and wellbeing of individuals and communities and potentially reduce demand for health and social care services.
- The challenges associated with housing in London are greater than in many other parts of England. Addressing issues such as homelessness, fuel poverty and improving Council housing will meet people's needs and improve mental health and wellbeing.

Introduction

The association between housing and mental health has long been recognised and there are a range of housing-related factors that affect mental health outcomes⁴. Damp and cold housing is associated with an increase in mental health problems such as depression and anxiety⁵. Other factors affecting health include the housing layout (impacting on accessibility and usability); noise; overcrowding; neighbourhood quality and infrastructure (including accessibility to health services and neighbourhood safety); and the wider environment (availability and cost of housing, housing investment, housing tenure and urban planning)^{1,2,3}.

The increasing evidence base linking housing and mental health and wellbeing can be used to guide primary preventive, social and economic measures and interventions including design, construction, renovation, use and maintenance.

Local Picture

Since 2004 house prices in Kingston have risen by over 50% up to an average cost of £391,000 in June 2014 (compared with £172,000 in England and Wales and £437,600 in London)⁶.

The housing tenure breakdown in the borough has been changing, with a significant increase in private rented housing and the majority of new housing being in apartment blocks (Table 1). The total number of households has increased by 3.6% over the ten years from 2001 to 2011.

Table 1: Housing Tenure, Kingston, 2001 and 2011

Housing tenure type: Kingston (Excluding communal establishments)	2001	2011
Owner-occupiers	43,499 (70.8%)	40,762 (64.1%)
Renting from private landlord/letting agency	8,847 (14.4%)	13,391 (21.0%)
Renting from Council/Housing Association	6,832 (11.1%)	7,502 (11.8%)
Other tenure types (renting from other types of landlord/shared ownership/living rent-free)	2,248 (3.7%)	1,984 (3.1%)
Total	61,426	63,639

Sources: 2001 and 2011 Censuses

The rate of homelessness applications accepted in Kingston for 2013-14 was 3.04 households per 1,000 (which was higher than the England average of 2.32)⁷.

204 households were accepted by the Council as homeless and in priority need⁸ in 2013 – 14, compared with 187 in 2012-13, and 176 in 2011-12.

Nationally, 46% of those accepted as homeless and in priority need are female lone parents with dependent children and 20% are couples with dependent children⁹. Looking at the priority need categories, 8% of households nationally are vulnerable through mental illness and 7% through a physical disability¹⁰.

The Council prevented 421 households from becoming homeless in 2012-13 (compared with 161 in 2011-12)¹¹.

In March 2013 there were 436 households in Council-provided temporary accommodation, down from 497 in 2012. The equivalent figure for 2006 was 812 and total numbers have fallen every year since then.

Fuel poverty is estimated to impact 12% of households in Kingston (compared with 11% in England, 10% in London)¹². Please see the Local Action section below for more details.

Local Action

The Kingston Strategic Housing Plan 2011-15 is being implemented and includes a number of large projects including:

- 'Better Homes' – an improvement programme for Council housing providing warmer, better insulated homes in a reasonable state of repair with more modern facilities for tenants. This is scheduled to be completed by 2017. Last year, the Council's 'Better Homes' programme exceeded targets and improved the homes of 662 local tenants and leaseholders. This was a major achievement in the second year of the five year programme, which resulted in the Greater London Authority (GLA) advancing £2 million of the grant it has made available for the project. The internal works have included new kitchens, bathrooms, central heating upgrades and new electric installations. 91% of tenants expressed satisfaction with the improvements made to their homes. The Council will spend £16 million on the 'Better Homes' programme before June 2015. This investment will see 2,000 properties benefiting from external works such as new or replacement roofs, replacement windows and doors, improvements to public areas and external redecoration, and internal improvements to a further 800 tenanted properties. On completion of the 'Better Homes' programme all of Kingston's council homes will exceed the Government's 'Decent Homes' standard

- The Older and Vulnerable People's Housing Strategy which is looking at housing provision for these groups within the borough (see Case Study later in report)

- A review of the Housing Allocations Policy

The new Housing Strategy for 2015-19 is being drawn up with partners.

The link between both excess winter deaths and health risks associated with cold homes is well known. Nationally, the NICE guidelines on excess winter deaths¹³ will provide further guidance on how to tackle this issue.

A key area to be considered is the practical ways to reduce fuel poverty. Households are considered to be in fuel poverty if they have above average fuel costs and their residual income (if this amount was spent) leaves them below the official poverty line¹⁴.

The three key drivers are the energy efficiency of the property, cost of energy and household income. The age of much of the housing stock in Kingston means low energy efficiency drives up levels of fuel poverty in the borough¹⁵.

Locally a number of schemes are helping to address the issue of fuel poverty. The Council's 'Better Homes' programme directly reduces tenants' spend on fuel as homes are made more efficient, the 'Warm Home, Better Health' programme aims to increase the level of warmth in the homes of older residents in the borough and the 'Coldbuster Scheme' and 'Green Deal Assessments' help those in privately owned or rented accommodation.

To consider fuel poverty in more detail it is being researched as part of the Joint Strategic Needs Assessment and a new private sector Housing Stock Condition Survey will be completed during 2014-15 to provide evidence for future service planning and which will also help to inform the new Housing Strategy for 2015-19.

Recommendations

- The new housing strategy should have the appropriate public health input to ensure relevant Public Health Annual Report recommendations are taken into account
- Review the NICE guidelines on excess winter deaths following publication in 2015
- Take forward actions identified within the fuel poverty needs assessment

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2.2 Active Travel

Russell Styles, Associate Director of Public Health, Kingston Council
Leslie Hunt, Sustainable Travel Officer, Kingston Council

Key messages

- Active travel allows the opportunity to build into daily routine essential exercise which reduces the risk of mental health problems such as depression, as well as physical illnesses such as heart disease
- Walking or cycling to school or work can have an immediate effect on mental alertness and wellbeing. Cycling and walking are forms of exercise almost everybody can do. Safe, less 'motorised' and pleasant environments encourage more people to participate in these activities
- Improvements in the local built environment together with a sustained behaviour change programme are vital to increase cycling and walking rates in the borough

Introduction

*"Physical activity has an important role to play in promoting mental health and wellbeing by preventing mental health problems and improving the quality of life of those experiencing mental health problems and illnesses"*¹

Regular physical activity reduces the risk of depression and has positive benefits for mental health including reduced anxiety, enhanced mood and better self-esteem².

There is evidence it may improve at least some aspects of cognitive function that are important for tasks of daily living, and it is also associated with a reduced risk of developing problems of cognitive impairment in old age (see Chapter 4.3).

Active travel refers to journeys that use physical activity to move between locations, such as walking and cycling. These journeys are generally understood as travel for purposes such as going to work, school or the shops as opposed to recreational walking or cycling. Active travel is likely to be the main way many people meet their physical activity need because it is easily built into their daily routine.

The NICE Walking and Cycling Pathway states that both walking and cycling should be promoted as a means of incorporating physical activity into people's daily lives³.

Local Picture

The promotion of active travel has been a longstanding priority for the Council with a dedicated team working with business and schools on travel plans, promoting active travel and delivering cyclist training.

Kingston town centre, as a major retail and employment centre, is a significant trip generator. In addition Kingston Bridge attracts significant through traffic as one of the few crossing points for the Thames in South West London.

These factors, combined with the lack of a local connection to the London Underground, and peak hour trains running at capacity, mean that local roads can be congested, particularly in and around the town centre.

This backdrop provides additional impetus to help make the borough more walking and cycling friendly. The Council has been successful in recording a steady decrease in traffic volumes since 1999⁴.

"We are proud of the work that has been done to date to facilitate cycling both in terms of providing infrastructure, cyclist training and travel planning".

Leslie Hunt – Sustainable Travel Officer, Kingston Council

Kingston has seen a 14% increase in cycling between 2010 and 2012⁵, beating the Council's Local Implementation Plan targets by 100%, with current cycling rates at 4% of all journeys made⁶. This is one of the highest rates in London, but there is a long way to go to meet the Mayor's vision of a London-wide cycling rate of 20%.

Local Action

The Council's Smarter Travel Team promote active travel to reduce congestion and foster improved population health and wellbeing.

Free cyclist training is offered to all primary schools and work is undertaken with schools to ensure that school travel plans have clear actions to promote walking and cycling to school. The Council's Planning and Neighbourhood Engineering department helps to ensure that wherever possible the infrastructure is provided to facilitate walking and cycling. This includes safer routes, improved road crossings and the provision of ample cycle parking.

As noted above, walking to school forms a key element of school travel plans and the Council's Smarter Travel team has helped fund and promote reward schemes such as Living Street's Walk once a Week (WoW) and the Transport for London (TfL) Walk to School Week.

These events can help install the joys of walking in pupils and parents and can lead to reduced car use on the school run.

"Lovelace Primary School is fully engaged with walking to school to promote the health benefits of walking.

We recently celebrated the National Walk to School Week and combined this with a healthy school focus with many events scheduled throughout the week.

We understand that walking is important in enabling significant amounts of time for physical exercise and children arrive at school energised and ready to learn.

Additionally, this time outdoors makes the mind more alert and gives time for good social interactions with family and friends and so contributing to good mental health. Our Walk to School Week culminated with a focused 'Leave your car at home' day and our large car park was closed to staff.

Children came to school in fancy footwear and paraded and danced, alongside Debra the Zebra, the Walking to School mascot, around the front of our school which would normally be 'dead' space taken up by parked cars.

This thoroughly enjoyable community event was another great time to promote a healthy love for walking and its benefits."

**Matt Sedgwick – Deputy Headteacher
– Lovelace Primary School**



Positive partnerships are also being developed with major employers in Kingston to help them to facilitate walking and cycling through both travel planning and support with events and initiatives such as training, bike maintenance classes and bike repairs.

All of these factors contribute to Kingston's low road casualty rate, currently the lowest in Greater London – this contributes to giving the population confidence to walk and cycle more.

From 2014 the Council is increasing engagement with schools, businesses and residents to promote cycling with additional funding from TfL through the Council's Cycling Programme. The emphasis is on up-skilling adults with on-road cyclist training and encouraging community groups to organise their own leisure cycle rides.

Key to this engagement work is the Sustrans Active 'Travel for Health' programme in Norbiton and Malden Manor. This aims to improve health and wellbeing by encouraging people to incorporate more walking and cycling into their everyday lives. The programme will work to enable people who are currently inactive to engage in the project and increase levels of physical activity through a range of walking and cycling initiatives (See page 46).

Additional innovation is key to making further progress and Kingston will receive up to £30 million as part of the 'Mini-Holland' initiative to help make it as cycle-friendly as Dutch towns. This will include better facilities and conditions for cyclists and pedestrians across the borough with a high-quality network of cycle routes.

Recommendations

1. Increase the amount of Level 3 Bikeability Training in secondary schools to address the gap between younger children cycling and re-uptake of cycling in adulthood
2. Develop cycle to school partnerships across Kingston to normalise cycling to school, particularly to secondary school, and use the partnerships to drive infrastructure improvements
3. Increase the level of business engagement and use infrastructure improvements as a catalyst to increase the numbers of people regularly cycling to work

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Case Study

Active Travel for Health Project

Kingston's Active Travel for Health Project was launched in June 2014 in partnership with Sustrans. The benefits of physical activity in reducing social isolation, promoting community cohesion and increasing self efficacy are well documented. The cost of physical inactivity to health services in Kingston is nearly £15m per 100,000 people⁷.

This project focuses on two localities – the ward of Norbiton and Super Output Level areas of Malden Manor in Old Malden and Alexandra wards. The objectives are to:

- Enable adults and children in target areas to walk and cycle more by removing real and perceived barriers.
- Engage intensively and appropriately with populations in order to achieve an improved sense of wellbeing and control.
- Work with people who are currently inactive to enable them to start walking and cycling.
- Enable and encourage people to access employment and education via active travel amongst target populations.
- Recruit, train and support volunteers from the target communities to be involved with project delivery.



"We're excited about the scheme and helping more people to get cycling and walking as part of their daily routines. This kind of exercise is excellent for improving people's physical and mental health and overall wellbeing."

Councillor Julie Pickering, Cabinet Member for Adult Social Care, Health and Voluntary Services

Achievements to date

The programme of activity has already provided family rides; walking initiatives; bike skills sessions for families (including learn to ride and Level 1 and 2 bikeability training); Dr Bike drop-in sessions (to get old bikes working again); Build-a-Bike workshops; and bike polo for teenagers.

The launch of the project during Bike Week in June 2014 included successful Dr Bike stalls with many residents discovering more about the benefits of this programme whilst having their bikes fixed.

Between June and August 2014 a range of summer activities including the Malden Manor Community Day on 16 August has seen 196 local people engage in this initiative.

Key Outcomes

The key outcomes of the Active Travel for Health project are based on:

- Increased walking and cycling and the benefits of active travel in Norbiton and Malden Manor
- Increased sense of wellbeing of residents who take part in project activities
- Increased community capacity to promote walking and cycling by recruiting, training and supporting volunteers and local 'champions' to sustain the programme

2.3 Green Spaces

Russell Styles, Associate Director of Public Health, Kingston Council
Marie-Claire Edwards, Service Manager Green Spaces (Environment)
and Climate Change (Corporate Landlord), Kingston Council

Key messages

- A range of evidence suggests that contact with safe, green spaces improves many aspects of mental health and wellbeing
- Safe green spaces can increase levels of communal activity across different groups and increase community satisfaction in their locality. Access to green spaces can increase levels of physical activity for all ages, contributing to enhanced mental health and wellbeing. Contact with natural environments can reduce stress and improve mental health and wellbeing

Introduction

The term green space has a variety of meanings. It includes spaces used for recreation and amenity purposes such as parks, public gardens and sports fields; spaces managed for nature conservation; and spaces that have a specific function such as allotments and cemeteries.

There are also green spaces within transportation corridors, alongside river banks and streetscape (for example wayside gardens, planters, green walls, greenways and trees along the public highway). These more unconventional green spaces are equally important to provide access to open spaces as they offer relief from buildings and define the townscape where larger green spaces may be scarce.

There is mounting evidence that demonstrates the contribution that green space makes to mental health and wellbeing¹. Contact with safe green spaces can improve a number of aspects of mental health and wellbeing, as well as social and environmental indicators, including:

- Reducing symptoms of poor mental health and stress
- Increasing levels of communal activity
- Improving air quality and reducing noise through encouraging participation in active travel

Local Picture

Kingston is often referred to as a 'green and leafy' suburb of Greater London. This characterisation is given partly because of the diverse range of open spaces, from the formal parkland of Canbury Gardens in Kingston Town to the informal hay meadows of Tolworth Court Farm Fields. There are many large and small parks, playing fields and wayside gardens.

Kingston parks and open spaces experience very little crime, and are considered safe, nevertheless people's perceptions of the risk of crime can be a barrier to them visiting these areas². The Council therefore works closely with the police Safer Neighbourhood Team, ward councillors, local residents and park users to make small changes such as cutting back vegetation, repainting benches and providing safe footpaths.



In 2014 three Kingston parks won awards again that rated them among the country's best kept green spaces. Canbury Gardens, Surbiton's Fishponds Park and Manor Park in New Malden have each been awarded a Green Flag by the environmental charity Keep Britain Tidy. Green Flag status is given to parks and open spaces that are well managed and meet high environmental standards.

The Council's Green Spaces Strategy (2008-18) includes the Tree Strategy, Allotment Strategy and the improvement of the provision of play facilities. The framework of the strategy is broadly based, covering the wide range of opportunities that green spaces provide. The overall ambition of the strategy is to

undertake improvements so that each green space will fulfil at least six functions with the majority of sites being able to fulfil nine or ten.

It is important that the strategy remains current and responds to changing circumstances, and therefore engagement is taking place with a range of groups through workshops, and the wider public by an online questionnaire. The information gathered from the engagement will shape future priorities for green spaces.

Local Action

"We have been working hard to promote the range of opportunities that parks and open spaces offer the community; we do this by making sure the Green Spaces Strategy is relevant for today's lifestyle choices".

**Rachel Lewis, Head of Environment.
Kingston Council**

Since the start of 2014 Quadron Services, Kingston's Green Space Management contractor, has deployed its Sports Development Manager in the borough.

One of the major areas of focus has been improving the relationships between the Council and local fitness providers. The Sports Development Manager has actively been seeking providers and establishing contact. By offering the providers a fully supportive package Quadron has been able to increase the numbers of officially registered fitness companies in Kingston.

This approach has enabled the borough to be able to vet providers, gathering data such as qualifications, first aid certificates and public liability certificates. Increasing the number of providers who interact in this way will increase the quality of activity on offer to the public.

Some parks in the borough are spacious open spaces in which a number of activities can be experienced at any time that is convenient to the user. The Council is supporting the increase in personal fitness instructors by introducing a licensing scheme that protects the instructor and the participant. The regular appearance of this type of activity in green spaces provides a degree of assurance to other visitors and can contribute to an increased perception of safety.

With more high quality delivery available at affordable rates in the borough the Council aims to positively impact on mental health and wellbeing. Studies have also shown that when a park or green space is regularly used by groups for planned (or incidental) activities with many meeting points, people feel safer and community spirit can be increased^{3,4,5}.

Working with our new partners we have agreed plans to install a brand new outdoor gym in Alexandra Park.

The facility (similar to the picture) has been designed to engage the entire community with a mix of machines all operating a resistance adjustable hydraulic system so that they are accessible to people of different ability levels with space for static and dynamic stretching or activities such as yoga and Pilates.



Recommendations

1. Through the reprioritised Green Spaces Strategy ensure ways of maximising the use of available green spaces to promote health and mental wellbeing among all groups and communities
2. Kingston CCG to support GPs to make more use of alternatives to medication for mental illness, including the provision of advice to spend time and exercise in green spaces
3. The Green Spaces Strategy should explore how best to develop and maintain the public health, economic and environmental benefits of green spaces

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2.4 Planning

Russell Styles, Associate Director of Public Health, Kingston Council

Andrew Lynch, Lead Officer – Strategic Policy (Development, Planning and Regeneration), Kingston Council

David Horkan, Lead Officer – Development Control, Kingston Council

Key messages

- Healthy urban planning incorporates a number of policies and plans which promote mental health and wellbeing, including sustainable travel, better quality housing and enhanced green spaces
- The health implications of local plans and major planning applications need to be consistently taken into account and regulated to help enable a built and natural environment that is positive for enhanced wellbeing

Introduction

Improved planning has long been identified as a precondition for improving mental health and wellbeing for individuals and the communities in which they live^{1,2,3}.

The National Planning Policy Framework (NPPF)⁴ sets out how planning contributes to replacing poor design with better design; improves the conditions in which people live, work, travel and take leisure; and how it can widen the provision of high-quality homes.

The role of planners in planning, developing and regulating our environments can therefore have a significant impact on the mental health and wellbeing of people in Kingston.

Good design and good planning can help reduce healthcare costs over time by preventing mental health risks, including poor urban planning, worklessness, lengthy and time-consuming travel to work distances, poor access to community facilities and poor housing.

Healthy urban planning promotes healthy, successful places for people to live, study, work and socialise. It does this by providing homes, jobs, centres and services that people need, reducing environmental risks and delivering urban spaces which create conditions for the propagation of positive mental health and wellbeing.

The local Core Strategy, as part of the Local Development Framework (LDF), was adopted in April 2012 and sets out the development strategy over the next 15 years for Kingston. In order to create healthy and sustainable communities, the Marmot Review⁵ recommends a fully integrated planning system which includes housing strategic policy, transport and neighbourhood plans. The Core Strategy (together with the London Plan) is the overarching development plan that draws these strands together.

Local Picture

The Core Strategy and Health

The Core Strategy's area based spatial planning strategies and thematic policies influence mental health and wellbeing in many ways, reflecting that these are crosscutting issues.

The strategy outlines how the Council requires Health Impacts Assessments (HIAs) for all major development proposals. A HIA in planning is a process to help evaluate the potential health effects of a plan, project or policy before it is built or implemented. A HIA can provide recommendations to increase positive health outcomes and reduce or mitigate adverse health outcomes. HIAs bring potential public health impacts to the decision making process to add health outcome value to the consideration of land use.

The strategy also outlines how proposals will be supported in principle where they promote healthy, safe and active living, particularly for those living in disadvantaged communities. The Core Strategy (Theme three: Safe, Healthy and Strong – Healthy and Safer Communities) recognises the contribution that can be made to influence the promotion of positive mental health and preventing ill-health, including through:

- The provision of more sporting and recreational facilities and access to open space to create more opportunities for physical exercise and active travel (Policies CS3, DM5 and CS6)
- A good environment and the provision of decent quality and affordable housing together with access to jobs and skills training (Policies CS11, DM17 and DM18)

- Community hub type facilities to create more opportunities for social interaction, especially for elderly residents to reduce feelings of isolation and depression (Policies DM24)
- Encouraging the provision of a broader spectrum of non-alcohol-based leisure/cultural opportunities for the under 18s to help reduce the debilitating effects on health, wellbeing and community safety of the excess consumption of alcohol
- Developments that reduce pollution, flooding and fuel poverty (Policies DM 1-4)

The Core Strategy and Transport

Kingston's strategic road network, including the A3, carries large volumes of traffic that cause peak hour congestion on several key routes including the approaches to and from Kingston town centre.

Transport-related noise pollution (predominantly from roads, railways and planes) can adversely affect mental health and school performance in children. Socially disadvantaged people (who are more likely to live near busy roads) are at greater risk of the negative effects of noise pollution⁶.

There has been a reduction in traffic volumes since 2001 mainly as a result of the introduction of measures to both improve sustainable transport options and to manage car use and parking.

To encourage a shift to sustainable modes of travel, the Core Strategy outlines how the Council will:

- Protect and enhance the availability of employment and key facilities including shops, healthcare and leisure facilities within local communities
- Locate major trip generating development in accessible locations well served by public transport including Surbiton, New Malden, Tolworth and Kingston town centres

To support and encourage the use of public transport, cycling and walking the Core Strategy outlines how the Council will:

- Promote and enhance the strategic cycling and walking networks (see Chapter 2.2)
- Enhance and promote Kingston's network of quiet residential roads, traffic free routes and open spaces as attractive, safe and convenient walking and cycle routes

- Provide infrastructure, including cycle lanes and crossing facilities, to overcome specific barriers to the safety and convenience of cycling and walking trips, such as the A3, busy roads and junctions, rail lines and the Hogsmill River
- Tackle bike theft and provide adequate secure and convenient cycle parking.
- Promote cycling and walking including through school and workplace travel plans and provide supporting measures such as cyclist training

Neighbourhood Plans

Neighbourhood planning has been a longstanding commitment in Kingston, particularly through Neighbourhood Committees. A new level of planning is enshrined in the Localism Act, giving communities the opportunity to prepare a neighbourhood plan. The Council's Neighbourhood structure predates the Localism Act and has provided a framework to ensure local people can voice their planning ideas and concerns. The quality of a neighbourhood has been found to impact on mental health⁷. There is a positive impact on wellbeing through providing the mechanisms and empowering residents to participate in planning decisions that impact on their local living environment⁸.

Local Action

Planning Policy

Since the adoption of the Core Strategy in 2012 Kingston's Development, Planning and Regeneration team has prepared three supplementary planning documents (SPDs) to make a significant contribution for addressing poor design that will improve conditions for and the mental health and wellbeing of Kingston's resident, working and visiting populations.

The Affordable Housing SPD identifies how affordable housing contributions should be taken forward through planning application negotiations, and provides the necessary guidance to deliver the Core Strategy's affordable housing policy.

The Sustainable Transport SPD explains how walking, cycling and public transport should be incorporated into all development proposals to maximise access to and from a site, providing better links to key facilities and services.

The Residential Design SPD provides guidance to developers on key aspects of design for different housing formats and typologies, seeking to ensure new housing is as appropriately located and as well designed as possible.

The team are also working on a document that is key to the delivery of necessary new infrastructure – the Community Infrastructure Levy (CIL) Charging Schedule. When adopted this document will allow the Council to collect pooled contributions from developers that will be used to fund essential new infrastructure to ensure future developments are as sustainable as possible.

Planning Applications

The Development Management service determines applications seeking to maximise the benefits of any development for residents, workers and visitors to Kingston and to protect and enhance the environment.

The completion of Surbiton Health Centre and Lime Tree School on the former Surbiton Hospital site have provided vital new facilities for the health, education and wellbeing of the community.

Other recently completed developments such as the Turks Boatyard residential scheme and Bishops Palace House have delivered significant benefits to the built environment as well as providing an improved public realm with much needed affordable housing, leisure facilities and new cycle parking facilities.

Development Management continue to negotiate financial contributions for all major developments towards sustainable transport, public realm, health and social care facilities and education. These contributions are utilised by the various services of the Council to deliver wider benefits to the community and ensure that the impacts of any proposal are adequately mitigated.

Recommendations

1. Provide public health support for the Health Impact Assessment (HIA) reviews of major planning development applications
2. Prepare a Community Infrastructure Levy (CIL) charging schedule that will secure developer contributions for the provision of new infrastructure to include contributions towards health care facilities, improving the public realm and facilities for sustainable transport modes such as walking and cycling
3. Lobby regional government (the Greater London Authority) for key sub-regional infrastructure provision, such as Crossrail 2 that would deliver a step change in connectivity for Kingston, and would be a major boost for access to jobs and local employment opportunities

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2.5 Work and Income

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Andrew Sherville, Lead – Business Community, Kingston Council

Key messages

- People spend close to a third of their lives in the workplace and employers should be promoting and supporting health and wellbeing in the work environment
- As pressures on businesses increase so should awareness of the necessity to support employees in healthy work/home lifestyles. Employees performing remote, home-based and flexible working should also be considered for support
- It is essential for good mental wellbeing that individuals and communities are economically secure to ensure there is a solid foundation to help cope with the stresses of life and contribute to positive relationships with others
- The Council has built mechanisms and worked with partners to help mitigate the impacts of changes in economic security by coordinating their resources to empower residents to manage the change and provide assistance to the most vulnerable

Unemployment is associated with a 2.7 fold increased risk of having a common mental disorder³ and a 4.3 fold increased risk of a disabling⁴ mental disorder⁵. Adults who are economically inactive are at 1.9 times increased risk of 'Common mental disorder' and 5.6 times increased risk of 'Disabling' mental disorder⁵.

Work has an important role in promoting mental wellbeing, although beneficial health effects depend on the nature and quality of work⁶. It is an important determinant of self-esteem and identity. It can provide a sense of fulfilment and opportunities for social interaction. For most people, work provides their main source of income.

Happiness, wellbeing and mental health are important in a business context as happy, healthy and emotionally balanced employees are more likely to be engaged and productive. This has the potential to promote greater job satisfaction and to drive success for a business. Through proactive programmes to highlight support within the workplace long-term sickness and its financial impact on the business can potentially be avoided.

Promoting access to good jobs for people with mental health problems is critical to reducing local unemployment and tackling poverty and aiding their recovery⁷.

Introduction

A foundation of economic security is vitally important to help establish a positive and healthy living environment and good mental health and wellbeing. People in the lowest 20% of household income have a 2.7 fold increased rate of mental health problems compared with those in top 20%¹.

The economic downturn and changes to the benefit system have left some families under a great deal of stress. Small changes can be very difficult to manage and sometimes lead people into debt.

Higher levels of debt are associated with the following increased risks of mental health problems:

- Common mental health problem (3 times).
- Psychosis (4.1 times).
- Alcohol dependence (3.1 times).
- Drug dependence (3 times)².

Local Picture

Household Income

Since 2010 the Government has introduced a range of changes to welfare benefits. Since their introduction, 689 households (1,727 people) in the borough have been directly impacted by either the Benefit Cap (the introduction of an upper limit of total benefits per household) or the Social Sector Size Criteria⁸. The financial impact for most people has been under £50 per week but a small number of people (five households, 37 people in total) have seen reductions of over £300 per week. As at April 2014 40% of people affected by the Social Sector Size Criteria and open to adult social care were known to the Mental Health team.

In the future all people currently receiving Disability Living Allowance (DLA) will be re-assessed as this benefit is replaced by the Personal Independence Payment (PIP). Following national trends it is estimated that in Kingston approximately 1,700 residents will be unsuccessful when they are reassessed for PIP. DLA can currently provide support that helps residents stay in employment, and can also assist with social integration. Therefore these changes risk isolating individuals and impacting on their mental health. The assessment and appeal process is also likely to be a challenge for residents, particularly those with mental health problems, which could cause increased anxiety and financial difficulties.

By 2017 the Government plans to introduce Universal Credit. The main change with Universal Credit will be direct payments to claimants rather than directly to landlords, so claimants will need to manage their own finances. Potentially claimants may become vulnerable to eviction due to these changes and therefore local mechanisms to support claimants will be an important focus in the next few years.

Debt

Kingston Citizens Advice Bureau (KCAB) reported that in 2013 debt issues made up 23% of their total enquiries and in early 2014 this percentage has been increasing. Enquiries are not just from those out of work; people in work are also reporting increasing debt issues.

Kingston Food Bank

An analysis of people using Kingston's food bank by CAB indicated that 34% of them were unemployed in May 2014, 10% were sick or disabled and 8% were homeless⁹.

Unemployment

In February 2014, 1,420 Kingston residents were claiming Job Seekers Allowance (JSA); this represents 1.3% of the population¹⁰. The proportion of JSA claimants in Kingston is far lower than that in both London and England.

Table 1 shows that although the majority of working age claimants registered in Kingston are out of work for less than 6 months, 24% of claimants had been unemployed for more than 12 months.

Table 1. Number of working age claimants for Job Seekers Allowance registered in Kingston January 2014

Age	Number of months unemployed			
	0-5 months	6-11 months	12 months or more	Total
18-24 year olds	225	35	20	280
25+	730	205	350	1,285
Total	955	240	370	1,565

Source: DWP statistics

The Government has recently introduced benefit sanctions for JSA claimants so that if a claimant fails to comply with a mandatory requirement such as attending an appointment, they may have their benefits stopped for a period. A recent review of sanctions noted that many claimants may not have a good understanding of the sanctions process and recommended that these claimants should be identified and offered appropriate support¹¹.

Type of Employment

Working environments can pose risks for mental wellbeing by putting high demands on a person without giving them sufficient control and support to manage those demands. Adults with low levels of control over their work, low levels of variety of work and little opportunity to use their skills have a 1.5 fold increased risk of depression and a 1.3 to 1.4 increased risk of anxiety¹². Over 60% of those in employment in Kingston have managerial, professional or technical jobs which means they are less likely to be in jobs with low levels of control.

Local Action

At a macro level Kingston has shown strong economic resilience to recent economic downturns with continued low unemployment and low levels of empty shops and offices. With a clear vision to be the best place to live and work 'Kingston Futures' is an ambitious project aiming to maintain Kingston as a destination of choice and ensure continued economic prosperity for the borough.

At a micro level direct personalised assistance is provided to those impacted by the welfare reform changes. Working with partners including the Department for Work and Pensions, Council services and Kingston CAB every household impacted by the Benefit Cap or Social Sector Size Criteria has been directly contacted, their options discussed and plans put in place. As a result of this joint work:

- 37 (out of 179) households impacted by the Benefit Cap have gained employment
- More than 50 people were referred for financial capability courses
- Kingston CAB is running a 'Money Talks' programme to both professionals across the partnership and directly to residents, to tackle how people can budget better, save money on energy and avoid getting into debt
- A new, proactive joint working protocol across the Council and partners is in place to prevent homelessness and keep individuals safe from harm
- Information on benefit changes has been widely circulated to residents, professionals and partners
- Regular monitoring and reporting of service impacts and demographic changes in Kingston have been set up

In addition, households in crisis can apply for assistance. The localisation of some crisis funding from central government to the Council in April 2013 has resulted in close working between the Council, the local food bank, furniture project, credit union and other providers to assist many households.

Supporting People into Employment

The Council and Kingston Jobcentre Plus (JCP) are working together to reduce worklessness in the borough through the following:

- Work experience
- Supporting unemployed people who wish to set up their own business with the New Enterprise Allowance (NEA). 53 new businesses have been established in Kingston with the NEA and business mentors from the local community provide guidance and support including a course run by Kingston Chamber of Commerce for jobseekers who have a business idea but need guidance to make a start
- A Jobcentre member of staff is currently located with the Kingston Council Welfare Reform Office
- The 18-24 Coaching Team in Kingston JCP are working with the Leaving Care Team in the Council to prepare and support Care Leavers into sustainable employment

Improving Access to Work for Vulnerable People

Following discussions between the Council and the voluntary sector barriers to employment were identified which include skills or training needs (particularly in relation to IT), access to computers, homelessness, language barriers, childcare, drug and alcohol addictions and previous prison sentences. Some of the planned initiatives to address these are:

- Mental health, alcohol and drug addiction training from Council to Kingston JCP staff to ensure that all staff working with clients are able to support those with substance misuse or mental health problems
- More joined up work with libraries to provide computer access and support to those writing their Curriculum Vitae (CVs) and looking for/ applying for jobs
- Libraries have made it easier for homeless people to access their computers (following joint work with Kingston Churches Action on Homelessness (KCAH), the Council and Kingston JCP)
- A partnership bid has been made led by the Young Men's Christian Association (YMCA) and involving Kingston JCP, Kingston Council and KCAH to support homeless people gaining work experience opportunities to help them move into work

Balance (formerly Kingston Workstart) is a community interest company which provides support to enable individuals, including people with mental illnesses, to either return to their place of work (if they are currently signed off sick) or to become job ready if seeking paid employment. Types of support include volunteering opportunities, training, work placements, signposting and confidence building as well as practical help with CVs, application forms and interviews. Since June 2011, Balance has received 290 referrals and 119 people have been supported into paid employment.

In 2013 Balance was one of only two supported employment providers in London to be awarded the maximum four stars in the London Employability Performance Rating from London Councils for their performance against targets, contract compliance and client feedback on the quality of their mental health supported employment project. The project is run with a partner, Mind in Kingston, which offers places to participants on their emotional wellbeing themed workshops such as 'Managing Anxiety' and 'Mindfulness' which also offer opportunities for peer support.

Work Based Health Promotion

Kingston was one of the first London boroughs to take part in the London Healthy Workplace Charter (LHWC) which is coordinated by the Greater London Authority¹³. This includes a self-assessment framework for employers to support a systematic and embedded approach to promoting health at work. The framework includes seven standards, one of which is on mental health and wellbeing.

- To pass the 'Commitment level' employers have to show evidence of promoting mental wellbeing. The organisation also has to be committed to the principles of the Health and Safety Executive's management standards for stress
- For the 'Achievement level', as well as the above, managers have to have skills to identify symptoms of stress and offer support to employees who are unable to cope
- For the 'Excellence level' a mental health promotion and stress prevention strategy should be in place and have been developed collaboratively. Evidence of a service level agreement with a counselling service has to be in place as well as a staff survey that assesses the mental wellbeing of staff. An action plan has to be developed following the results of the survey. Training must be available to all staff on managing stress and pressure and developing resilience

Box 1 Kingston employers with London Healthy Workplace Charter awards	
Balance (Community Interest Company)	Commit
Coleman Solicitors	Excellence
Imagotech Media	Commit
Kingston Centre for Independent Living (charity)	Commit
Kingston Council	Achievement
Kingston Hospital	Excellence
New England Seafood	Excellence
Parabola Software	Commit
Sitel	Commit
Wolters Kluwer Publishing	Achievement

In Kingston ten businesses have achieved awards so far. One of these, Sitel, is gathering evidence for a higher award and there are also two new workplaces applying for their first awards. These are Kingston Voluntary Action & Kingston YMCA.

The Council's Public Health team continue to promote the healthy workplace agenda through onward communication of initiatives, campaigns and events related to the LHWC to the business community.

Work to support local businesses to promote mental wellbeing has included:

- Promotion of Adult Mental Health First Aid course to local businesses
- A conference on 'Preventing Stress, Advice for Managers' was held in June 2013 for Kingston employers. Over 55 people attended from 38 different local organisations

Recommendations

1. The Council should work with partners to plan and prepare for the introduction of Personal Independence Payments and the introduction of Universal Credit
2. Continue to monitor the impact of welfare benefit changes and use this information to plan future service delivery
3. Further develop targeted support for local businesses on best practice with regard to staff mental wellbeing and stress reduction
4. Investigate further the provision of supported work activity opportunities for people with more severe and enduring mental illnesses
5. Review support available to vulnerable residents regarding Job Seekers Allowance sanctions

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Case Studies

Balance Case Study

Balance started working with Ms N in November 2012 after she was referred from the Kingston Wellbeing Service. Ms N had recently resigned from her position as a Healthcare Assistant due to stress and depression resulting partly from a lack of job satisfaction and frustrations with her working environment.

In the first few sessions the Employment Consultant and Ms N discussed her previous environment and the factors that had contributed to her feeling that she was left with no option but to resign. The Employment Consultant was able to talk through practical techniques that could help her deal with stress in the workplace. Ms N was also offered a place on Mind in Kingston's 'Managing Anxiety' workshop which she found useful for both the advice given and the peer support she accessed. Alongside this support Ms N and the Employment Consultant were able to move on to job profiling and worked together to try to think of the most suitable environments and job roles for Ms N to pursue. It was established through this process that the key factors for Ms N were working with people and working outdoors.

With job roles in mind Ms N started to job search more actively. The Employment Consultant gave her some suggestions as to how she could make her job search more effective. Ms N was also given space to discuss potential job opportunities and how she felt about applying for them. Ms N found job application forms difficult especially the 'Personal Profile' sections so she was given support to complete her application form, to update and tailor her CV to best fit the types of roles that she was interested in.

In February 2013 Ms N got an interview for a site instructor position with an outdoor activity company. The Employment Consultant gave her some advice in preparing for the interview. Ms N was successful and is now working full time leading groups of adults and children in abseiling and zip wires. She is really enjoying her role as it involves being outdoors and working with people. Ms N is still in contact with the project should any work related problems emerge but to date she has not required any further intervention from mental health services.

Case Studies

Healthy Workplace Charter Case Study

New England Seafood has been committed to promoting and protecting the wellbeing of its employees since it began trading in 1991.

In recent years it has actively managed attendance and has progressively reduced employee absence by implementing return to work interviews for all absentees, by re-enforcing its use of pre-employment medical questionnaires (carried out by independent occupational health specialists), by implementing night shift worker medical reviews and independent medical reviews of long term absentees. Long term absentees returning to work have full risk assessments carried out with them whatever the cause of their absence (physical, mental health, personal or social issues). As a result of these reviews the company considers actions such as: phased return to work, changes to the work environment (temporary or permanent), alternative roles or whatever other adjustments may be necessary to ensure a smooth transition back to work by the employee. To ensure management have the skills necessary to work with people with mental health problems, three members of the human resources team have been through the Council's Mental Health First Aid course.

Last year, New England Seafood was awarded the Mayor of London's Achievement Award for taking part in the London Workplace Wellbeing Charter. Following a gap analysis the company spent six months working towards achieving the next level which was the Excellence Award. There has been a focus on involving employees in more sports activities – such as running, jogging and cycling. A discounted bike purchase scheme is offered via the Cycle to Work programme.

New England Seafood encourages physical activity by offering a discounted gym membership and organising weekly bike rides. A stress risk assessment has been undertaken and action has occurred as a consequence. The company received the Excellence Award in October 2013.

Since the introduction of the charter the turnover and absence rates have dropped significantly which is extremely important for any business.







Section 3

Parenthood, Children and Mental Health

Dr Jane Scarlett

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Overview

Up to 25% of all children at some point in their childhood show signs of mental health problems¹, more than half of which track through into adulthood. Up to half of lifetime mental health problems start by the age of 14².

The children most at risk of mental illness are those being raised in families where parents have a mental illness or misuse drugs or alcohol. Genetic transmission of mental illness³ is a non-modifiable risk. The expression of genetic risk is, however, influenced by the environment (which includes parenting⁴). More detail on supporting parents with mental illness is provided in chapter 3.1.

Early identification and intervention for children and young people who are developing problems is critical as estimates suggest that between a quarter and a half of adult mental illness may be preventable with appropriate interventions in childhood and adolescence². More detail about prevention and early intervention is provided in chapter 3.2.

Interventions during childhood and adolescence can lead to improved educational outcomes, reduced antisocial behaviour, reduced crime and violence, improved family health, as well as improved earnings in adulthood⁵. A survey in 2004 found that only 25% of children with mental health problems were in treatment¹. More detail about local treatment services is provided in chapter 3.3.

Support for children and young people ranges from general advice by teachers, GPs, youth workers and others to specialist Child and Adolescent Mental Health Services.

The 2011-12 Director of Public Health's Annual Report⁶ included a chapter on the mental health and wellbeing of children and young people in Kingston. In the two years since this report was published there has been some progress to address the service gaps identified, for example:

- Progress on consultation with head teachers and other frontline staff to support best practice, promoting mental health awareness in children and young people and providing training to support early identification of mental health problems in children and young people is detailed in chapter 3.2

- Progress on developing a single point of access to CAMHS Tier 2 and 3, including ensuring GPs are able to access Tier 2 services for their patients and on providing a wider range of easily accessible services for young people who do not meet the threshold for Tier 3 CAMHS in Kingston is highlighted in chapter 3.3

Progress needs to be made in other areas including user involvement, the development of comprehensive care pathways and improving access to services by BME groups, and these are reflected in the recommendations in each of the chapters in this section.

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3.1 The Mental Health of Pregnant Women and Parents

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Key messages

- Mental illnesses during pregnancy and the postnatal period can have serious consequences for the health and wellbeing of a mother and her baby, as well as for her partner and other family members
- A recent consultation as well as discussion with local providers has highlighted several gaps in current services, including help for partners to understand how to support women with perinatal mental health problems, improved access to psychological therapies, parents' support groups, and childcare to enable parents to access mental health support
- Recent initiatives include 'See the Adult, See the Child', to improve joint working and the 'Families Connected' project to improve support for parents with mental health problems and their children

Introduction

Mental illness during pregnancy and the postnatal period can have serious consequences for the health and wellbeing of a mother and her baby, as well as for her partner and other family members. A range of mental illnesses can affect mothers around the time of pregnancy and childbirth, including common conditions such as anxiety disorders and depression, as well as rarer postnatal psychotic disorders such as bipolar disorder and schizophrenia. Maternal postnatal depression can be significantly harmful to young infants particularly between the ages of six to eighteen months of age resulting in an increased incidence of insecure attachment¹. Poor mental health affects the ability of parents to parent effectively, which in turn impacts on children's wellbeing.

NICE has produced guidance on antenatal and postnatal mental health¹, which describes the care all women should receive. This includes questions at first contact with health services in pregnancy to

predict and detect possible problems early, access to psychological treatment within one month of initial assessment, discussion about the risks of treatment and of not having treatment, advice on selection of appropriate medication if required, and the organisation of services.

Women should be asked two specific questions to identify possible depression at first contact with primary care, at their booking appointment, and at four to six weeks and then three to four months after the birth of their baby.

A recent study suggests that maternal depression may be more common at four years following childbirth than at any time in the first 12 months after childbirth. The researchers identified some possible risk factors for depressive symptoms at four year's postpartum, including previous depression, relationship transitions, intimate partner violence and social adversity². These findings suggest a need for continued surveillance on the part of all professionals working with mothers four years after childbirth, particularly mothers with the risk factors identified above.

Parents with a mental health problem

Parental mental illness can adversely affect child mental health and development, whilst child psychological and psychiatric disorders and the stress of parenting can have a negative impact on adult mental health.

An estimated one-third to two-thirds of children whose parents have mental health problems will experience difficulties themselves³. There is a 4–5 fold increased rate of emotional or conduct disorders in children whose parents have a mental illness⁴.

Up to one in four adults will experience a mental illness during their lifetime, and at the time of their illness, a quarter to a half of these will be parents.

Meeting the needs of parents with mental health problems and their families raises practical, professional and organisational challenges for services. The Social Care Institute for Excellence's guide, 'Think child, think parent, think family'⁵ recommends the approach outlined in Box 1.

Box 1: Recommended approach to meeting the needs of parents with mental health problems and their families.

Signposting and improving access to services

Organisations should tackle the stigma and fears that parents and children have about approaching services.

Screening

Screening and referral systems should routinely identify and record which adults with mental health problems are parents, and which children have parents with mental health problems.

Assessment

Assessment and recording processes need to take account of the whole family and staff should be trained in their use.

Planning care

Care planning needs to be flexible enough to meet the needs of each individual family member as well as the family as a whole.

Providing care

The care provided needs to meet the full spectrum of needs, including the practical priorities of parents with mental health problems and their children.

Reviewing care plans

Reviews should consider changes in family circumstances over time and involve children and carers in the process.

Strategic approach

Multi-agency, senior-level commitment is required.

Workforce development

Appropriate training is needed for adult and children's frontline managers and practitioners to support this.

Putting it into practice

Induction, training, supervision, performance management, assessment and recording tools can help promote the work, and prompt people to 'Think Family'.

'What about the children?'⁶ a thematic inspection of adult mental health services and drug and alcohol services by Ofsted and the Care Quality Commission, which looked at the effect of parental mental health on children found:

- Mental health services did not consistently consider the impact of the adult's mental health difficulties on children and this led to referrals to children's services not being made at an early enough stage
- Most adult mental health and drug and alcohol services were not proactive in helping families to access early support
- Professionals did not routinely approach the assessment as a shared activity between children's social workers and adult mental health practitioners. As a result, the majority of assessments did not provide a comprehensive and reflective analysis of the impact on the child of living with a parent or carer with a mental illness

Local Picture

The estimated prevalence of postnatal depression is 10%⁷. There were 2,213 births in Kingston in 2012-13. With an estimated prevalence of postnatal depression of 10%, around 220 women would be expected to have postnatal problems each year.

Given the number of births in Kingston each year, there would be expected to be around 184 referrals for psychological therapies, 92 referrals to specialist perinatal mental health services and 9 admissions to a mother and baby unit⁸.

Kingston's Joint Annual Public Health report 2011-2012⁹ estimated that there are likely to be between 500 and 2,000 young carers living in the borough of Kingston. The wide span of these numbers reflects the size of the issue of 'hidden' carers. Over a third will be caring for a parent with a mental health condition.

Parental mental health issues were a factor in 42% of families considered at Initial Child Protection Conferences in Kingston (data for April to December 2011).

Local Action

Ante-natal services

Local services are centred around Kingston Hospital maternity services. There is a Specialist Midwife for Perinatal Mental Health, who works within a team of specialist midwives known as the ISIS team, who ensure that the needs of vulnerable women are met. The perinatal mental health role includes reviewing all women booked for delivery at Kingston Hospital who have mental health problems (many of these women will not be Kingston residents). These women have plans made for their antenatal care and delivery and for their postnatal care if they are considered to be at high risk because of their mental health problems.

Postnatal services

Care for women postnatally usually passes from the midwife to the GP on the tenth day after the baby is born. The health visitor who works in the community alongside GPs is the professional who is most likely to assess women's mental health.

Health visitors in Kingston screen all mothers for postnatal depression (PND) using the Edinburgh Postnatal Depression Screening tool. They run a postnatal depression support group for mothers with PND in the Surbiton Children's Centre and 37 mothers (25% of all those who were diagnosed) attended in 2011-12. 60% of these (22/37) came from the Surbiton area although we do not know whether this was because those women who lived near Surbiton were more likely to attend or whether there is more PND in Surbiton. Ethnicity was poorly recorded, with 45% recorded as not known.

Specialist services

The Kingston Wellbeing Service provides psychological therapies. There is a fast track system to ensure that all pregnant or postnatal women with depression are seen within a month, in line with NICE recommendations. However this fast tracking does not cover women with anxiety. The fast tracking service has been recently set up and no data on the numbers of pregnant or postnatal women seen are available yet.

It has been suggested that referral numbers from health visitors into the Kingston Wellbeing Service may be lower than expected. Health visitors tend to refer women with mental health problems to GPs rather than to specialist services and the issue of direct referral in to services should be investigated further. Closer links between health visitors with an interest in postnatal mental health and services such as the Kingston Wellbeing Service may improve this situation.

Discussion with the Kingston Wellbeing Service has highlighted the importance of protocols to manage women who do not attend appointments. In addition the service is currently piloting a group called 'The Feeling Good course' tailored to working with women with perinatal mental health issues. There are also plans to provide Mindfulness courses for pregnant women whether or not they have mental health problems.

South West London and St George's Mental Health Trust provides a highly specialised consultant led psychiatric liaison service, for assessment, management or signposting of women with mental illnesses during pregnancy and after their child is born. Referrals are accepted from all health professionals. In 2013-14 there were a total of 18 contacts from Kingston including 4 first assessments. This is well below the expected 92 referrals to specialist perinatal mental health services based on NICE estimates, and raises the possibility that some perinatal mental health difficulties are either not being detected or not being appropriately managed in Kingston. In addition the service provides advice to GPs to support their care of women in the community.

Women who require inpatient care for a mental disorder within 12 months of childbirth should normally be admitted to a specialist mother and baby unit. There are no units in South West London so women have to be admitted to other parts of London or further afield. There were no admissions to mother and baby units for women from Kingston in 2013-14.

Discussion with local providers has highlighted several gaps in current services, including support for fathers with mental health problems, a need for support and therapy for couples in the post-natal period, and help for partners to understand how to support women with perinatal mental health problems. Availability of childcare to allow mothers to access services is also a gap, and provision of services in children's centres may help. A specialist perinatal mental health nurse role which would include home visits to women who need them should be considered for Kingston. This role would also deliver training to professionals on early identification of perinatal mental health problems.

Supporting parents with a mental health problem and their children

The Parental Mental Health working group is a multi agency group of professionals working in health, social care and voluntary agencies supporting adults with mental health problems and their children. It has recently reviewed multi-agency work to minimise the

impact of parental mental health issues on children and young people and reports its progress to the Local Safeguarding Children Board (LSCB). A new protocol for the assessment and care co-ordination of parental mental ill health and the needs of children and young people, 'See the Adult, See the Child', will be launched in late 2014.

Consultation about parental mental health

A consultation was carried out with parents with mental health problems in Kingston in early 2014. Following various events a total of 83 responses were received from parents. Respondents were asked where they had sought help, how helpful it had been and whether they had ever sought help but been unable to find what they needed (for most of these questions, 45 people responded). Please see the photo below for comments made at a workshop.

79% of the parents who had sought support had found it either somewhat or very helpful. Those who had not found their support helpful cited reasons such as long waiting times and only being given medication when they wanted counselling.

22 respondents (half of the 44 who answered this question) said they had sought help unsuccessfully at some time. Several had wanted practical help and advice with managing their child or aspects of understanding child development and parenting.

When asked what might prevent them from seeking help, fear of judgement was a common response, whilst a small number of people feared the involvement of social services.

Other issues raised were:

- the opportunity to meet with other parents with experience of similar problems would be very helpful
- fear of being seen to be a bad parent, and/or afraid of having their children taken away – and so reluctant to admit to having mental health problems

- not being able to access a service e.g. not meeting the criteria for adult mental health services despite the impact of their problems on their ability to parent

The following groups or communities of parents whose needs are not currently being met were mentioned:

- BME parents, including Korean, Sri Lankan, and others for whom English is not their first language
- Refugees and asylum seekers
- Parents of children with special needs. One comment received was:

"My son has autism and is very difficult to manage. I am not able to work as his school placements keep collapsing, he has endless appointments and so on. I am very isolated."

- Parents with undiagnosed mental health problems
- Young parents

The professionals who responded (23 responses were received) suggested a range of options that they felt would benefit parents. These included improved access to counselling and psychotherapy, practical support with parenting skills, parents' support groups, childcare to enable parents to access mental health support, and improved integration of services. Gaps included early intervention and easy early access for people who are struggling but not necessarily formally diagnosed with a mental illness.

Families Connected

The 'Families Connected' pilot project started in October 2013 and ran for a year in Kingston. The aim of this project was to assist parents with mental health problems and their children to access support appropriate to their needs. A permanent service will then be developed which will be informed by an independent evaluation of the pilot and the consultation with parents described above.



Recommendations

1. Improve links between health visiting and the Kingston Wellbeing Service team
2. Increase availability of the Kingston Wellbeing Service to allow the service to offer fast tracked support to women with perinatal anxiety
3. Consider commissioning a specialist nurse for perinatal mental health role, to allow home visits to women and an ongoing local training programme
4. Explore the possibility of psychological support services provision within Children's Centres to allow childcare for women attending appointments.
5. Improve support to fathers, both for their own mental health problems and to enable them to support partners with mental health problems
6. Review data on the numbers of women with post-natal depression accessing services once this data is available from Kingston Wellbeing Service
7. Review the referral rate to the South West London and St George's Mental Health Trust consultant led psychiatric liaison service
8. Evaluate the 'Families Connected' pilot project for parents with mental health problems and their children
9. Launch the 'See the Adult, See the Child', protocol

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3.2 Prevention and Early Intervention in Children and Young People

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Key messages

- Considerable lifetime savings can be achieved through early interventions in children and young people's mental health.
- Effective interventions include supporting good parenting skills, developing children's social and emotional skills and intervening early with mental disorders.
- There are plans to increase access to parenting support for all parents as well as a number of initiatives underway to support schools to promote the mental health of their pupils.

Introduction

Universal and targeted interventions during the first few years of life can influence the entire life course and can reduce future health inequalities¹. To take an example, since 40-70% of children with conduct disorder develop antisocial personality disorder in later life, prevention of conduct disorder in childhood will prevent many cases of antisocial personality disorder in adults². Targeted programmes are effective for children at higher risk of depression and anxiety³; furthermore research has shown that undiagnosed or untreated depression in young people creates a more treatment resistant form of the illness in adult life⁴.

Key universal interventions to promote the mental health and well-being of children and young people include:

- Supporting good parenting skills
- Developing children's social and emotional skills
- Intervening early with mental disorders (this is described in more detail in Chapter 3.3)

Considerable lifetime savings can be achieved through early interventions, as was shown when a number of interventions with a good evidence base were subject to economic modelling by the London School of Economics⁵. Two examples are given here.

The provision of parenting interventions for children with persistent conduct disorders was estimated to cost £1,117 per family and results in savings of £9,288 to all sectors (including the costs to victims of crime) over a 25 year period, so exceeding costs by eight to one. Other impacts such as improved employment prospects, reduced adult mental health issues, and improved outcomes for the child's family and peers are likely to be substantial, making the intervention an even better investment.

The provision of school based social and emotional learning programmes to prevent conduct problems in childhood was estimated to cost £132 per child and results in savings to all sectors (including the costs to victims of crime) of £10,032 after ten years.

Supporting good parenting skills

Positive parenting is fundamental to good mental wellbeing. During infancy, a child's secure attachment to their main caregiver promotes their self-esteem and resilience, and influences the way in which the child relates to and behaves with others. Effective parenting brings multiple benefits to children and is therefore fundamental to giving every child the best start in life⁶. Positive, proactive parenting (providing praise, encouragement and affection) is strongly associated with high child self-esteem and social and academic competence, and is protective against later disruptive behaviour and substance misuse⁷.

Whilst most parents living in poor social circumstances provide a loving and nurturing environment despite many difficulties, children living in a disadvantaged family are more likely to be exposed to adverse factors. Children exposed to multiple risks such as social disadvantage, family adversity and cognitive or attention problems are much more likely to develop behavioural problems⁸. Longitudinal analysis of data for 16,000 children suggested that boys with five or more risk factors were almost 11 times more likely to develop conduct disorder under the age of ten than boys with no risk factors. Girls of a similar age with five or more risk factors were 19 times more likely to develop the disorder than those with no risk factors⁹.

There are fewer opportunities after the preschool period to close the gap in behavioural, social and educational outcomes¹⁰. NICE recommends that health professionals in antenatal and postnatal services, health visitors, school nurses and early years practitioners should identify factors that may pose a risk to a child's social and emotional wellbeing, as part of an ongoing assessment of their development¹¹.

Brief, group-based parenting programmes that are focused primarily on enabling parents to support their children's growing independence using positive methods of discipline and good supervision have been shown to be effective in the short term in improving both parental psychosocial functioning¹² and the emotional and behavioural adjustment of young children¹³.

One of the parenting programmes with the strongest evidence base is the Triple P programme and there are different versions of this both to support parents of children and young people of different ages as well as parents of children with particular problems e.g. children with Attention Deficit Hyperactivity Disorder (ADHD)¹⁴ and Autistic Spectrum Disorder¹⁵.

Developing social and emotional skills

The reasons why a child or young person experiences mental health problems are often complex. However, certain factors are known to influence the likelihood of someone experiencing problems. Chapter 3.3 highlights the local characteristics of those vulnerable groups more prone to experiencing poor mental health and describes local services which can intervene early with these groups.

Seemingly against all the odds, some children exposed to significant risk factors develop into competent, confident and caring adults. An important key to promoting children's mental health is therefore an understanding of the protective factors that enable children to be resilient when they encounter problems and challenges.

Resilience seems to involve several related elements. Firstly, a sense of self-esteem and confidence; secondly a belief in one's own self-efficacy and ability to deal with change and adaptation; and thirdly, a repertoire of social problem solving approaches¹⁶.

Difficult events also increase the risk of mental health problems for children. These include:

- Loss or separation – resulting for instance from death, divorce, hospitalisation, being taken into care
- Life changes – such as the birth of a sibling, moving house or changing schools or during transition from primary to secondary school

- Traumatic events such as abuse, domestic violence, bullying, violence or accidents

NICE recommends that early education and childcare services should ensure all vulnerable children can benefit from high quality services which aim to enhance their social and emotional wellbeing. The role that schools play in promoting the resilience of their pupils is important, particularly so for some children where their home life is less supportive. Table 1 below lists some of the risk factors and protective factors in schools for child and adolescent mental health.

Table 1: Risk factors and protective factors in schools for child and adolescent mental health

Risk Factors	Protective Factors
Bullying	Clear policies on behaviour and bullying
Discrimination	'Open-door' policy for children to raise problems
Breakdown in or lack of positive friendships	A whole-school approach to promoting good mental health
Deviant peer influences	Positive classroom management
Peer pressure	A sense of belonging
Poor pupil to teacher relationships	Positive peer influences

Source: Mental health and behaviour in schools. Departmental advice for school staff. Department for Education, June 2014

School Based Interventions

Evidence shows that whole school approaches are most effective in promoting pupils' mental health and should include the following:

- A culture within the school that values all pupils; allows them to feel a sense of belonging; and makes it possible to talk about problems in a non-stigmatising way
- An ethos of setting high expectations of attainment for all pupils with consistently applied support. This includes clear policies on behaviour and bullying that set out the responsibilities of everyone in the school and the range of acceptable and unacceptable behaviour for children
- Ensuring all adults working in the school understand their responsibilities to children with special educational needs and disabilities (SEND), including pupils whose persistent mental health problems mean they need special educational provision

- Working with parents and carers as well as with the pupils themselves
- Continuous professional development for staff that makes it clear that promoting good mental health is the responsibility of all members of school staff and community, informs them about the early signs of mental health problems, what is and is not a cause for concern, and what to do if they think they have spotted a developing problem
- Clear systems and processes to help staff who identify children and young people with possible mental health problems. Schools should work closely with other professionals to have a range of support services that can be put in place depending on the identified needs (both within and beyond the school)
- Working with others to provide interventions for pupils with mental health problems
- A healthy school approach to promoting the health and wellbeing of all pupils in the school¹⁷

Schools with these characteristics mitigate the risk of mental health problems in their pupils by supporting them to become more resilient and preventing problems before they arise with resulting benefits for academic performance, social and emotional skills and classroom behaviour^{18,19}.

School-based mental health promotion programmes, when well implemented, are effective in both promoting positive mental health for all, and targeting those with problems²⁰ and can reduce classroom misbehaviour, anxiety and depression^{21,22}.

A review of targeted approaches undertaken for NICE suggested that effective interventions both for depression and anxiety and conduct disorders offer a mix of CBT and social skills training for children, training of parents in appropriate reinforcement and better methods of discipline, and training of teachers in the same²³.

An example of this is the Australian 'Friends for Life' programme²⁴, for children from 7 to 16 years of age, which has been shown to help in the prevention of anxiety by helping children to build the cognitive skills needed to avoid the development of anxiety disorders. There is evidence for its effectiveness and appropriateness in school settings in the UK²⁵. The programmes have been designed to act both as a treatment for targeted groups of children and also as a universal prevention programme.

Schools need to support children experiencing difficult life events such as death or divorce, intervening before mental health problems develop.

Universities

There has been an increase in numbers of students with poor mental health joining universities nationally; foreign students are particularly at risk²⁶. Good practice guides have been developed to promote student mental wellbeing²⁷.

"It is vital that the early signs of mental illness in children and young people are not ignored or brushed aside. Intervening at a young age significantly decreases the chances of a problem developing in adult life and the Council are committed to helping our younger residents overcome any such problem and live happy, healthy lives."

Councillor Andrea Craig, Lead Member, Children Youth and Adult Learning, Kingston Council

Local Picture

Early Years

The Early Years Foundation Stage Profile (EYFSP), which assesses pupils in Reception, found that, in July 2013, 58% of pupils in the school population living in and educated in Kingston achieved a Good Level of Development (GLD) by being classed as 'expected' or 'exceeding' in Personal, Social and Emotional Development. This compares favourably with a national figure of 52%²⁸.

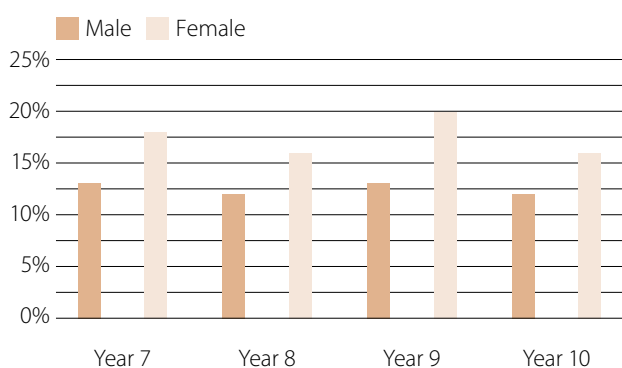
School Health Education Unit Survey

Between July 2013 and March 2014, the School Health Education Unit (SHEU) was commissioned to undertake health behaviour surveys in Kingston secondary schools. The surveys involved 3,982 pupils, from years 7-10, in the pupil referral unit and eight secondary schools (except the two Tiffin Schools), 62% of whom were girls²⁹.

Figure 1 shows self esteem scores. Although Kingston pupils' reported self esteem levels were higher than the national average, a significant number did not fall within the medium to high self esteem range. For example, 20% of year 9 girls achieved 'low' or 'medium-low' composite self esteem scores (Figure 1). Overall, females scored lower on self esteem composite scores than their male equivalents.

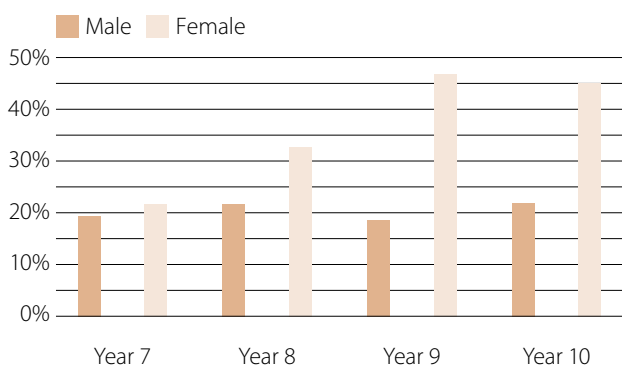
Levels of low self esteem were reflected in the numbers reporting self-dissatisfaction. 30% of Kingston pupils agreed with the statement 'There are lots of things about myself that I would like to change' – and nearly half of all year 9 girls agreed with this statement (Figure 2). Whilst levels of dissatisfaction rise with age in Kingston female students, there was little variation in males across year groups.

Figure 1: Composite self esteem score: Percentage scoring 'low' or 'medium-low'



Source: Kingston School Health Education Unit Survey 2013

Figure 2: Percentage who agreed with the statement 'There are lots of things about myself that I would like to change'.



Source: Kingston School Health Education Unit Survey 2013

In terms of stress and anxiety, across all year groups (and for both sexes) SATS/tests/exams were reported as the biggest source of worry. However, there were gender differences between the top five sources of worry – and girls reported far higher levels of worry than boys (Table 2). Just 19% of girls reported not worrying 'quite often' or 'very often' about any of the issues listed, whilst this percentage was 35% for boys. For both boys and girls, levels of worry tended to increase with increasing age (Figures 3 and 4).

Table 2: Percentage of boys and girls reporting 'quite often' or 'very often' to the question "How often do you worry about the following?"

Boys: Top five sources of worry

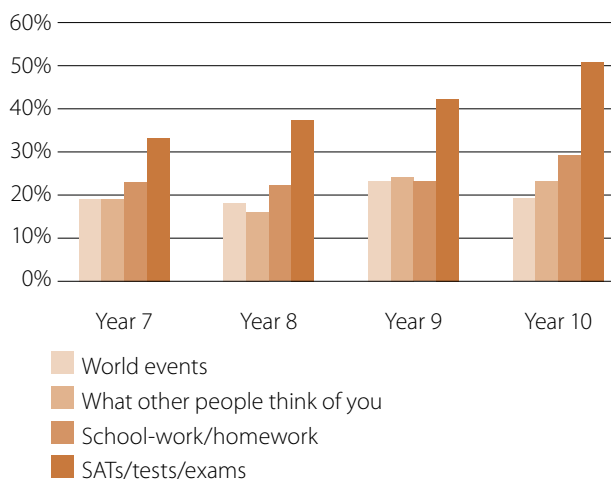
	% worrying 'quite often' or 'very often'
SATS/ tests/ exams	41
School-work/homework	24
What other people think of you	21
World events	20
Violent crime in your local area	18

Girls: Top five sources of worry

	% worrying 'quite often' or 'very often'
SATS/ tests/ exams	59
The way you look	45
Your weight	43
What other people think of you	42
School-work/ homework	39

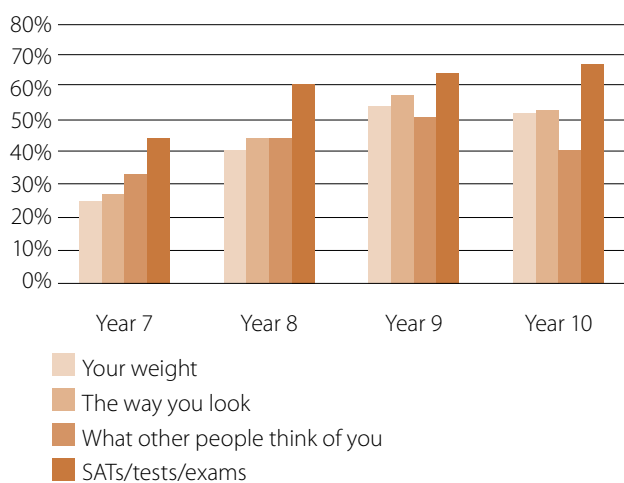
Source: Kingston School Health Education Unit Survey 2013

Figure 3: Boys by year group: Percentage reporting worrying 'quite often' or 'very often' about topics listed



Source: Kingston School Health Education Unit Survey 2013

Figure 4: Girls by year group: Percentage reporting worrying 'quite often' or 'very often' about topics listed



Source: Kingston School Health Education Unit Survey 2013

In terms of bullying prevalence, 4% of students reported being afraid to be in school because of bullying 'often' or 'very often'. Increasingly bullying is done via technology with 5% of students reporting being bullied through their mobile phone at least 'a few times' in the last month, and 4% reporting being bullied on the internet at least 'a few times' in the same time frame. 21% of students overall believe their schools deal with bullying 'not very well' and 6% reported not having anyone to talk to about their problems. This figure varied little across groups although it was highest in Year 9 girls, with 9% reporting having no one to talk to.

Local Action

Parenting Support

Achieving for Children (AfC), which provide children's services for Kingston and Richmond, has produced a parenting plan which aims to make sure that support is available to all parents in Kingston who want it and need it. Their approach will be to provide a range of programmes which include:

- Universal support for all parents, to prevent problems before they arise
- Targeted support focused on spotting early signs of problems and working with parents to prevent them taking hold
- Specialist support for parents who are having to deal with complex problems
- Specialist acute input for parents who cannot or will not co-operate

There is work underway to improve access to parenting advice and support for BME parents. Following meetings between some local BME community groups and the Council's parenting lead there are plans to deliver parenting courses for Korean, Tamil and Somali parents utilising interpreters in local schools.

Promoting child social and emotional skills

Early years

Local Children's Centres provide a variety of programmes for children and families with a targeted approach for those needing additional help. AfC's Early Years (EY) department supports providers of EY services, e.g. nurseries, when needs arise, aiming to improve school readiness and reduce the requirement for specialist support and interventions by facilitating early help. Kingston has high quality EY provision and children's emotional wellbeing is a key feature of the statutory EY Foundation Stage framework³⁰.

School based mental health promotion

Sponsored by the Mayor of London, Healthy Schools London is designed to help schools make a difference to pupils' health and wellbeing ensuring they are happy, healthy and able to achieve more. Schools can work towards Bronze, Silver and Gold awards and must demonstrate how health topics such as emotional health and wellbeing, personal, social and health education (PSHE), healthy eating and physical activity are embedded within the curriculum and school ethos³¹. In November 2013, Kingston launched the Healthy Schools London programme locally with the presentation of the first Bronze award to Burlington Junior School. At the end of July 2014, 32 local schools were registered with the scheme and 9 primary schools had achieved their Bronze awards.

Schools in Kingston are using a variety of resources to promote resilience and emotional wellbeing. In July all Kingston schools were offered training to provide the 'Friends for Life' programme and 30 professionals attended. The effectiveness of this will be evaluated over the next academic year.

The Council's Public Health directorate commissioned free training for schools and other professionals working with children and young people on 'Child and Adolescent Mental Health Awareness', 'Promoting Positive Mental Health in Primary and Early Years' and 'Teens Turmoil and Transition: Mental Health in Adolescence.' It is also promoting the use of the MindEd website (developed by the MindEd Consortium)³². This provides free, open access, online education, to help adults to support children's mental wellbeing and identify, understand and support

children and young people with mental health issues. The new Kingston and Richmond Tier 2 Child and Adult Mental Health Service (CAMHS) will offer a menu of training for professionals across Kingston and Richmond to raise awareness and build workforce capacity in supporting children's mental health.

In 2013 the Council's Public Health directorate worked with Kingston schools and voluntary sector organisations to look at how to increase the quality and availability of early intervention services to improve children and young people's mental health and wellbeing as part of the Department for Education funded Better Outcomes, New Delivery (BOND) initiative. As a result a small grants programme was launched in October 2013 and nine schools are now being supported to develop and evaluate projects based on the needs in their school using a whole school approach.

The national BOND programme also led to the development of a Youth Wellbeing Directory (www.youthwellbeingdirectory.co.uk/about-us/) which aims to provide a one stop shop for schools and other commissioners of services to identify organisations that can assist with improving the emotional wellbeing of children and young people. Kingston's local services and schools will be encouraged to use this site.

In February 2014 Kingston held its first student mental health conference at The Hollyfield School (see photo below). This was well received and the pupils who attended went on to hold assemblies in their schools about mental health. It is hoped this will become an annual event and the next conference will be hosted jointly by Coombe Boys' and Girls' schools.



© FlashFrame Photography and Filming 2014.

Advice to Parents

Pilot workshops have been held with parents in Richard Challoner School to advise parents on how they can support their children's emotional wellbeing and where they can get support. These will be rolled out to other schools and evaluated.

Health Link Workers

Kingston has recently introduced a team of Health Link Workers (HLW) to provide universal early intervention and prevention support to improve health outcomes for young people in Kingston. HLW have been active in all ten of Kingston's secondary schools, the local Pupil Referral Unit (PRU), Malden Oaks, Kingston College and St Phillips Special School. During the 2013-14 academic year, mental health has been a key focus of HLW activity in these education settings.

Since September 2013, the team has reached almost 2,000 young people in years 7 to 13. Most of their work with young people has been through universal or targeted group work activity, but there has also been demand from schools for the HLW to support individual children with issues such as anxiety, self esteem and stress management. Further work is needed to look at how the gaps in services for these schools can best be filled so that these young people can be appropriately supported.

In addition to direct work with young people, the HLW team has provided training courses on cyber bullying, Mental Health First Aid, self-harm, stress and anxiety. In addition, 28 parents attended a cyber bullying workshop.

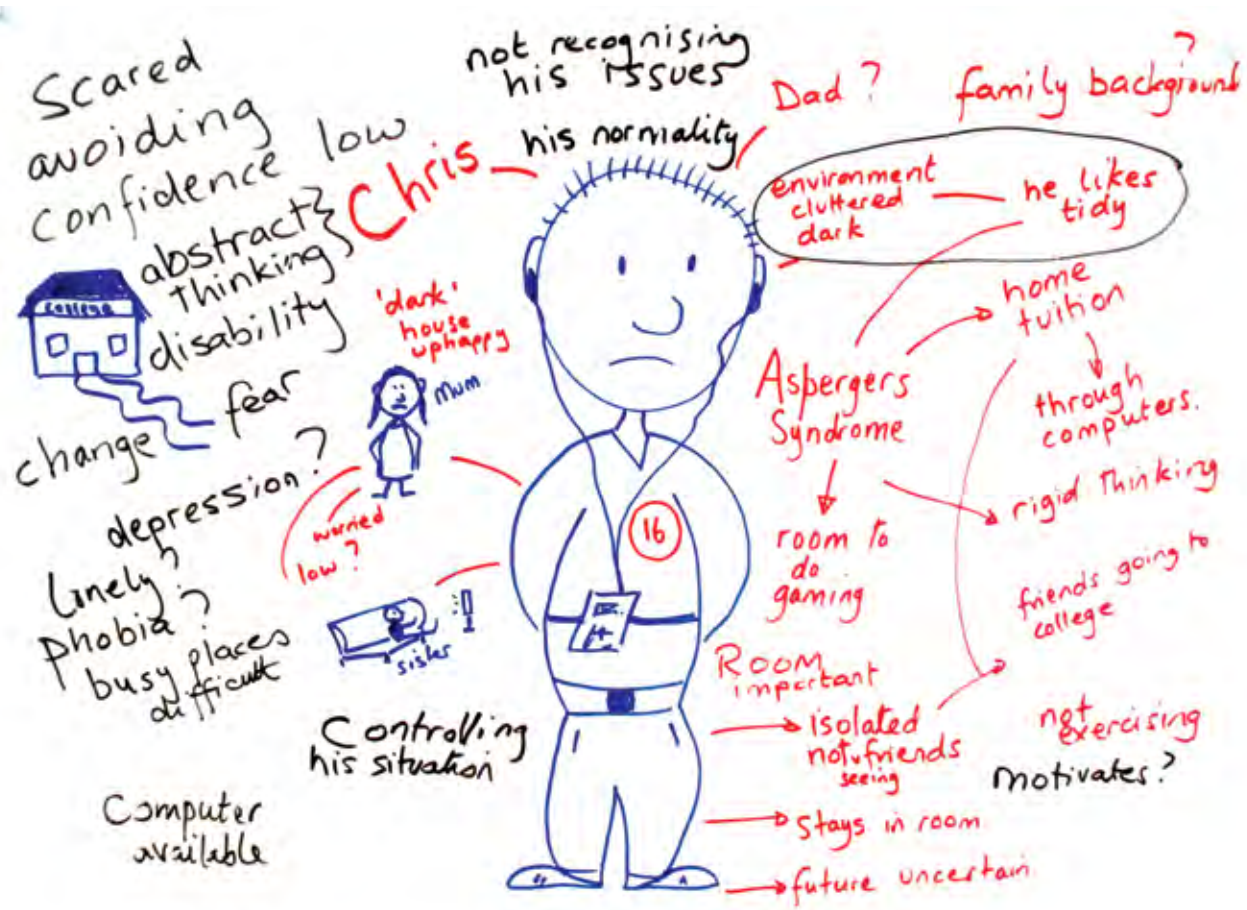
Educational Psychologists

Educational Psychologists (EPs) work as a resource for schools for all children, promoting psychological wellbeing, inclusion and raising standards across the full range of age and abilities. The EP service operates a consultation model of service delivery that promotes early intervention in order to minimise pupils' barriers to learning. EP support includes:

- Psychological assessment of children and young people's difficulties
- Group level psychological interventions to develop particular skills, for example dealing with exam stress, social skills and addressing self-esteem or anxiety issues
- Support to staff in managing particular issues, for example challenging behaviour or disaffection
- Parent workshops
- Supporting schools to develop whole school strategies and systems

Emotional Literacy Support Assistants

A total of 28 teaching assistants across 19 schools have been trained by the Educational Psychology service to be Emotional Literacy Support Assistants (ELSA) whose role is to help schools meet the needs of emotionally vulnerable pupils. In a recent evaluation line managers reported that the ELSA role



Flipchart produced during a Youth Mental Health First Aid course to describe a boy's mental health.

impacted on the following areas (percentage of those who agree in brackets):

- Academic achievement (88%)
- Relationships (100%)
- Reducing bullying (71%)
- Emotional wellbeing (100%)
- Behaviour (100%)
- Attendance (88%)

One quote from a local school was:

"ELSA provision has supported so many children and families in our school, made children happier to attend... we have seen huge changes in confidence and ways that children approach their learning and peers."

School Nurse Team

Support from the school nurse team is made available to young people under the age of 19 through the delivery of school health drop-ins and some personal, social and health education provision.

College and University provision

Kingston University uses the 'Healthy University' guide and is part of a mental health advisors network.

They have recently increased the capacity of their counselling service. They have a large group of foreign students (with the largest group being from India) and the Council's Public Health team has been working with the University to ensure that these students are put in touch with relevant community groups in Kingston. The University runs mental health and wellbeing events for students.

Kingston College provides a counselling service offered for students of all ages with issues such as exam stress, depression, anxiety and bereavement. It also runs regular health days and awareness raising events around topics including alcohol and substance misuse, Healthy Lifestyles Week, LGBT History Month and World Mental Health Day. The College also provides a one to one pastoral support service where students are offered at least six sessions with a Student Advisor. Here students can get support for personal and emotional problems.

This sometimes includes referral to agencies outside the College like Kingston Mind or local Child and Adolescent Mental Health services (CAMHS).



Poster used to promote world mental health day event at Kingston University.

Recommendations

1. Increase access to evidence based parenting support, in particular to parents from Black and Minority Ethnic groups
2. Evaluate the implementation of the 'Friends for Life' training programme
3. Encourage local organisations and schools to use the Youth Wellbeing directory and promote the MindEd website to professionals and parents
4. Run and evaluate a student mental health conference for Year 9 young people and provide more workshops for parents about their children's mental health in both primary and secondary schools
5. Support schools to respond to the issues identified in the School Health Education Unit survey

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Case study 1:

Student mental health conference

"Going to the student mental health conference has helped me and the people around me in many ways. Most importantly it enabled me to help and give necessary advice to the people surrounding me.

One thing I realised during the day is that even the little things in the way people act or feel could be a sign that they have some sort of mental health issue, even if they feel that it's normal. Most teenagers would feel depressed at some point in their life; I know I did at some point; however in some cases if that person shows signs of being severely depressed then it is important to guide that person towards help before it results in something more serious. This conference has made me more alert at things happening around me and in a way it gave me the confidence I need to help the people that maybe feel anxiety or stress (even if it's by just listening).

The conference taught me the negative consequences of mental health issues on teenagers and the way it affects their life socially (e.g. spending less time with friends and family) and physically (e.g. eating disorders). It also allowed me to meet new people who have different viewpoints, experience and understanding of these mental issues – this made the conference even more interesting.

The conference showed me that what may seem like a small matter to some can be a big concern to others, which could potentially lead them to some sort of mental health issues. I now know that there are qualified people who can help teenagers or anyone else with any sort of mental health issues. Yet, the main thing I learned was that even though I cannot professionally help those around me, just guiding them towards those who can and supporting them is a big step forward."

Year 12 pupil at Tolworth Girls' School and Sixth Form

3.3 Child and Adolescent Mental Health Services

Dr Jane Scarlett, Consultant in Public Health, Kingston Council
Elizabeth Brandill-Pepper, Joint Children's Health Commissioner, Kingston Council and Kingston Clinical Commissioning Group

Key messages

- This section focuses on the need for and provision of community services for children and young people with emotional and mental health problems
- The reasons why a child or young person experiences mental health problems are often complex. However, certain factors are known to influence the likelihood of someone experiencing problems. These include social disadvantage and disability
- A recent review of Child and Adolescent Mental Health Services (CAMHS) highlighted gaps, including provision for children in their early years, support for children and young people entering the care system and support for children and young people with autistic spectrum disorder
- A new joint Kingston and Richmond Tier 2 service and single point of access to CAMHS services have just been introduced

- Tier 3: Specialist services working with children and young people with complex, severe and/or persistent needs in the community
- Tier 4: Highly specialised services for children and young people with complex, severe and/or persistent needs including in-patient units

Historically, across the country, there has been fairly patchy development of Tier 2 services and, as a result of this, many children whose needs did not meet the criteria of a Tier 3 service, and should ideally have been seen within a Tier 2 service, were not being offered treatment or accessing any support. Many of these children and young people were presenting to primary health, education and social services^{1,2}.

Considerable work since then has established Tier 2 services in many areas, and a review in 2008 found that many areas had made good progress³. Further review in 2010 found that Children and Young People's Trusts had continued this work⁴.

Local Picture

Despite the increasing recognition of the importance of the early years as a focus for early intervention, there has been less research on the profile and rates of behavioural problems in the under fives. The most recent study in the UK was in 1993 which showed that the prevalence of problems for three year old children was 10%⁵. Differentiating normal from abnormal behaviour in younger children can be difficult and a substantial proportion of children will 'grow out of' early childhood problems⁶. However, longitudinal studies suggest that 50–60% of children showing high levels of disruptive behaviour at three to four years will continue to show these problems at school age⁷.

More recent studies give varying prevalence estimates for mental health disorders in pre-school children. These range from a rate of 19.6% found in the US in 2006⁸ to a rate of 7.1% found in Norway in 2003-04⁹. Applying these estimates to Kingston suggests that from 630 to 1,740 pre-school children resident in Kingston in 2012 will have mental health difficulties¹⁰.

Introduction

This section focuses on the need for and provision of community services for children and young people with emotional and mental wellbeing needs requiring a structured intervention (Tier 2) and those with mental health needs that require treatment (Tier 3).

Child and Adolescent Mental Health Services (CAMHS) are usually described in a four tier framework. However, it should be noted that whilst this is a useful conceptual tool, neither services nor people fall neatly into tiers and some children and young people may require services from a number of the tiers at the same time. The four tiers are:

- Tier 1: Professionals working in universal services offering general advice and promoting good mental health
- Tier 2: Early intervention, consultation, training and targeted services

For older children, estimates vary by condition, age and gender, with boys more likely to experience a problem than girls (11.4% compared with 7.8%)¹⁰. The prevalence of a range of mental health conditions increases as children age. Many of the prevalence studies were undertaken several years ago^{11,12}.

Detailed estimates have been produced by CHIMAT for school age children, which suggest that overall around 2,080 children registered with Kingston GPs in 2012 would have a mental health disorder¹⁰. The commonest disorders likely in children aged five to 16 based on the 2012 population are:

- Conduct disorders 1,245
- Emotional disorders 795 (includes anxiety, depression and phobias)
- Hyperkinetic disorders 335 (includes attention deficit hyperactivity disorder and attention deficit disorder)
- Less common disorders 300 (includes autistic spectrum disorder and eating disorders)

Since children may have more than one disorder, these numbers total more than the estimated number of children and young people with problems overall.

For autistic spectrum disorder (ASD) the best available evidence applies only to children aged 5-10, giving an estimated number of 195 children aged 5-10 with autistic spectrum disorders in Kingston¹⁰.

Rates of mental health problems in children and young people in the UK rose over the period from 1974 to 1999, particularly conduct and emotional disorders¹³. In the absence of more recent data, it is unknown whether this trend has continued. The Chief Medical Officer's report in 2012 recommended that these surveys be repeated to provide more up-to-date information in order to aid planning of healthcare services¹⁴.

Based on the estimated level of services required to manage and support children and young people who may experience a mental health problem, a high proportion of patients can be supported in the community with brief and targeted interventions from Tier 2 services and/or within universal settings¹⁵. It has been estimated that around 15% of children would require services at Tier 1 level, 7% would require Tier 2 services, and 2% would require Tier 3 services¹⁵. Applying these estimates to the 2012 population of Kingston suggests that 2,074 children aged up to 15 would require Tier 2 and 593 would require Tier 3 services. However, these estimates were based on surveys carried out before the latest prevalence information from 1999 and 2004 became available so these should be interpreted with caution¹⁶.

Risk Factors for Poor Mental Health in Children and Young People

Introduction

The reasons why a child or young person experiences mental health problems are often complex. However, certain factors are known to influence the likelihood of someone experiencing problems. This section highlights the characteristics of those vulnerable groups more prone to experiencing poor mental health.

Social Disadvantage

Research from around the world has found that the risk of developing a mental health problem is strongly increased by social disadvantage and adversity. In the ONS survey from 2004 the prevalence of mental disorder was higher in children and young people¹²:

- In lone-parent (16%) compared with two-parent families (8%)
- In reconstituted families (14%) compared with families containing no stepchildren (9%)
- Whose interviewed parent had no educational qualifications (17%) compared with those who had a degree-level qualification (4%)
- In families with neither parent working (20%) compared with those in which both parents worked (8%)
- In families with a gross weekly household income of less than £100 (16%) compared with those with an income of £600 or more (5%)
- In families where the household reference person was in a routine occupational group (15%) compared with those with a reference person in the higher professional group (4%)
- Living in areas classed as 'hard pressed' (15%) compared with areas classed as 'wealthy achievers' or 'urban prosperity' (6% and 7% respectively)

Disability

Physical illness, disability and developmental co-morbidities also raise the risk of developing a mental health problem. Young people living with a long-term physical illness are twice as likely to suffer from emotional or conduct disorders¹⁷. Children and young people with learning disabilities and children and young people with ASD are at greatly increased risk of developing a co-morbid mental health problem. The prevalence rate of a diagnosable psychiatric disorder is 36% in children and adolescents with learning disabilities, compared with 8% of those who did not have a learning disability¹⁸.

Looked After Children

Looked after children are at significant (5 fold increased) risk of experiencing mental health problems, six to seven times increased risk of conduct disorder and were four to five times more likely to attempt suicide. Overall 45% of children and young people aged five to 17 years who were looked after by the Local Authorities in England had a mental health disorder¹⁹.

Young Offenders

There is a strong relationship between poor mental health and offending behaviour.

Young people in contact with the criminal justice system have a fourfold increased risk of anxiety and/or depression²⁰ and a threefold increased risk of mental disorders²¹. Substance misuse is also a particular problem²².

Children of Prisoners

Children of prisoners have a threefold increased risk of antisocial or delinquent outcomes²³.

Young Lesbian, Gay, Bisexual and Transgender (LGBT)

Young LGBT people are at increased risk of mental health problems. Depression was the most common mental health problem, and young LGBT people are more likely to have attempted suicide than their heterosexual peers^{24,25}.

Local picture

Social Disadvantage

- In 2011 the level of child poverty in Kingston was less than the England average with 13.6% of children aged under 16 years living in poverty, compared to 26.5% for London and 20.6% in England²⁶
- 8.6% of children are eligible for free school meals in 2014. This compares to 18.8% in London and 13.6% in England
- The rate of family homelessness²⁷ in 2012/13 was similar to the England average.
- The 2011 census showed that there were 3,550 lone parent households with at least one dependent child aged 0-18 in Kingston. This equates to 18% of all households with dependent children, the same figure as in 2001 and significantly lower than averages for London and England in 2011 (28% and 25% respectively)

Disability

688 (2.5%) children and young people in Kingston schools had a statement of educational need in 2014. The London average is 2.7% and the England average is 2.8%. There were more boys (70%) than girls (30%).

Looked After Children

There were 130 children in care at 31 March 2013, which equates to a lower rate than the England average²⁸. The Strengths and Difficulties Questionnaire (SDQ) is the standardised measure used to screen the emotional and behavioural health of looked after children aged 4-16 years. Information on this is given in the Mental Health Profile (Section 6.1). The Kingston score has risen from an average of 13.2 per child in 2011 to an average of 15.4 per child in 2013. The reasons behind this rise should be investigated further.

Young Offenders

Kingston had 53 first time entrants²⁹ to the youth justice system in 2012. This is a rate of 388 per 100,000 which is less than the England average of 537 per 100,000.

Children of Prisoners

The Families Apart project, provided by Kingston Welcare, works with up to 15 families with a parent in prison.

Young Lesbian, Gay, Bisexual and Transgender (LGBT)

Approximately 5% to 7% of the population is estimated to be LGBT³⁰. Using this figure for 15-19 year olds (estimated to be 9,357 in 2008) we would expect at least 468 local young people to be LGBT. In 2013, a sexual health needs assessment on LGBT populations in Kingston showed that this group is disproportionately affected by mental health issues compared to the general population and younger LGBT residents were prone to self-harm and eating disorders³¹. This suggests a specific vulnerability for this group.

Local Services

The current commissioning and delivery of Tier 2 and 3 Child and Adolescent Mental Health Services is complex. There are joint commissioning arrangements in place between Kingston CCG and Kingston Council, led by the Joint Children's Commissioner. Services currently commissioned include a Tier 2 service known as the Family Advice Support Service (FASS), which is targeted at children and young people with emerging or moderate emotional and behavioural issues, and primarily aims to offer a consultation service to support professionals working with young people, rather than offering direct work with young people themselves. This service is primarily for children in Kingston schools but is also available to children who are resident in Kingston.

The Tier 3 service commissioned locally is the FACT (Family Adolescent and Child Team) service. Specific services are commissioned to provide targeted support to looked after children, young offenders and children with disabilities.

In 2012-13 the FASS Tier 2 team received 372 requests for consultation from professionals, of which 194 led to direct work with children and young people. During the same period the FACT Tier 3 CAMHS in Kingston received 893 referrals. This does not fit with national work showing that a high proportion of patients can be supported in the community with brief and targeted interventions from Tier 2 services and/or within universal settings.

Very few children and young people are using Tier 2 services, with over twice as many accessing Tier 3 services. Applying the national estimates to the Kingston population suggests 2,667 children and young people would need Tier 2 or 3 services, while only a total of 1,265 are actually accessing services in Kingston. This suggests that the problem is a lack of utilisation of Tier 2 services rather than excessive use of Tier 3 services.

GPs are the most common source of referrals to CAMHS overall, and especially into Tier 3 services (Table 1). The very low number of referrals from GPs to Tier 2 services may suggest either that many people are not consulting GPs until problems have become severe or that GPs are not referring to FASS since this service does not tend to undertake direct work with children and young people. Nearly 10% of referrals to Tier 3 services are received from acute hospitals.

Table 1: Referrals to Kingston CAMHS by source 2013-14

	FASS (Tier 2)	FACT (Tier 3)	Total
Hospital	0	87	87
Community health services	17	12	29
GP	25	659	684
School	147	19	166
Self/parent	31	0	31
RBK Prevention and Early Help Service	45	*	-
RBK Education Services	22	12	34
RBK Social Care Services	51	48	99
Other	34	55	89
Total	372	893	1265

* = suppressed as less than five

Source: A Review of Targeted Tier 2 Child and Adolescent Mental Health Service in Kingston and Richmond. Elizabeth Brandill Pepper October 2013³²

Children and young people may present with more than one problem. Of the 372 referrals into FASS there were 649 presenting problems identified, with the commonest identified need being behavioural issues in 28% of referrals.

Within Tier 3 services information is available on the primary diagnosis of children open to services, rather than on referral. This data is produced each quarter, so any children seen for more than one quarter will have their diagnosis recorded more than once. Of 5,503 diagnoses recorded over the year, most ongoing work was due to hyperkinetic disorders such as ADHD (30%) and autistic spectrum disorders (18%) followed by emotional disorders (15%) which included depression, phobias, anxiety and stress. Conduct disorders accounted for only 2% of the diagnoses recorded over the year. How far the predominance of hyperkinetic disorders and autistic spectrum disorders is due to their ongoing nature rather than their incidence in the population cannot be ascertained from this data.

When compared to the national estimates from CHIMAT, this local pattern of service use is very different to that predicted. Conduct disorder is the commonest disorder predicted from national research, followed by emotional disorder, and with a much lower prevalence of autistic spectrum disorder. This disparity needs to be investigated further, including an assessment of presenting conditions on first referral into services and length of treatment within services by diagnosis.

The same number of boys and girls are referred into FASS, but the FACT team has fewer boys than girls on its caseload (549 to 618 boys each quarter compared to 782 to 824 girls each quarter). Given the national prevalence surveys showing more mental health difficulties in boys than in girls, and the low numbers overall receiving mental health services in Kingston, this suggests that under-treatment of mental health problems may be a particular problem in boys in Kingston. The reasons for this should be investigated further.

NICE (National Institute for Clinical Excellence) have published guidelines on best practice for managing and treating many mental health conditions³³. Effective treatments include many common features, and the availability of these locally is described in Table 2.

Table 2: Availability of effective treatments in local CAMH Service

Interventions offered by teams:	FASS (Tier 2)	FACT (Tier 3)
Education and training programmes for parents	√	√
Education and training for professionals	√	√
Parenting programmes		
Psycho social	√	√
CBT	√	√
Interpersonal therapy		√
Psychotherapy		√
Multi systemic / family therapy		√
Pharmacological		√

Overall, services in Kingston follow evidence of effectiveness but there is no provision of parenting programmes as part of the service offered by either FASS or FACT.

Local Action

In 2013, a young people's risky behaviour needs assessment (RBNA) for Kingston was undertaken³⁴. This assessment found that there are few services in Kingston providing counselling support for young people with low level concerns such as depression, anxiety and stress. Most young people with low level mental health needs are not able to access these limited services. Support for young people with low level mental health needs was consistently highlighted by both young people and professionals as the most significant gap in service provision in Kingston. Recommendations from the report included extending the existing CAMHS service to include a psychological therapies service for children and young people.

A number of reports and reviews have identified a mismatch between the number of children and young people estimated to need Tier 2 CAMHS and the number referred into services. The slightly greater than estimated use of Tier 3 services noted above may reflect this under-provision of services at Tier 2.

A recent CAMHS review has also highlighted other gaps, including:

- Provision for children in their early years
- A lack of parenting support for families accessing CAMHS
- Support for children and young people entering the care system
- Support for children and young people with ASD to manage the impact of their condition on their day to day social functioning

In addition the CAMHS review found that very few young people are referred on to adult services. Reasons behind this should be explored further given that 25 to 40 young people in the FACT service reach 18 years of age each quarter. It may be that many have achieved the desired outcomes in advance of their eighteenth birthday. However, given national findings that many adult mental health problems start in childhood, this cannot be assumed to be the case.

Recent Developments

Psychological Therapies and Parenting Support

The FASS and FACT teams were successful in submitting a collaborative bid to the Department of Health for funding to support the Improving Access for Psychological Therapies (IAPT) transformation programme. A key element of this initiative is introducing self referral mechanisms into services

as well as session by session outcome monitoring and evidence based programmes. Four trainees are attending courses at Reading University in evidenced based therapies and are delivering interventions under supervision in the Royal Borough of Kingston. The CAMHS teams are preparing for the use of routine outcome measures with all their clients by attending local training and trialling the measures on some patients.

The training offered as part of the IAPT programme will support the CAMHS workforce to deliver parenting programmes. The specialist training parenting programmes being delivered as part of this new service are part of a comprehensive parenting plan which will be delivered in the Royal Borough of Kingston. This will provide universal support for all parents to prevent problems from developing, and targeted support focused on detecting early signs of problems and working with parents to prevent them taking hold. Please also see Chapter 3.2 on early intervention.

Tier 2 Service Relaunch

The planned joint Kingston and Richmond Tier 2 service will offer the following evidenced based interventions as part of a time limited package of support as recommended by NICE. These could be delivered as a group session or individually:

- Psychosocial education and support
- Cognitive behavioural therapy
- Solution focused therapy
- Harm reduction interventions
- Post trauma interventions
- Parenting programmes
- Bespoke systemic behavioural strategies

It is proposed the Tier 2 Service will also offer a menu of enhanced services that children's centres, schools, colleges and academies can purchase with their own resources that are additional to the core offer defined in the specification.

It is proposed that all requests for support and direct referrals to Tier 2 services should be made via Single Point of Access (SPA) hubs that will be established in Kingston and Richmond. The role of each SPA will be to provide follow up to each referral and offer some initial advice and guidance and consultation to referring agencies. It is proposed that the Tier 2 service will directly support the functions of the SPAs by holding a weekly meeting with the CAMHS SPA clinicians to jointly review referrals.

"I am delighted that we have established a Single Point of Access for all referrals to local community CAMHS services in partnership with South West London St. George's Mental Health Trust following a review of best practice and consultation with professionals, young people and their carers. Together with the launch of a new Tier 2 CAMHS Service across Kingston and Richmond I am confident these new services will improve access and enable us to provide a wider range of evidence based treatments for Kingston children and young people who are experiencing mental distress."

Nick Whitfield, Chief Executive and Joint Director of Children's Services, Kingston Council

Recommendations

1. After the re-launch of the Tier 2 service there needs to be ongoing monitoring to ensure that the availability and accessibility of the service meets local needs
2. The disparity between the estimated disorders by category and the observed pattern of service use in the Tier 3 service needs to be investigated further, including an assessment of presenting conditions on first referral into services and length of treatment within services by diagnosis
3. The reasons behind the low numbers of boys in treatment in Tier 3 services should be explored
4. Availability of parenting support for parents of children with mental health issues should be reviewed
5. The reasons behind the rise in the Strengths and Difficulties Questionnaire scores for looked after children should be investigated further
6. The need for transition services should be reviewed and in line with findings from this appropriate services established if required to meet the need of vulnerable young adults

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Section 4

Adults and Mental Illness

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Overview

No other illness matches mental illness in the combined extent of its prevalence, persistence and impact. Mental illness is a term that describes a range of diagnosable conditions that usually need treatment from either primary health care or specialist mental health services. These illnesses include depression and anxiety (referred to as common mental health disorders) as well as schizophrenia, bipolar disorder, and other severe mental illnesses.

Stigma and discrimination against people with mental illness can have a very negative effect on the lives of people, worsening mental illness or preventing recovery. It is such an important issue that this report has devoted Chapter 4.1 to stigma and discusses ways of tackling it.

Mental illness can occur at any point in life, Chapters 4.2 and 4.3 focus on adulthood and older age, whilst mental illness in children is covered in Chapter 3.3. There is an ongoing debate about whether to classify dementia as a mental illness or not, and this report examines the pattern of dementia in the local population and describes current action to address the growing needs of this group. Each chapter also describes the services and wider support in place to care for people with these illnesses.

Self harm and suicide are covered in chapters 4.4 and 4.5, and are important both because of their impact, and the opportunity there is for prevention. These chapters cover all age groups.

Carers play a crucial role in the lives of people with mental illness, and Chapter 4.6 focuses on carers and carer issues in Kingston.

4.1 Stigma

Liz Trayhorn, Public Health Programme Lead for Mental Health, Kingston Council
Dr Helen Raison, Consultant in Public Health, Kingston Council

Key messages

- The stereotype of someone with mental illness is not an accurate one
- Stigma and discrimination are major barriers to full participation in healthcare, education and citizenship
- Significant but modest gains have been made in the reduction of stigma and discrimination, but most people with mental illness still experience these negative reactions
- Carefully delivered interventions do reduce stigma and discrimination, if sustained over a sufficiently long time

Introduction

Whilst mental health problems are common and most people fully recover, there is a strong social stigma attached to mental illness. It is of note that the most common single type of newspaper article on mental illness are those that contribute to stigma, accounting for nearly half of all coverage in a sample of local and national newspapers across England between 2008 and 2011¹.

Stigma arises from negative stereotypes associated with the symptoms or diagnosis of mental health problems. Programmes to tackle mental health stigma have begun to place more emphasis on discrimination, addressing society's response rather than placing the onus on people with a history of mental health problems².

Stigma and discrimination against people with mental illness can lead to reduced life expectancy^{3,4} victimisation⁵ and exclusion from higher education⁶ and employment (adults with mental health problems have the lowest employment rate for any of the main groups of disabled people)². Stigma and discrimination can also worsen someone's mental health problems, delay them getting help and treatment, and impede their recovery.

The Equality Act 2010 makes it illegal to discriminate directly or indirectly against people with mental health problems in public services and functions, access to premises, work, education, associations and transport. The subsequent 2013 Mental Health

(Discrimination) Act removed sections from several pieces of legislation which had disqualified people on the grounds of mental ill health from a number of offices and roles.

Nearly nine out of ten people with mental health problems say that stigma and discrimination have had a negative effect on their lives⁷.

"Mental health stigma is alive and well. It manifests itself when we talk about 'them' and fail to recognise it is us. 1 in 4 of us will have a diagnosable mental health problem in any one year; which means we all know someone close to us who is living with mental health challenges. Parity of esteem is a national priority to ensure those of us with mental health issues are treated to the same high standards and in equally good facilities as those of us with physical problems. We have a long way to go but that journey has started and we are committed to seeing it through."

Dr Phil Moore, Deputy Chair (Clinical) Kingston Clinical Commissioning Group

Key Statistics

A survey of mental health service users in England in 2011 found that:

- 19% reported experiencing discrimination in seeking work; 17% had experienced discrimination while in employment; and 46% reported not looking for work due to the anticipation of discrimination
- About 70% of mental health service users feel the need to conceal their illness
- 50% reported being shunned by others
- 25% reported problems with personal safety related to having a diagnosis of mental illness, including verbal or physical abuse
- 87% reported experiencing discrimination in at least one aspect of life in the preceding 12 months⁸

Interventions

There is growing evidence of the effectiveness of anti-stigma interventions – both national programmes and those targeted at specific groups⁹. As a result of Scotland's 'See Me' campaign¹⁰ the proportion of people with a mental illness who reported experiencing discrimination dropped significantly between 2002 and 2008¹¹. At the individual level social contact interventions are more effective for adults, while educational interventions are more effective for young people¹².

'Time to Change' is England's national programme to reduce stigma and discrimination against people with mental illness¹³. It is run by the mental health charities Mind and Rethink Mental Illness. Their approach has been to encourage people with mental health problems, as well as those who know someone with a mental health problem, to talk about it through conversations, for example with friends or colleagues. This has been supported by media campaigns as well as a grants programme to encourage community events. Most recently they have been developing work with children and young people, to change their attitudes regarding mental illness.

Evidence from its first year showed significant improvements in areas in which relationships are informal, such as family, friends and social life¹⁴ but none in more formal areas including mental and physical healthcare. Thus, initial treatment-seeking for mental illness may increase if public attitudes and behaviours improve, but negative experiences at the hands of health professionals may deter people from seeking further help.

A significant improvement in employment related attitudes was observed between 2006 and 2010¹⁵. Employers also report use of adjustments in the workplace, such as modified hours, for people with mental health problems with increasing frequency, and these can be important for facilitating openness and disclosure by employees¹⁶.

Local Action

The Council's Public Health directorate has been promoting 'Time to Change' at World Mental Health Day and other events as well as promoting 'Time to Change' mental health awareness training in local schools. Kingston Somali Association used a 'Time to Change' grant to organise mental health awareness workshops for their community.

Thirteen people have been trained as instructors in adult Mental Health First Aid (MHFA) since 2012. Ten people have been trained as instructors in young

people MHFA and three more are due to be trained by October 2014. Instructors train others so as to increase mental health awareness in professionals and community groups including black and minority ethnic (BME) groups.

Since April 2012 the MHFA instructors have trained over 200 people in adult MHFA and over 100 in youth MHFA. Some of the instructors are mental health service users, which has enriched the learning experience for participants.

A student mental health conference was held to increase mental health awareness in young people and a number of local schools have run mental health awareness sessions for their pupils. For more details see Chapter 3.2.

For more information on local initiatives to improve mental health in local workplaces see Chapter 2.5 and for more information on local initiatives to improve support for parents with mental health problems see Chapter 3.1.

Recommendations

1. Encourage both individual and organisations to sign the Time to Change pledge
2. Work with Kingston's Mental Health Parliament to identify groups to prioritise for anti stigma campaigns
3. Review the Mental Health First Aid programme and target groups who have yet to attend.



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4.2 Mental Illness in Adults and Mental Health Services

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Key messages

- Mental health problems are the largest source of disability in the United Kingdom
- Mental illness is influenced by the interaction of social determinants and personal characteristics such as violence and abuse, unemployment, debt, poverty, poor housing and homelessness, ethnic group, gender and age, adversity in childhood, and the presence of physical illness
- Common mental health disorders such as anxiety or depression affect one in six people, at any point in time. That is over 21,000 residents, or 25,000 people registered with Kingston GP practices
- Severe mental illnesses, such as schizophrenia and bipolar disorder, affect less than 1% of the population at any point in time
- Under-diagnosis of common mental health disorders is present in Kingston, and undertreatment is also likely. Certain groups are more at risk of under-diagnosis and undertreatment, including older people and those with physical illnesses. Improving diagnosis should be a priority, as it will enable earlier treatment and a quicker recovery
- Spending on mental illness in Kingston accounts for 12% of the NHS secondary care budget, although mental illness makes up a quarter of the burden of disease
- Up to 90% of mental illness is managed in primary care. People with depression and anxiety can be referred to psychological therapies at the Kingston Wellbeing Service which also provides drug and alcohol treatment
- Specialist mental health services are currently provided in the form of: community services comprising two Community Mental Health Teams and community-based assertive outreach, early intervention, recovery college, and long term psychotherapy; inpatient services for acutely unwell people at Tolworth and Springfield Hospitals which includes a crisis-intervention element; psychiatric liaison services at Kingston Hospital and highly specialist services such as Eating Disorders
- Other services include Adult Social Care, supported accommodation and advocacy, as well as a broad range of voluntary and private sector services
- People with mental illness should be at the heart of improving and designing high quality services
- The future of mental health is an integrated model with people managed in primary care using a matrix of statutory services, voluntary sector and specialist input, whilst more complex, new or unstable mental illness is managed in community services or secondary care

Introduction

No other health condition matches mental illness in the combined extent of its prevalence, persistence and impact. Mental health problems are the largest source of disability in the United Kingdom, accounting for 23% of the total 'burden of disease'¹, far higher than cardiovascular disease or cancer.

For some people mental illness can last for years, particularly if inadequately treated. Just like most physical illnesses, the greatest degree of effective recovery from mental illness is gained from early identification and treatment.

People with mental illness are able to run their own lives, participate in family and community life and work productively to varying degrees. Supportive services should enable people to continue to do these things when they are unwell, or to return to them as soon as possible. It should not be forgotten that being unwell with a mental illness can be isolating, disorientating and sometimes frightening, and so services need to be responsive, accessible and caring.

This chapter looks at both common and severe mental illnesses, and the variation in diagnostic rates. It describes the local services, and highlights some issues raised by local people about living with a mental illness in Kingston. Whilst all ages are covered here, it focuses more on working age adults, as there are separate chapters on children and older people.

This chapter uses the term 'mental illness' to refer to people diagnosed with clinical mental illness, but also uses the terms 'mental disorder' and 'mental health problem' interchangeably.

Factors influencing mental illness

There are many social determinants of mental illness. Adverse life events such as violence and abuse² debt, unemployment, poverty, poor housing, homelessness and living in cold homes all increase someone's risk of mental illness³. Local action to improve these social determinants is described in various chapters throughout the report.

Age, gender and ethnic group also affect the risk of mental illness. This is probably due to both individual vulnerability and social factors. It is important to recognise that these groups may have higher needs. Adults with learning disabilities have a higher rate of mental health problems⁴. Some, but not all, black and minority ethnic groups living in the UK are more likely to be diagnosed with common and severe mental health problems, be admitted to hospital, experience

a poor outcome from treatment and disengage from mainstream mental health services, leading to social exclusion and deterioration in their mental health⁵.

Adversity in childhood is also associated with adult mental illness, as is the presence of physical illnesses.

Whilst mental health problems are common and most people fully recover, there is a strong social stigma attached to mental ill health, and people with mental health problems can experience discrimination in all aspects of their lives. This is covered in its own chapter (4.1). Stigma can also be tackled through the provision of socially and culturally competent services based on people's needs rather than just their diagnosis, and is an essential step towards more inclusive, recovery based approaches to care⁶.

Local picture

Common Mental Illness

Common mental health disorders (CMDs), such as depression, generalised anxiety disorder, panic disorder, obsessive compulsive disorder (OCD) and social anxiety disorder, affect one in six of the population at any one time⁷. Depression and anxiety can have a lifelong course of relapse and remission. There is considerable variation in the severity of CMDs, but all can be associated with significant long-term disability.

Over 21,000 residents are estimated to have a CMD as shown in Table 1. There are more people registered with Kingston GPs than live in Kingston, and approximately 25,000 of these people have a CMD.

Table 1. Predicted number of people (aged 16 and above) affected by common mental health disorders (CMD) in Kingston residents, by age

Age band	16-24	25-34	35-44	45-54	55-64	65-74	75+	All 16+
Mixed anxiety and depressive disorder	2,221	2,841	2,218	2,377	1,270	704	605	11,928 (9.0%)
Generalised anxiety disorder	784	1,105	1,383	1,295	651	363	267	5,831 (4.4%)
Depressive episodes	479	579	757	785	302	110	154	3,048 (2.3%)
All Phobias	327	500	548	318	222	33	10	1,855 (1.4%)
Obsessive compulsive disorder	501	395	287	233	79	33	41	1,458 (1.1%)
Panic disorder	240	421	339	191	159	55	51	1,458 (1.1%)
Any CMD	3,811	4,946	4,514	4,224	2,238	1,166	1,016	21,470 (16.2%)

Note: People may have more than one type of CMD, so the total percentage of any disorder is not the sum of those with specific disorders. APMS 2007 sampled adults aged 16 and over, without an upper age limit. Point prevalence.

Source: ONS 2007 Adult Psychiatric Morbidity Survey among adults in England and ONS 2012 mid-year estimates.

CMDs tend to be highest in mid-life and are more common in women (19.7%) than men (12.5%) of working age. This pattern is also true of eating disorders⁸. CMDs are also higher among some ethnic groups. More details of the estimated prevalence and incidence of mental health disorders by age and gender are included in the Mental Health Profile (Chapter 6.1).

The peak of incidence in mid-life is attributed to the accumulation of problems persisting from youth together with the onset of new ones. This is the life stage where there is often the realisation of limited achievement, pressure of caring responsibilities for children and ailing parents, work stress, the menopause and life events that are more common in mid-life such as marital breakdown⁹.

The vast majority of depressive and anxiety disorders that are diagnosed are treated in primary care⁷. However, many individuals do not seek treatment, and both anxiety and depression often go undiagnosed. Under recognition is generally more common in mild rather than severe cases.

Under-treatment is also a likely scenario in Kingston. Only a quarter of people (24%) with CMDs were in

receipt of some kind of mental health medication or therapy (when interviewed for a national survey in 2007¹⁰). 76% were not.

Depression

Depression is characterised by sadness, loss of pleasure, feelings of guilt or low self worth, disturbed sleep and appetite, tiredness and poor concentration, which is present for most days over at least two weeks. When severe, sufferers can be completely unable to cope with everyday life.

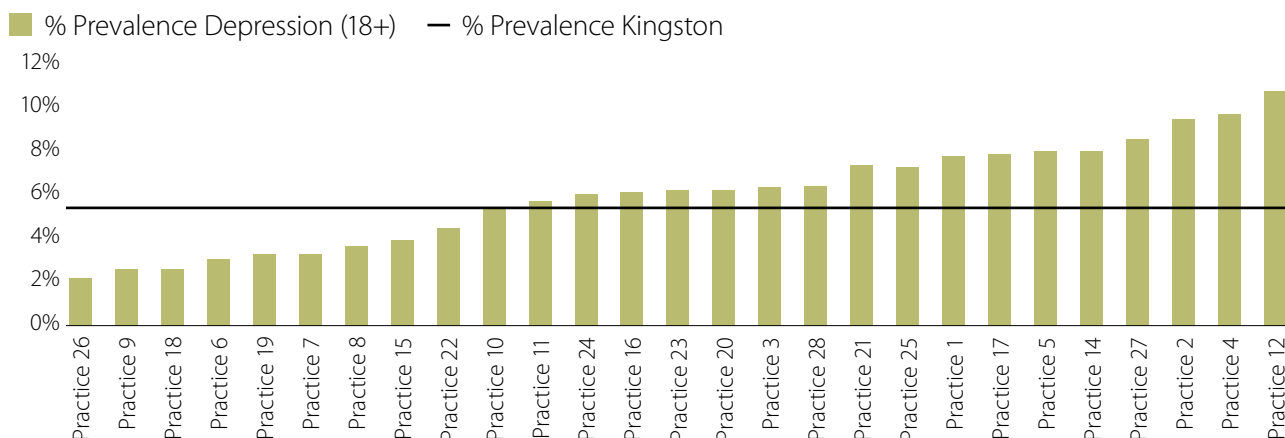
Depression is currently the fourth highest cause of disease burden in the world, and is expected to be the second highest by 2020¹¹.

The percentage of people in Kingston diagnosed and recorded by GPs with depression is rising – it was 4.0% in 2012-13¹² and a year later had risen to 5.3%¹³. Compared to England (5.8%), London and comparator populations¹⁴ the rate of GP diagnosis of depression locally is low, but the recent rise may indicate improved diagnosis and recording by GPs, and/or reflects a real rise in the number of people with depression. In either case, these percentages are lower than the estimated total prevalence shown in Table 1. GPs should be

encouraged to enquire about depressive symptoms and more systematically record these in registers. This is particularly important in older people or those with physical illness such as cancer where depression is often overlooked. A more extensive discussion about mental illness in people with physical illness can be found in Chapter 5.1.

There is great variation between individual GP practices in the proportion of people diagnosed with depression (Figure 1). This may reflect the population of each practice, as well as the GP practice's use of the register. More work to understand this variation may reveal that some practices are missing depression diagnoses, and therefore treatment opportunities, in some patients.

Figure 1: Recorded prevalence of diagnosed depression in Kingston General Practices, 2014



Source: Disease prevalence – Practice focus Report, QMS, March 2014, Practice Population – PCSS, March 2014

Anxiety

Anxiety comes in a number of forms. In Generalised Anxiety Disorder people have excessive anxiety about events and activities, and difficulty controlling the worry which lasts over a period of time. Panic attacks are another form of anxiety. People with severe anxiety often also have depression and vice versa.

The prevalence of individual anxiety conditions varies. At any one time in the population there are an estimated 4.4% with generalised anxiety disorder, 1.1% with panic disorder, 1.4% with phobias and 1.1% with Obsessive Compulsive Disorder (OCD). The estimated numbers of people affected are shown in Table 1. It is also estimated that 3% of the population has post traumatic stress disorder (PTSD)¹⁵.

Recognition of anxiety disorders by GPs is particularly poor nationwide, and only a small minority of people who experience anxiety disorders ever receive treatment⁷. In part this may stem from GPs' difficulties in recognising the disorder, but it may also be caused by patients' worries about stigma leading them to avoid seeking help with their anxiety.

Severe mental illnesses

Severe mental illness (SMI) includes diagnoses which typically involve periods of psychosis (losing touch with reality or experiencing delusions) needing high levels of care, and which may require hospital

treatment from time to time. When people become acutely and severely unwell it is known as a crisis, and they may be unable to communicate their wishes. Some people will only have a single episode of psychosis and make a fast recovery, whereas for others it is a longer process during which time they may not be able to care for themselves.

People with severe mental illness can have very disrupted lives, particularly during episodes of illness. As well as being disoriented and frightened about what is happening to them, they will need a lot of support from carers, including their family, and may struggle to get or keep employment and accommodation. They may also misuse alcohol or drugs. If well supported, they can often live or return to a life where they can feel part of the community and can work productively.

SMIs are less prevalent than common mental health disorders. Schizophrenia and bipolar disorder (also known as manic depression) make up the majority of cases, but people may also have severe depression, schizoaffective disorder and severe personality disorders that require episodes of intense care.

SMIs are more common in certain ethnic groups. The Adult Psychiatry Morbidity Survey (2007) found psychotic disorders to be higher in Black men in particular. SMIs are slightly more common in men than women and they peak between the ages of 35 and 44.

Schizophrenia

Schizophrenia affects the way people think. A person's perceptions, thoughts, mood and behaviour are significantly altered. Each individual will have a unique combination of symptoms which may include hallucinations (seeing things, smelling things, hearing things) and/or delusions (fixed or falsely held beliefs) and a set of negative symptoms (apathy, lack of drive, poverty of speech, social withdrawal and self neglect). Typically a person will have a period of deterioration before a full episode of psychosis, and after treatment the symptoms will diminish or disappear and there may be many years before symptoms return. Although this is a common pattern, it varies considerably between people.

Schizophrenia is associated with considerable stigma, fear and limited public understanding.

Approximately 1% of the population will experience schizophrenia in their lifetime, although at any point in time less people have symptoms of schizophrenia.

Bipolar disorder (also known as manic depression)

Bipolar disorder is a mood disorder that causes mood to alternate dramatically between highs (mania) and lows (depression). Symptoms of mania can be increased energy, excitement, impulsive behaviour, increased belief in one's own powers and agitation. Symptoms of depression can be lack of energy, feelings of worthlessness, low self esteem and suicidal thoughts. A person with bipolar disorder may also have psychotic symptoms such as hallucinations or delusions.

Bipolar disorder often has a long course. After treatment for episodes of deterioration, a person can take medicines to stabilise their illness which prevents extreme mood swings to mania or depression.

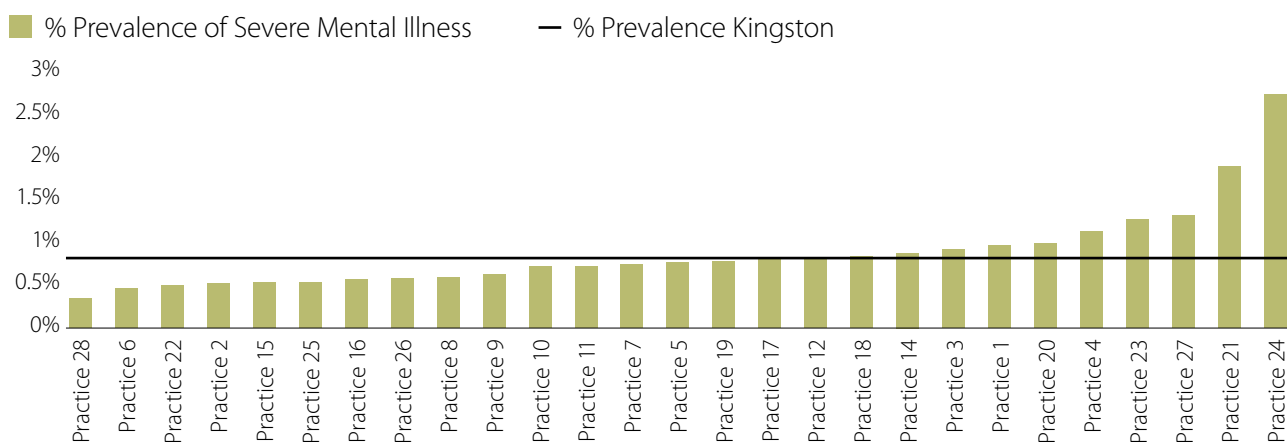
The annual incidence of bipolar disorder is seven per 100,000 and the estimated lifetime prevalence is 4 to 16 per 1,000 people.

GP registers for severe mental illnesses

Severe mental illnesses (schizophrenia, bipolar disorder and other psychoses) are recorded by GPs on to registers as this helps to co-ordinate care. As can be seen in Figure 2 there are two Kingston practices with high prevalences of SMI, whilst there are some practices with very low prevalences. There is a five fold difference in prevalence between the practices with the highest and lowest prevalences. The reasons for this are complex, reflecting the populations of each GP practice, as well as the use of the register by GPs.

The National Institute for Health and Care Excellence (NICE) recommends that people diagnosed with a SMI have a documented primary care consultation which includes a plan for care, including a plan in the event of a relapse. As up to half of people with SMI may only be seen in a primary care setting, it is important that the primary care team takes responsibility for discussing and documenting the care plan in each patient's primary care record. Across Kingston CCG as a whole, 84.4% of patients have a documented care plan, and this is not significantly different from the England average of 87.3%. However there is great variation between the different GP practices with some practices reaching 100%, whilst five are significantly below the Kingston average, the lowest percentage being approximately 50%¹⁶. Up-skilling of GPs in mental health, together with appropriate specialist input from secondary care services, will help to improve care plans for all people with SMI.

Figure 2: Prevalence of severe mental illness (%) in GP Practices in Kingston, persons, all ages, March 2014



Source: Practice Focus Report, QMS, February 2014. Practice Population – PCSS, March 2014

Note: Severe mental illness register indicates patients on register with schizophrenia, psychosis or bipolar disease.

Physical health of people with severe mental illness

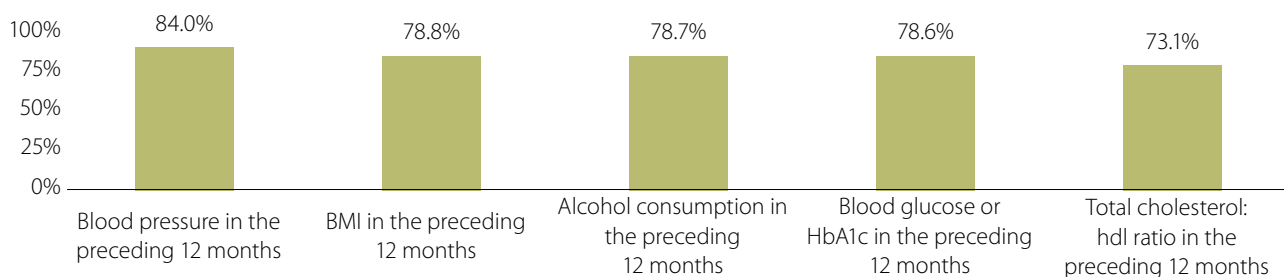
People with severe mental illness have a mortality rate two to three times higher than the general population. Whilst suicide accounts for one fifth to one third of these early deaths¹⁷, they are mainly due to physical disorders¹⁸ such as heart disease, diabetes, respiratory disease and cancer. The underlying reasons for this are complex, ranging from poor health behaviours, such as smoking and diet, to the

under diagnosis and under treatment of physical illness in people with mental health problems, altered help seeking behaviour in people with mental illness and physical problems caused by antipsychotic medication.

A GP register is a systematic method of managing these patients and their treatment.

Figure 3 shows the proportion of people on the severe mental illness registers across Kingston CCG who are receiving key physical health checks.

Figure 3. Percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure, BMI, alcohol consumption, HbA1c and cholesterol in preceding 12 months in Kingston CCG, July 2014.



Source: *The Practice Focus Report, QMS, July 2014*

BMI = Body Mass Index

HbA1c = Glycosylated haemoglobin – A measure of blood glucose over time

Other mental health disorders

Personality disorders

Personality disorders are life-long conditions in which an individual differs significantly from an average person in how they think, perceive, feel or relate to others. There are many types of personality disorder. Whilst some people live with a personality disorder without knowing they have one, others may be overwhelmed by negative feelings, anxiety, become emotionally disconnected, have difficulty managing feelings without self-harming, have odd behaviours and have difficulty managing close relationships. Some people may have periods of psychosis (losing contact with reality).

Personality disorders are common, affecting around one in every 20 people. Many people only have mild to moderate symptoms which may respond to psychotherapy. Other people may have more severe problems and may need specialist help for longer periods.

There is little data on the number of people with personality disorders in Kingston, but if the prevalence is the same as the national rate (4.4%¹⁹), then approximately 5,700 adult residents have a

personality disorder.

Eating Disorders

Eating disorders are syndromes characterised by a persistent and severe disturbance in eating attitudes and behaviour, to an extent that significantly interferes with everyday functioning. The three main conditions are anorexia nervosa, bulimia nervosa and eating disorder not otherwise specified.

Eating disorders are estimated to affect 6.4% of the adult population but with only 1.6% reporting they have a significantly negative effect on their life (this equates to 2,096 Kingston residents negatively affected)¹⁰. Not all of these people will be known to services. Women are more likely to be affected than men, and the incidence in adults decreases with age.

Activity and spending on mental health services

NHS Spending

Spending on mental health services in Kingston accounts for 12% of the NHS secondary care budget²⁰, which is in line with the average percentage spend in other areas in England. However it is much less

than the proportion spent on physical illnesses. The full costs to the NHS go well beyond this figure as it does not include costs to primary care or increased costs elsewhere caused by mental health conditions exacerbating other health problems.

The wider economic costs include adult social care and other service costs, lost days at work, unemployment and the substantial costs incurred by family members.

Further work would be needed to build a more comprehensive picture of the costs to all services and the wider economic costs in Kingston.

People using secondary care mental health services

The number of people in Kingston in contact with mental health services (1,951 per 100,000 population in the first quarter of 2013-14) is significantly lower than the England average (2,176 per 100,000 population in the first quarter of 2013-14). However, for those who are in contact with these services, 3.9% are inpatients in psychiatric hospitals which is significantly higher than the England average of 2.4%. The number of bed days at 6,456/100,000 population is also significantly higher than the England average at 4,686/100,000 population¹⁶.

These findings are mainly reflective of the way local mental health care is organised and highlight that in England as a whole a smaller proportion of care is delivered in an inpatient setting compared with Kingston.

Adult Social Care activity

Tables 2 and 3 show the number of people known to have mental health problems using social care services from April 2013 to March 2014.

Table 2: Number of people with mental health problems receiving services from Adult Social Care, 2013 – 2014

	Aged 18-64	Aged 65+	Total
Residential or nursing care	26	87	113
Community based services	505	255	760

Note: people have to be categorised as 'mental health client' to be counted in this data.

Source: Adult Social Care data, Kingston Council

Table 3: Numbers of people with mental health problems receiving a range of community based services from Adult Social Care, 2013 – 2014

Community based service	Aged 18-64	Aged 65+
Home Care	16	84
Day Care	17	26
Meals	*	38
Short Term Residential – not respite	*	*
Direct Payments	41	14
Professional Support	483	153
Equipment & Adaptations	*	32

Note: People can have more than one community service so the individual totals will be more than the total number receiving community based services. These numbers include patients with dementia, and may not include all people with mental health problems if it is not their primary issue

** = numbers suppressed as less than five*

Source: Adult Social Care data, Kingston Council

Quality of mental health services

The quality of mental health services is complex to measure. A small number of quality measures are benchmarked against England averages, allowing some comparisons to be made. A key measure of quality is the proportion of people using mental health services who are on the Care Programme Approach (CPA), which is significantly higher in Kingston (663/100,000) than England (531/100,000 population¹⁶). CPA is a system to combine health and social service assessments to ensure people receive properly assessed, planned and co-ordinated care and should ensure patients get regular contact with a care co-ordinator. It is important that people understand why they are, or are not, on CPA and have a care co-ordinator because anecdotal reports suggest local people are not clear how this operates.

There is a multi-disciplinary Clinical Quality Review Group for the main local provider of specialist mental health services, South West London and St Georges Mental Health Trust. This group monitors quality issues and takes action where required. This

Case Study 1:

How my GP has helped me

By a resident with mental health problems

I have lived in Kingston all my life and have chronic mental and physical health difficulties. I have had distressing experiences within mental health services and I find it hard to trust those in the health/social care sector. Despite my level of need remaining high, after my last admission to hospital I discharged myself from all mental health services.

Recognising the difficulties I face, my GP has gone above and beyond normal provision to ensure my safety and engagement with primary health services (for example offering to meet me in McDonald's to take my blood pressure when I felt too afraid to go to the surgery!). He has given time to building a relationship that is based on trust and respect. Without his willingness to work within my limitations, I may have disengaged from all care. Instead his support has enabled me to attend to my health needs and seek help when appropriate.

includes serious incidents, reviewing findings of Care Quality Commission (CQC) inspections, audits, CQUIN achievements (quality and innovation targets), and scrutinising Integrated Governance Reports which contain detailed monthly quality information.

Recent work has been undertaken to improve the quality of discharge summaries, and crisis plans when people leave hospital, which are important for continuity of care and ensure that GPs know the needs of their patients.

The CQC publishes a Community Patient Survey for South West London and St Georges Mental Health Trust as a whole. The 2013 survey showed that a relatively low proportion of service users thought their NHS Care Plan covered what they should do in a crisis. A crisis plan enables the patient to jointly agree in advance how they will be cared for in the event of becoming acutely unwell. The Trust has been working towards improving crisis plans over the past year. The 2014 Community Patient Survey is due to be published towards the end of 2014.

Local Services

Primary Health Care Services

General practice

GP practices in Kingston deliver care to people with mental health problems. Up to 90% of mental health problems are thought to be managed in primary care²¹.

GPs support people to manage the majority of common mental illnesses such as depression and anxiety, by offering self care advice, prescribed medicines (such as anti-depressants), or by referring to psychological therapies (IAPT) or other local support services. GPs also manage people with severe mental illness (such as schizophrenia or bipolar disorder) who are stable and under shared care with the Community Mental Health teams.

It has been recognised locally that primary care should be the centre of care for people with mental illness and there is a need for GPs to receive good training in managing people with mental illness. An example of a GP who goes above and beyond for one of his patients is shown in Case Study 1.

Psychological therapies

A programme of psychological therapies (mainly cognitive behavioural therapy) for people with depression and anxiety disorders is provided in Kingston.

In 2013, Kingston commissioned the Kingston Wellbeing Service that provides support for people with depression, anxiety and trauma and/or problems with drug or alcohol misuse, in recognition that in some people these problems are linked.

The service offers psychological therapies (sometimes called the IAPT service), drug and alcohol treatments and is also developing a range of wellbeing activities, such as peer mentoring and support, constructive practical activities, education, training and employment support and a community links service to promote integration into the local community.

During the first year of operation the service is still working towards fully integrating the substance misuse and IAPT parts of the service. Although the service has not met all of its targets, it will be working towards these during its second year, for example improving referral to treatment times and recovery times. Commissioners should monitor the actions taken by the service to make these improvements, and the service should ensure that it is well linked to other services.

The potential for confusion about the pathways into the Kingston Wellbeing Service and the Community Mental Health Team (CMHT) was explored by a rapid review in Spring 2014²². The findings were that in the main the right patients are being referred to the right service (9% of referrals to the CMHT and 2.5% to the Kingston Wellbeing Service were considered inappropriate in the view of the service staff). GPs and other referrers are not always clear which service to send someone to, and more work is ongoing to ensure these pathways are clearer and well-promoted. One possible solution to the complexity of services is a Single Point of Access to all mental health services, although providing this will not be without its challenges.

Secondary Care Mental Health Services

The current secondary care mental health services are described here. When a new model for providing care to people with mental health problems is put in place, these services may be organised differently.

Community Mental Health Services (CMHS) – care for people with stable mental illness

The CMHS comprises two Community Mental Health Teams (CMHTs) and some Specialist Community Services.

The two CMHTs cover the north and south of Kingston. They provide support to adults, usually of working age, who are living at home or in the community and who, in the main, have stable mental illnesses. They primarily work with people with:

- Major psychoses such as severe schizophrenia and bipolar disorder
- Long-term lower severity illness such as depression in people with poor treatment adherence
- People requiring specialist or intensive treatments not available in primary care such as vocational rehabilitation or medicine maintenance requiring blood tests such as clozapine
- People with complex problems who are under the Mental Health Act
- Severe personality disorders not managed by other services

The specialist community services are:

- Assertive outreach – supporting people with a history of severe mental health problems, who are no longer in regular contact with mental health services, who still have complex needs requiring support to remain in the community
- Early Intervention in Psychosis – providing early identification and assessment to adults aged 18 to 35 years with a first onset of psychosis, and subsequent support (in the form of treatment and self help) for the first three years of their illness
- Recovery College – South West London Recovery College provides a range of courses and resources for service users, families, friends, carers and staff to support people to become experts in their own self care, to better understand mental health conditions and to support people in their recovery journey. Courses are co-facilitated by a practitioner trainer and cover understanding mental illness, taking back control, understanding self harm and returning to work or study.

Performance and activity data for CMHS is sparse and difficult to understand. This needs urgent improvement by the service.

The redesign of CMHS by the provider (South West London and St Georges Mental Health Trust) is looking to reduce the clinical case load and increase the non-traditional support networks and recovery college attendance. This is potentially a concern if this

results in an inappropriate reduction in support from health and social care services. The redesign should not reduce the number of qualified clinical staff below nationally recommended ratios.

Inpatient services for people with acute mental illness

Patients who are acutely unwell are often cared for in hospitals. Most Kingston patients are admitted to Tolworth Hospital. Sometimes people may be admitted further afield at Springfield Hospital in Tooting when there are no beds at Tolworth, or if they have a condition that is best treated at Springfield. On occasion people may be admitted elsewhere in London if their condition requires this.

Crisis Resolution and Home Treatment Service

The Crisis Resolution and Home Treatment Service supports adults with severe and enduring mental health problems to remain in the community (rather than hospital) during an acute crisis. The team also facilitates early discharge back to the community when people have been in hospital.

Liaison Psychiatry at Kingston Hospital

Liaison psychiatry is provided by South West London and St Georges Mental Health Trust to Kingston Hospital. There is an established service for adult inpatients as well as a pilot of liaison psychiatry for older people that took place during 2013-14. Liaison psychiatry provides psychiatric assessments, interventions and care to people admitted to the general hospital for a physical illness but who also have a mental health problem. Staff education and training and liaison back to the community is also provided by the liaison team. The older people's pilot has demonstrated good patient experience, care and timely discharge from hospital.

Specialist services – Eating Disorders

Specialist services include the Eating Disorders service provided by South West London and St Georges Mental Health Trust. Intensive hospital based treatment for five days a week or community based support is available, usually via referral from a GP.

Social Care, Supported Accommodation and Advocacy

Adult Social Care services for people with mental health problems include residential and day care as well as a range of community based services, professional support and direct payments.

Supported accommodation is available for people with severe mental health problems. The Case Study (pages 108 – 109) on the Older and Vulnerable People's Housing Strategy describes how a review of housing services has taken account of the needs of people with mental health problems.

Certain people – called 'qualifying patients' – are entitled to help and support from Independent Mental Health Advocates (IMHAs). This includes people who have been detained under the Mental Health Act for longer than 72 hours and people living in the community under Mental Health Act guardianship, conditional discharge and supervised community treatment. In Kingston this service is provided by Rethink.

Separate advocacy services are available for inpatients at Tolworth Hospital delivered by Kingston Advocacy Group (KAG). Independent Mental Capacity Advocates (IMCA's) can support people who lack capacity to make specific decisions where there are no other suitable, unpaid independent people who can²³:

- Support and represent the person
- Consult with others
- Ascertain the person's wishes, feelings, preferences and values
- Ensure all possible courses of action are considered
- Check the framework of the Mental Capacity Act 2005 is followed

The Council commissions Kingston Advocacy Group (KAG) to provide this service in Kingston.

Mental health services and the justice system

Around a third of young people who have committed offences have mental health needs, and a fifth have a learning disability. Personality disorders, psychosis, attention deficit disorders, post traumatic stress disorder and self-harm are all more common in offenders than the general population.

The Bradley Report²⁴ recommended that every stage of the justice system needs mental health input, from youth offending teams, to custody, prison and probation. It recommended the development of liaison and diversion services in order to identify offenders who have mental health, learning disability or substance misuse vulnerabilities when they first come into contact with the criminal justice system. NHS England launched a new pilot liaison and diversion

scheme in April 2014 that places mental health teams in police custody suites and courts in London.

Kingston custody suite is one of the pilot sites, and since May 2014 has had a Forensic Mental Health Practitioner in post. All vulnerable adults and young people with mental health issues, who are suspected of committing an offence, can be assessed and referred for treatment at the earliest opportunity.

Two police officers have recently been trained as instructors for Mental Health First Aid, and they will be providing training to their colleagues.

Mental health service for serving personnel and veterans from the armed forces

People who serve or have served in the armed forces are at increased risk of mental health problems, especially depression, anxiety and post-traumatic stress disorder²⁵. The Defence Medical Services provides care to serving personnel. There are regional mental health services dedicated to the care of veterans, which are delivered by the NHS and the charity, Combat Stress.

Other services and support for people with mental illness

Carers and family members are the people who often provide the majority of care to a person with mental illness. The carer's perspective is covered in Chapter 4.6.

The breadth of services, support and projects that is potentially available to people in Kingston is not comprehensively captured here, but includes housing support for people with severe mental illness as well as employment, benefits and welfare support.

Counselling is offered by a number of private and voluntary organisations including Mind (see Case Study) and Refugee Action Kingston. Kingston Carers Network offers counselling to carers who have mental health problems or for those caring for others with mental health problems. Relate offers relationship counselling, and the Bereavement Service supports people who have recently lost loved ones.

Self help support is available from the Kingston Centre for Independent Living. A Mental Health Support Group Drop-in operates on the Cambridge Road Estate. The SUN Project is a service user network for people with personality disorders in Kingston and Southwest London.

Some of these support systems, services and networks are held in a directory on the Council website, which will need to be kept up to date on a regular basis. A comprehensive picture of support for people with depression, who are self harming or suicidal will be undertaken as part of a needs assessment planned for 2015.

Local Action

A mandate for mental health services

The Kingston Health and Wellbeing Board agreed a Mental Health Mandate in 2013 which set out the values and principles for the commissioning of services for people with mental health problems. The priority issues set out in the Mandate are shown in Box 1.

Commissioning Mental Health Services

Kingston Council and Kingston CCG have a long-standing commitment to working together on mental health issues and have developed a Joint Mental Health Commissioning Team. The Commissioners are responsible for planning, purchasing and monitoring of mental health services in Kingston for adults and older people, which are currently distinct services. They also jointly commission, with the Council's Public Health directorate, the integrated substance misuse and psychological therapies service (the Kingston Wellbeing Service). They are also responsible for ensuring support services are provided for service users and carers.

The importance of local people's involvement in shaping services is reflected in the membership of the newly established Kingston Mental Health Planning Board which will have patients and carers represented on the group, and will meet for the first time in Autumn 2014. The Planning Board will take the Mental Health Mandate forward, will consider and make decisions on new ways of providing services and be guided by the local Joint Strategic Needs Assessment.

How people with mental health problems influence services

People with mental health problems, their families, friends and carers should be at the heart of improving and designing high quality mental health services. Representative organisations in Kingston include the Kingston Mental Health Parliament, the Mental Health Task Group of Healthwatch Kingston and the Kingston Mental Health Carers Forum. Input may also come from many other organisations across Kingston.

Box 1: Kingston Health and Wellbeing Board Commissioning Mandate for Mental Health Services: Priority issues

We expect commissioners to consider the full range of services and issues regarding mental health services. From our understanding of local concerns and aspirations, we expect commissioners to pay particular attention to the following issues:

- How access to services can be simplified and made quicker – and ensure people reach the right service for their needs
- How services can achieve earlier diagnoses of mental illnesses, including dementia
- How mental health services for children and young people can link more effectively to services for adults
- How carers can be better supported, and better involved in decisions about care
- How people with mental health problems can be given support with parenting; and how children of people with mental health problems can themselves be supported
- How the quality of local specialist inpatient services can be improved
- How the balance of care provided in the community, instead of in hospitals, can continue to increase
- How services can keep their users as safe as possible, and minimise avoidable harm
- How people with mental health problems can be supported to access housing, education and employment

To achieve improvements in these areas, we expect commissioners to work closely together, across health and social care, and with colleagues planning and managing services beyond mental health care.



Launch of Kingston Mental Health Parliament with The Worshipful the Mayor of the Royal Borough of Kingston upon Thames

The Kingston Mental Health Parliament was launched on 19 June 2014. It is an advocacy service led by people who have used mental health services, and is operated by Mind in Kingston. The parliament will decide and set their own agenda of issues that truly matter to service users. There will be outreach to gather views, which will then be brought back for debate at the Parliament. This will enable people who may find it difficult to take part in meetings convened by the statutory services to be heard and to remain anonymous if they choose to. The members of the

parliament will then decide a course of action which may mean meeting with service providers to raise and resolve issues.

Healthwatch Kingston has recently established a Mental Health Task Group. The group will gather feedback from local people on mental health issues, provide input into responses to mental health concerns and issues raised by members of the public, represent Healthwatch Kingston at mental health meetings and events as agreed with the Healthwatch Board, and put forward members to assist Healthwatch Kingston in investigating mental health services. Membership is open to Healthwatch Kingston members, local people with an interest in mental health services and representatives of people with mental health conditions in Kingston upon Thames.

Mind has a range of service user involvement services. They run Patient's Council meetings, café meetings, house meetings and ward discussion forums. These are all channels through which service users can be included in the decision making process both in the community and on hospital wards. There is a dedicated Service User Involvement Worker who sits on a variety of panels in the borough.

The Fircroft Trust runs a mental health network for all voluntary and statutory organisations involved in mental health service delivery. It is informed by direct experience of users and carers in contact with the services who attend this network.

Coproduction of services

In 2013 a project called Mental Health in Coproduction (MiC) worked with a group of residents (known as 'Champions') with an interest in mental health, or personal experience of mental health services to play an active role in guiding the commissioning of services. Champions gathered views from the wider community and a summary of key issues and solutions will be published in a future report. The key areas for improvement or development were:

- Lack of GP expertise and understanding around mental health, negatively affecting the quality of care and information provided
- The need for greater involvement and improved information and support directly to carers
- The need for better signposting and provision of information to people affected by mental health problems
- Current barriers to people accessing timely and effective mental health support
- The need to overcome barriers to accessing mental health support faced by Black and Minority Ethnic groups
- The need to overcome factors reducing the continuity of care for people with mental health needs such as follow up after discharge
- Communication issues reported between mental health professionals and people affected by mental health problems regarding their treatment and support
- Ideas for additional support that could be available in Kingston, for example volunteer buddies for people with mental health problems

Sustainable ways of involving people with mental health problems in service design is a priority in Kingston.

Involving carers

Information on the Triangle of Care best practice guide and the place of carers on the Mental Health Planning Board is given in the Carers' chapter (4.6).

The future of Mental Health Services

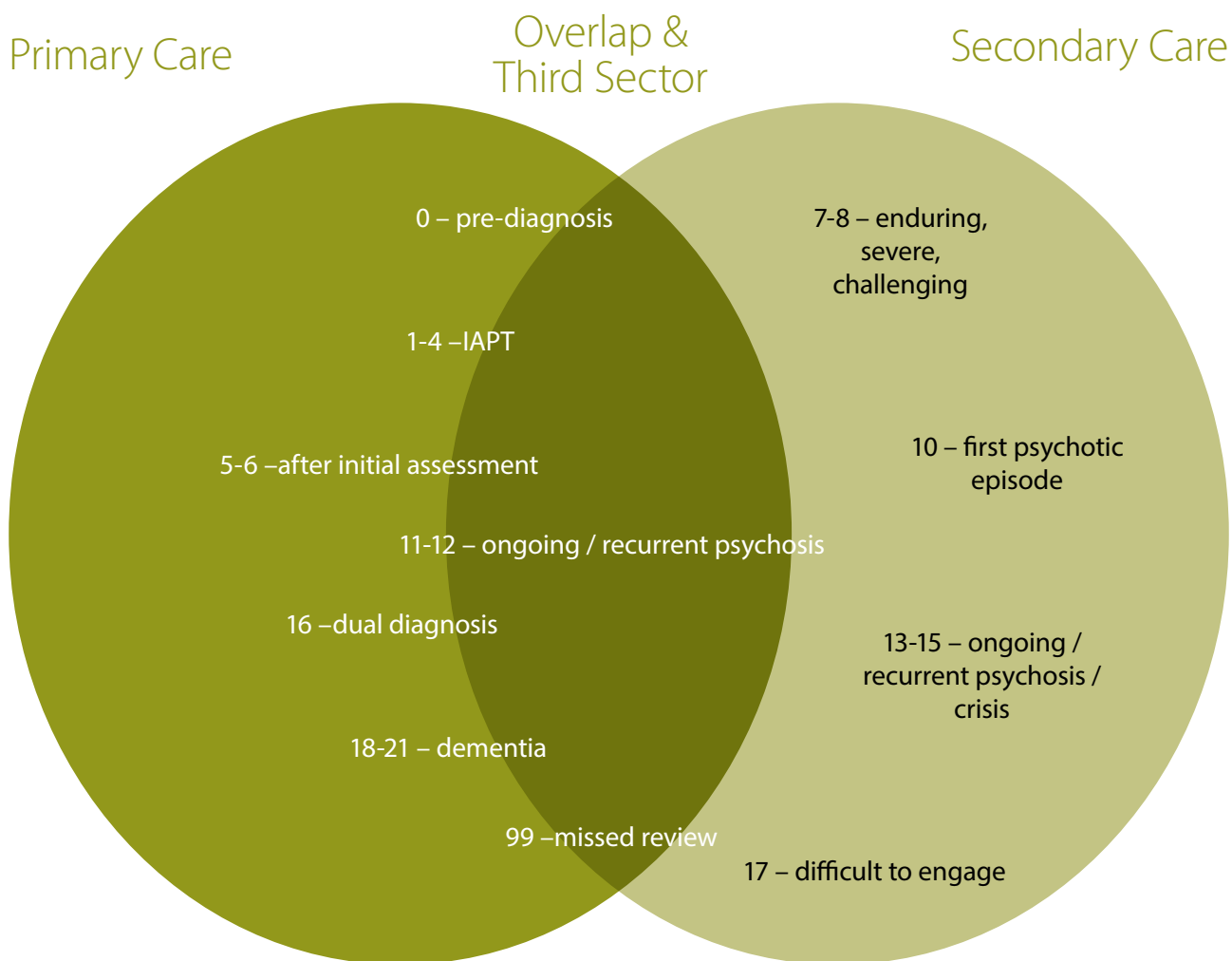
For most mental illnesses, a stepped-care model of service that provides the least intrusive and most effective intervention first is preferred. Services should provide integrated care across both primary and secondary care services that minimises the need for transition between different services or providers, are built around the best pathway for patients, and are clearly linked to other services (including those for physical healthcare needs). The voluntary sector should also be integrated into this model.

Kingston Mental Health Commissioners intend to adopt such an integrated approach. Figure 4 shows the proposed model of care for people at any stage of their illness. The diagram is based on mental health 'clusters'. Clusters categorise mental illness and a person's current needs. This figure is a pictorial representation of a local vision that much of mental illness can be managed in primary care with voluntary sector support and some specialist input from secondary care, whilst more complex, new or unstable severe mental illness is managed by secondary care. This will involve a shift in the way mental health care is currently provided in Kingston.

The patient and their family and carers remain at the centre of this model, and there will need to be good links to adult social care services, housing support, employment support, welfare and benefits support and other wellbeing support such as leisure and health improvement services (such as stop smoking and physical activity support) to provide a holistic package.

Figure 4: A proposed model of health care for people in each mental health cluster

Reproduced with permission of Dr Phil Moore, South West London Mental Health Lead and NHSCC Mental Health Commissioners Network Chair



Recommendations

1. A needs assessment for people with depression, those who are self-harming or suicidal should proceed as planned during 2015, and would contain a mapping of all services available locally and look into the variation in depression diagnosis rates in general practice
2. Commissioning by health and social care should take a holistic view along the whole journey of mental wellbeing through to mental illness, encompassing prevention as well as treatment services
3. Kingston CCG and the Council's Public Health Commissioners should closely monitor the Kingston Wellbeing Service as it makes improvements towards its targets
4. Commissioners should require the CMHS to provide more meaningful performance and activity data
5. Sustainable ways of involving people with mental health problems in service design should be further developed, building on the new Mental Health Parliament, and the representation of patients and carers on the Mental Health Planning Board
6. The redesign of CMHS must ensure the recommended qualified clinical staff: patient ratios are in place

Case Study 2:

Life with mental illness

Written by a carer about his adult son

When my son reached his teenage years he changed from being a friendly, outgoing, social, sports-loving boy to one who became very withdrawn. He lost contact with friends and interest in social activities. We initially thought this was teenage angst but eventually contacted our GP, who personally knew our son. Our GP suggested that smoking pot was quite widespread amongst the boys of that school, and that could be a contributory factor.

Although probably quite unwell at the time, he subsequently obtained a degree in English. As an indication of his problems, he declined to attend the graduation ceremony. On his return home after University, his problems included being very reclusive with low motivation.

His GP made a diagnosis of psychosis. Subsequently two Psychiatrists endorsed the GP's diagnosis, but during this stressful time there were long delays and silences with no contact from anyone, problems with mislaid correspondence between the professionals, and a junior Psychiatrist doubting the diagnosis. Meanwhile, our son's condition was deteriorating. More reclusive. Little or no communication and eating little.

Eventually a Consultant Psychiatrist said our son would have to be sectioned. However, very soon after admission, a tribunal upheld his appeal against the section, and he returned home with no obligation to take medication. Another section was organised, but the ambulance was delayed and our son took advantage of the situation and left by the back door. He was subsequently taken to Tolworth Hospital again, very distressed at events. Various medication was tried and eventually clozapine prescribed.

After some weeks in hospital and then some time at Rose Lodge, he was allocated a flat in a refurbished house. He was initially visited every day by his care worker to ensure he took his medication and this worked well. These visits became weekly or occasional as he became compliant with his medication. The housing association tenancy was for one year, and he felt under considerable pressure from the housing department, as he was offered two flats which were semi-derelict and obviously not suitable for someone in his situation. After intervention by me, he was then offered a modern flat in central Kingston which although in poor order was repairable. He has lived in this flat now for two years.

He has had several care workers, some of whom I think are part-time temporary staff. He would probably prefer no contact, but agrees to see his care worker at Tolworth once a fortnight for about 15 to 20 minutes. She did occasionally visit him at home and meet up with him in town, both of which worked well, but unfortunately that doesn't happen anymore.

He did have six monthly reviews with his Psychiatrist at Tolworth which we as a family were invited to, and these were very helpful for jointly managing his care. These have become less frequent over time, presumably because his illness is more stable. I gather that he now has a new psychiatrist, but I don't know the name. I don't need to contact his care worker often, but find it quite difficult to do so as they are busy and calls seem always to go to voicemail and I don't always receive a reply. More reliable ways of contacting professionals would really help my son, and me as carer.

Case Study 3:

Housing Needs of People with Mental Health Problems

Paul Kingsley, Project Manager Strategic Housing, Kingston Council

People with mental health needs are often hidden from the view of Housing Services. Even where known to Housing Services, the mental health dimension has traditionally not been as well integrated into housing working practices as it could have been.

As part of the 'One Kingston' suite of projects during 2013-14, Housing Services led a wide-ranging cross-departmental strategic review of older and vulnerable peoples' housing, which included those with mental health needs.

The Council has records of 553 people aged 16 to 64 receiving services for their mental health need, and an additional 135 general council housing households logged with a mental health need, but Housing services come into contact with far more people with mental health needs than are formally identified.

Consultation with people who have mental health needs

The project's consultation team carried out 17 one to one interviews with people with mental health needs. They were identified through general needs housing tenancy records, the Housing Resettlement team, Mind in Kingston, the Kingston YMCA and others. Interviews were held in the Mind café.

The participants were from a range of ethnic origins and their ages ranged from 27 to 63. There were more men than women (ratio of three to two). Key findings concerning these adults with mental health needs were:

- Respondents were mostly single people and lived on their own
- Most common conditions amongst the respondents were depression and anxiety
- Most of the respondents also had physical health problems
- Around half of the respondents were current or past illegal substance users
- Common reasons for moving to present addresses were facing homelessness, after being discharged from hospital and due to health reasons
- Those seeking to move and those content to stay in present accommodation were about evenly divided; the same applied to hostel residents as a group
- Interviewees emphasised the importance of emotional support. Nearly all respondents were getting some form of professional support

Current support and future plans

Housing Services' contribution to the recovery and wellbeing of vulnerable adults currently consists of providing:

- Suitable housing advice
- Access to council housing, or other suitable accommodation, for those with a priority need for accommodation
- Access to disabled adaptations (using the Disabled Facilities Grant, or 'DFG')
- Access to housing-related support (such as resettlement or short term support)

The strategic review resulted in a comprehensive action plan, and those actions most relevant to people with mental health needs are:

- As part of integrated preventative support, the Council's Adult Social Care directorate and Kingston CCG will commission peripatetic housing advice and support services for patients moving towards discharge from hospital, and as they move on to stable accommodation
- Housing advisors and others in the Council and third sector providing gateways into housing services will receive additional training in the detection and management of mental health issues
- The Vulnerable Adults housing plan (as part of the Housing Strategy) will be developed to incorporate other key vulnerable groups, e.g. drug and alcohol misusers, homeless people and victims of domestic violence
- The short term proposals to use one partially decanted sheltered scheme for Mental Health clients will be taken forward
- Housing Development, Adult Social Care and Kingston CCG will meet at least twice yearly to review long term projects and ensure that the needs of vulnerable adults and children are represented in the Council's housing development programme

Case study 4:

Mind in Kingston – services, support and activities

Joanne Chinnery, Chief Executive

Service User Involvement Services

Patient's Council meetings, café meetings, house meetings and ward discussion forums are channels through which service users can be included in the decision-making process both in the community and on secure wards.

Our Service User Involvement Worker sits on a variety of panels in the borough. We encourage service users to be involved in this process and offer support. We encourage service user led involvement such as the annual art and music festival and the Kingston Mental Health Parliament. The service user involvement officer makes these opportunities a reality for local people.

Small Grants Fund

This provides small grants for people who may need money to purchase items to improve their quality of life.

Telephone line

Based at our offices in Kingston this acts as a 'sign posting service' to specialist organisations/groups. It is often used for isolated individuals to feel listened to as well.

Counselling service

This offers a face to face assessment session plus 12 weekly sessions, each lasting 50 minutes. The sessions take place at the Noble Centre in New Malden between 6pm and 9pm. The counselling service benefits people with mild to medium mental health issues such as depression, anxiety, work related stress, low self-esteem and low self-confidence. At the end of the 12 weeks people will gain a better self-awareness which will enhance self-confidence and improve wellbeing.

Supporting People

Our Supporting People service supports individuals to live independently in the community. This comprises a number of different options including shared homes and individual accommodation. Our partners are registered social landlords.

Acute Recreation Project

Mind in Kingston provides recreational activities on the wards at Tolworth Hospital on Tuesday and Thursday evenings when staffing levels are lower and there is less structured activity available.

Drop-in Cafes

We have two drop-in cafes, the Bridge and the Star. They offer subsidized meals, low level support and promote social inclusion. The cafes are open in the evening and at weekends when other non-crisis services are closed. We have introduced more activity based sessions such as drama, art, music, mini Olympics, barbecue and film nights. There is access to free internet and daily newspapers.

In recent years we have introduced 'Wellbeing Wednesdays'. This is a rolling programme of workshops such as anxiety management, feel the fear and do it anyway, nutrition, mindfulness, anger management, Art Therapy etc. These courses are designed for people who cannot access daytime services or do not meet statutory services criteria. There are charges for this service which we aim to keep to a minimum. We have a service agreement with Balance C.I.C which is an employment specialist for people experiencing mental health problems so that their clients can access some of the courses for free.

Due to the success of Wellbeing Wednesday we have introduced a similar evening on Tuesdays.

Peer led groups

This enables service users to run a group where they have a particular interest like photography or sewing. This is a new venture and started in March 2014.

Outreach Information Stall

The stall is set up at various locations in the borough and distributes booklets to the public. We attend spring and summer fairs, local health and well-being events and have recently targeted the borough's libraries and other community groups.

Mid Siren Music Band

The group has had a number of changes to management but it is now solely run by Mind in Kingston (MiK) with a volunteer from MiK and one from RISE (the Recovery Initiative Social Enterprise). The band has played gigs at the MiK Art and Music Festival and various other Mind functions such as events at the cafes.

Mind United Football Team

The football team is affiliated to Surrey Football Association. We currently play in the Surrey community league which is run by Woking FC. We train twice a week and have away matches and leagues across England and Europe. This also offers the ability to train as a referee, coach or manager.

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4.3 Dementia and Mental Illness in Older Age

Dr Helen Raison, Consultant in Public Health, Kingston Council
John Levy, Mental Health Commissioning Manager, Kingston CCG on behalf of the Transformation of Services for Older Peoples Mental Health Group

Key messages

- The number of people with dementia is rising. There are approximately 1,600 people with dementia living in Kingston borough and this number is expected to rise to over 1,800 by the year 2020. The number of people with dementia who are looked after by Kingston GPs is higher (1,826) because people from outside Kingston borough are registered with Kingston GPs and this number is also rising
- Depression affects an estimated 5,650 older residents in Kingston. Depression is often overlooked, with only one in six older people ever discussing depression with their GP and, of those, only half being diagnosed and treated
- Anxiety is common in older people. Between 1,900 and 4,600 of older residents in Kingston have some symptoms of anxiety
- There is a need for the transformation of services to improve dementia care, and to appropriately manage the levels of need from the rising number of people with dementia. The evidence points to the need for services to be closer to the patient, but still maintain specialist input
- Dementia friendly communities aim to improve understanding of dementia, take away any stigma and help us understand that something can be done for people with memory problems
- People in Kingston are signing up as a Dementia Friend and Kingston organisations can sign the Dementia Friendly Pledge. The Kingston Dementia Action Alliance aims to bring organisations together to improve the lives of people with dementia

Introduction

Ageing may be accompanied by a sense of wellbeing and good health, but there are a significant number of older people affected by a mental health problem. Some people will grow old with conditions that started earlier in life such as anxiety, schizophrenia and bipolar disorder. Others will develop symptoms in later life, particularly dementia, but also depression.

Last year's Public Health Annual Report contained a chapter on older people and mental health. This year we look at the local prevalence of the main mental illnesses in older age, and focus on the local action being taken on dementia. Dementia is a priority both nationally¹ and locally in Kingston.

Local Picture

The number of people aged 65 and over with dementia or mental health problems is expected to rise as the population grows.

Dementia

Dementia is a syndrome where there is progressive functional decline in memory, reasoning, communication skills and the ability to carry out daily activities. Individuals may also develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering. These symptoms cause problems in themselves, complicate care, and can occur at any stage of the illness.

There are several types of dementia: Alzheimer's disease (60% of all cases in people aged over 65) and vascular dementia (15% to 25% of all cases in people over 65) are the most common.

Dementia mainly, but not exclusively, affects older people although it is most definitely not an inevitable part of ageing. There are approximately 1,600 residents with dementia (diagnosed and undiagnosed) in Kingston and this number is expected to rise to over 1,800 by 2020. There are more people registered with Kingston GPs than live in the borough, and that means that the estimated number of people with dementia (diagnosed and undiagnosed) who are registered with GPs in Kingston is already 1,826 (year 2013-14), and will rise to 1,900 by 2015 – 16 (see Table 1).

The prevalence of dementia is much higher amongst older adults with learning disabilities (21.6%) compared to the general population (5.7%)².

The prevalence of diagnosed dementia varies between general practices (see Figure 1), and this is due to both the demographic makeup of the registered population and the diagnostic rate within each practice.

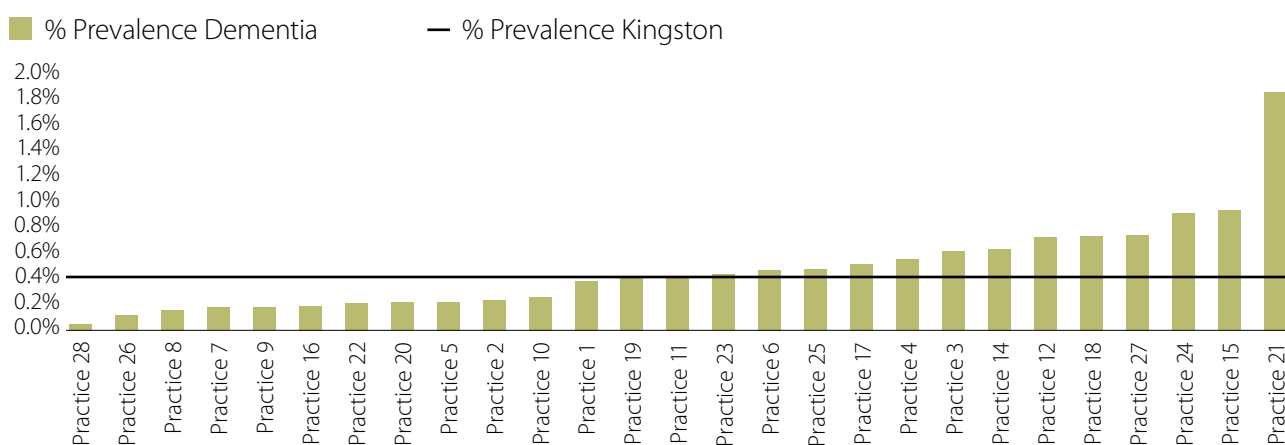
In 2013 it was estimated that only 40% of people in Kingston with dementia had received a diagnosis, which is much lower than many other parts of England. New treatments and integrated support services can result in a better quality of life for those who have been diagnosed.

Table 1: Number of patients registered with Kingston GPs predicted to have dementia (Kingston Clinical Commissioning Group population)

Year	2011 – 12	2013 – 14	2014 – 15	2015 – 16
Number of people with dementia	1,786	1,826	1,864	1,902

Source: NHS Dementia Prevalence Toolkit. Based on GP patient list sizes (this calculator is temporarily offline and new trajectories will be available in late 2014).

Figure 1: The prevalence of dementia (%) in GP Practices in Kingston, persons, all ages, March 2014



Source: Practice Focus Report, QMS, March 2014

Preventing Dementia

Vascular dementia is caused by vascular disease and accounts for 27% of dementias. The risk of vascular dementia can be reduced by healthy lifestyle measures such as physical activity and stopping smoking, and by managing conditions such as high blood pressure.

Depression in older people

Depression affects one in five people over the age of 65 years living in the community and two in five living in care homes³. A third of people who provide unpaid care for an older person with dementia have depression. Up to 70% of new cases of depression in older people are related to poor physical health (see Chapter 5.1). Depression is often overlooked, with only one in six older people ever discussing depression with their GP and, of those, only half being diagnosed and treated. There is a tendency for older people to be treated with antidepressants rather than with psychological therapies, which can be just as

effective and do not have the side effects that can be associated with medication.

In 2012, there were an estimated 5,650 older people in the Royal Borough of Kingston with depressive symptoms (590 of whom would be expected to have severe depression), and this is predicted to rise to nearly 6,000 by the year 2020⁴.

Anxiety in older people

Anxiety is a feeling of unease, such as worry or fear. Anxiety often overlaps with the symptoms of depression. Between 1,900 and 4,600 (10% to 24%)⁵ of older people living in the community in the Royal Borough of Kingston have some symptoms of anxiety. A smaller number, between 380 and 760 (2% to 4%), of older residents will have symptoms severe enough to be diagnosed, usually as generalised anxiety disorder. The prevalence of anxiety among older people living in care homes is 6% to 30% (1,150 – 7,500 older people locally).

Delirium in older people

Delirium is confused thinking and disorientation, usually of sudden onset. It is caused by underlying medical conditions, most commonly infection, and it resolves with the appropriate treatment of the underlying condition. The reporting of delirium is very poor so it is not possible to provide an estimate of the number of local people with delirium.

Psychotic disorder in older people

About 190 (1%) of over 65 year olds in the community in Kingston will have a diagnosed psychotic disorder.

Approximately 95 of these (0.5% of all older people) have schizophrenia. Whilst the majority are pre-existing problems persisting into later life, some schizophrenia-like disorders arise for the first time in older age, particularly in some minority ethnic groups⁶.

The distinction between schizophrenia and dementia is important in older adults because of the risks associated with treatment, for instance some anti-psychotic medication can have severe side effects in people with Alzheimer's disease⁷.

Local Action on dementia

Box 1 sets out how Kingston is responding to the national policy 'Improving Care for People with Dementia'⁸

Box 1: How Kingston is responding to the four key areas of the national policy: Improving Care for People with Dementia

1. Increasing Diagnosis Rates

- Two GP Dementia Champions in Kingston are working with GPs to discuss earlier diagnosis, make sure doctors give information about memory services and refer people for assessment if needed
- Kingston CCG and the Council have started to work with partners to look at new ways of delivering care to people with dementia, including memory services

2. Adapting Health and Care services

- Kingston Hospital has committed to becoming dementia-friendly, and has won an award for its work on dementia (please see the case study)
- A national website summarising local services is being developed so people can have a better understanding of services in Kingston
- Kingston CCG and the Council are looking at transforming dementia care
- Many Kingston care homes and services are signing up to the Dementia Care and Support Compact, which sets out new standards for dementia care
- Kingston health and care services are adapting wards and care homes for dementia patients
- A range of dementia training resources are available for health and care professionals
- The Council and Kingston CCG fund breaks for carers of people with dementia

3. Building Dementia-friendly communities

Dementia friendly communities aim to improve understanding of dementia, take away any stigma and help us understand that something can be done for people with memory problems.

- People in Kingston are signing up as a dementia friend through the dedicated website www.dementiafriends.org.uk or by taking part in local training sessions
- Kingston organisations can sign the dementia friendly pledge
- The Kingston Dementia Action Alliance was launched in May 2014 and aims to bring organisations together to improve the lives of people with dementia

4. Supporting Dementia research

- Kingston will benefit from the increase in the Government's annual funding for dementia research
- South West London and St George's Mental Health Trust has an extensive research programme, including the evaluation of memory service models, attitudes of general hospital doctors to patients with mental illness, and mindfulness in cognitive impairment and dementia

Transformation of health and care services for people with dementia and memory problems

Currently GPs care for people with memory problems but refer to the Kingston Older Peoples Mental Health Service (provided by South West London and St George's Mental Health Trust) for more specialist input.

Kingston Hospital and Your Healthcare both care for large numbers of people with dementia who may also have other physical problems. Adult Social Care teams also provide care for people with dementia and the Amy Woodgate Specialist Resource Centre provides specialist residential and day services.

Kingston CCG and the Council fund other organisations to provide some dementia care, for example the Dementia Care Advisor at the Alzheimer's Society, sometimes utilising short term funding.

The need for a transformation of services for people with dementia has been recognised in a national drive to improve dementia care, and to appropriately manage the increasing levels of need from the rising number of people with dementia.

A working group from Kingston CCG, the Council's Adult Social Care team and Public Health has begun to explore the case for change to services for people with dementia and memory problems of any age, and will work with patients, the public, carers and professionals to design a new model of services. The evidence points to the need for services to be closer to the patient, but still maintain specialist input. Dementia services will need to dovetail with care provided for other mental health problems of older age, such as psychosis and depression.

The voluntary sector and other organisations working with people who have dementia

The voluntary sector plays a major role supporting many people with dementia. During 2013-14, the Alzheimer's Society provided a dementia care advisor, dementia support worker, a support group for carers, the Carers Information and Support programme (CriSP), Singing for the Brain (singing groups to bring people together in a stimulating environment) and has published a comprehensive guide called 'The dementia guide – living well after diagnosis', containing both national and local information.

StayWell (previously Age Concern Kingston Upon Thames) provides a range of services to support people with dementia including a navigator service and the Dementia Saturday Club.

Home Instead is an organisation providing care services to people with dementia. They also run the Memory Cafe at the Rose Theatre.

Stay Well, Kingston Hospital, The Alzheimer's Society and Home Instead are all members of the working group 'Dementia at Home' who work together to provide a range of services supporting people with dementia, their carers and their family. Other organisations such as the Council work closely with the Dementia at Home group. These same organisations are the founding members of Kingston Dementia Action Alliance launched earlier this year.

More information on carers and carer support can be found in Chapter 4.6.

Depression and older people

The IAPT service has started working with GPs to promote referral of older people with depression and anxiety. The service reports activity by age group to enable progress to be tracked.

Recommendations

1. Kingston should work towards being a dementia friendly community, both through the work of the Dementia Action Alliance, and other initiatives. Kingston CCG and the Council should encourage staff to become dementia friends and promote this to their commissioned service providers
2. Broader support services for people with dementia, such as those provided by the voluntary sector, should be fully considered in the transformation work being led by Kingston CCG and the Council. The other mental health needs of patients with dementia should also be addressed during transformation work
3. The under-diagnosis of depression in older people should be addressed

Case study 1:

Kingston Hospital's Dementia Strategy

Duncan Burton, Director of Nursing and Patient Experience

Kingston Hospital has been nationally recognised for its work to transform the care provided to patients with dementia at the Patient Safety and Care Awards in July 2014.

The Hospital is currently implementing its first three year dementia strategy, which was developed with patients, carers, staff, voluntary and community groups. A number of initiatives have already been introduced to improve the experience of patients with dementia including the introduction of the 'Forget-Me-Not' scheme, where all inpatients with dementia have a forget-me-not flower symbol above their beds and on the ward patient information board. Patients with dementia who come into accident and emergency are given a blue bracelet to wear to ensure they are easily recognisable to accident and emergency staff. The hospital has recruited 100 dementia champions across the organisation, provides additional support to help with eating and daily activity sessions for patients and adapted the Friends and Family Test to identify patients with dementia and their carers and using the feedback from the test to make changes to the care and services provided.

Kingston and Richmond have one of the highest life expectancies in England and, as a result, nearly half of Kingston Hospital patients over 75 have dementia, which is double the national average. The hospital has had to completely rethink the way that patients with dementia are cared for and has worked closely with patients, families, carers, staff, health and social care providers and the voluntary sector to do this. Patients with dementia often have complex and multiple needs and being in hospital can be very unsettling and, for some, a frightening experience.



The Dementia Strategy was agreed by the Trust Board at the end of January 2014 and has five key themes:

1. Early diagnosis, excellent clinical treatment and care – ensuring we diagnose dementia and delirium at the right time, in the right place and provide the right support afterwards.
2. Positive relationships of care – ensuring we have a culture of excellent compassionate care provided by staff who are confident in their roles to deliver this.
3. Involved and supported carers – ensuring a culture that always involves and engages carers as partners in care, where carers are actively welcomed and invited into this role and their changing needs are actively addressed
4. Active days and calm nights – enabling patients to maintain their rituals and routines despite being in hospital and supporting patients to engage in meaningful activities to encourage social engagement, maintenance of function and recovery
5. Environments of care – creating a truly dementia friendly hospital site with secure, safe, homely and comfortable social and therapeutic environments that facilitate all types of functioning

References

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4.4 Self Harm

Dr Helen Raison, Consultant in Public Health, Kingston Council

Key messages

- Self harm is the intentional act of self poisoning or self injury usually as a reaction to severe distress or as a distraction from intolerable situations
- Self harm across the UK is rising and is more common in women than men. Rates of hospitalisation for self harm in Kingston are low, but much self harm remains hidden
- The rate of self harm in Kingston resulting in a hospital admission is highest in 15 to 19 year olds
- Most people who self harm have no suicidal intentions at all, but at least half of people who take their own life have a history of self harm, and one in four have been treated in hospital for self harm in the preceding year
- A needs assessment on depression, self harm and suicide in Kingston will begin in Autumn 2014 and report in 2015. It will look at how the recommendations for preventing self harm in the national strategy 'Preventing Suicide in England' have been implemented in Kingston

Introduction

Self harm is the intentional act of self-poisoning or self-injury, and is poorly understood in our society. People may intentionally harm themselves to reduce internal tension, to distract themselves from intolerable situations, as a reaction to distress or other difficult feelings, or to punish themselves.

The incidence of self harm has risen in the UK over the past 20 years¹. Self harm is one of the top five causes of emergency admissions to hospital and those who self harm have a one in six chance of a repeat attendance for self harm at accident and emergency within the year². Many people who self harm do not go to hospital at all, and so are not included in NHS statistics.

People who attend hospital or other health services for treatment of their injuries or overdose often describe the experience as difficult, with staff appearing to lack understanding or displaying

negative attitudes³. The risk of death by suicide is much higher in people who have a history of self harm and the approach taken by all professionals as well as wider society is very important.

Self harm is more common in women and girls than in men and boys. People of all ages may harm themselves although in the UK there has been a rise in young people harming themselves. There is a high incidence of self harm in some vulnerable groups: prisoners, asylum seekers, veterans from the armed forces, people bereaved by suicide, some cultural minority groups and people from sexual minorities¹.

Most people who self harm have no suicidal intentions at all, but there are a proportion of people with self harming behaviour who go on to attempt suicide. At least half of people who take their own life have a history of self harm, and one in four have been treated in hospital for self harm in the preceding year.

Intervention in people who self harm is a priority in the national strategy 'Preventing Suicide in England'³. The National Patient Safety Agency (NPSA) has produced guidance⁴ on improving the care and follow-up of people who attend accident and emergency for self harm or suicide attempts and for people identified by GPs as having an increased risk of self harm or suicide. NICE has also produced guidance^{5,6} (Box 1). In addition the NPSA has produced a toolkit for services to measure how well they are meeting best practice on suicide prevention⁴.

Box 1: NICE recommendations for helping people who persistently self harm include:

- Professionals should develop trusting, supportive and engaging relationships
- Undertake a psychological assessment of needs, including coping strategies and family support
- Undertake risk assessments including suicide risk, risk of further harm, and safeguarding issues
- Establish an agreed and regularly reviewed care plan

Local Picture

Most people who self harm do not attend services such as hospital or GPs, making it difficult to gauge the true prevalence of self harm.

Admission to acute hospitals for self harm

Kingston residents have a low rate of hospital admissions due to self harm compared to London and England (the directly standardised rates are Kingston 66 per 100,000 resident population, London 125 per 100,000 and England 212 per 100,000)⁷.

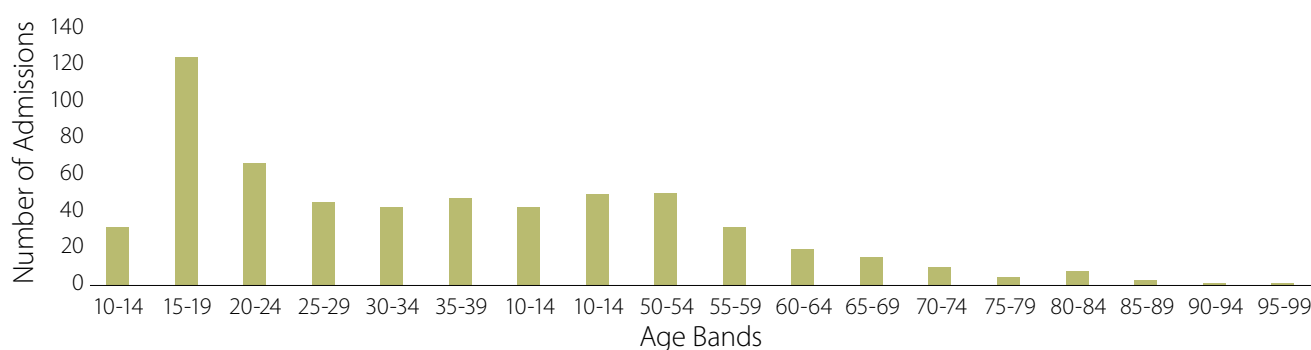
Between 2010 and 2013 there was an average of 171 admissions per year to Kingston Hospital for self harm. Four fifths of these admissions are people who live in Kingston and the rest are from surrounding boroughs.

The numbers fluctuate slightly from year to year, but it should be remembered that the majority of people who self harm do not present at hospital at all.

By far the most common cause of admission for self harm is due to poisoning with medicines (85%, of which over half were painkillers), followed by narcotic and hallucinogenic drugs (7%), and injury by a sharp object (3.5%).

Young people aged 15 to 19 years old have the highest number of admissions into Kingston Hospital for self harm followed by those aged 20 to 24 years (Figure 1). A larger number of working age adults are admitted compared to older people, but this reflects the demographic makeup of the population.

Figure 1: Admissions for self harm at Kingston Hospital 2011 to 2014, by age groups, all admissions



Source: Kingston Hospital Trust

Attendances or admissions to other services for self harm, such as the mental health trust, the psychological therapies service or General Practice are not available for this report, but should be sought in the future in order to build a better picture of self harm in Kingston.

Kingston Samaritans receive nearly 43,000 contacts a year from both Kingston residents and other people routed to their phone number or email address. These are made up of 20,692 calls where there is a conversation with the person who has called, plus a further 17,734 calls where the caller hangs up before speaking (known as a 'snap'), and 4,401 emails and SMS messages. Anecdotally a considerable number of calls are from people who are threatening to, or have already, self harmed. Whilst not all these contacts are from local people, it provides some evidence of the level of need in Kingston.

Local Action

Kingston Hospital

An audit on self harm in children and young people presenting to Kingston accident and emergency was undertaken on behalf of the Local Safeguarding Children's Board (LSCB). The results were as follows:

- Kingston Hospital has been liaising appropriately with partner agencies and providing good care to young people who present with self harm
- Child and Adolescent Mental Health Service (CAMHS) and school nursing services are providing proactive follow up support, but the latter only for young people attending school in Kingston
- The support provided by GPs once the young person has been discharged from hospital was variable

Changes to be implemented are:

- All children who reside in Kingston who attend Kingston Hospital Accident and Emergency department with deliberate self harm will be reported back to the SPA (Single Point of Access). The SPA is a central information hub comprised of safeguarding support assistants, health visitors, social workers and a service co-ordinator. They record information, facilitate appropriate referrals, and ensure the common assessment framework has been completed
- The CAMHS services to provide a timely discharge letter to the GP following intervention from the service
- GPs to ensure that there are systems in place to proactively follow up children and young people who have self harmed

South West London and St Georges Mental Health Trust

People who self harm are fully assessed in accordance with the Trust's suicide prevention strategy.

Every 18 to 24 months the Trust runs a Liaison Psychiatry study day for staff from all three local acute trusts – the last one was in Kingston Hospital and that training day included a session on self harm.

All qualified clinicians in the Trust attend RATE training (Risk Assessment Training and Education) which uses video for participants to practise assessment and get feedback from experienced clinicians.

Liaison Psychiatry

In Kingston Hospital the Liaison Psychiatry team see up to 200 people per month, 50% of whom have self harmed. Every patient is seen for a detailed psychosocial assessment.

Young People's Health Link workers

Young People's Health Link workers discuss self harm during Youth Mental Health First Aid courses delivered in schools. They are also able to assist schools with their lesson planning on self harm.

Voluntary sector

Local voluntary sector organisations raise awareness and support people who have self harmed, or are threatening to do so. These organisations include Mind and The Samaritans (the latter provide outreach to schools and other organisations). More details on the Samaritans can be found in Chapter 5.5.

Needs assessment on depression, self harm and suicide

A needs assessment on depression, self harm and suicide was chosen locally as a high priority for 2014-15, and will be led by the Council's Public Health team. The needs assessment will look in more detail at data and trends in self harm. It will assess how Kingston has responded to the recommendations on self harm in the national suicide strategy, and at the response of the health service to the NICE Clinical Guidelines on Self Harm, including the number of people who attended accident and emergency for self harm that received a psychological assessment. It will map all treatment, prevention and awareness raising work across organisations and communities and also assess whether the national consensus statement on information sharing and suicide prevention has been promoted and enacted locally.

Recommendations

1. The Council's Public Health directorate should work with health commissioners, local services and the voluntary sector to undertake a comprehensive needs assessment on depression, self harm and suicide. It is anticipated this will summarise available information on the topic and review Kingston's progress in responding to best practice guidance
2. Progress the actions agreed following the audit on self harm in children and young people presenting to Kingston accident and emergency, undertaken on behalf of the Local Safeguarding Children's Board (LSCB)

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4.5 Suicide

Dr Preya Patel, GP Registrar, Kingston Council

Dr Helen Raison, Consultant in Public Health, Kingston Council

Sundus Hashim, Associate Director of Public Health, Kingston Council

Key messages

- Suicide is a devastating event. There were 21 suicides among Kingston residents between 2011 and 2013
- Most of these took place in people's own homes. The most commonly used methods were hanging and self poisoning
- Preventive work is undertaken by a range of organisations including The Samaritans and South West London and St George's Mental Health Trust
- The six key actions set out in the national strategy Preventing Suicide in England offer a framework for a coordinated approach to prevention in Kingston

Introduction

Suicide is a major issue for society and a significant cause of years of life lost¹. In England, one person dies every two hours as a result of suicide. When someone takes their own life, the effect on their family and friends is devastating. Many others involved in providing support and care, as well as any witnesses, will feel the impact. However, suicides are not inevitable; there are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.

The national strategy for preventing suicide in England identifies the following groups as at higher risk of suicide: young and middle-aged men, people in the care of mental health services including inpatients, people with a history of self harm, people in contact with the criminal justice system and specific occupational groups such as doctors, nurses, veterinary workers, farmers and agricultural workers¹.

Other factors may also trigger someone to make a suicide attempt such as chronic pain, alcohol or drug misuse and very stressful life events. For many people, it is the combination of factors which is important rather than one single factor. Stigma, prejudice, harassment and bullying can all contribute to increasing an individual's vulnerability to suicide.

This report demonstrates the rates of suicides in residents of Kingston and describes work that is already ongoing, together with suggestions for other action that can be taken to prevent suicide.

Local Picture

The data allowing us to compare suicide rates with the rest of the country is based on local residents. The suicide rate for Kingston residents in 2010-12 was 7.7 per 100,000 people which is lower than the London and England averages (8.9 and 10.3 per 100,000 people respectively), although the differences are not statistically significant.

There were more men committing suicide than women during both time periods in Kingston (as in both London and England as a whole), but the ratio of male to female suicides was lower in Kingston than in London and England. Whilst the suicide rate for Kingston residents has increased slightly over time, again it is not a significant finding as the numbers are so small. The data is provided in more detail in the Mental Health Profile (Chapter 6.1).

A rapid audit of the mortality files for Kingston was undertaken in summer 2014². Mortality files are confidentially held datasets containing details about deaths in a resident population over a given time period.

There were 21 cases of suicides and death by intentional harm among residents of Kingston between 2011 and 2013. There were a similar number each year, with a total of six in 2011, eight in 2012 and seven in 2013 (it may be that coroner's verdicts for some deaths in 2013 are not yet available and this number may rise).

The most common method of suicide in the borough between 2011 and 2013 was hanging or suspension with six of the 21 suicides (28.6%) occurring in this way. The next most common method of suicide was intentional self poisoning with one or more drugs. The types of drugs used are not clear in all instances, but in some cases they were a mixture of prescription and illicit drugs. Five of the 21 suicides (23.8%) occurred in this way. The majority of suicides (61.9%) took place in an individual's own home.

Residents from other boroughs may also take their own lives in Kingston. The full data on this is not available in time for this report. However, an overview of this is particularly relevant when identifying and targeting hotspot locations for suicides, and a more comprehensive picture of suicides including non-residents should be drawn up in the future.

Additional information may be recorded in coroners' reports, and for this reason the benefits of an audit of coroners' records should be assessed. The Coroner for Kingston also covers neighbouring boroughs such as Richmond, and combining this audit with neighbours should provide a more comprehensive picture of suicides.

Local Action

A number of organisations are undertaking activity relevant to suicide prevention.

As part of its prevention agenda, the Public Health directorate undertakes suicide audits and will work with other organisations on suicide prevention.

The Kingston outreach branch of the Samaritans is involved in three local initiatives:

1. A five year partnership is in place with Network Rail aimed at reducing the number of suicides on the railways by 20%. Kingston Samaritans work closely with local train stations, in particular Surbiton station, helping educate rail staff and to provide emotional support to people in distress at railway sites as well as to support rail staff and members of the public who have witnessed a fatality.
2. A scheme targeting young people, who are one of the most vulnerable groups in terms of suicide and self harm. Kingston Samaritans visit local schools and colleges to help young people recognise and deal with their feelings and issues related to suicide. Schools should be encouraged to take part in this scheme as it is a key prevention measure.
3. The Samaritans also provide a listener peer support scheme whereby they select, train and support prisoners to offer confidential emotional support to their fellow inmates who may be experiencing feeling of distress or despair, which may lead to suicide. The objectives of the scheme are to assist in reducing the number of self inflicted deaths, reducing self harm and helping to alleviate the feelings of those in distress. Whilst there are no prisons in Kingston, local residents who are in prison will benefit from this initiative.

The main provider of mental health services to Kingston residents, South West London and St George's Mental Health Trust, has a suicide prevention strategy³. The strategy focuses on:

- Providing appropriate levels of care
- Preventing inpatient suicides
- Post-hospital discharge prevention of suicides
- Family/carer contact
- Prescription of appropriate medication
- Co-morbidity/dual diagnosis management
- Post incident reviews
- Full staff training

Local Community Mental Health Teams have suicide prevention strategies for their at-risk service users. Healthcare professionals are able to offer extra support consisting of information, guidance and contact details for times of crisis.

Whilst there is activity across the borough, there is scope to improve the coordination of suicide prevention. The creation of a multi-organisation suicide prevention group should be considered. The group should use the National Suicide Prevention Strategy to guide its activities. See Box 1.

Box 1: Preventing suicide in Kingston: Six key actions based on the national suicide strategy¹

1. Reduce the risk of suicides in key risk groups
2. Tailor approaches to improve mental health in specific groups at high risk of suicide
3. Reduce access to the means of suicide (such as high buildings, firearms)
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

Recommendations

1. Consider the creation of a multi-organisational group for the prevention of suicide to decide on how to implement the recommendations of the national strategy, and to oversee progress
2. Explore other data sources of suicides and look at ways of combining mortality file audits with other boroughs
3. Assess the additional benefit that an audit of coroner's records would bring in providing a greater understanding of the patterns and trends in suicides

References

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4.6 Carers

Kirstie Cochrane – Carers Support and Service Development Coordinator, Kingston Council

Key messages

- Carers of people with mental health issues make up to 25% of the estimated six million carers in the UK
- 29% of young carers are caring for a family member with mental health needs
- Three out of five people will be a carer at some point in their life
- Full time carers are two and a half times more likely to be in poor health
- Two out of three people with dementia living in the community are dependent on a carer
- Two out of five carers receiving support from Kingston Carers' Network care for somebody with mental illness

Introduction

A carer is someone who provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help due to frailty, illness, disability, a mental health condition or substance misuse. The care they provide is unpaid. There are over six million people in the UK who provide care. In 2011 almost 1.3 million people in England and Wales were devoting their retirement to caring for ill partners, disabled adult sons or daughters or their own ageing parents, an increase of 35% in the last ten years¹. With an ageing population and people living longer with disability and ill-health, plus a general shift towards improved community based support to enable people with long term conditions to remain in their own homes, the number of family members and friends taking on a caring role is growing.





Kingston Carers on a trip to the London Eye

Although for many the experience can be rewarding, the consequences of caring can have detrimental effects:

- Those providing care over a long period of time are at particular risk of poor health. A carer's mental and physical health is more likely to deteriorate when they have been caring for a long period of time²
- 74% of carers surveyed struggled to pay essential bills and 52% said they were cutting back on food just to make ends meet³
- Carers are at increased risk of social isolation⁴
- Carers are more likely to have reduced life experiences, including employment and learning opportunities⁵

Focusing on how best services can work with carers of people with mental health problems, the Triangle of Care⁶ is a best practice guide that identifies the six key elements (standards) required to achieve better collaboration and partnership with carers in the service user and carer's journey through mental health services. It is built on the premise that achieving change depends upon staff becoming willing 'champions' for better partnership working and being able to challenge practice that excludes carers.

It also sets out the argument that better recognition that carers are key partners in the commissioning, planning and provision of mental health care makes sound economic sense.

Local Picture

The UK 2011 census reports that in Kingston 13,288 carers (8.3% of the population of Kingston) provide care for people with physical and mental disorders, mostly in their own homes. The Mental Health Profile in Chapter 6.1 contains more data on carers.

Kingston data from South West London and St George's Mental Health Trust (SWLSTG) reveals that 31% of people with mental illness on the Care Programme Approach had an identified carer with an average of 278 carers in 2013-14 being known to the Community Mental Health Teams (CMHT). Over half were invited to have their own needs assessed and 39% accepted the offer.

Out of the 1,600 carers known to Kingston Carers' Network (KCN), 514 are caring for someone with a mental illness: 160 adults are caring for someone with dementia, another 240 adults are caring for someone

with a mental illness and 114 young carers are caring for a parent with mental health issues. The impact on young carers of caring for a parent with mental illness can include lower educational attainment, poorer mental and physical health, poverty and difficulties in transition to adulthood. However, with appropriate support, these negative outcomes can be addressed.

Many people providing care to a relative or friend may not require any additional help. This could be because they are only providing low levels of support, they may already have their own support networks or they may be in good health and manage the care well. However, many people who would benefit from services and support do not access it as:

- They may not recognise themselves as carers
- They may not know that support is available
- They may not know where to go to obtain information and advice
- They may be reluctant to ask for help

With only about 1,600 carers in touch with either social services or Kingston Carers' Network (a local voluntary organisation dedicated to supporting carers) one of the largest challenges locally is to raise awareness about who is a carer, their rights and welfare entitlements, and the range of services and support available to assist them.



A Kingston carer with her granddaughter

Local Action

A range of mechanisms exist to support carers locally, including:

- Finding out what carers need through an assessment undertaken by health and social care staff
- Replacement care (relief care) to enable carers to take a break
- Flexible breaks direct payments for carers on a low income to enable them to take breaks of their choice
- Carers Emergency Alert Scheme for carers to register on to raise an alert in case they are involved in an accident or other emergency situation
- A dementia adviser post providing first line information and advice to individuals/carers/family members
- Carers Information and Support Programme (CrISP) sessions for carers of people with dementia
- Dementia signposting and hospital in-reach Navigator Support Service providing signposting support through a dedicated contact number to individuals/carers/family members. The Navigator initially contacts the individual or carer on the ward. The Navigator can offer further assistance if needed to identify appropriate support services including universal services, social activities and practical services
- A dedicated mental health carers worker based at Kingston Carers' Network who provide monthly outreach advice sessions held at Tolworth Hospital
- Young Carers Project providing a range of activities
- Carers Champions aligned to the mental health wards and within the CMHTs.
- Emotional support from peer groups, such as the Mental Health Carers' Support Group, Memory Cafe, Saturday Club and Dementia Carers Group
- Carer Led Mental Health Carers Forum.
- Representation on the Carers Board (a multi agency partnership based to address carers issues and influence policy, practice and shape change.)
- Caring Matters Scheme, a collection of books about carers and caring at Kingston Library – 23 specifically for carers of people with dementia. These books are also accessible through the borough libraries.
- Counselling for carers
- Ways for carers to look after themselves, such as back care training, relaxation techniques and fitness sessions

- Maximising income through benefit checks, benefit applications, including assistance at appeals and tribunals or advice and support into employment where possible
- Help to complete lasting power of attorney and deputyship applications
- Time out through activities, outings and learning opportunities

For further information on any of the above, please contact Kirstie Cochrane on **020 8547 6124** or **kirstie.cochrane@kingston.gov.uk**

Carers will sit, along with users, on the newly formed Kingston Mental Health Planning Board. The main provider of mental health services, South West London St Georges Mental Health Trust, has made some progress with carer involvement over the past year and a carer representative sits on the Clinical Quality Review Group for the Trust.

Recommendations

1. Introduce the 'Triangle of Care' (a therapeutic alliance between service user, staff member and carer that promotes safety, supports recovery and sustains well being) across Mental Health Services in the borough. This will be piloted on local wards and by the Early Intervention service
2. SWLSTG Mental Health Trust to introduce a weekly drop in for carers at Tolworth Hospital, and look to embed carer specific workers into mental health teams
3. Continue to improve practice by training mental health staff in identifying, recording and involving carers in practice
4. Improve recognition and support for carers by primary health care professionals
5. Continue resource provision to enable voluntary organisations to support carers
6. Ensure services do not assume that carers are able and/or willing to take on or continue caring – they should be given a choice
7. Mechanisms should be in place to share examples of best practice in involving, consulting and supporting carers so that learning can be applied across local statutory, private and voluntary organisations

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A Kingston carer's experience

The value of support for carers can be seen in this example

Following a carer's assessment Mrs R (a local carer) was referred to Kingston Carers' Network for general support and information. In addition the Council provided Mrs R with money to take a flexible break and referred Mrs R to Kingston Centre for Independent Living to assist her with the record keeping necessary for a direct payment.

Following a direct payment she was able to employ two relief care workers, enabling her to have some time to herself for the first time since her caring role started. She wanted to learn to read and write in English, so she was referred to the open learning centre, which she is still currently attending. Mrs R also wanted to undertake some physical exercise as she is overweight and suffers with joint problems and arthritis, so she was referred to the Fit as a Fiddle classes and informed of the adult beginner swimmers classes at the New Malden Health Centre.

She was also assisted to apply for the higher rate Disability Living Allowance for her husband and was assisted in applying for a Taxicard and a Blue Badge which has made shopping and taking her husband out much easier.



Section 5

Physical Health, Lifestyles and Mental Health

Dr Helen Raison

Consultant in Public Health,
Kingston Council

Overview

Mental health and physical health are closely intertwined. Mental health is often less prioritised than physical health, yet there are many examples of how problems with both co-exist and have equal influence on a person's overall health: a person with diabetes is two to three times more likely to suffer from depression than the general population¹ and a Londoner with schizophrenia has their life expectancy shortened by 15 years or more^{2,3}. People's lifestyles can also impact on their mental health.

These issues can be thought of in three broad areas:

1. People with physical long term conditions, such as heart disease, diabetes or respiratory disease who are all at increased risk of poor mental health (particularly anxiety and depression)
2. People with severe mental illness, such as schizophrenia, bipolar disorder and severe depression, who have related physical health needs (these needs are discussed in Chapter 4.2)
3. The impact of lifestyles on mental health and vice versa. These include smoking, diet, physical activity and alcohol

The Governments strategy No Health Without Mental Health⁴ sets out an objective that:

'More people with physical ill-health will have better mental health and fewer people with mental health problems will die prematurely'.

The following chapters look at the interplay of mental health with long term conditions (Chapter 5.1) and lifestyles (Chapters 5.2 to 5.6).

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5.1 Long Term Physical Conditions

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Key messages

- People with long term conditions (LTCs) are two to three times more likely to experience mental health problems than the general population, particularly depression and anxiety.
- Deprivation exacerbates this link: people living in deprived areas are more likely to have multiple long term conditions and the effect of mental health problems on these LTCs is more pronounced when deprivation is present
- People with coexisting LTCs and mental health problems tend to have worse clinical outcomes, poorer self care and poorer quality of life, compared to people with LTCs without coexisting mental health problems
- There are approximately 12,000 residents (and 14,000 people registered with Kingston GPs) who have coexisting LTCs and mental health problems
- Poor mental health increase the average yearly cost of NHS service use by each person with a LTC from approximately £3,910 to £5,670
- Improvements in care for people with combined physical and mental health problems are being addressed to varying extents by all services and organisations in Kingston. Care can be improved further by ensuring the place of physical, mental and social care needs in every care pathway, and ensuring that self care advice and support to people with LTCs has a mental health and wellbeing component. Self care programmes should be targeted at people with LTCs and coexisting mental health problems. GPs should be up-skilled in identifying mental health problems, particularly depression and anxiety, amongst their patients with LTCs

Introduction

People with long term physical health conditions (LTCs) are the most frequent users of health care services. LTCs include strokes, diabetes, cardiovascular disease (CVD), pulmonary (lung) disease, asthma, many neurological conditions and arthritis, and can start at any age.

People with LTCs are two to three times more likely to experience mental health problems than the general population, particularly depression and anxiety. Dementia and cognitive decline often coexist with long-term conditions in older people¹. The co-existing mental health problems can cause deterioration in both the person's LTC as well as their quality of life.

There is a particularly strong association between cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD), cancer and musculoskeletal disorders and high levels of mental health problems (see Box 1).

Box 1: Prevalence of coexisting mental health problems in people with long term physical health problems

Depression is two to four times more common in people with cardiovascular diseases (heart disease, coronary artery disease, stroke, angina, heart failure, heart attack survivors). Anxiety is also common.

Depression is two to three times more likely in people with diabetes than the general population.

Mental health problems are three times more likely in people with chronic obstructive pulmonary disease (COPD) than in the general population. Anxiety is very common – panic disorder (a type of anxiety) is 10 times more common in people with COPD.

Depression is present in one third of women with arthritis and in one fifth of men with arthritis.

Cardiovascular disease and diabetes are risk factors for the development of mild cognitive impairment and vascular dementia. The risk of developing dementia is even higher in people with depression as well as diabetes².

In patients with cancer the risk of mortality increased by 17% in patients with depression compared with those without depression.

Sources: Based on an extract of research evidence from Naylor et al (2012), The Kings Fund. Cancer data based on Pinqart and Duberstein³

The link between mental and physical health is likely to be two-way in that having a LTC increases the risk of a mental health problem, but equally having a mental health problem increases the risk of onset of a physical illness⁴ (see Chapter 4.2).

The implications for people with LTCs who also have a mental health problem are considerable. They experience:

- Poorer clinical outcomes and prognosis – they may have more exacerbations of their LTC per year (cardiovascular patients with depression have 50% more acute exacerbations per year⁵), more complications of their LTC, and may have higher mortality rates (patients with chronic heart failure are eight times more likely to die within 30 months if they have depression⁶) although this varies between different LTCs.

- Adverse health behaviours and poorer self care – poor mental health can reduce the motivation and energy a person has to self care for their LTCs, and may mean people are less able to attend for their medical appointments. As well as poorer lifestyles (see later chapters in this section), they are also less likely to take their prescribed medicines and take part in rehabilitation programmes. Studies have shown that depression resulting in poor self care and lifestyle impacts on the number of cardiovascular events in people with cardiovascular disease^{7,8}.
- Lower quality of life – surveys show that people consider it worse to have a coexisting mental health problem than it is to have an additional long term physical condition⁹.

The effect of multiple long term conditions and deprivation

Coexisting mental health problems are particularly common in people with multiple LTCs. People with two or more LTCs are up to seven times more likely to have depression than those without a long term condition⁹. The relationship is more extreme in people admitted to hospital – to take one example between 35% and 70% of chronic heart failure inpatients also have a depressive disorder¹⁰.

This is exacerbated by socio-economic deprivation in two ways: a greater proportion of people living in poorer areas have multiple LTCs and the effect of multiple LTCs on mental health is stronger when deprivation is also present¹¹.

Medically unexplained symptoms

Medically unexplained symptoms are persistent physical complaints, such as fatigue, heart palpitations or pain, which do not appear to have an obvious cause. Not understanding the cause can make them more distressing and difficult to cope with and some people will develop mental health problems such as depression or anxiety disorders. For these people, psychological treatment can often relieve the physical symptoms.

Medically unexplained symptoms are common, accounting for a fifth of all GP consultations in the UK¹².

Costs of co-existing mental health problems

Poor mental health substantially increases a person's use of health services for their physical problems:

- The risk of admission to hospital increases by a factor of 2.8
- Length of stay in hospital increases
- The use of outpatient services is doubled^{13,14}

The cost of health care for physical illnesses is increased if someone also has a mental health problem. The increase in costs is broadly similar whatever the severity of the physical illness. Poor mental health increases the average cost of NHS service use by each person with a LTC from approximately £3,910 to £5,670 a year¹ i.e. by £1,760. This equates to a 45% increase. Research in the United States found that anxiety increases costs even more than depression does, and that the costs were more inflated for respiratory diseases and arthritis than for cardiovascular diseases¹⁵. Between 12% and 18% of all expenditure on long term conditions is linked to poor mental health and wellbeing¹.

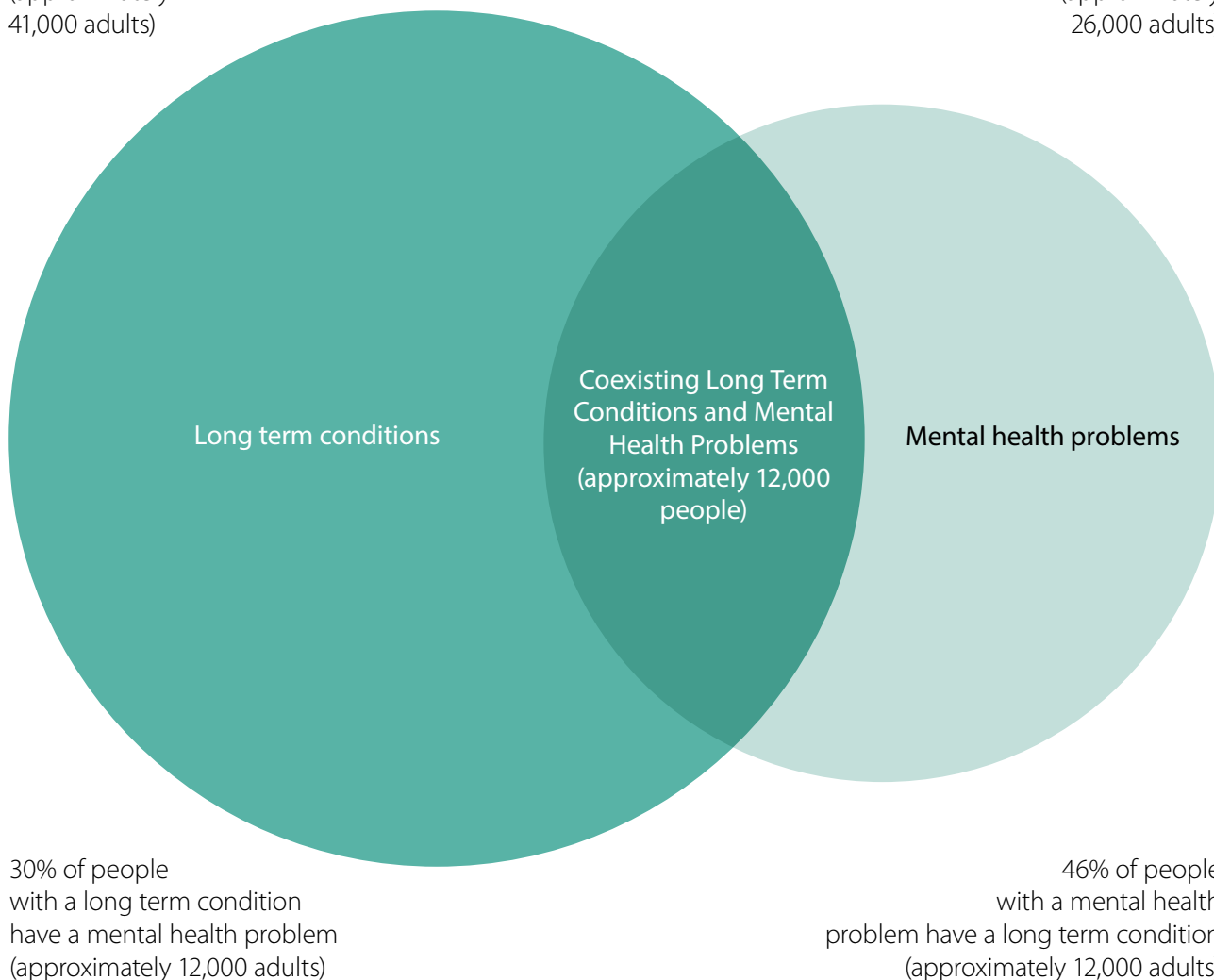
Local Picture

Nearly one in three (31%) adults in Kingston has a LTC¹⁶ – that is approximately 41,000 adult residents. At least 30% of adults with LTCs are estimated to also have a mental health problem¹⁷, so at any one time there are approximately 12,000 adult residents with combined physical and mental health problems. Within the GP-registered adult population the numbers with combined LTC and mental health problems is approximately 14,000. The extent of the overlap between mental health problems and LTCs is illustrated in Figure 1.

Figure 1: The overlap between long term conditions and mental health problems – Kingston resident population

Long term conditions:
31% of population of Kingston
(approximately
41,000 adults)

Mental health problems: 20%
of population of Kingston
(approximately
26,000 adults)



Source: Prevalence based on Naylor et al (2006), The Kings Fund. Kingston population based on ONS 2013 mid-year estimates for adult residents n=131,000.

Although as noted above medically unexplained symptoms are a common reason for patients presenting at their GP surgery, at present there is no local data collected on this.

In Kingston there are an estimated 12,000 residents with coexisting mental and physical health problems. This equates to millions of pounds of extra costs to the NHS for providing extra care for LTCs exacerbated by the co-existing mental health problem. If 10% of these residents are accessing services the extra costs can be estimated at £2.1M whilst if the percentage is 50% the figure is £10.5M.

Whilst it would not be possible to eliminate all depression and anxiety in local people with LTCs,

tackling these could not only improve their quality of life and sense of wellbeing, but significantly reduce NHS costs. The costs to social care and wider society have not been calculated here, but it is reasonable to expect they would also be reduced.

Co-existing depression and physical illness in primary care

Up until 2013, GPs were incentivised to record the proportion of people with coronary heart disease or diabetes who had been asked two questions to identify if they had depression. Table 1 shows that nearly 89% of patients with these two conditions registered with Kingston GPs were screened for depression, which was similar to the London and England rates.

Table 1: Screening for depression in patients with diabetes and/or coronary heart disease (%) in Kingston, London and England, persons, all ages, 2011 – 2013

Year	Kingston (%)	London (%)	England (%)
2011 – 12	87.15% (86.48 to 87.79)	88.50% (88.41 to 88.59)	88.57% (88.54 to 88.60)
2012 – 13	88.66% (88.03 to 89.26)	88.26% (88.17 to 88.34)	88.33% (88.30 to 88.36)

Notes: Values in brackets denote 95% confidence intervals
Data is for Kingston PCT
Source: The NHS Indicator Portal, 2014 (Unique identifier – P01015)

The effectiveness of the screening questions for depression were shown to have a marginal effect over usual GP care, and GPs no longer have to record this statistic. However, enquiry by GPs to identify depression (and anxiety) is important.

Depression is often normalised in the presence of LTCs so that it is accepted as part of the picture, and this tends to hamper assessment and management¹⁸. Improving Access to Psychological Therapies (IAPT) services are evidence-based psychological therapies

that should be offered to people with LTCs who have been diagnosed with depression or anxiety¹⁹.

Local Action

A Kings Fund report recommended a framework for care and support that should be provided across a local area to reduce the number of people with long term conditions (LTCs) going on to develop mental health problems such as depression and anxiety (Table 2).

Table 2: Framework for reducing mental health problems in people with long term conditions (LTCs)

Prevention	Detect co-morbid mental health problems	Integrate mental health into long term conditions programmes	Support self management	Integrate mental health into primary care	Integrate mental health support into acute settings	Social Support and Voluntary Sector
Wellbeing activities: Promoting wellbeing at work, debt advice, befriending interventions for older people. Target those with LTCs	GPs screen people with LTCs for mental health problems	Mental health element designed into disease management and rehabilitation programmes	Peer support, self management programmes adjusted for people with additional mental health problems, training of staff	Closer input from mental health specialists alongside primary care staff especially for mild and moderate mental health problems	Well integrated liaison psychiatry or Rapid Assessment Interface and Discharge (RAID) model	Peer-delivered services, collaborations between voluntary and statutory sector

Source: Adapted from The Kings Fund, 2007

In Kingston a range of activities take place that fit into the framework described in Table 2.

Integrating Care

The current initiative to bring organisations and people together to better integrate care, known as the Kingston Better Care Programme, has started to explore the overlap between physical and mental health, but it is recognised that while there is good work going on in different organisations, there is still much to do to make mental and physical care for patients more joined up. This would include ensuring all care pathways always consider people's mental, physical and social needs.

General Practice

The last systematically collected records of GPs screening of people with diabetes or coronary heart disease for depression was in 2012-13. The extent to which GPs assess people with any LTC for mental health problems is currently not known. Targeting of mental health assessment and support to populations in deprived areas and with a high prevalence of LTCs should be considered. A new initiative to train GPs in mental health which is being led by the CCG will be an opportunity for the relationship with physical illness to be highlighted.

Risk stratification has recently been introduced by Kingston CCG and is being used to search through GPs records to identify people with multiple problems who are at high risk of deterioration. This could include people with coexisting LTCs and mental health problems. It will be possible to offer extra support to keep people well and prevent them from needing an admission to hospital.

Long Term Conditions management programmes

Some, but not all, programmes for LTCs in Kingston contain a specific mental health element. Programmes commissioned more recently, such as the Angina Patient-Centred Self Management Programme uses cognitive behavioural therapy approaches and the COPD programme uses health coaching.

The IAPT service is required to ensure access to its psychological therapy services are accessible to people who may otherwise miss out which includes those with LTCs and people from more deprived parts of the borough. Discussion is underway about how this can be developed.

The IAPT service is described in more detail in chapters 4.2 and 5.2.

Kingston Hospital

A liaison psychiatrist from the Mental Health Trust works in Kingston Hospital to help assess patients who are inpatients with a physical illness but who also have symptoms of mental illness. The accident and emergency department often see people who are physically unwell or injured, but who are also in crisis with a mental health problem that needs more detailed psychiatric assessment.

Kingston CCG is planning an innovative model of liaison psychiatry called Rapid Assessment Interface and Discharge (RAID) where the RAID team works in Kingston Hospital to assess and treat patients, as well as train hospital staff in mental health skills and psychological literacy. This model has been shown elsewhere to reduce acute hospital bed use, largely amongst older age patients, with the associated savings exceeding the cost of the RAID service.

Community Services

Your Healthcare (YHC), the local provider of community based health care (including district nursing, community matrons and specific services such as continence), works with people who often require a holistic assessment. To give one example, a patient may have a decline in their diabetes self care triggered by coexisting depression.

Many complex patients being cared for by the Integrated Community Team have a mental health problem and YHC are working with South West London and St Georges Mental Health Trust to have a Community Psychiatric Nurse seconded into the Integrated Team. This model has been shown to be effective in other parts of England.

Local Authorities: Social Care

Adult Social Care teams take a holistic approach to the people they support who have physical disabilities and mental health problems. One team usually takes the lead for assessment and care planning, and calls in specialist input as required. For example, frail older people with a combination of physical and mental health conditions usually have their care coordinated by the Social Care Long Term teams, with specialist input from Community Mental Health teams as required.

Local Authorities: Public Health

The Public Health team has a role in informing others about the association between mental and physical health. A key message is that a greater proportion of people living in poorer areas have multiple LTCs and that the effect of these multiple LTCs on mental health is stronger when deprivation is also present. By undertaking this role with other organisations,

including those participating in the Better Care Programme, the Public Health team can support targeting of care to the people in greatest need.

Voluntary and Community Sector

The voluntary and community sector has direct experience of supporting people with both physical and mental health problems. They offer direct assistance to people as well as signposting to other services, groups or resources that offer support. It is important that knowledge of all the assets Kingston has to support people is widely shared.

Self Help

People who have coexisting mental and physical health problems will have a range of motivations to help themselves to manage their illnesses. Each person needs to be treated individually to assess the amount they can support themselves. Often people need additional support in times of crisis. Self help may seem impossible for someone with multiple problems, and staff from organisations working with them should be sensitive to that. Programmes such as the Expert Patient Programme are one strand of support available in Kingston. A programme to educate health and care staff is vital in achieving the self care philosophy, and is being started by Your Healthcare for their staff. Change across the whole system will need dedicated co-ordination.

Recommendations

1. Kingston CCG and the Council's Public Health directorate should consider gathering more comprehensive information on the extent of co-existing physical and mental health problems in Kingston
2. The Better Care Programme should ensure the relationship between physical and mental health runs as a thread through the programme. The place of physical, mental and social care needs in every care pathway should be promoted. To take one example patients with long term physical conditions should routinely be assessed for coexisting anxiety or depression
3. A coordinated programme to embed self care across organisations should have a mental health/wellbeing component, and should build on the work started by YHC as part of the Better Care Programme. Self care programmes should be targeted at people with LTCs and coexisting mental health problems
4. Kingston CCG should encourage GPs to assess all patients with LTCs for mental health problems and offer subsequent referral to IAPT where appropriate. People with cardiovascular disease, diabetes, COPD, asthma, cancer, musculoskeletal conditions and multiple LTCs will all benefit
5. Targeted training in identifying people with LTCs who have mental health problems should be provided to practices serving deprived populations

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5.2 Alcohol and Drugs

Stephanie Royston-Mitchell, Drug and Alcohol Strategy Manager, Kingston Council

Key messages

- People who have both mental health problems and drugs or alcohol problems (a 'dual diagnosis') are more likely to have worse physical health, higher levels of personality disorder, greater levels of disability and lower quality of life than those who are not identified as having a dual diagnosis
- There are clear benefits to jointly commissioning mental health and substance misuse services
- There is a growing awareness of the importance of addressing the social, physical and psychological needs of people with co-occurring mental health and substance misuse problems
- Services should actively engage users and carers in order to better understand the service user's experience and perspective of accessing mental health and substance misuse services
- A flexible and adaptive therapeutic response is important for the integrated management of the dual conditions and treatment should be appropriate to the individual's readiness for change and level of engagement with the service
- There should be a greater focus on supporting individuals to develop positive social networks to support them to engage in meaningful activities

Introduction

Drug and alcohol use (also known as substance use) is a complex issue. Drugs and alcohol are mind altering substances and whilst use of them may give a temporary feeling of wellbeing or being in control, in some people they can have a severe impact on their physical and mental health. People's substance misuse and dependency issues can affect everyone around them.

Heavy drinking is associated with mental illness. Almost all drinkers seeking help report symptoms of anxiety or depression¹. Depression may accelerate an already serious alcohol problem or lead to a relapse after a long period of sobriety. Alcohol misuse may accelerate or uncover a predisposition to other mental illnesses².

Drugs (illicit drugs and misuse of prescription drugs) can affect mental health³. Drugs can make symptoms of mental illness worse and there is some research to show that the use of certain drugs may be linked to developing mental illness such as schizophrenia. Drug misuse can make mental illness more difficult to treat.

The national mental health strategy, No Health Without Mental Health⁴ and the national drug strategy, Reducing Demand, Restricting Supply, Building Recovery⁵ both acknowledge the association between mental health and drug and alcohol dependence and that early intervention and effective joint working between drug and alcohol treatment and mental health services can improve successful outcomes.

Dual Diagnosis

The most common term used to describe people with mental health problems who also have issues with drug or alcohol misuse is that they have a 'dual diagnosis'. As well as mental health problems, people with a dual diagnosis may also be involved in drug related crime or violence, have physical health problems, have their children placed into care, be homeless or have housing problems and be unemployed.

Research⁶ has shown that the majority of service users accessing substance misuse services have common mental health problems (such as anxiety and depression). The same study also found high levels of drug use and hazardous and harmful drinking in the populations using mental health services. The study concluded that:

- 75% of users of drug services and 85% of users of alcohol services were experiencing mental health problems
- 38% of drug users with a psychiatric disorder were receiving no help for their mental health problem
- 44% of mental health service users either reported drug use or were assessed to have used alcohol at increasing risk or higher risk levels in the past year

Another study⁷ found that:

- Dual diagnosis was present in 20% of community mental health clients, 43% of psychiatric inpatients and 56% of people in secure services
- The group identified as dually diagnosed had worse physical health, higher levels of personality disorder, greater levels of disability and lower quality of life than those who were not identified as having a dual diagnosis

Whilst guidance and recognised pathways are available for accessing appropriate services for people with both mental health problems and substance misuse issues, it is still a challenge to make this a reality on the ground. Services for these people, particularly people who have less severe mental health problems are often less developed and at greater risk of fragmentation arising from the different commissioning arrangements for mental health and substance misuse services. Given that as noted above most people accessing drug and alcohol treatment services have common mental health problems, good links should be made between these treatment services and both local psychological therapy services (such as Improving Access to Psychological Therapies services) and GPs to improve the management of patients who do not meet the criteria for access to community mental health services.

Local Picture

Occurrence of Dual Diagnosis

In 2012-13 14%⁸ of people starting drug treatment and 12%⁸ starting alcohol treatment were recorded as having a dual diagnosis. This reflects the number of people whose co-morbidity met the criteria for access to community mental health services and does not include those people with co-morbid common mental health problems such as anxiety or depression.

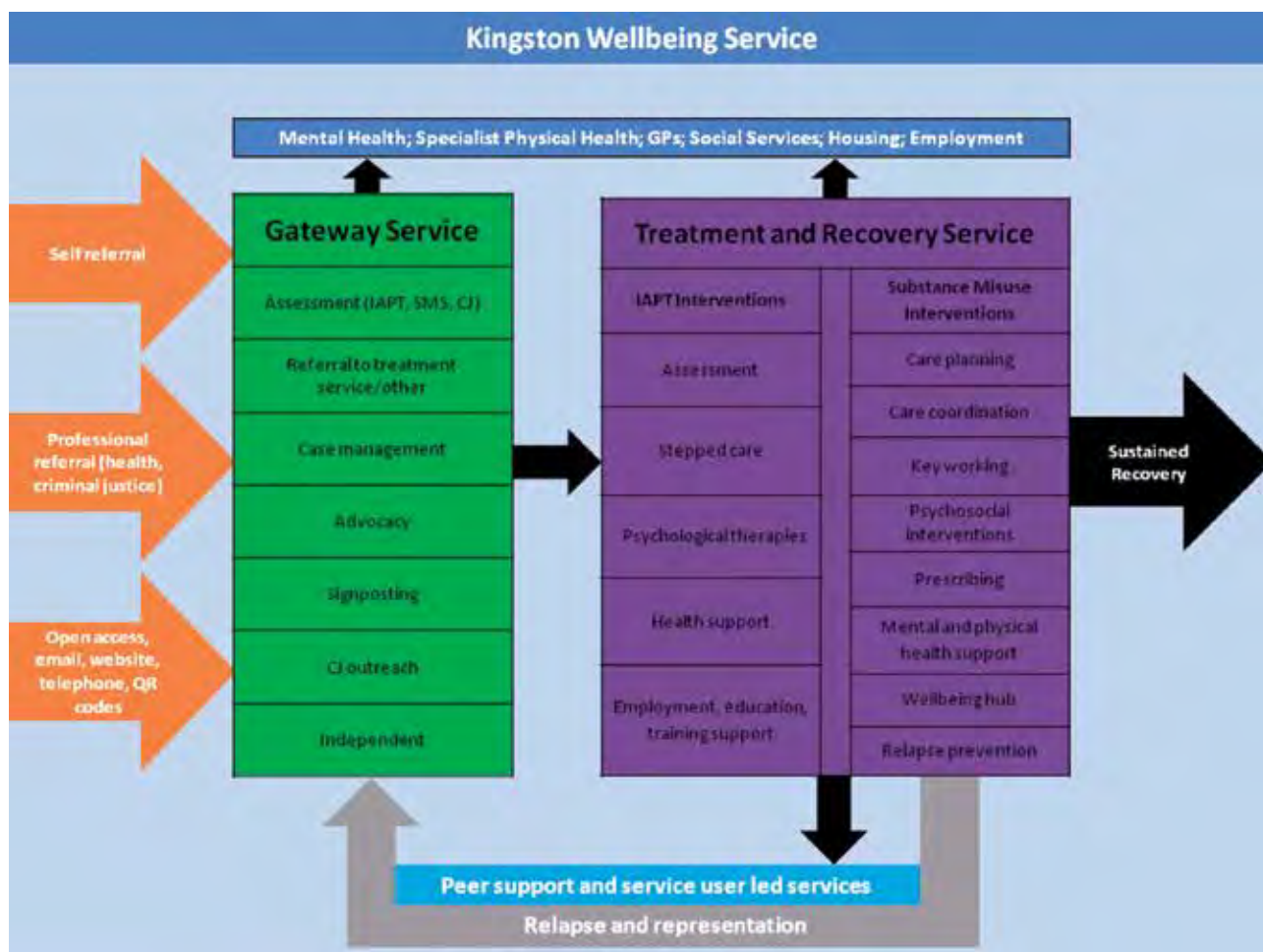
Local Action

An appropriate response to dual diagnosis is essential for the effective delivery of key policy objectives. In line with best practice recommendations Mental Health and Substance Misuse Commissioners worked in partnership to undertake a local needs assessment which highlighted a number of strengths in Kingston services but also identified key areas for improvement and opportunities to allocate resources more effectively. This provided an opportunity for commissioners, service users and key stakeholders to shape and redesign local services to deliver a more integrated service. Improving Access to Psychological Therapies (IAPT) and adult substance misuse services were tendered together in order to deliver an integrated Community Wellbeing Service. The new service is known as the Kingston Wellbeing Service.

Kingston Wellbeing Service

The new service model is depicted in Figure 1 and comprises a Gateway Service (providing a single assessment and referral pathway for psychological therapies and substance misuse) and a Treatment Service (providing substance misuse treatment interventions and psychological therapies). The model enables clients with a dual diagnosis (including those with anxiety or depression) to access appropriate support and treatment for their mental health problem as well as their substance misuse issue. This is either provided within the Kingston Wellbeing Service or (for those people with more severe mental health problems that meet referral criteria) by the Community Mental Health Team.

Figure 1: Kingston Wellbeing Service Model



Recommendations

1. Review how the new Kingston Wellbeing Service is meeting the needs of people with a dual diagnosis, including those with anxiety or depression
2. Review and agree local definitions, care pathways and protocols for individuals with co-occurring mental health and substance misuse problems
3. Develop a tiered training programme on dual diagnosis for staff in specialist and generic settings

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5.3 Smoking

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Key messages

- People with a mental health problem are more likely to smoke, with about one in three doing so in comparison to the general population where it is about one in five
- Smokers with a serious mental health problem have a 25 year lower life expectancy than the general population
- It is never too late to quit smoking and the benefits continue throughout life
- People with a mental health problem are more likely to be successful in quitting smoking with tailored advice and support from someone trained to provide this
- Local health service providers should support the NHS England Mandate to ensure that the NHS focuses on preventing illness, with staff 'making every contact count', using every opportunity to help people stay in good health

Introduction

Tobacco smoking is still by far the biggest avoidable risk to people's health, causing almost 80,000¹ avoidable deaths every year.

There is a strong association between smoking and mental health problems. In a 2007 survey people with any mental health diagnosis had a smoking prevalence of 33% compared with 22% for the total population². The percentages varied depending on the type of mental health problem with people who had mixed anxiety and depression having a prevalence of 29% whilst the percentage for those with probable psychosis was 40%.

42% of all tobacco consumption in England is by those with mental health problems. Smoking is one of the main reasons why people with a mental illness tend to die at a younger age³ and smokers with serious mental health problems (such as psychotic disorders) have a 25 year lower life expectancy than the general population.

Smoking is a major determinant of health inequality for those with mental illness⁴ and stopping smoking will greatly improve patients' physical health and life expectancy.

General benefits of stopping smoking for individuals

All people who stop smoking will benefit from:

- Increased life expectancy
- Improved physical health including reduced risk of coronary heart disease, stroke, many cancers and chronic obstructive pulmonary disease (COPD)
- More money in their pocket

Additional benefits of stopping smoking for people with mental health problems

In addition to the general benefits listed above, there are particular benefits of stopping smoking for people with mental health problems. One of these is supporting recovery (as they overcome their mental illness and discover a new sense of self and purpose with and beyond the limits of their condition).

Regaining control of aspects of life is at the core of recovery-focused care and, for the previously noted health and financial reasons, stopping smoking can be an important place to start⁵.

People with mental health problems may have some additional specific needs in terms of utilising smoking cessation services which should be taken into account. These include:

- Support over a longer period of time
- Access to a range of group or individual talking therapy sessions
- Medication monitoring as smoking interacts with some drugs used to treat people with mental health problems
- Tailored support as people with depression have particular difficulty when they try to stop smoking and have more severe withdrawal symptoms during attempts to give up⁶
- On-going relapse prevention support

Local Picture

Between 2010 and 2014 South West London and St George's Mental Health Trust (SWLStG) had a CQUIN (an incentive scheme to improve quality of care) which included smoking cessation support. This Trust

covers five boroughs in South West London. The Trust employed a team of Stop Smoking Advisors and introduced processes to ensure patients were asked whether they smoked and whether they wanted support to stop. The staff team offered programmes to support those who wanted to stop or reduce their smoking to do so; they also offered training and support to staff.

A report produced by the SWLStG Mental Health Trust in February 2014 showed that the Trust achieved 86% smoking status recording, with 34.3% of the Trust's service users from across South West London recorded as being smokers. A data snap-shot of patients in the care of the Trust at this date showed a caseload of 1,922 Kingston patients; 1,587 of whom had their smoking status recorded (82.6%), of whom 534 were smokers (33.7%), with 139 referred to the Trust Smoking Cessation Advisors (SCA).

- Of those referred, 59 did not have any information recorded (42.5%)
- 12 did not engage with the SCA (8.6%)
- 37 dropped-out after initial engagement with the SCA (28.1%)
- Five (3.6%) cut down the number of cigarettes they smoked by more than 25%
- Ten smokers did not quit but were engaged in the service (these smokers were recontacted periodically by an SCA to invite them to re-engage in the service).
- 16 quit smoking (11.5%)

When the CQUINs agreed between the Commissioners and the Trust changed in April 2014, the Trust redirected the funding for the in-house stop smoking team to other care and there is no longer a team within the Trust, although the processes set up by the team remain. Kick-It, the local stop smoking service provider, continues to offer support to the Trust when requested. They offer training advice and support, and will follow up patients referred to them in the community for ongoing advice and support to quit.

People accessing the Kingston Wellbeing Service (which provides psychological therapies for people with mental health problems and also treatment for people with substance misuse issues) are asked about their smoking status, and staff working in the service have been trained to provide smoking cessation advice and support. Monitoring of signposting to the specialist stop smoking service is a key performance indicator (KPI) for the service.

Recommendations

1. South West London and St George's Mental Health Trust should continue to maintain the processes and services developed during the period of the 2010-14 CQUIN to record smoking status, offer tailored advice and support, and onward referral to the Stop Smoking Service provider for community follow-up of patients. This should form part of their contract requirement to improve the physical health of their patients by 'making every contact count', and should be monitored by commissioners
2. People visiting the Kingston Wellbeing Service should continue to be asked about their physical health, including smoking status. In-house stop smoking support should be given, or signposting to local community providers for support (community pharmacists or GP practices) or onward referral if wished to Kick-It, the specialist stop smoking service. This should be monitored through delivery of their contractual KPI
3. Kick-It, the local Stop Smoking Service provider, should ensure that it is able to meet the particular needs of smokers with mental health problems and meet their contract obligations with respect to liaison with and support for South West London and St George's Mental Health Trust, which should be monitored as part of contract performance management
4. Local support should be given to the Department of Health and Public Health England's planned smoking cessation campaign targeted at people with mental health problems, which is due to be launched in 2014-15.

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5.4 Physical Activity

Shirley Piotrowski, Physical Activity Lead, Public Health, Kingston Council

Key messages

- Increasing physical activity is associated with positive mental health and wellbeing, resulting in a reduction in symptoms of depression and anxiety
- Even small amounts of physical activity are sufficient to start gaining wellbeing benefits, for example by undertaking a brisk ten minute walk every day
- There are many different reasons why people do not participate in physical activity. Some of the common reasons include financial barriers, lack of time, feeling limited by a health condition, low confidence or lack of exercise facilities
- Making physical activity accessible and achievable for those with mental health problems is an important factor in the design of physical activity programmes. Bespoke programmes offering free or low cost access with the support of volunteers or buddies seems to be effective at initially engaging this population group
- Providing opportunities for social contact and social interaction through group physical activity increases the prospect of developing social networks and making friends, and this in turn improves uptake and adherence to physical activity

Introduction

Physical activity is highly beneficial to people with mental health problems. It reduces anxiety and depression, improves mood and reduces reactivity to psychosocial stressors¹. Exercise is associated with a reduction in the symptoms of depression, anxiety, and malaise^{2,3}. Even ten minutes of an activity such as brisk walking increases mental alertness, energy and positive mood.

Findings from the Health Survey for England 2013 reveal that adults who met the government guidelines for physical activity (150 minutes per week) reported the highest levels of wellbeing, and those reporting being inactive as having the lowest levels of wellbeing. Individuals who exercise regularly felt more socially integrated than those exercising infrequently or not at all⁴. Physical activity brings rewards far beyond just physical fitness including better social cohesion, improved confidence and raised self-esteem.

Local Picture

The percentage of physically active adults (achieving at least 150 minutes of physical activity per week) in Kingston was 56.4% in 2012. This was slightly higher than the national average of 56%⁵. The percentage of people with mental health problems in Kingston who are physically active is not known but is likely to be considerably less. Given the benefits of physical activity for people with mental health problems, there needs to be a focus on making the programmes offered accessible to this population group.

In 2013, the Council's Public Health directorate commissioned a consultation to gather views about physical activity from people with mental health conditions, community mental health partners and leisure providers. The consultation focused on identifying barriers to exercise and how people could be better supported to access services. The output from the consultation is summarised in Figure 1. The findings have been used to shape local provision.

Figure 1: Consultation on Mental Health and Physical Activity



In Kingston, all residents can access low cost or free inclusive physical activity programmes such as walking groups, gardening and dance. Feedback received suggests that more could be done to facilitate the uptake of physical activity by people with mental health problems, such as programmes offering reduced intensity of exercise and an exercise befriending scheme, particularly for those with dementia.

Kingston has an established and successful exercise referral programme called Get Active. Of the 596 referrals of people with mental health problems since the start of the programme in 2008, a third completed the programme but only 7% continued to be active post-programme compared to an average of 40% of all other participants completing the programme. It is likely that this is in part due to the withdrawal of the one to one instructor support and lack of confidence in exercising independently after the 12 week programme.

Local Action

A Get Active Wellbeing Project pilot arose from the 2012 Olympic and Paralympic Health legacy to encourage the implementation of exercise programmes as part of the service offered by the Kingston Wellbeing Service to people with anxiety and depression. The aim of this project was to embed exercise programmes as part of the Stress Management Courses (SMC) to alleviate and manage people's symptoms. Although participation in the physical activity sessions as part of the SMC course was low, those who did participate reported improved mood and reduced anxiety. Lessons learnt from the pilot indicated the need to promote group physical activity programmes (as opposed to individual interventions) and to enhance opportunities for social interaction. Get Active now offers group exercise sessions as a result of the pilot.

A recent walking for health pilot for people with chronic pain, set up jointly between the Council's Public Health directorate and Kingston Hospital, showed some very positive results in terms of mental health outcomes. The majority (80%) of participants said that their mood, confidence and mental wellbeing had improved as a result of the programme. The success of the pilot has resulted in this short walk becoming a permanent activity choice for those who may find the borough's longer walks too challenging for their health status.

A one year pilot programme has been launched for people with mental health conditions, called the Good Energy Club, based on the findings of last year's consultation discussed above. This programme includes a buddy scheme to support, motivate and encourage people to participate in activities, and training for community leisure providers to help them better understand mental health issues and incorporate this learning into the services they provide. The pilot will be evaluated by Spring 2015.

Recommendations

1. Continue to monitor the impact of the Good Energy Club programme during the one year pilot and report on the outcomes
2. Incorporate opportunities for social interaction into physical activity programmes
3. Improve collaboration between physical activity and mental health service providers to better respond to the needs of service users with regard to improving access to physical activity
4. Train leisure and exercise providers in the psychological aspects of physical activity, to enable them to engage clients in a positive way and increase their confidence in taking exercise
5. Through the Healthy Weight and Physical Activity Strategy, support the ongoing review of physical activity provision in the borough for people with mental health problems
6. Provide accessible information to raise awareness of opportunities for physical activity, in particular focusing on capturing the attention of those who currently undertake minimal physical activity

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Case study

A local resident's experience of physical activity

"My name is Ron and I have been diagnosed with bipolar for the last 20 years and have been in a psychiatric hospital six times.

Each time I have been in hospital I have been encouraged to do some form of physical exercise such as playing pool, using the gym, badminton and walking.

It can take a person with mental health problems a long time to do any form of exercise in the community. Through my Community Psychiatric Nurse I joined a charity and just went on their walks. When I felt comfortable, I played badminton which is good for focusing and improves your concentration. It helped me to socialise and gave me the ability to mix and talk with others again.

After a few years I joined Kingstonian 'Mind' service user football team in Kingston, I used to help out in the office and play football. Through 'Mind' I have played in service user football tournaments in Prague, Czech Republic, Munich in Germany and in our country Oxford and Liverpool. For many players, experiences like that cannot be put into words, but can definitely boost your self esteem and help you when you go through any bad times.

These experiences gave me more confidence to express myself, not only in writing but also in wanting to volunteer to help others with the benefits of physical exercise. I would say the main benefits are to stay healthy, build confidence and motivation and to socialise.

I joined the charity Hestia in conjunction with Kingston Council to volunteer helping other people with mental health problems participate in physical exercise. You soon realise that others do need help and encouragement to change their lifestyles and incorporate exercise into their daily lives. It is also a high priority for people with mental health problems to be able to socialise with others and swap ideas about activities that they enjoy doing by themselves and in a group. Physical activity has now become part of my everyday life."

5.5 Healthy Weight and Healthy Eating

Karen Buckley, Community Food Project Worker, Kingston Council
Alison Gahagan, Specialist Public Health Dietitian, Kingston Council
Jo Lockhart, Public Health Programme Lead, Kingston Council

Key messages

- The food we eat and our weight can impact on our emotional and mental health and wellbeing
- People who are obese are 55% more likely to experience depression, and people experiencing depression are 58% more likely to become obese
- Provision of healthy eating and weight management services across the life course is key to improving mental health and wellbeing
- Working with partners across Kingston to improve the understanding and awareness of the complex relationship between mental health, weight and diet is a priority to ensure people can access services that can improve their wellbeing, weight and overall health

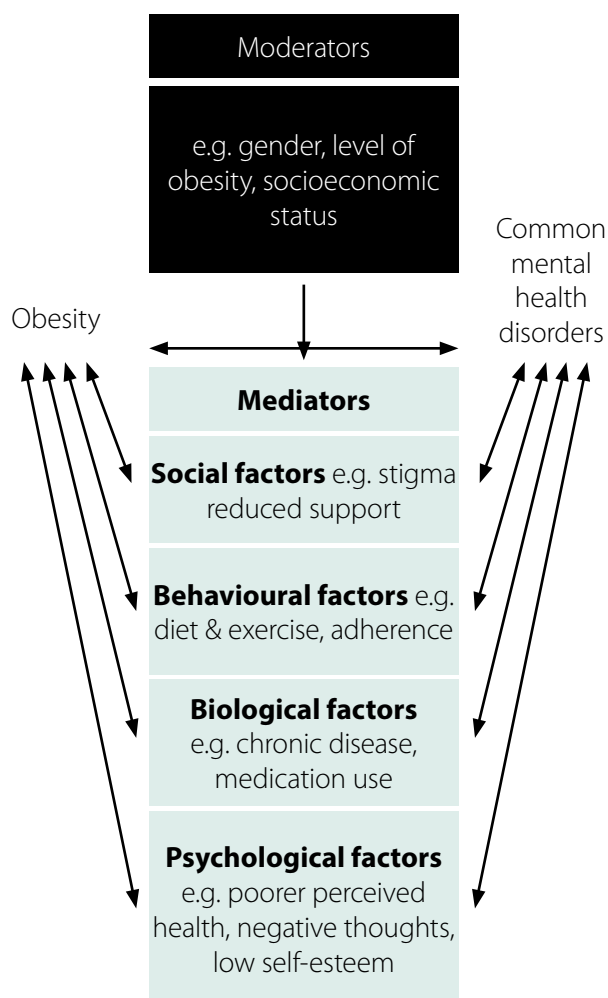
Introduction

Throughout life an unhealthy weight or eating an unhealthy diet can have a significant impact on an individual's mental health and wellbeing. The relationship between obesity and common mental health disorders is complex and multifactorial. People who are obese are 55% more likely to experience depression, and people experiencing depression are 58% more likely to become obese¹.

A suggested model that seeks to explain the relationship between obesity and common mental health disorders is shown in Figure 1. In adults there are a number of mediating factors that help explain the relationship between obesity and common mental health disorders. These can be social, biological, behavioural or psychological. In addition there are moderating factors that influence the strength of the relationship between obesity and mental health conditions such as the level of obesity (with higher levels increasing the strength), gender (female gender increasing the strength) and socioeconomic status (data tending to show that low status increases the strength of the relationship)².

Figure 1: Relationship between obesity and common mental health disorders.

Adapted from: The National Obesity Observatory, 2011.



Overweight and Obesity and Mental Health and Wellbeing

Overweight and obesity can impact on mental wellbeing, by causing low self-esteem, poor body image, social rejection and psychological distress as a result of weight-related stigma, teasing and bullying^{3,4,5}. These factors can put obese people at an increased risk of depression and anxiety⁶.

People with mental health disorders may also have more difficulty controlling their consumption of food, exercising and maintaining a healthy weight. This is often due to adopting unhealthy eating behaviours through using food as a coping mechanism, leading

to comfort eating which results in a temporary reduction in distress and as a consequence risking becoming caught in a negative cycle of behaviour.

The link between mental health disorders and weight is well recognised; with NICE recommending that psychological comorbidities (including disordered eating) should be screened for in a weight management assessment^{7,8}. Weight should be measured at the initial patient assessment for bipolar disorder and referral to specialist weight management programmes or specialist dietetic support should be available to the patient where necessary⁹.

Weight gain is a common side effect from some pharmacological treatments for mental health disorders in both adults and children¹⁰. It is recommended that a patient's history of weight gain is considered when prescribing medication for depression and that weight is monitored whilst patients take drugs known to have weight gain as a side effect^{11,12}.

The aim of weight management interventions is to reduce obesity related co-morbidities and improve wellbeing. It is important to recognise that obesity is as much a psychological issue as a physical condition and it is imperative to consider both aspects within a patient's treatment.

Healthy Eating and Mental Wellbeing

Eating a healthy balanced diet improves wellbeing and reduces the risk of developing mental health problems. Essential fatty acids (omega-3 and omega-6) are associated with improved mood and cognition^{13,14}. Adequate intakes of folate, selenium, zinc, magnesium and iron, and vitamins B, C and E are also associated with good mental health and wellbeing¹⁵. Essential amino acids (tryptophan and phenylalanine) make neurotransmitters (serotonin, adrenaline and dopamine) in the brain which have an influence on mood and motivation. Eating a healthy balanced diet, that includes all micro – and macro-nutrients, especially omega-3 (from oily fish intake), may contribute to the prevention and/or treatment of mental health problems such as behavioural problems in children^{16,17} and depression in adults¹⁸.

The link between diet and health (as well as its link with school performance) has been recognised by the Department for Education and the Department of Health supporting new mandatory food standards for all meals (breakfast, lunch, snacks, after school clubs) to come into effect in January 2015¹⁹. Eating breakfast improves health and wellbeing, concentration, memory, attainment, social behaviour and cognitive performance in children^{20,21,22}.

Growing food encourages physical activity, social interaction and increased fruit and vegetable consumption, all of which contribute to improving mental wellbeing^{23,24}. This is true for both children and adults, and schools who actively engage with food growing report improved academic performance and attainment, especially in core subjects such as science.

Breastfeeding

Approximately 81% of women in England initiate breastfeeding at birth, but by six weeks, the number drops to 55%, of which only 23% are exclusively breastfeeding²⁵. The role of breastfeeding is important in children's physical and cognitive development^{26,27}. Children who are breastfed have a decreased risk of obesity in later life, and therefore a reduced risk of the associated mental health implications^{28,29}. Breastfeeding also promotes mother-child bonding, improving mental wellbeing for both the adult and child in later life^{30,31}. Maternal depression is associated with lower breastfeeding rates, and can thereby prevent effective mother-child attachments³¹.

Children

Local Picture

In 2012-2013³² in Kingston 6.1% of children in Reception Year (aged four to five years) and 17% of children in Year 6 (aged ten to 11 years) were obese. Although the prevalence of obese children is below both the national and regional rates, there is a large increase in the prevalence of obesity between Reception Year and Year 6. By Year 6, over 30% of children in Kingston are above a healthy weight and are at an increased risk of poor mental health and wellbeing.

The Schools Health Education Unit (SHEU) Young People's Health Behaviour Survey in 2013 was completed by 3,982 young people aged ten to 15 years attending secondary schools in Kingston. A third (32%) said they worry 'very often' or 'quite often' about their weight. 27% of pupils said they worry about their diet and 12% went to school without anything to eat or drink for breakfast.

A Young People's Healthy Weight and Physical Activity Needs Assessment to explore perceptions of healthy weight services in Kingston was completed in May 2014. The consultation reached 115 young people and results revealed that body image had a significant impact on young people's mental wellbeing. Young people reported knowing about healthy choices but felt pressure from peers, and so chose to eat what their friends ate.

Local Action

Child and family based lifestyle weight management groups (the 'Factor Programmes') run across Kingston, although uptake needs to be improved. There is also a specialist dietetic service available in secondary care. Both of these interventions provide a family-based approach to care and aim to improve the psychological well-being and quality of life of obese children.

Kingston's child weight management care pathway has been developed in consultation with local providers to ensure that referral arrangements are clear. This care pathway needs sharing widely to ensure any emotional or psychological wellbeing concerns with any overweight or obese children can be managed through appropriate referrals made in line with NICE guidelines³³.

Adults

Local picture

In Kingston 14.6% of adults are estimated to be obese³⁴. Drawing from a recent systematic review and meta-analysis, obesity was found to increase the risk of depression¹. Applying the results of this meta-analysis to Kingston's population, we can estimate that approximately 3,400 obese residents will suffer from depression³⁵.

Further work is required analysing local data sources to establish a clearer picture with other mental health conditions.

Local Action

Weight Management in the Community

A range of programmes are open to anyone who lives in Kingston, or is registered with a Kingston GP which will include people with mental health problems. As well as improving diet choices, cooking skills and aiding weight loss, these courses build participation with others and decrease social isolation. Some community cooking programmes are specifically run for people with poor mental health (such as the Cook and Eat programme run with the Community Mental Health Team in partnership with the Kingston United Reformed Church).

Community Dietetics and Specialist Weight Management

Approximately 50% of the morbidly obese population (with body mass index over 35) use food to manage their emotional lives⁴. The prevalence of Binge Eating Disorder (BED) in the morbidly obese is around 30% in patients seeking weight management services. Screening is required to identify those people that

are emotional eaters who do not meet the diagnostic criteria for BED^{36,37} but may benefit from psychological input to aid adherence and success in managing their weight. Whilst there is a Community GP dietetic service in Kingston, a tier 2/3 specialist weight management service with multidisciplinary input would be the best service to manage such people. There is no service at present in Kingston, but the commissioning of this service is planned.

Surgery for Obesity and Screening for Mental Health Problems

Sometimes surgery for obesity is needed. 70 people from Kingston were referred for bariatric surgery assessment in 2012 – 13. The specialist bariatric team at St George's Healthcare NHS Trust screens all adults referred for psychological and lifestyle issues which may interfere with attempts to manage weight and engagement including:

- Anxiety and depression
- Self-harm and suicidal behaviours
- Eating disorders (for example, BED and Bulimia Nervosa)
- Borderline personality disorders
- Alcohol or substance misuse

Psychological Therapies Service and Eating Issues

People receiving treatment for mental health problems relating to anxiety and depression at the Improving Access to Psychological Therapies (IAPT) Service complete the PHQ-9 questionnaire at the initial assessment which includes a question on appetite / overeating and they are also asked about their interest in weight control. Clients are also encouraged to self-report their weight, especially if they mention disordered eating behaviours. Where weight concerns are raised, interested adults are signposted to weight management services in Kingston and in addition the IAPT Mindfulness courses for people with repetitive behaviours (such as binge or comfort eating). This service also sees people with mild to moderate eating disorders who do not meet the criteria for the specialist service.

Dietetics Service for People using Mental Health Services

Kingston's Mental Health dietetic service is provided for all patients under the care of local mental health services provided by South West London and St George's Mental Health Trust as an outpatient service. The main reasons for referral include:

- Weight management secondary to medication provided to manage mental health problems
- Nutritional support (especially in older adults)
- Where a patient has a diagnosis of disordered eating and accompanying range of mental health issues but where the patient does not have severe anorexia nervosa or bulimia nervosa requiring highly specialist care
- Other conditions that require dietetic input such as diabetes secondary to antipsychotic medication

When patients are discharged from the Trust they are discharged back into the care of community mental health services and Kingston's local dietetics service if follow-up is required for weight management.

For people with severe eating disorders, the Mental Health Trust runs a specialist Eating Disorders service.

Breastfeeding

In Kingston, an Infant Feeding Team (IFT) was recruited in 2012-13 to support breastfeeding locally. The IFT predominately see women experiencing difficulty with breastfeeding, who often experience stress, a feeling of inadequacy and confusion, and poor emotional wellbeing. The service works to the UNICEF Baby Friendly guidelines to support optimum nutrition and prevent the distress that can be associated with being unable to breastfeed. When women present signs of postnatal depression the IFT work with the Health Visiting Team and refer women to the Kingston Wellbeing Service where necessary. From April 2013 to March 2014 there were 252 referrals to the IFT for breastfeeding support (predominantly undertaken by home visits). In addition, approximately 30 mothers per week are seen at drop-ins. In 2013-14, 86% of women in Kingston initiated breastfeeding³⁸ and by six to eight weeks the prevalence was 76%, a 4% increase since 2012-13 and considerably higher than the national average.

Recommendations

1. Work with partners to act on the recommendations outlined in the secondary school SHEU surveys and Children and Young People's Healthy Weight and Physical Activity needs assessment to improve dietary habits and weight management of young people in Kingston, and thereby improve wellbeing, body image and self-esteem
2. Develop further training for the local provider and programme leaders of the Factor children's Weight Management Programmes to increase understanding and recognition of when a child and family may need additional psychological support to address mental health and wellbeing concerns
3. Work closely with Kingston CCG, Your Healthcare, Kingston Hospital and CAMHS to increase awareness of the child weight management pathway and those children and families who may require psychological assessment and input
4. Review current training packages for local community healthy lifestyle programmes (such as Cook and Eat) to maximise the opportunities for participants to improve their mental health and wellbeing as well as their cooking skills and confidence
5. Support schools in meeting the new mandatory food standards and developing an active growing, cooking and eating environment to support children and young people's emotional wellbeing
6. Continue to meet the recommendations within the Healthy Weight and Physical Activity Strategy 2013-16 which include specific actions around improving services for patients with mental health conditions
7. Progress the commissioning of a tier 2/3 specialist adult weight management service with multidisciplinary input

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5.6 Sexual Health

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Key messages

- High quality personal, social and health education should be provided to children and young people so that they are able to deal with relationship issues
- Unwanted pregnancy is associated with an increased risk of mental health problems and teenage mothers have three times the rate of postnatal depression and a higher risk of poor mental health for three years after the birth
- As a group, people with HIV have higher rates of mental health problems than those seen in the general population
- Local work is being undertaken to address mental health issues in the lesbian, gay, bisexual and transgender population

Introduction

There are a number of aspects of sexual health which link to a person's mental wellbeing, although these may not be immediately apparent. This chapter discusses a number of areas including stigma, young people's issues, Human Immunodeficiency Virus (HIV), and issues affecting the lesbian, gay, bisexual and transgender populations.

Embarrassment and Stigma

Stigma and poor sexual health are closely associated. People's embarrassment, fear of judgement or experience of discrimination can have significant effects. For example:

- Stigma and discrimination associated with HIV infection can have an effect on quality of life and mental health¹
- Stigma and fear of judgement can deter people from getting tested for sexually transmitted infections (STIs) and taking their treatment
- Undiagnosed and untreated STIs, including HIV, pose a greater risk of onward transmission to uninfected partners and of complications occurring
- Embarrassment may result in not using contraception, which significantly increases the risk of unintended pregnancy and the mental health issues that may then arise

In order to reduce stigma and embarrassment, sexual health services are available in a wide range of settings so people can access them in a way they feel comfortable with. Local residents can receive advice and free condoms from many schools, GPs, community pharmacies and Kingston Integrated Sexual Health (KISH) outreach events. These services will also direct people to specialised sexual health clinics for further advice and screening when appropriate.

Unwanted Pregnancy, Teenage Pregnancy and Mental Wellbeing

Mental health during and after pregnancy is covered in more detail in Chapter 3.1. A recent review by the Academy of Medical Royal Colleges and the National Collaborating Centre for Mental Health concluded that unwanted pregnancy is associated with an increased risk of mental health problems².

Locally a wide range of contraceptive services are commissioned to reduce the number of unwanted pregnancies. Community clinics, GPs and some pharmacies provide free contraceptive provision and advice, while The Wolverton Sexual Health Centre provides a comprehensive level 3 sexual health service which includes services for women with complex needs. Local abortion services are provided by the British Pregnancy Advisory Service and may be accessed without GP referral.

Continuing to reduce pregnancies in women aged under 18 is a high priority because teenage mothers have three times the rate of postnatal depression and a higher risk of poor mental health for three years after the birth³. A partnership group has been established in Kingston to improve and standardise the delivery of sex and relationships education (SRE) to young people. Additionally the Public Health Link Workers support SRE in schools (see Chapter 3.2). The KU19 service provides a full sexual health service accessible to those aged 19 and under, and young people have free access to condoms through the pan London 'Come Correct' scheme.

Young People's Issues

Knowledge of sexual health, interpersonal relationships, and body image concerns are factors that have an impact on the development of self-esteem during the years of adolescence. Sex and relationships education in schools is a key method for tackling the mental wellbeing issues linked to sexual health. This includes consent to have sex, dealing with difficult partners and how to seek help.

The new Supplementary Advice to the Government's Sex and Relationship Education Guidance⁴ explains how schools can address contemporary sex and relationships issues that have emerged because of concerns about sexual exploitation and technological change and will set the standard for teaching that is inclusive of all pupils.

In January 2014, the Sex Education Forum released results showing that three in ten young people did not learn about consent in school and that young people report that learning tends to be too theoretical and fails to discuss real-life situations including what to do 'if something happens'. A third of young people 'didn't know' or were 'unsure' where to get help if sexually assaulted and 40% were unsure where to find their local sexual health clinic.

High quality personal, social and health education (PSHE) of an agreed standard is needed across Kingston which should include sex and relationships, mental health and behaviour issues⁵. Since June 2013 there has been a partnership working group in Kingston with the aim of delivering this through the sharing of best practice with all educational settings. The objectives of this group include:

- Review of settings which have less comprehensive PSHE or lack quality assurance in delivering PSHE
- Commissioners to agree a model of PSHE with measureable, achievable, and relevant objectives and outcomes
- Establish a system using the above proposed model that is accessible to all relevant settings providing national (for example PSHE Association), regional, and local resources of evidenced and evaluated best practice guidance and tools

Human Immunodeficiency Virus (HIV)

Being diagnosed and living with a serious illness like HIV is likely to have a major emotional impact, and people with HIV, as a group, have higher rates of mental health problems than those seen in the general population⁶. Starting treatment for HIV with antiretroviral therapy may cause a variety of symptoms, including depression, anxiety, and sleep disturbance, and may make some mental health issues worse. Mild cognitive changes or more severe cognitive conditions, such as dementia, are associated with advanced HIV disease.

Patients with HIV who have mental health problems will be seen by the relevant generalist or specialist service.

Lesbian, Gay, Bisexual and Transgender (LGBT) Population

Gay and bisexual populations often have experiences that affect their mental wellbeing, including:

- Hostility, rejection and bullying from family, parents, friends and 'significant others' such as teachers and work colleagues
- Rejection by most mainstream religions
- Danger of violence in public places
- Harassment from neighbours
- Casual homophobic comments on an everyday basis
- Embarrassed response (and occasionally prejudice) from professionals

As part of the Kingston sexual health needs assessment for LGBT⁷, mental wellbeing was considered. Of the 125 LGBT people who responded to the survey, 12% were lesbian, 77% were gay men, 8% were bisexual and 0.8% identified themselves as 'other'. The findings are in Table 1 below and demonstrate the high level of mental health issues in the local population.

Table 1: Mental health and wellbeing in the lesbian, gay, bisexual and transgender population of Kingston

Mental health issue	Kingston LGBT findings
Anxiety and depression	81% of Kingston LGBT respondents had experienced mental health issues. The most common issues were stress (67% of all respondents), anxiety (57%) and depression (54%).
Suicidal thoughts and attempted suicide	30% of Kingston LGBT respondents stated that they had experienced suicidal thoughts. No data was available regarding suicide attempts.
Self harm	14% of all respondents reported experiences with self-harm. All were aged under 50.
Eating disorders	13% of all respondents reported experiences with eating disorders. All were aged under 50.

Source: Survey for LGBT needs assessment, Kingston

The LGBT needs assessment has identified the need to increase the access and availability of mental health counselling support across LGBT communities. A review of provision at the Wolverton Centre (which provides sexual health services) and in primary care is being led by Public Health.

Recommendations

1. Improve effectiveness of sex and relationships education through delivering the objectives of the Partnership Working Group
2. Public Health should continue to ensure the recommendations from the LGBT needs assessment are progressed, including the provision of mental health counselling support for LGBT communities

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Section 6

Profiles

6.1 Mental Health Profile

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Introduction

This chapter summarises the key data available for Kingston on the determinants and risk factors that affect mental health and wellbeing as well as providing information on the occurrence of mental health problems. Comparisons are made with other areas as appropriate.

It also summarises the most recent data from services for people with mental health problems, including outcomes data.

Domain 1 – The Wider Determinants of Wellbeing

1. Social isolation

Social disconnectedness or isolation (small social networks or infrequent participation in social activities) and perceived isolation (perceived loneliness or lack of social support) are associated with mental and physical illness. Older adults who feel more isolated report higher level of depressive symptoms than those who feel less isolated, regardless of their actual levels of connectedness¹. Among older people, lower levels of contact with social networks and loneliness have been found to be associated with an increased risk of cognitive decline and dementia².

The subjective experience of loneliness can affect mental health in a number of ways. Loneliness can lead to feelings of anger, vulnerability, depression and pessimism. Whilst not all people living alone feel lonely, the number of people living alone gives a guide of those who are at risk of social isolation due to their living circumstances.

Table 1 shows the percentage and number of older people living alone in Kingston. It can be seen that a higher percentage of older women live alone compared with men. Table 2 presents the self reported levels of social contact as an indicator of social isolation for users of social care. The percentage of social care service users who are as connected as they wish to be in Kingston (40.7%) is slightly higher than the regional average (39.8%) but lower than the national average (43.2%).

Table 1: Older people living alone (rates and predicted numbers in Kingston)

Age range	% Males	% Females	Predicted numbers in Kingston	
			Males	Females
65-74	20%	30%	1,065	1,703
75+	34%	61%	1,367	3,805

Source: POPPI and 2012 mid-year population, ONS
 Figures are taken from the General Household Survey, 2007.
 Table 3.4 Percentage of men and women living alone by age using ONS 2012 mid-year population estimates.

Table 2: Social isolation in people aged 18 and above who attend social care services in Kingston, London and England, 2012-13

	Kingston	London	England
Percentage of adult social care users who have as much social contact as they would like	40.7% (35.1 to 46.3)	39.8% (39.0 to 40.6)	43.2% (42.7 to 43.7)

Values in brackets denote 95% confidence intervals
 Source: Adult Social Care Survey, England 2012/13

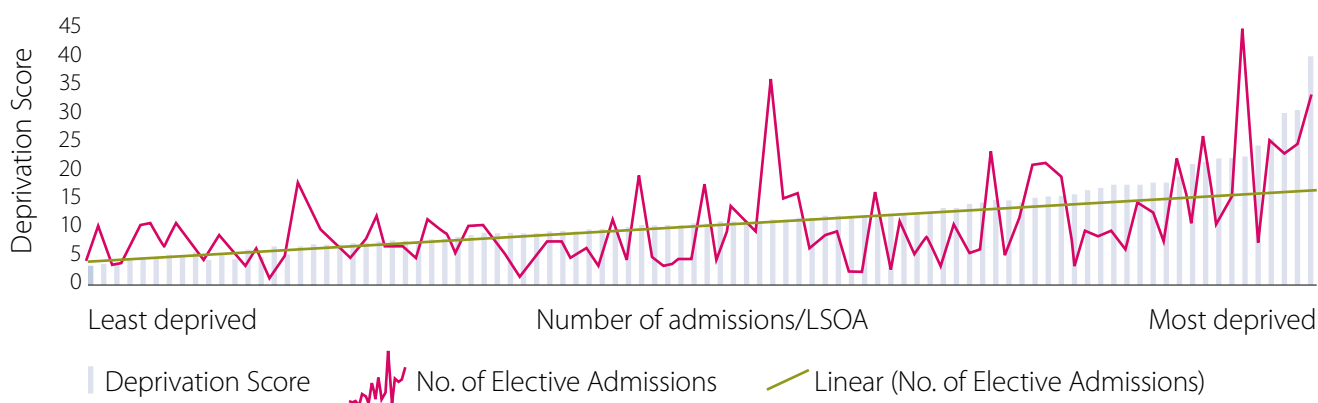
2. Deprivation

Poverty can be both a determinant and a consequence of poor mental health. Poverty and social inequality have direct and indirect effects on the social, mental and physical wellbeing of an individual. Income inequality produces psychosocial stress, which leads to deteriorating health and higher mortality over time³.

Large numbers of studies have demonstrated an inverse relationship between mental illness and social class. Psychiatric disorders have been consistently shown to be more common among people in lower social classes⁴.

Locally, data received from South West London and St George's Mental Health Trust demonstrates that there is a moderate correlation between a higher number of both elective and emergency admissions to specialist mental health care and living in areas of disadvantage (Figures 1 and 2).

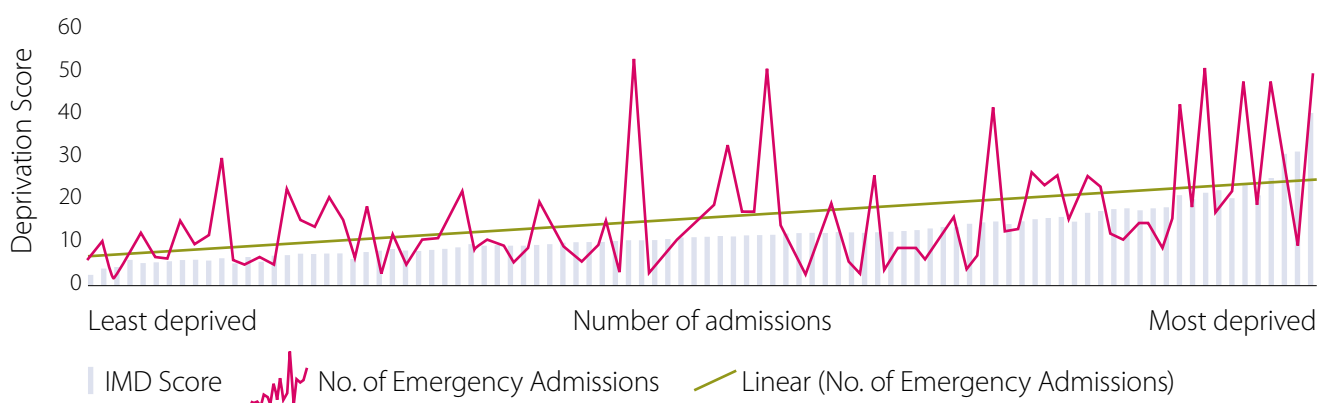
Figure 1: Elective admissions to SWL and St George’s Mental Health Trust by deprivation score, 2009-13, Kingston residents. R = 0.58



R denotes the 'Pearson Product-Moment Correlation Coefficient' which measure of the strength and direction of the linear relationship between two variables. $R=0.58$ indicates a moderate correlation between number of admissions and the deprivation scores. The Deprivation Score is based on Lower Super Output Areas.

Source: SWL and St George's Mental Health Trust, 2009-13 elective admissions, July 2014

Figure 2: Emergency admissions to SWL and St George’s Mental Health Trust by deprivation score, 2009-13, Kingston residents. R = 0.52



R denotes the 'Pearson Product-Moment Correlation Coefficient' which measure of the strength and direction of the linear relationship between two variables. $R=0.52$ indicates a moderate correlation between number of admissions and the deprivation scores. The Deprivation Score is IMD based on Lower Super Output Areas.

Source: SWL and St George's Mental Health Trust, 2009 – 2013 elective admissions, July 2014

3. Ethnicity

Rates and experiences of mental health problems differ between ethnic groups. The general consensus is that Black and Minority Ethnic groups living in the UK are more likely to be diagnosed with a mental health problem, more likely to be admitted, more likely to have poor outcomes and more likely to disengage from mental healthcare^{5,6}.

Table 3 shows the ethnic makeup of the Kingston population and the number of patients admitted to SWL and St George’s Mental Health Trust by ethnicity. The elective and emergency admission rates for people from White and Black ethnic groups were similar to each other and were higher than admissions of Asian people.

Table 3: Elective and emergency admissions to SWL and St George’s Mental Health Trust by ethnicity, 2009-13, Kingston residents

Ethnic Group	Population	Number of elective Admissions	% of the population admitted	Number of emergency Admissions	% of the population admitted
White	118,974	787	0.7%	1,156	1.0%
Asian	26,889	64	0.2%	95	0.4%
Black	6,133	49	0.8%	59	1.0%
Other Ethnic Background	6,335	22	0.3%	38	0.6%
Chinese	2,961	7	0.2%	11	0.4%
Total	161,292	932	0.6%	1,361	0.8%

Source: SWL and St George’s Mental Health Trust, 2014

4. Unemployment

Unemployment and economic inactivity are associated with increased risks of developing mental health problems. In addition people with mental health problems are at increased risk of becoming unemployed^{7,8}.

In Kingston, the percentage of 16 to 18 year olds who are not in education, employment or training (NEET) increased from 3.3% in 2011 to 3.6% in 2012 and the regional percentage also increased from 4.5% to 4.7% during the same period whilst the national prevalence decreased from 6.1% in 2011 to 5.8% in 2012. However, the percentage of NEET in Kingston was still significantly lower than the London and England percentages in 2012 (Table 4).

Table 4: Percentage (%) of 16-18 year olds not in education employment or training in Kingston, London and England, Persons, 2011-12

	Kingston	London	England
2011	3.30% (2.80 to 3.87)	4.50% (4.44 to 4.60)	6.10% (6.10 to 6.17)
2012	3.60% (3.03 to 4.10)	4.70% (4.62 to 4.78)	5.80% (5.77 to 5.84)

Value in brackets denote 95% confidence intervals
Source: Department of Health, 2014

Table 5 illustrates the percentages of employed and unemployed people in Kingston, London and England. The percentage of employed workers in Kingston (74.3%) was higher in 2012-13 than the percentages for London (69.8%) and England (70.9%).

The unemployment rate of workers aged 16 and over was lower in Kingston (5.4%) than the rates for London (8.7%) and England (7.8%).

Table 5: Employment rates (%) in Kingston, London and England, 2012/13

	Kingston	London	England
Employment rate (working age 16 to 64 years, %)	74.3%	69.8%	70.9%
Male employment rate	76.7%	76.7%	76.3%
Female employment rate	71.7%	62.8%	65.5%
ILO Unemployment rate (proportion of residents aged 16+ who are unemployed-model based)	5.4%	8.7%	7.8%

ILO = International Labour Organisation
Source: the Labour Force Survey (LFS), ONS

Domain – 2 Risk factors

Main risk factors to good mental health

1. Crime

Crime can result directly in psychological distress and subsequent mental health problems. It affects the mental wellbeing of both victims and non-victims. There is a direct impact on victims and an indirect impact on society due to the fear of crime. Evidence indicates a decrease in mental wellbeing after crime victimization and that the crime rate has a negative impact on the mental wellbeing of non-victims⁹.

Table 6 shows that Kingston has a lower level of crime than the London average and both the Kingston and London rates have declined in 2013-14 in comparison with the previous year.

Table 6: Total crime rate in Kingston and London, per 1,000 population, 2012-14

	Kingston	London
August 2012 – July 2013	60.3	89.3
August 2013 – July 2014	55.2	82.4

Source: Metropolitan Police website accessed on 3/9/14

The Metropolitan Public Attitude Survey measures the public's confidence in local policing. Results of this survey published in February 2014 indicated that 79% of Kingston residents believe police are performing 'well' or 'excellently' with only 4% replying negatively.

2 Substance misuse

a. Alcohol

Alcohol misuse is closely linked with mental health issues including anxiety and depression.

The estimated prevalence of high risk drinking in Kingston, London and England is shown in Table 7. The percentage of high risk drinking is estimated to be higher in Kingston (8.03%) than the regional (6.87%) and the national (6.75%) averages.

Table 7: The percentage of people engaged in high risk drinking, aged 16 years and over, Kingston, London and England, synthetic estimate, Mid – 2009

	Kingston	London	England
Percentage of people engaged in high risk drinking, 16+	8.0% (2.7 to 25.3)	6.9% (2.4 to 22.5)	6.8% (2.4 to 21.8)

High risk drinking is defined as usual consumption of more than 50 units of alcohol per week for males, and more than 35 units of alcohol per week for females.

Value in brackets denote 95% confidence intervals

Source: Local Alcohol Profiles for England, 2014

Table 8 illustrates the two indicators of hospital admissions due to alcohol-related conditions. The original indicator (Broad) considers all codes (primary and any secondary codes) that are recorded in relation to a patient's admission record, and if any of

these codes has an alcohol-attributable fraction then that admission would form part of the alcohol-related admission total.

The new indicator (Narrow) seeks to count only those admissions where the primary code has an alcohol-attributable fraction. Although alcohol-attributable fractions exist for external cause codes (such as 27% of assaults), these cannot be recorded as a primary code so the new indicator also includes admissions where the primary code does not have an alcohol-attributable fraction but where one of the secondary codes is an external cause code with an alcohol-attributable fraction.

Both of the narrow and broad rates of alcohol related admissions in 2012-13 were significantly lower in Kingston than the London and England rates (Table 8).

Table 8: Directly standardised rate of hospital admissions due to alcohol-related conditions, per 100,000 population, Kingston, London and England, all ages, 2012-13

	Kingston	London	England
Rate of alcohol related admissions (Broad definition)*	1,664.2 (1,592.9 to 1,737.8)	2,147.5 (2,135.5 to 2,159.6)	2,031.8 (2,027.8 to 2,035.8)
Rate of alcohol related admissions (Narrow definition)**	386.4 (353.7 to 421.3)	553.8 (548.0 to 559.6)	636.9 (634.7 to 639.1)

Note: *Broad measure [primary diagnosis or any secondary diagnosis]

**Narrow measure [primary diagnosis or any secondary diagnosis with an external cause]

Values in brackets denote 95% confidence intervals

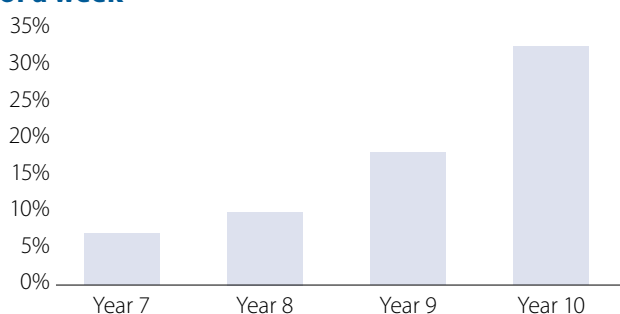
Source: LAPE (Local Alcohol Profiles), 2014

Children drinking Alcohol

The Kingston Young People's Survey that was undertaken in 2013 included pupils from secondary and academy schools in Kingston and focused on pupils in Years 7 to 10.

This survey showed that the proportion of children drinking alcohol increase with increasing age from 7% for Year 7 to 32% at Year 10 (Figure 3). The survey also indicated that 5% of the pupils who took part in the survey and 11% of Year 10 pupils got drunk on at least one day in the last week.

Figure 3: Percentage of pupils who had at least one alcoholic drink over a period of a week



Source: Kingston Young People's Survey, 2013

b. Drugs

Drugs can worsen the symptoms of mental illness and also make mental health problems more difficult to treat. Table 9 shows that less people were misusing drugs in Kingston than in London and England. The estimated prevalence of OCU (see definition below Table 9) and opiate use in Kingston was significantly lower in 2011-12 than the London and England averages. Estimates of crack use in Kingston during the same period indicated that significantly fewer people used this drug than the London average.

Table 9: Estimates of the prevalence of opiate use and/or crack cocaine use per 1,000 population, 2011-12

	Kingston	London	England
OCU*	4.69 (3.86 to 6.89)	9.55 (9.35 to 10.05)	8.40 (8.32 to 8.63)
Opiate Users	3.95 (3.31 to 5.51)	7.63 (7.46 to 8.08)	7.32 (7.25 to 7.53)
Crack Users	3.39 (2.55 to 5.08)	6.96 (6.65 to 7.29)	4.76 (4.62 to 4.96)

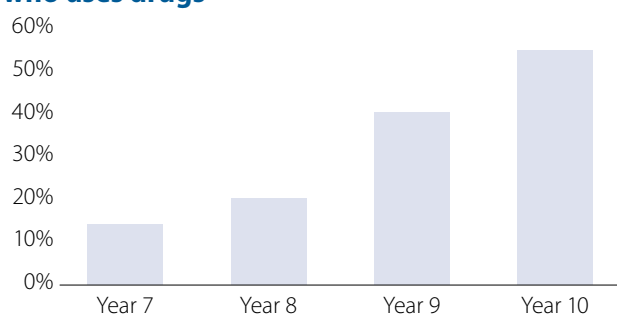
Value in brackets denote 95% confidence intervals

*"OCU" is defined as a client presenting with opiates and / or crack cocaine as their main, second or third drug recorded at any episode during their latest treatment journey.

Source: National Treatment Agency

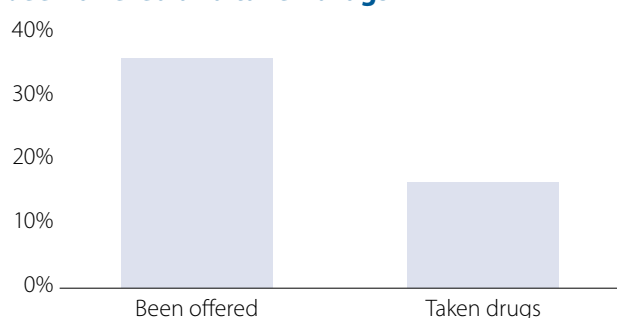
Data from the Kingston Young People's Survey show that the proportion of pupils who know someone who is using drugs increases with age from 14% in Year 7 to 54% in Year 10 (Figure 4). Figure 5 indicates that 36% of Year 10 pupils who were offered drugs and 17% reported that they had used them.

Figure 4: Percentage of pupils who said they are fairly sure or certain that they know someone who uses drugs



Source: Kingston Young People's Survey, 2013

Figure 5: Percentage of Year 10 pupils who have been offered and taken drugs



Source: Kingston Young People's Survey, 2013

3 Homelessness

Mental health problems are much more common among homeless and vulnerably housed people than in the general population. In many instances mental health problems plays a significant part in the circumstances which cause people to lose their accommodation and this in turn makes it even harder for these people to achieve stability in their housing.

The prevalence of common mental health problems in the UK is over twice as high amongst the homeless population compared to the general population. This is worse among street homeless people, who may be 50 to 100 times more likely to have a psychotic disorder than the general population¹⁰.

Local authorities have a duty under homelessness legislation to house homeless households that are eligible for assistance, unintentionally homeless and in priority need. Table 10 presents the crude rate of these households for which the local authority accepts responsibility for securing accommodation. The crude rate of these households increased from 2.01 per 1,000 households in 2010-11 to 2.59 in 2011-12. The rates were lower in Kingston than in London in 2011-12 but were higher than the national rates.

The crude rate of households in temporary accommodation declined from 7.53 per 1,000

households in 2010-11 to 7.31 in 2011-12 in Kingston while both of the regional and national rates increased during the same period. The rates of households in temporary accommodation in Kingston during 2010-11 and 2011-12 were significantly lower than the regional rates but higher than the national rates (Table 11).

Table 10: Statutory homeless households, crude rate per 1,000 estimated households in Kingston, London and England, all ages, 2010-12

	Kingston	London	England
2010/11	2.01 (1.69 to 2.38)	3.14 (3.08 to 3.20)	2.03 (2.01 to 2.05)
2011/12	2.59 (2.22 to 3.00)	3.92 (3.85 to 3.99)	2.31 (2.29 to 2.33)

Values in brackets denote 95% confidence intervals
Source: Department of Communities and Local Government, 2014

Table 11: Households in temporary accommodation, crude rate per 1,000 households in Kingston, London and England, all ages, 2010-12

	Kingston	London	England
2010/11	7.53 (6.89 to 8.21)	11.05 (10.94 to 11.17)	2.22 (2.20 to 2.24)
2011/12	7.31 (6.68 to 7.98)	11.33 (11.21 to 11.44)	2.32 (2.30 to 2.34)

Values in brackets denote 95% confidence intervals
Source: Department of Communities and Local Government, 2014

Table 12 presents estimates of rough sleepers provided by the Department of Communities and Local Government (DCLG) in 2013. A total of 11 people were estimated to be sleeping rough in Kingston, 543 in London and 2,414 in England. These figures may underestimate the actual numbers given information from night counts that have been undertaken.

Table 12: Street sleeping and estimates of rough sleeping in Kingston, London and England, 2013

	Kingston	London	England
Total*	11	543	2,414

Source: Rough Sleeping Statistics in England, autumn 2013 official statistics by DCLG

*based on a street count or an estimate for each London borough (Kingston was an estimate)

4 Unpaid carers

The 2011 census reports that in Kingston 13,288 carers (8.3% of the population of Kingston) provide care for people with physical and mental health problems, mostly in their own homes. Of these, 2,346 provide care for over 50 hours a week. There are 251 young carers aged under 16 (Table 13). The peak age for carers is between the fifth and seventh decades¹¹. Figure 6 compares the number of hours of unpaid care provided per week for Kingston, London and England.

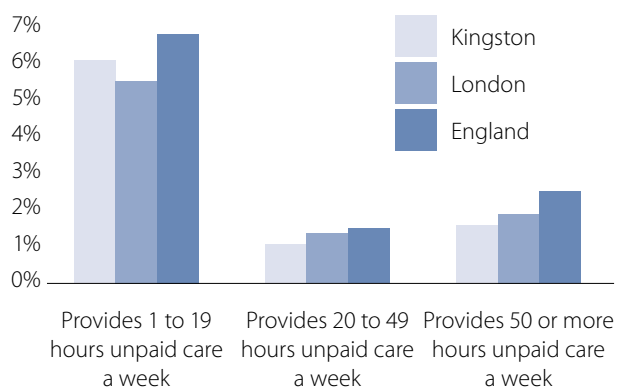
An estimated 40 to 50% of all carers provide care for another family member or friend with a mental health problem¹². A survey of over 1,000 carers in contact with carers' organisations found that just less than 50% believed that their health was adversely affected by their caring role¹³. Mental health problems included stress and tension (38%), anxiety (27%) and depression (28%). Carers may attribute symptoms of an illness to their work as a carer and fail to recognise the onset of an illness¹⁴.

Table 13: Provision of unpaid care by number of hours and age in Kingston, 2011

Age	Provides unpaid care: Total		Provides 1 to 19 hours unpaid care a week		Provides 20 to 49 hours unpaid care a week		Provides 50 or more hours unpaid care a week	
	Count	%	Count	%	Count	%	Count	%
All Ages	13,288	8.3%	9,331	5.8%	1,611	1.0%	2,346	1.5%
Age Under 16	251	0.8%	206	0.7%	19	0.1%	26	0.1%
Age 16 to 24	786	3.6%	629	2.9%	108	0.5%	49	0.2%
Age 25 to 34	1,229	4.8%	852	3.3%	184	0.7%	193	0.8%
Age 35 to 49	3,705	10.1%	2,569	7.0%	459	1.3%	677	1.8%
Age 50 to 64	4,787	18.8%	3,630	14.3%	548	2.2%	609	2.4%
Age 65 and over	2,530	12.4%	1,445	7.1%	293	1.4%	792	3.9%

Source: Table LC3304EW, 2011 Census, ONS. % refers to % of total population in the relevant age band

Figure 6: Provision of unpaid care by number of hours in Kingston, London and England 2011, Percent of the total population providing unpaid care



Source: 2011 Census, ONS

Domain 3: Levels of Mental Wellbeing and Mental Illness in Kingston

1 Wellbeing

National survey

Table 14 illustrates subjective measures of wellbeing based on four questions included in the Integrated Household Survey:

- Overall, how satisfied are you with your life nowadays?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?
- Overall, to what extent do you feel the things you do in your life are worthwhile?

Table 14 shows that Kingston residents score 11th highest in London on life satisfaction, 25th highest on feeling that the things they do are worthwhile and 19th highest for both happiness and anxiety.

Table 14: Self reported wellbeing of people aged 18 years and over in Kingston and London rank 2012/ 13

	Year	Life satisfaction	Worthwhile	Happiness	Anxiety	Sample Size
Average Rating	2012/13	7.3 (7.1 to 7.5)	7.5 (7.3 to 7.7)	7.2 (6.9 to 7.4)	3.2 (2.9 to 3.5)	410
Rank in London (2012/13)		11	25	19	19	

Responses are given on a scale of 0-10. (Where 0 is "not at all satisfied/happy/anxious/worthwhile" and 10 is "completely satisfied/happy/anxious/worthwhile"). High is good for satisfied/happy/worthwhile, low is good for anxious.

Values in brackets denote 95% confidence intervals

Source: Annual Population Survey (APS); Office of National Statistics (ONS).

Local Kingston Lifestyle Survey

The findings from the Kingston Lifestyle Survey give us a baseline of how people are feeling in Kingston. They reveal that, while overall the results are good, Kingston residents are less positive about their feelings about the future and about how relaxed

they feel compared to the other emotional wellbeing questions in the Kingston survey. The findings also showed that residents are most positive about being able to make up their mind, thinking clearly, dealing with problems well and feeling useful (Table 15).

Table 15: Self reported emotional wellbeing of people aged 16 years and over in Kingston (%), 2014

Survey Question	None of the time	Rarely	Some of the time	Often	All of the time	Don't Know
Optimistic about the future	9.33% (6.86 to 11.80)	8.12% (5.65 to 10.59)	28.75% (26.28 to 31.22)	29.78% (27.31 to 32.25)	19.23% (16.76 to 21.70)	4.79% (2.32 to 7.26)
Feeling useful	4.98% (2.51 to 7.45)	5.24% (2.77 to 7.77)	22.43% (19.96 to 24.90)	36.04% (33.57 to 38.51)	27.99% (25.52 to 30.46)	3.32% (0.85 to 5.79)
Relaxed	7.54% (5.07 to 10.01)	14.70% (12.23 to 17.17)	32.97% (30.50 to 35.54)	29.39% (26.92 to 31.86)	13.48% (11.01 to 15.95)	1.92% -
Dealing with problems well	4.41% (1.94 to 6.88)	5.50% (3.03 to 7.97)	23.07% (20.60 to 25.54)	41.41% (38.94 to 43.88)	22.75% (20.28 to 25.22)	2.88% (0.41 to 5.35)
Thinking clearly	3.51% (1.04 to 5.98)	2.49% (0.02 to 4.96)	15.46% (12.99 to 17.93)	39.94% (37.47 to 42.41)	36.23% (33.76 to 38.70)	2.36% -
Able to make up your own mind about things	2.94% (0.47 to 5.41)	2.11% -	9.65% (7.18 to 12.12)	31.88% (29.41 to 34.35)	51.25% (48.78 to 53.72)	2.17% -
Close to other people	3.32% (0.85 to 5.79)	2.81% (0.34 to 5.28)	12.01% (9.54 to 14.48)	31.05% (28.58 to 33.52)	48.18% (45.71 to 50.65)	2.62% (0.15 to 5.09)

Note: '-' indicate that number of responses were too small to allow calculation of the confidence interval.

Number of people who responded to this question was 1,656.

Questions based on 'Warwick – Edinburgh Mental Well-being Scale' (WEMWBS).

Source: Kingston Lifestyle Survey, 2014

Ward level scores for wellbeing (nationally derived)

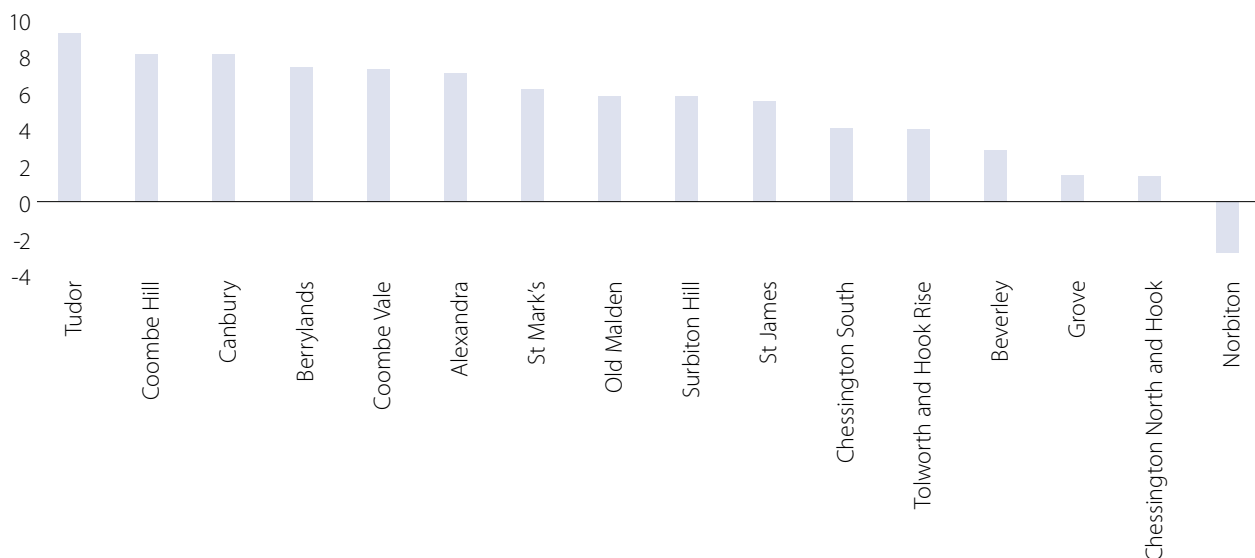
The ward level wellbeing scores presented overleaf are objective scores that represent a combined

measure of well-being based on 12 different measures: Life expectancy, incapacity benefits claimant rate, unemployment rate, income support claimant rate, crime rate, deliberate fires, GCSE point scores,

unauthorised pupil absence, out-of-work households with children, public transport accessibility scores and access to public open space and nature. This indicator score can be compared with the England and Wales average, which is zero. Scores higher than zero indicate

a higher probability that the population on average experiences positive wellbeing according to these measures (Figure 7). The wellbeing scores of all Kingston wards apart from Norbiton have positive values.

Figure 7: Ward level well-being probability score, Kingston, 2012



Source: Intelligence Unit, Greater London Authority

Young People's Emotional Health and Wellbeing

Local Survey

Results of the Kingston Young People Survey are discussed in chapter 3.2.

Looked after children

Looked after children especially those in residential care are identified as a group whose mental health needs are known to be greater than those of the general population of the same age⁵.

Since 2008, the government has placed an onus on local authorities to monitor the emotional wellbeing of looked after children via a tool called the strengths and difficulties questionnaire (SDQ). This produces a single summary figure for each child (the total difficulties score), ranging from 0 to 40, with children having no difficulties scoring between '0 to 13', few difficulties '14 to 16', some difficulties '17 to 28' and severe difficulties '29 to 40'. Table 16 illustrates the average SDQ score for all looked after children aged between five and 16 years (inclusive) who have been in care for at least 12 months. The results indicate that on average looked after children in Kingston were facing more difficulties in 2012-13 than the previous two years. This was not the case for looked after children in London and in England as a whole.

Table 16: Emotional wellbeing score of looked after children in Kingston, London and England, 2010/11 – 2012/13

	Kingston	London	England
2010/11	13.20	13.60	13.90
2011/12	14.10	13.60	13.90
2012/13	15.40	13.50	14.00

Note: Higher scores indicate more difficulties

Source: Department of Education.

2 Prevalence of main Mental Health Conditions in Kingston

Overall Prevalence of Mental Health Disorders

Estimates of the prevalence of common mental health disorders vary considerably depending on where and when surveys are carried out, and the period over which prevalence is measured. The 2007 Office for National Statistics (ONS) household survey of adult psychiatric morbidity in England found that 16.2% of adults aged 16 to 64 years met the diagnostic criteria for at least one disorder in the week prior to interview. Estimates of the proportion of people who are likely to experience specific disorders during their lifetime are shown in Table 17.

Table 17: Summary of lifetime prevalence rates for common mental health disorders

Disorder	Prevalence estimates
Major depression	16.6% (lifetime)
Dysthymia (neurotic or chronic depression)	2.5% (lifetime)
Generalised Anxiety Disorder	5.7% (lifetime)
Panic disorder	4.7% (lifetime)
Agoraphobia without panic disorder	1.4% (lifetime)
Phobia (specific)	12.5% (lifetime)
Social anxiety disorder	12.1% (lifetime)
Obsessive compulsive disorder	1.6% (lifetime)
Post Traumatic Stress Disorder	6.8% (lifetime)

Source: Common Mental Health Disorders, NICE National Clinical Guideline Number 123, 2011

Neurotic Symptoms and Disorders

The term neurotic symptoms and disorders cover a range of diagnostic groups, such as anxiety disorders and mood disorders. About one fourth of the population in developed countries will suffer from neurotic disorders during their lifetime. This may result in significant costs to society from missed work as well as from direct healthcare costs. The prevalence of these conditions in the UK and the estimated number of affected adults in Kingston are shown in Tables 18 and 19

Table 18: Prevalence of Common Mental Disorders (CMD) in the UK by age (%)

	Age groups							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	All (16+)
Percentage								
Men								
Mixed anxiety and depressive disorder	8.2%	7.4%	7.4%	8.1%	6.8%	3.9%	3.8%	6.9%
Generalised anxiety disorder	1.9%	4.1%	4.7%	4.1%	2.7%	2.9%	2.2%	3.4%
Depressive episodes	1.5%	2.7%	2.6%	2.6%	1.5%	0.4%	0.5%	1.9%
All Phobias	0.3%	1.5%	1.5%	0.7%	0.6%	0.3%	-	0.8%
Obsessive compulsive disorder	1.6%	1.5%	1.2%	0.7%	0.4%	0.2%	0.3%	0.9%
Panic disorder	1.4%	0.9%	1.3%	0.8%	0.6%	1.0%	0.3%	1.0%
Any CMD	13.0%	14.6%	15.0%	14.5%	10.6%	7.5%	6.3%	12.5%
Women								
Mixed anxiety and depressive disorder	12.3%	14.1%	9.7%	14.3%	9.0%	8.6%	7.2%	11.0%
Generalised anxiety disorder	5.3%	4.3%	5.9%	8.0%	5.5%	3.6%	2.9%	5.3%
Depressive episodes	2.9%	1.7%	3.2%	4.9%	2.2%	1.6%	2.1%	2.8%
All Phobias	2.7%	2.4%	2.7%	2.2%	2.2%	0.4%	0.2%	2.0%
Obsessive compulsive disorder	3.0%	1.5%	1.0%	1.6%	0.7%	0.4%	0.5%	1.3%
Panic disorder	0.8%	2.3%	1.4%	1.1%	1.4%	0.1%	0.6%	1.2%
Any CMD	22.2%	23.0%	19.5%	25.2%	17.6%	13.4%	12.2%	19.7%
All Adults (aged 16 and above)								
Mixed anxiety and depressive disorder	10.2%	10.8%	8.5%	11.2%	8.0%	6.4%	5.9%	9.0%
Generalised anxiety disorder	3.6%	4.2%	5.3%	6.1%	4.1%	3.3%	2.6%	4.4%
Depressive episodes	2.2%	2.2%	2.9%	3.7%	1.9%	1.0%	1.5%	2.3%
All Phobias	1.5%	1.9%	2.1%	1.5%	1.4%	0.3%	0.1%	1.4%
Obsessive compulsive disorder	2.3%	1.5%	1.1%	1.1%	0.5%	0.3%	0.4%	1.1%
Panic disorder	1.1%	1.6%	1.3%	0.9%	1.0%	0.5%	0.5%	1.1%
Any CMD	17.5%	18.8%	17.3%	19.9%	14.1%	10.6%	9.9%	16.2%

Note: People may have more than one type of CMD, so the total percentage of any disorder is not the sum of those with specific disorders.

Source: ONS 2007 Survey of Psychiatric Morbidity among adults in Great Britain

Table 19: Predicted number of people (aged 16 and above) affected in Kingston by age

	Age groups							All (16+)
	16-24	25-34	35-44	45-54	55-64	65-74	75+	
Number								
Men								
Mixed anxiety and depressive disorder	858	970	969	852	531	208	153	4,439
Generalised anxiety disorder	199	537	615	431	211	154	88	2,188
Depressive episodes	157	354	340	274	117	21	20	1,222
All Phobias	31	197	196	74	47	16	-	515
Obsessive compulsive disorder	167	197	157	74	31	11	12	579
Panic disorder	147	118	170	84	47	53	12	643
Any CMD	1,361	1,913	1,964	1,526	827	399	253	8,042
Women								
Mixed anxiety and depressive disorder	1,391	1,862	1,261	1,530	726	488	449	7,501
Generalised anxiety disorder	599	568	767	856	444	204	181	3,614
Depressive episodes	328	224	416	524	177	91	131	1,909
All Phobias	305	317	351	235	177	23	12	1,364
Obsessive compulsive disorder	339	198	130	171	56	23	31	886
Panic disorder	90	304	182	118	113	6	37	818
Any CMD	2,511	3,037	2,535	2,696	1,419	761	761	13,433
All Adults (aged 16 and above)								
Mixed anxiety and depressive disorder	2,221	2,841	2,218	2,377	1,270	704	605	11,928
Generalised anxiety disorder	784	1,105	1,383	1,295	651	363	267	5,831
Depressive episodes	479	579	757	785	302	110	154	3,048
All Phobias	327	500	548	318	222	33	10	1,855
Obsessive compulsive disorder	501	395	287	233	79	33	41	1,458
Panic disorder	240	421	339	191	159	55	51	1,458
Any CMD	3,811	4,946	4,514	4,224	2,238	1,166	1,016	21,470

Note: People may have more than one type of CMD, so the total number of any disorder is not the sum of those with specific disorders.

Estimates are based on ONS Mid-Year Estimates for 2012

Source: ONS 2007 Survey of Psychiatric Morbidity among adults in Great Britain and ONS 2012 Midyear Estimates

Depression

The estimated point prevalence for major depression among 16 to 65 year olds in the UK is 21 per 1,000 population (males 17, females 25) which equates to approximately 2,400 people in Kingston¹⁶.

Table 20 shows the estimated prevalence of severe depression in people aged 65 and over and the projected number of cases in 2017, 2022 and 2027.

Table 20: People aged 65 and over predicted to have severe depression, by age, projected to 2027, Kingston

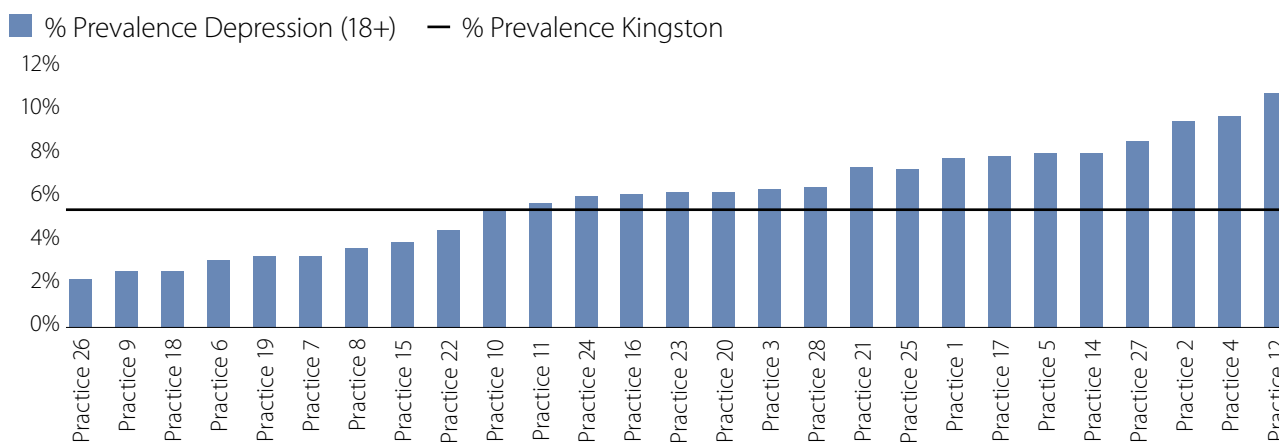
	Age group	Prevalence	2012	2017	2022	2027
Kingston	65-69	2.5%	163	178	180	208
	70-74	1.6%	72	96	106	107
	75-79	3.5%	133	144	189	210
	80-84	3.0%	93	93	102	138
	85+	3.9%	129	144	164	187

Source: POPPI (for rates of severe depression) & 2012-based Subnational Population Projections for Local Authorities in England, Office of National Statistics, 2012

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

Figure 8 illustrates the prevalence of depression on Kingston practice registers. The average prevalence of diagnosed depression is 5.3%.

Figure 8: Recorded prevalence of diagnosed depression in Kingston General Practices, 2014



Practice Population – PCSS, March 2014 Source: Disease prevalence – Practice focus Report, QMS, March 2014

Appropriate assessment of the severity of depression is an indicator of good practice and is valued by patients¹⁷. Table 21 shows that in 2012-13 a higher percentage of patients in Kingston (94.8%) were assessed at the outset of treatment than in London (88.6%) and England as a whole (90.6%).

Table 21: Percentage of people receiving a depression severity assessment at outset of treatment in people aged 18 and above in Kingston, London and England, 2011 to 2013

	Kingston (%)	London (%)	England (%)
2011/12	93.1% (91.4 to 94.6)	90.2% (89.9 to 90.4)	91.4% (91.3 to 91.5)
2012/13	94.8% (93.1 to 96.1)	88.6% (88.3 to 88.9)	90.6% (90.5 to 90.7)

Values in brackets denote 95% confidence intervals

Note: Data for 2012/13 is for Kingston CCG, whilst data for 2011-12 is for Kingston PCT

Source: The NHS Indicator Portal, 2014 (Unique identifier – P01016)

The prevalence of psychoses in the community and in general practice

The 2007 National Survey of Psychiatric Morbidity in the UK found that the overall prevalence of psychotic disorder (the main types are schizophrenia and affective psychosis, such as bi-polar disorder) in the past year was 0.4% (0.3% of men, 0.5% of women). In both men and women the highest prevalence was observed in those aged 35 to 44 years (0.7% and 1.1% respectively).

The proportion of patients in general practice with serious mental illness including all people with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses in primary care is shown in Table 22. In 2012-13 the percentage was lower in Kingston than London, where the difference reached statistical significance.

Table 22: Prevalence of psychoses (%) in General Practice, Kingston, London and England, persons, all ages, March 2014

	Kingston (%)	London (%)	England (%)
2011/12	0.8% (0.7 to 0.8)	1.0% (1.0 to 1.0)	0.8% (0.8 to 0.8)
2012/13	0.8% (0.8 to 0.8)	1.0% (1.0 to 1.0)	0.8% (0.8 to 0.8)

Note: Values in brackets denote 95% confidence intervals

Data for 2012/13 is for Kingston CCG, whilst data for 2011/12 is for Kingston PCT

Source: The NHS Indicator Portal, 2014(Unique identifier – P00996)

Dementia

The term 'dementia' is used to describe a collection of symptoms, including a decline in memory, reasoning and communication skills, and a gradual loss of skills needed to carry out daily activities.

Table 23 illustrates the estimated prevalence of dementia in the UK by age and gender and the estimated number of cases in Kingston. The total number of cases in Kingston is estimated to be 1,929 (1,177 women and 752 men).

Table 23: The estimated prevalence of dementia in the UK and the predicted number of people with dementia in Kingston, 2012

Age group	Prevalence of dementia in the UK		Predicted number in Kingston, in 2012	
	Male	Female	Male	Female
30-59	0.2%	0.1%	55	31
60-64	1.6%	0.5%	59	18
65-69	2.2%	1.1%	69	36
70-74	4.6%	3.9%	99	92
75-79	5.0%	6.7%	85	140
80-84	12.1%	13.5%	155	246
85-89	18.5%	22.8%	127	308
90+	29.0%	32.0%	103	306

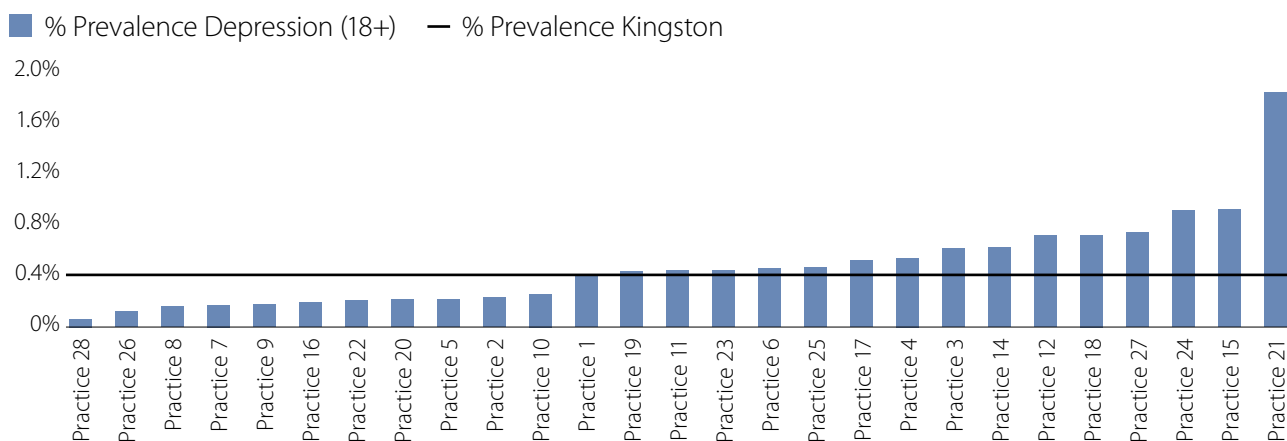
Source: Dementia 2010 – The economic burden of dementia and associated research funding in the United Kingdom, Alzheimer's Research Trust. A Report produced by the Health Economic Research Centre, University of Oxford.

Dementia UK, Alzheimer's Society 2007 (for the Prevalence of dementia in people aged 90+)

2012 Mid-year Population Estimates, ONS

Figure 9 shows the prevalence of people with dementia on practice registers in Kingston. Only one practice reported a higher prevalence than 1% and the average rate of diagnosis was 3.9 cases per 1,000 total population.

Figure 9: The prevalence of dementia (%) in GP Practices in Kingston, persons, all ages, March 2014



Source: Practice Focus Report, QMS, March 2014
Practice Population – PCSS, March 2014

The different types of dementia are explained in the Glossary. Table 24 illustrates the percentage breakdown of the different forms of dementia in 2012 and the predicted number of cases of each form in 2017, 2022 and 2027.

Table 24: Prevalence of dementia and projected number of cases in Kingston by type of illness

	Projected Prevalence in Kingston				
	Rate	2012	2017	2022	2027
Alzheimer’s disease (AD)	62%	1,017	1,056	1,166	1,348
Vascular dementia (VaD)	17%	279	290	320	370
Mixed dementia (AD and VaD)	10%	164	170	188	217
Dementia with Lewy bodies	4%	66	68	75	87
Fronto-temporal dementia	2%	33	34	38	43
Parkinson’s dementia	2%	33	34	38	43
Other dementias	3%	49	51	56	65

Source: Alzheimer’s Society. Dementia UK. The full report, 2007 & GLA 2013 Round SHLAA based population projections

Domain 4 – Access to Treatment and Services

1. Access to Child and Adolescent Mental Health Team services

The Child and Adolescent Mental Health Service (CAMHS) is a specialist service which provides assessment and treatment of children and young people experiencing significant mental health difficulties. Table 25 presents the number of contacts made by the CAMHS with clients registered with a Kingston GP in 2013-14.

Table 25: Number of contacts made by the CAMHS in 2013-14 with patients registered with Kingston GPs

Local Services	Currency	Activity
CAMHS Community Assessment	Contacts	644
CAMHS Community Psychiatric Contact	Contacts	1,764
CAMHS Community Psychology Contact	Contacts	1,049
CAMHS Community CPN Contact	Contacts	646
CAMHS Community Psychotherapy Contact	Contacts	551
CAMHS Community Therapy Contact	Contacts	549
CAMHS Learning Disability Assessment	Contacts	*
CAMHS Learning Disability Contact	Contacts	25

Source: SWL and St George's Mental Health Services, SWL Commissioning Support Unit, 2013/14

* = suppressed as less than five

Note: Patients may be counted more than once

2. Access to Community Mental Health Services

Community mental health services in Kingston include community mental health teams, an Early Intervention in Psychosis service, a recovery college and assertive outreach.

Community mental health teams (CMHT) provide specialist mental health care to patients with severe mental health problems such as severe depression, schizophrenia, bipolar disorder and some personality disorders.

Table 26 shows the number of contacts made by the Kingston Community Mental Health Teams with adult clients in 2013-14.

Table 26: Number of contacts made by the CMHT with adults registered with Kingston GPs in 2013-14

Local Services	Currency	Activity
Adult Outpatient Attendance	Contacts	3,252
Adult Community CPN	Contacts	7,041
Adult Community Psychology	Contacts	1,712
Adult Community OT	Contacts	1,501
Adult Community Vocational	Contacts	87
Adult Peer Support Worker	Contacts	59
Adult Assessment	Contacts	766
Total		14,418

Source: SWL and St George's Mental Health Services, SWL Commissioning Support Unit, 2013-14

Note: Patients may be counted more than once

Access to Community Mental Health Services by ethnic group

Different ethnic groups have different rates and experiences of mental health problems, reflecting their different cultural and socio-economic contexts and access to culturally appropriate treatments. In general, people from Black and Minority Ethnic groups living in the UK are:

- More likely to be diagnosed with mental health problems
- More likely to be diagnosed and admitted to hospital
- More likely to experience a poor outcome from treatment
- More likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health

These differences may be explained by a number of factors, including poverty, racism or failure of the mainstream mental health services to understand or provide services that are acceptable and accessible to

Black and Minority Ethnic (BME) communities and meet their particular cultural and other needs. It is likely that mental health problems go unreported and untreated as people in some ethnic minority groups are reluctant to engage with mainstream health services. It is also likely that mental health problems are over-diagnosed in people whose first language is not English.

In Kingston, the crude rate of access to community mental health services for patients registered with Kingston practices is 2,170 per 100,000 people (Table 27). This rate however varies between the different ethnic groups. The average rate of access for the White group is 2,234, for the Black group is 2,313 whilst for the Other Ethnic groups it is 3,683. Less people from the Asian and Mixed groups access mental health services (1,094 and 1,196 per 100,000 people respectively). This mirrors the picture seen for admissions to inpatient care (Table 3).

Table 27: Access to community mental health services by ethnicity in Kingston CCG, crude rate per 100,000 population, 2011-12 and 2012-13

	Total Number using Services	Population	Rate Per 100,000
White	2,663	119,219	2,233.7
Asian or Asian British	286	23,269	1,093.6
Black or Black British	93	4,021	2,312.9
Mixed	75	6,269	1,196.4
Other Ethnic Groups	162	4,399	3,682.7
Not Known	159		
Not Stated	36		
Total	3,474	160,060	2,170.40

Source: Mental Health Minimum Data Set (MHMDS) and ONS population statistics, 2014

3. Activity and outcome of local mental health teams that is monitored nationally

Table 28 shows the Community Mental Health Teams' and specialist services' activity return which collects data on new cases taken on in the year by Early Intervention (EI) in Psychosis services, number of patients on the Care Programme Approach (CPA) followed up within 7 days of discharge from psychiatric inpatient care and gate keeping of inpatient admissions by Crisis Resolution Home Treatment (CRHT) teams.

Nearly all patients on CPA who were discharged from psychiatric inpatients care were followed up within seven days of discharge and all patients who were admitted to acute care were assessed by the crisis resolution team prior to admission.

Table 28: Mental Health Teams' Activity – Early Intervention (EI) Services, Care Programme Approach (CPA) and gate keeping by the Crisis Resolution Home Treatment (CRHT) teams, Kingston CCG, 2013-15

Quarter	Number of new cases of psychosis served by Early Intervention teams (YTD)	Number of patients on CPA who were followed up within seven days after discharge from psychiatric inpatient care (QA)	Total number of patients on CPA discharged from psychiatric inpatient care (QA)	Proportion of patients on CPA who were followed up within seven days after discharge from psychiatric inpatient care (QA)	Number of admissions to acute wards that were gate kept (assessed) by the CRHT teams (QA)	Total number of admissions to acute wards (QA)	Proportion of admissions to acute wards that were gate kept by the CRHT teams (QA)
Q1 2013-14	10	95	97	97.9%	24	24	100%
Q2 2013-14	17	93	94	98.9%	45	45	100%
Q3 2013-14	22	87	88	98.9%	40	40	100%
Q4 2013-14	28	82	84	97.6%	39	39	100%
Q1 2014-15	*	99	103	96.1%	43	43	100%

YTD – Year activity to date

QA – Quarter activity

Source: Unify2 data collection – MHPrvCom Accessible via NHS England

* = data suppressed as less than 5

4. Care Plans for people with severe mental illness in General Practice

Patients on general practice registers of severe mental illness should have a documented primary care consultation that acknowledges, especially in the event of a relapse, a plan for care.

Table 29 shows the proportion of patients on the practice register who have a comprehensive care plan documented in the records. The proportion of mental health patients who received a care plan increased in Kingston from 83.9% in 2011-12 to 84.4% in 2012-13.

The percentage of patients who received a care plan in Kingston during the two years was significantly lower than the percentages for London and England, although the gap for both had reduced in 2012-13 compared with 2011-12.

Table 29: Comprehensive care plan for patients on severe mental health register (%) in Kingston CCG, London and England, persons, all ages, 2011-13 (financial years)

	Kingston (%)	London (%)	England (%)
2011/12	83.9% (81.8 to 85.8)	88.7% (88.5 to 88.9)	88.4% (88.3 to 88.5)
2012/13	84.4% (82.4 to 86.3)	88.1% (87.9 to 88.3)	87.3% (87.2 to 87.4)

Values in brackets denote 95% confidence intervals

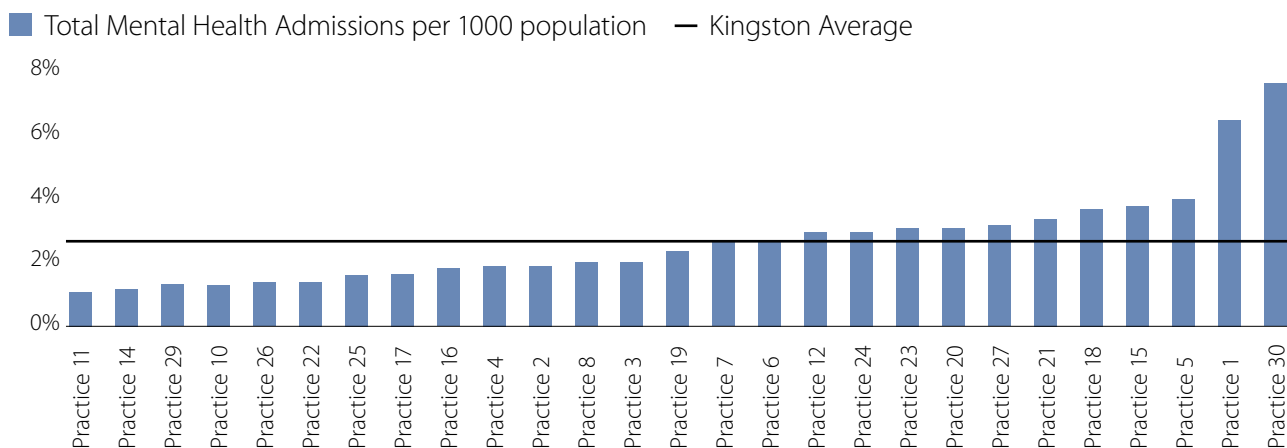
Note: Data for 2012-13 is for Kingston CCG, whilst data for 2011-12 is for Kingston PCT

Source: The NHS Indicator Portal, 2014 (Unique identifier – P01013)

5. Access to Secondary Care

Figure 10 shows the number of mental health hospital admissions for patients registered with Kingston GP practices. The admission rate of different practices varied between one and 7.3 per 1,000 people and the average rate of admissions for all practices was 2.5 per 1,000 patients. It should be noted that the practice with the highest admission rate had one of the lowest list sizes and that the data is from 2011-12 so may not reflect the current admission pattern.

Figure 10: Rate of admission to Mental Health Specialities per 1,000 population registered with Kingston practices, April 2011 to March 2012



Source: The NHS Indicator Portal, 2013

Table 30 presents the rate of people seen by NHS-funded adult specialist mental health services between April and June 2013, regardless of a formal diagnosis. It includes the use of community as well as hospital based services. Less people are in contact with mental health services in Kingston than the national average, however the populations of Richmond, Sutton and Merton are the most similar demographically to Kingston, and they all have significantly lower rates of people in contact with mental health services. One would expect Croydon to have a higher rate than Kingston given its demographic profile but the rates are similar for the two boroughs.

Table 30: Rate of patient contact with mental health services, Quarter 1 – 2013-14

Area	People in contact with mental health services per 100,000 population
Kingston CCG	1,950.6 (1,874.5 to 2,029.1)
Richmond CCG	1,513.6 (1,451.3 to 1,577.9)
Sutton CCG	1,123.7 (1,070.3 to 1,179.1)
Croydon CCG	1,908.2 (1,857.0 to 1,960.5)
Merton CCG	1,139.4 (1,087.2 to 1,193.4)
Wandsworth CCG	1,319.7 (1,275.2 to 1,365.3)
London	2,630.0
England	2,175.7

Source: Community Mental Health Profiles, 2014, Mental Health Minimum Dataset, Health and Social Care Information Centre.

People with an open Adult Mental Health Care Spell in NHS funded adult specialist mental health services at the end of the Reporting Period expressed as a rate per 100,000 aged 18+

6. Admission to specialist mental health hospital

Table 31 below illustrates the percentage of people in contact with mental health services who were treated in a psychiatric hospital. This indicator shows the proportion of the population whose mental illness requires the most intense services. During the time period April to December 2013 the Kingston percentage was higher than the England average.

Table 31: Service users in specialist hospital – percentage of mental health service users who were inpatients in a psychiatric hospital, 2013-14

	Kingston CCG	England
2013-14 Q1	3.65% (2.98 to 4.46)	2.53% (2.49 to 2.56)
2013-14 Q2	3.43% (2.79 to 4.22)	2.44% (2.41 to 2.47)
2013-14 Q3	3.91% (3.22 to 4.74)	2.36% (2.33 to 2.39)

Source: Community Mental Health Profiles, 2014, Mental Health Minimum Dataset, Health and Social Care Information Centre

Commissioners need to understand both the need and the demand for mental health services in order to plan effective treatment. Table 32 looks at the use of the most intensive services; namely beds in mental health trusts. The rate of bed days used in secondary mental health care hospitals by Kingston patients (6,456 per 100,000) is significantly higher than the national average (4,685 per 100,000 population).

Table 32: Number of bed days in secondary mental health hospitals per 100,000 Population (crude rate)

	Kingston CCG	England
2013-14 Q1	6,456 (6,318 to 6,597)	4,686 (4,679 to 4,692)

Source: Community Mental Health Profiles, 2014, Health and Social Care Information Centre; Office for National Statistics

Table 33 illustrates the hospital episode rate for schizophrenia in Kingston, London and England. The episode rate for schizophrenia in Kingston was higher than the national averages during 2011-12 but lower than the regional average and this latter difference was statistically significant.

Table 33: Directly standardised hospital episode rate for schizophrenia per 100,000, people aged 15 to 74 years, in Kingston, London and England, persons, 2010-11 to 2011-12

	Kingston	London	England
2010-11	76.7 (65.6 to 87.8)	149.01 (146.8 to 151.4)	74.6 (73.9 to 75.2)
2011-12	77.6 (66.2 to 89.1)	149.7 (147.5 to 152.0)	74.2 (73.5 to 74.8)

Note: The definition used for measuring schizophrenia includes "schizophrenic-like psychotic disorders" and "schizo-affective disorders". These definitions are provisional and under review
Source: Hospital Episode Statistics (HES), The Health and Social Care Information Centre

7. Support provided by the Local Authority

Councils must provide support to people with mental health needs as set out in the Mental Health Act 1983. Councils provide community, residential or nursing home social services to eligible people based on their needs. Table 34 presents the rate per 100,000 population of people aged 18 to 64 with a mental health problem in residential or nursing care. Table 34 illustrates that a smaller proportion of people with mental illness were in residential or nursing care in Kingston (27.9 per 100,000) than in England (32.7).

Table 34: People with a mental illness aged 18 to 64 in residential or nursing care per 100,000 population (crude rate)

		Kingston CCG	England
People with a mental illness in residential or nursing care per 100,000 population	2012 – 13	27.9 (18.4 to 39.2)	32.7 (32.1 to 33.3)

Source: Community Mental Health Profiles, 2014, Referrals, Assessments and Packages of Care (RAP), National Adult Social Care Intelligence Service, Office for National Statistics

Domain 5 – Outcomes

1. Patient experience of community mental health services

South West London (SWL) and St George's Mental Health Trust is the main provider of mental health services in Kingston. Table 35 illustrates the percentage of mental health patients attending SWL and St George's Mental Health Trust who had a positive experience and compares it with the national average. The local percentage is slightly lower than the national figure, but the gap narrowed between 2012 and 2013.

Table 35: Patients who had a positive experience of community mental health services in Kingston and England, 2012 and 2013

	SWL and St George's Mental Health NHS Trust	England
2012	83.9%	86.5%
2013	84.7%	85.8%

Note: The statistic is weighted average of 4 survey questions from the community mental health survey (score out of 100)
Source: National Patient Survey Program, NHS Operating Framework indicator.

2. Improving Access to Psychological Therapies (IAPT)

The Improving Access to Psychological Therapies service (part of the Kingston Wellbeing Service) provides advice, information and therapy for people aged 16 and over who are feeling stressed, anxious, low in mood or depressed.

The recovery rate for patients referred in Kingston in 2012-13 was below the England average (Table 36) but was at the same level as the London average.

Table 36: IAPT recovery rates for Kingston and England, 2012-13

		Kingston CCG	London	England
Rate of recovery for IAPT treatment – %	2012-13	40.2% (37.3 to 43.1)	40.2%	45.9%

Source: Community Mental Health Profiles, 2014

3. People with mental illness and or disability in settled accommodation

Table 37 shows the percentage of adults who were receiving secondary mental health services and recorded as living independently, with or without support, as a percentage of adults who were receiving secondary mental health services. The proportion of adults receiving secondary mental health services who were living independently during 2012-13 was higher in Kingston at 81.3% than the regional (79.4%) and the national (58.5%) averages.

Table 37: Percentage of adults (18 to 69 years) in contact with secondary mental health services who are living independently in Kingston, London and England, 2012-13

	Kingston	London	England
% of adults in contact with secondary mental health services who live in stable and appropriate accommodation	81.3%	79.4%	58.5%

Source: Mental Health Minimum Dataset (MHMDS)

The Care Programme Approach (CPA) is the system which coordinates the care of many patients receiving specialist mental health services. Table 38 shows

that in the first quarter of 2013-14, more people in Kingston (662.85 per 100,000) were on the Care Programme Approach than in England (530.64 per 100,000). A higher proportion of adults on the CPA were in settled accommodation in Kingston (67%) when compared with the England average (61%).

Table 38: People on care programme approach in settled accommodation in Kingston, London and England, 2013-14

		Kingston CCG	England
People on Care Programme Approach per 100,000 population (crude rate)	2013/14 Q1	662.9 (618.8 to 709.23)	530.6
% CPA adults in settled accommodation	2013/14 Q1	67.0% (63.5 to 70.3)	61.0%

Source: Community Mental Health Profiles, 2014

The percentage of adults receiving secondary mental health services in paid employment at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting is illustrated in Table 39. During the first quarter of 2013-14, a higher percentage of working-age adults on the CPA were employed in Kingston (9.0%) in comparison to 7.1% in England.

Table 39: People on Care Programme Approach in paid employment, Kingston and England, Q1 2013-14

		Kingston CCG	England
% CPA adults in employment	2013/14 Q1	9.04% (7.17 to 11.34)	7.05%

Note % CPA adults in employment: People aged 18-69 with an open Care Programme Approach Episode at the end of the quarter whose most recent record of Employment Status in the previous 12 months showed they were employed expressed as a proportion of all people aged 18 to 69. Employed refers to those who are either employed for a company or self-employed. It also includes those who are in supported employment (including government supported training and employment programmes), those in permitted work (i.e. those who are in paid work and also receiving Incapacity Benefit) and those who are unpaid family workers (i.e. those who do unpaid work for business they own or for a business a relative owns).

Source: Community Mental Health Profiles, 2014

4. Detentions under the Mental Health Act

Under the Mental Health Act, a patient can be formally detained in hospital for his or her own safety, or that of others. Table 40 shows that the rate of detention in Kingston (13.2 per 100,000 people aged 18 and over) was lower than the national rate (15.5 per 100,000) and the London rate (20.2).

Table 40: Detentions under the Mental Health Act per 100,000 population, April to June 2013, Kingston CCG and England

	Kingston CCG	London	England
2013/14 Q1	13.2 (7.7 to 21.1)	20.2	15.5

Note: The number of detentions under the Mental Health Act (1983) on admission to hospital expressed as a rate per 100,000 aged 18+. Uses of short term sections and holding powers and Place of Safety Orders that coincided with the day of admission are excluded. Detentions on day of admission includes uses of sections 2, 3, 35, 36, 37 (with or without s41 restrictions) 38, 44, 46, 45A and 47 and 48 (with or without s49 restrictions), and detentions under previous legislation (Fifth Schedule) and other Acts. This indicator looks at detentions under the Act in comparison to the total population for an area.

Source: Community Mental Health Profiles, 2014. Data source is Mental Health Minimum Dataset, Health and Social Care Information Centre

5. Self harm

Table 41 shows that the rate of emergency admissions due to self harm was significantly lower in Kingston (62.8 per 100,000) than the national average (191) during 2012-13.

Table 41: Directly standardised rates of hospital admissions due to self harm for Kingston and England

		Kingston CCG	England
Emergency admissions for self harm per 100,000 population (DSR)	2012 – 13	62.8 (51.3 to 76.0)	191.0 (189.8 to 192.2)

Source: Community Mental Health Profiles, 2014

6. Suicide

The suicide rates for Kingston in 2009-11 and 2010-12 were lower than the regional and national averages (Table 42). There were more men committing suicide than women during both time periods in Kingston (as in both London and England as a whole) but the ratio of male to female suicides was lower in Kingston than in London and England.

The suicide rate for Kingston increased slightly from 7.4 per 100,000 population in 2009-11 to 7.7 in 2010-12.

Table 42: Mortality from suicide and injury undetermined (ICD10 X60-X84, Y10-Y34 excluding Y33.9), directly standardised rate (DSR), 15-74 years, per 100,000 population, 3-year average in Kingston, London and England, 2009 to 2012

		Kingston	London	England
2009-11	Female	4.9 (2.21 to 9.32)	4.4 (3.96 to 4.86)	4.8 (4.60 to 4.96)
	Male	9.9 (5.72 to 15.95)	13.5 (12.76 to 14.33)	15.8 (15.48 to 16.13)
	Person	7.4 (4.82 to 10.91)	8.9 (8.48 to 9.37)	10.3 (10.07 to 10.44)
2010-12	Female	5.4 (2.55 to 9.88)	4.3 (4.54 to 4.90)	4.7 (4.54 to 4.90)
	Male	10.2 (5.91 to 16.40)	13.6 (12.79 to 14.35)	16.0 (15.66 to 16.32)
	Person	7.7 (5.07 to 11.29)	8.9 (8.46 to 9.35)	10.3 (10.13 to 10.50)

Values in brackets denote 95% confidence intervals

Source: The NHS Indicator Portal, 2014

Note: Rate per 100,000 and using the European Standard Population as standard population – Data are based on the latest revisions of ONS population estimates for the respective years

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6.2 Demography

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This chapter provides a basis on which to build a picture of the health of Kingston's population. Information is presented on demographic changes, risk factors, prevalence of different health conditions, social determinants of health, provision of health services and deaths.

Kingston Population

The mid 2013 population of Kingston was estimated to be 166,793, an increase of 2,887 people from 163,906 in mid 2012. The population was estimated to have grown by 1.8% between mid-2012 and mid 2013, which is higher than the average population growth in London (1.3%), and in outer London boroughs (1.1%). The percentage of the total population made up by children newborn to 15 increased during this period from 18.1% to 18.2% whilst the percentage of the total population who were aged 65 and over increased from 13.0% to 13.1%. The adult population (defined as those aged 16 to 64) declined from 69.0% of the total population to 68.7%. Table 1 shows the detailed population structure in 2012 and 2013 by age and gender whilst Figure 1 provides a graphical representation of the 2013 population.

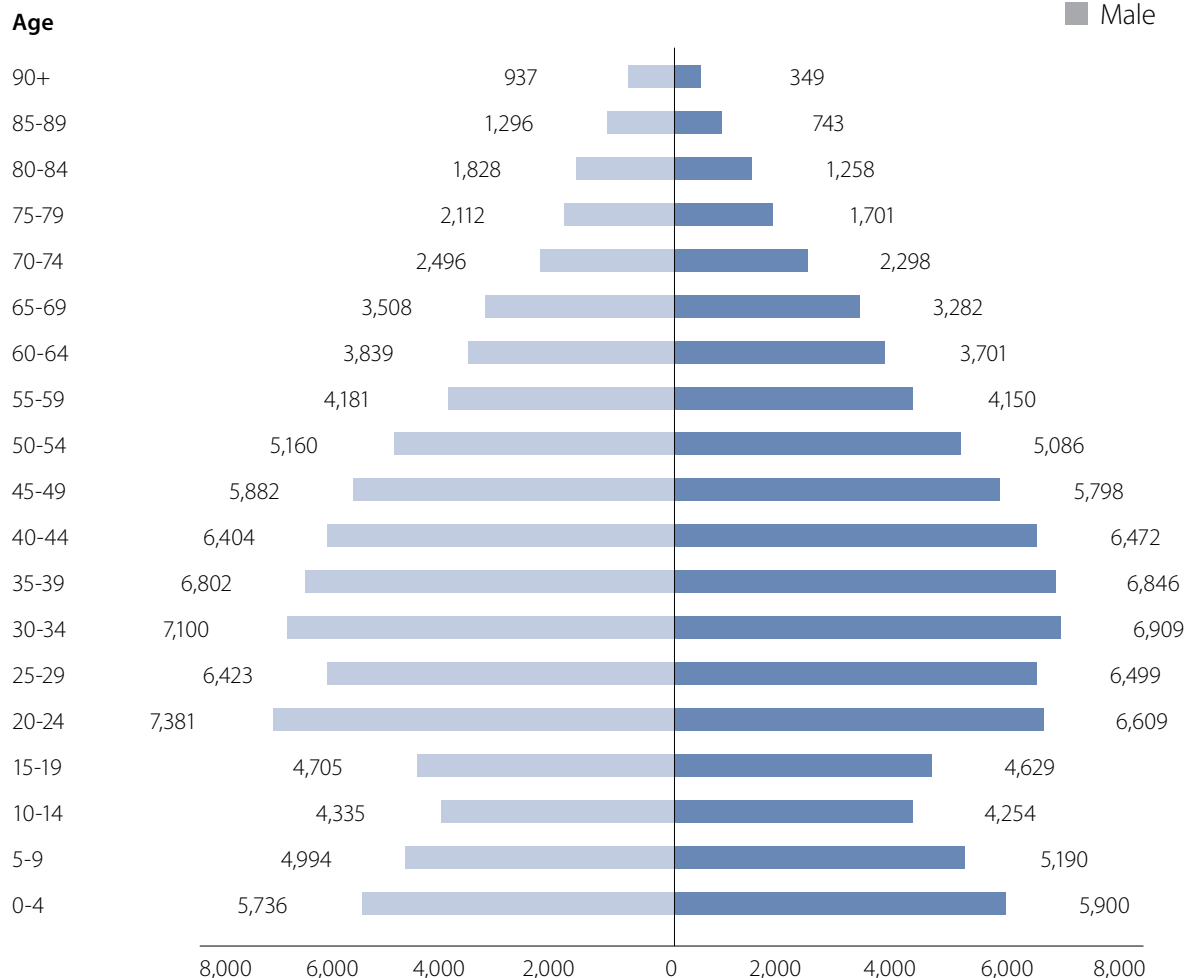
Table 1: The age and gender structure of the population of Kingston in 2012 and 2013

2012 Mid Year Population Estimates				2013 Mid Year Population Estimates			
Age Group	Male	Female	Person	Age Group	Male	Female	Person
0-4	5,830	5,670	11,500	0-4	5,900	5,736	11,636
5-9	4,863	4,694	9,557	5-9	5,190	4,994	10,184
10-14	4,221	4,348	8,569	10-14	4,254	4,335	8,589
15-19	4,589	4,686	9,275	15-19	4,629	4,705	9,334
20-24	6,734	7,519	14,253	20-24	6,609	7,381	13,990
25-29	6,378	6,243	12,621	25-29	6,499	6,423	12,922
30-34	6,728	6,960	13,688	30-34	6,909	7,100	14,009
35-39	6,784	6,702	13,486	35-39	6,846	6,802	13,648
40-44	6,308	6,296	12,604	40-44	6,472	6,404	12,876
45-49	5,629	5,789	11,418	45-49	5,798	5,882	11,680
50-54	4,895	4,911	9,806	50-54	5,086	5,160	10,246
55-59	4,087	4,137	8,224	55-59	4,150	4,181	8,331
60-64	3,719	3,927	7,646	60-64	3,701	3,839	7,540
65-69	3,181	3,285	6,466	65-69	3,282	3,508	6,790
70-74	2,142	2,392	4,534	70-74	2,298	2,496	4,794
75-79	1,695	2,103	3,798	75-79	1,701	2,112	3,813
80-84	1,282	1,825	3,107	80-84	1,258	1,828	3,086
85-89	690	1,352	2,042	85-89	743	1,296	2,039
90+	355	957	1,312	90+	349	937	1,286
0-16	16,690	16,452	33,142	0-16	17,049	16,864	33,913
0-18	18,500	18,229	36,729	0-18	18,920	18,618	37,538
18-64	53,158	54,572	107,730	18-64	54,066	55,226	109,292
18+	62,503	66,486	128,989	18+	63,697	67,403	131,100
All Ages	80,110	83,796	163,906	All Ages	81,674	85,119	166,793

Source: ONS, 2012 and 2013 Mid-year Population Estimates:
Pivot table Analysis Tool for the United Kingdom, 2013 and 2014

Figure 1: 2013 Mid-year population estimates for Kingston by age and gender

Female
Male



Source : ONS, 2013 Mid-year Population Estimates: Pivot table Analysis Tool for the United Kingdom, 2014.

Kingston Population Projections

Predicting future health needs is challenging as populations constantly change in size and composition as a result of economic, cultural, social and environmental factors. These factors affect the number of births as well as the inward and outward migration patterns. The balance between births and deaths gives 'natural change' before migration. The net effect on total population of all migration is the balance between movements inward and outward from overseas (international migration flows) and from the rest of the UK (internal migration flows). Table 2 illustrates the net impact of the natural change and migration flows on the population of Kingston in 2011-12 and 2012-13. It can be seen that the largest component of population change in Kingston is international migration, making up 62% of the population increase in 2011-12 and 63% in 2012-13, whilst 'natural change' contributed 37% in 2011-12 and 39% in 2012-13.

Table 2: The components of population change in Kingston, 2011-12 and 2012-13

The population components of change	2011 to 2012	2012 to 2013
2011 ^a and 2012 ^b Mid-year resident population	160,436 ^a	163,906 ^b
Births	2,306	2,213
Deaths	1,014	1,097
Net natural change	1,292	1,116
Internal migration inflows	12,688	12,281
Internal migration outflows	12,667	12,334
Net internal migration	21	-53
International Inflows	3,400	2,865
International Outflows	1,262	1,038
Net international migration	2,138	1,827
Other changes	19	-3
Net migration and natural change	3,470	2,887
2012 ^c and 2013 ^d Mid-year resident population	163,906 ^c	166,793 ^d

Source: Office for National Statistics, 2013

Table 3 shows that over the next five years (2013–18) the population of Kingston is predicted to grow by 10,023 people (6%). The growth rate of the population of Kingston is then forecasted to decline in the following five years (2018–23) to 3.8% and to 3.7% during 2023–28.

Table 3: The projected population of Kingston, 2013–28

Age Group	2013	2018	2023	2028
0-4	11,506	11,936	12,034	12,005
5-9	9,895	11,264	11,583	11,668
10-14	8,473	9,778	10,992	11,309
15-19	10,011	9,832	10,981	12,192
20-24	14,729	15,252	14,324	15,612
25-29	12,842	13,589	13,248	12,681
30-34	13,785	14,201	14,424	14,027
35-39	13,372	13,927	14,233	14,446
40-44	12,714	12,885	13,379	13,753
45-49	11,585	12,170	12,143	12,666
50-54	10,134	11,120	11,485	11,406
55-59	8,212	9,472	10,322	10,597
60-64	7,452	7,497	8,576	9,349
65-69	6,682	6,656	6,699	7,663
70-74	4,721	5,989	5,972	6,052
75-79	3,808	4,147	5,265	5,284
80-84	3,069	3,081	3,410	4,375
85-89	2,075	2,161	2,296	2,604
90+	1,313	1,445	1,730	2,144
All Ages	166,378	176,402	183,096	189,833

Note: Central scenario: Assumes recent migration patterns are partially transient and partially structural. Beyond 2018, domestic outflow propensities increase by 5% and inflows by 3% as compared to the High variant population projections

Source: GLA 2013 Round of demographic projections, Local authority population projections – Trend-based population projections, Central scenario

Table 4 illustrates the forecasted percentage population change from 2013 in 2018, 2023 and 2028. Table 4 illustrates that the greatest percentage increase from 2013 – 2018 will be in people aged 70-79 (35.8%). This remains the case when the population change from 2013 – 2023 is looked at (64.8%) but those aged 80-89 will have the greatest increase (68.1%) from 2013 to 2028.

Table 4: The predicted population change in Kingston, 2013 – 2028

Year	Age Group									
	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90+
2013 – 2018	17.6%	13.6%	9.4%	7.2%	6.4%	25.1%	0.2%	35.8%	4.5%	10.0%
2013 – 2023	21.6%	39.4%	0.4%	11.1%	10.0%	39.0%	15.3%	64.8%	21.8%	31.7%
2013 – 2028	22.3%	55.3%	4.7%	9.8%	17.5%	41.6%	40.1%	67.0%	68.1%	63.3%

Source: GLA 2013 Round of demographic projections, Local authority population projections – Trend-based population projections, Central scenario.

Ethnicity

Understanding the ethnic composition of the population is important because of differences in health related behaviour and differing rates of disease in different ethnic groups. For example, rates of heart disease are higher among people of South Asian origin than in the non-Asian population. The occurrence of diabetes in individuals of South Asian origin is twice that of the general population. Black Caribbean men have a higher incidence of stroke – the risk is almost two thirds higher than the general population¹.

The population of Kingston is becoming more diverse as the percentage of the population made up of people from Black and Minority Ethnic (BME) groups increased from 25.5% in 2011 to 26.2% in 2012. The GLA estimates also show that the percentage of the population from these communities will steadily increase during the next 15 years. In 2012, the largest BME groups in Kingston were the 'Other Asian' and the 'Indian' groups which constituted 10.2% and 4.0% of the population respectively (Figure 2). Table 5 and Figure 3 show the ethnic composition by age highlighting that the BME population is primarily composed of children, young people and working age adults.

Table 5: Ethnic composition of Kingston in 2012

Age group	All Ethnicities	White	Black Caribbean	Black African	Black Other	Indian	Pakistani	Bangladeshi	Chinese	Other Asian	Other	BME
0 – 4	11,197	7,231	51	222	457	360	306	81	136	1,632	721	3,966
5 – 9	9,391	6,094	43	189	343	297	284	77	103	1,412	551	3,297
10 – 14	8,458	5,666	35	187	254	277	259	51	99	1,199	430	2,792
15 – 19	9,740	6,530	72	262	246	465	256	82	165	1,235	427	3,210
20 – 24	13,563	9,300	121	360	263	664	279	128	426	1,431	591	4,262
25 – 29	12,238	8,499	81	252	182	558	272	105	374	1,339	574	3,738
30 – 34	13,295	9,467	87	275	154	617	273	115	318	1,413	577	3,828
35 – 39	13,203	9,516	89	250	133	549	256	84	244	1,517	565	3,686
40 – 44	12,341	9,090	93	220	96	515	229	58	211	1,383	448	3,251
45 – 49	11,357	8,625	104	184	97	424	169	35	203	1,173	344	2,732
50 – 54	9,719	7,573	93	102	66	382	146	28	183	859	286	2,145
55 – 59	8,121	6,513	46	69	35	331	102	23	171	609	221	1,608
60 – 64	7,565	6,300	31	46	32	296	78	23	131	458	171	1,265
65 – 69	6,363	5,424	35	33	26	221	67	8	72	308	168	939
70 – 74	4,497	3,796	27	15	11	196	59	8	52	213	119	701
75 – 79	3,788	3,325	13	10	12	132	38	10	34	141	74	464
80 – 84	3,093	2,819	9	*	*	79	17	*	25	97	38	274
85 – 89	2,065	1,962	5	*	*	24	*	0	7	44	17	102
90+	1,300	1,243	5	*	*	8	*	0	8	20	12	57

Note: Figures might not add up due to rounding.

Data suppressed where number is less than five

Source: GLA 2012 Round Ethnic Group Projections – SHLAA Final. © Greater London Authority, 2013

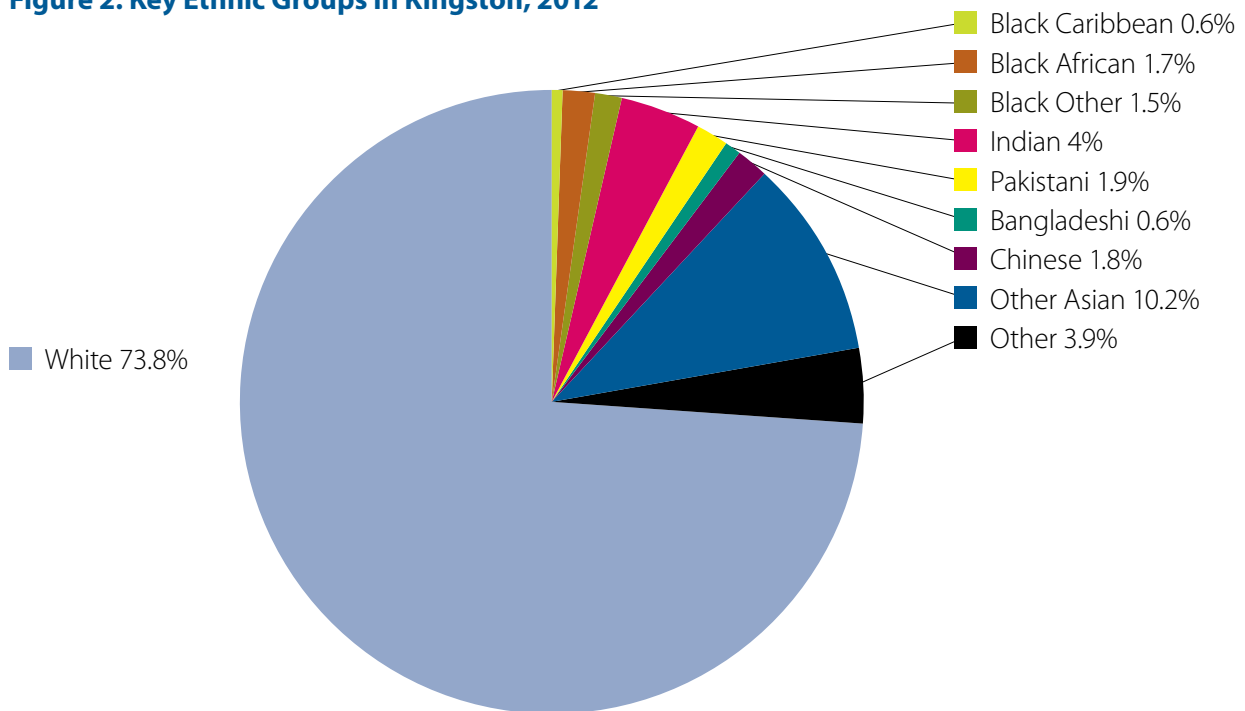
A more detailed description of the main ethnic groups in Kingston is shown in Table 6 below, taken from 2011 Census data. The Indian ethnic group which is the largest ethnic group in Kingston constitutes 4% of the population of Kingston. The second largest group is the Sri Lankan community (2.5% of the population of Kingston) and the third largest ethnic minority group is the Korean community which is composed of 3,408 residents and constitutes 2.1% of the resident population.

Table 6: The main ethnic groups in Kingston, 2011 Census

Ethnic Group	Number	Percentage of the 2011 Census population
White: English/Welsh/Scottish/Northern Irish/British	101,015	63.1%
Asian/Asian British: Indian or British Indian	6,325	4.0%
Asian/Asian British: Sri Lankan	4,012	2.5%
Asian/Asian British: Korean	3,408	2.1%
White: Other Western European	3,160	2.0%
Asian/Asian British: Pakistani or British Pakistani	3,009	1.9%
Asian/Asian British: Chinese	2,883	1.8%
White: Irish	2,718	1.7%
Black/African/Caribbean/Black British: African	2,616	1.6%
Mixed/multiple ethnic group: White and Asian	2,500	1.6%
Other ethnic group: Arab	2,439	1.5%
White: Any other ethnic group	2,362	1.5%
White: European Mixed	2,181	1.4%

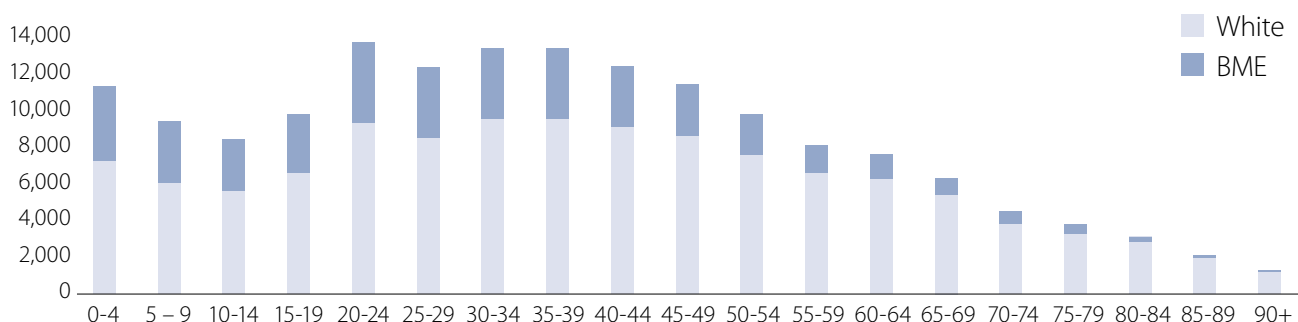
Note : Only ethnic groups that have more than 2,000 residents at the time of the 2011 Census are included in this table.
 Source: 2011 Census, the Office of National Statistics, 2012

Figure 2: Key Ethnic Groups in Kingston, 2012



Source: GLA 2012 Round Ethnic Group Projections – SHLAA Final. © Greater London Authority, 2013

Figure 3: The distribution of the Ethnic Minority population in Kingston by age



Source: GLA 2012 Round Ethnic Group Projections – SHLAA Final. © Greater London Authority, 2013

Projections of the Population of Kingston by Ethnicity

In 2027, the BME population is projected to comprise 32.6% of the population, compared with 26.2% in 2012. The ‘Other Asian’ group is the fastest growing,

and will increase from 10.2% of the population in 2012 to 14.2% in 2027. Table 7 illustrates the change in the ethnic composition of the population of Kingston between 2012 and 2027.

Table 7: Projections of the population of Kingston by ethnicity

	2012	2017	2022	2027	Ethnic Composition in 2027
All Ethnicities	161,292	165,959	170,372	174,315	
White	118,974	117,471	117,139	117,442	67.4%
Black Caribbean	1,040	1,160	1,283	1,377	0.8%
Black African	2,679	3,046	3,367	3,604	2.1%
Black Other	2,414	2,819	3,097	3,289	1.9%
Indian	6,394	6,635	6,766	6,868	3.9%
Pakistani	3,096	3,405	3,601	3,746	2.2%
Bangladeshi	917	1,040	1,131	1,196	0.7%
Chinese	2,961	3,364	3,737	4,051	2.3%
Other Asian	16,482	20,081	22,733	24,782	14.2%
Other	6,335	6,938	7,521	7,961	4.6%
Black and Minority Ethnic Population (BME)	42,318	48,488	53,234	56,873	
BME (%)	26.2%	29.2%	31.3%	32.6%	

Source: GLA 2012 Round SHLAA based Ethnic Group Borough Projections, © Greater London Authority, 2013

The Electoral Ward population

The Greater London Authority (GLA) publishes electoral ward population projections annually for all London Boroughs. Table 8 shows the estimated population of Kingston wards over the next 15 years. These estimates indicate that the population of all the electoral wards are expected to

grow during this period but the highest growth is likely to be shown by Tolworth & Hook Rise, Canbury and Grove whose populations are expected to increase between 2012 and 2027 by 25.9%, 22.5% and 21.2% respectively.

Table 8: Projections of the electoral wards population, Kingston, 2012-27

	2012	2017	2022	2027	Change(%) 2012-17	Change(%) 2012-22	Change(%) 2012-27
Alexandra	9,400	10,100	10,600	11,050	7.5%	12.8%	17.6%
Berrylands	9,600	10,100	10,500	10,900	5.2%	9.4%	13.5%
Beverley	10,250	10,800	11,250	11,700	5.4%	9.8%	14.2%
Canbury	12,650	14,000	15,050	15,500	10.7%	19.0%	22.5%
Chessington North and Hook	8,850	9,300	9,650	10,000	5.1%	9.0%	13.0%
Chessington South	10,350	10,850	11,250	11,700	4.8%	8.7%	13.0%
Coombe Hill	10,550	11,100	11,450	11,950	5.2%	8.5%	13.3%
Coombe Vale	9,900	10,400	10,750	11,200	5.1%	8.6%	13.1%
Grove	11,300	12,300	13,000	13,700	8.9%	15.0%	21.2%
Norbiton	10,350	11,050	11,650	12,450	6.8%	12.6%	20.3%
Old Malden	9,550	10,000	10,350	10,700	4.7%	8.4%	12.0%
St James	9,100	9,550	9,900	10,250	5.0%	8.8%	12.6%
St Mark's	10,750	11,300	11,600	12,100	5.1%	7.9%	12.6%
Surbiton Hill	10,650	11,300	11,800	12,150	6.1%	10.8%	14.1%
Tolworth and Hook Rise	10,050	11,200	12,150	12,650	11.4%	20.9%	25.9%
Tudor	9,700	10,100	10,450	10,850	4.1%	7.7%	11.9%
Kingston	162,950	173,400	181,350	188,750	6.4%	11.3%	15.8%

Source: 2012 Round of Demographic Projections – SHLAA trend based ward projections, © Greater London Authority, 2013

General Practice Population

A total of 197,291 people were registered with Kingston General Practices in March 2014 which represents an increase of 3,128 people over the previous year. The total number of registered men (97,542) was slightly lower than the number of women (99,749). Table 9 shows that fewer people (33,385) live in Kingston than those registered with local practices and the difference between the two populations is at its highest amongst people aged 30 to 49 years.

Table 9: 2012 Mid year resident population estimates and GP registered population (31st March 2014)

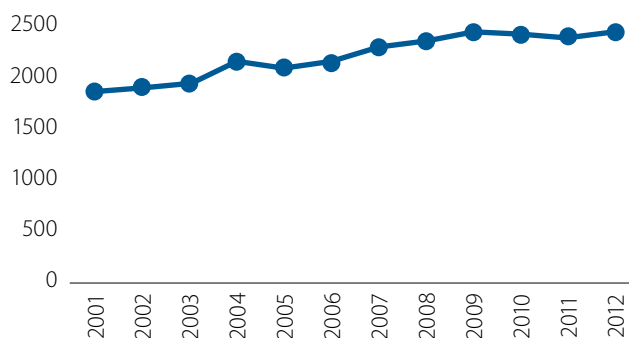
Age Group	Resident population	GP Registered population	Population Difference
0-9	21,057	24,746	3,689
10-19	17,844	21,169	3,325
20-29	26,874	30,641	3,767
30-39	27,174	33,695	6,521
40-49	24,022	30,961	6,939
50-59	18,030	22,482	4,452
60-69	14,112	16,643	2,531
70-79	8,332	9,925	1,593
80-89	5,149	5,598	449
90+	1,312	1,431	119
Total	163,906	197,291	33,385

Source: PCSS, March 2014 for the GP Registered population
ONS, 2012 Mid-year Population Estimates for the resident population

Main Health Indicators

Births

Figure 4: Annual Number of live births in Kingston, 2001-12



Source: Vital Statistics Tables, VS1, 2002-12

Between 2001 and 2009 the number of births increased steadily in Kingston but in 2010 and 2011 the number of births dropped slightly (Figure 4). There were 39 more live births in 2012 than the previous year as the total number of births was 2,289 in 2011 and 2,328 in 2012.

The fertility rate declined from 60.7 live births per 1,000 women aged 15 to 44 years in 2011 to 60.6 live births in 2012. As a result the total period fertility rate (TPFR) in Kingston (which is the average number of

live births that would occur per women resident in an area, if that women experienced her area's current age-specific fertility rates throughout her childbearing lifespan), has also declined during the same period from 1.8 to 1.7 children per women. The regional TPFPR declined from 1.9 in 2011 to 1.8 in 2012 whilst the national TPFPR remained unchanged at 1.9 during the same period.

The birth rates of women in different age groups are shown in Table 10. The highest birth rate of 92.4 per 1,000 women occurred in women aged 35 to 39 years. Birth rates at older ages are associated with higher risk for both mother and baby. Maternity services will need to adapt to provide for the changing demographics and the risk associated with pregnancy and birth at an older age. Key birth statistics for 2012 show the percentage of mothers over 40 years of age increased in Kingston to 6.7% from 6.5% in the previous year. The proportion of over 40 years old mothers also increased in London from 5.4% to 5.5% and in England from 4.0% to 4.1% during the same period. Please see the Statistical Annex for more information about birth rates and fertility.

Table 10: Birth rate of women in different age groups, 2012

Age	Live births	Females in the Age group	Birth rate (per 1,000)
Under 16	*	4,411	-
16-19	*	3,792	-
20-24	204	7,519	27.1
25-34	1,039	13,203	78.7
35-39	619	6,702	92.4
40 and Above	160	12,085	13.2

Note: *Data that may potentially identify individuals have been removed. The population for 40 and above is the number of women aged 40 to 49 years.

Source: The NHS Indicator Portal, 2013. 2012 Mid-Year population Estimates, ONS 2012 Mid-year population Estimates, ONS

The percentage of mothers under 20 years of age declined in Kingston from 2.3% in 2011 to 1.6% in 2012. Similarly, the London percentage decreased from 2.7% to 2.5% whilst the national percentage declined from 5.0% to 4.6% during the same time period.

Low birth weight is the leading cause of infant mortality and is associated with chronic diseases later in life. A low birth weight infant weighs less

than 2,500g. The percentage of live and still births weighing less than 2,500 grams is lower in Kingston (7.0%) than the regional and national averages (7.9% and 7.2% respectively).

Life Expectancy in Kingston

Life expectancy at birth compares the average number of years to be lived by a group of people born in the same year in different geographical areas, if mortality at each age remains constant in the future. Life expectancy at birth is used as a measure of the overall quality of life in an area.

Life expectancy in Kingston in 2010-12 (81.4 years for males and 84.8 for females) continues to be higher than the regional (79.7 for males and 83.8 for females) and national (79.2 for males and 83.0 for females) averages. Table 11 shows the change in the life expectancy of people living in Kingston, London and England in recent years.

Table 11 also shows that for 2010-12 the relative ranking of male life expectancy in Kingston has improved from being the 38th highest life expectancy in England in 2009-11 to occupying the 36th rank. During the same period, female life expectancy moved up 16 ranks from the 49th position that it occupied in 2009-10 to the 33rd.

Table 11: Male and Female life expectancy (in years) at birth for Kingston, London and England in, 2007-12

Gender	Year	Kingston	London	England	Rank (Kingston)
Males	2007-09	80.3	78.5	78.2	42
	2008-10	80.9	78.8	78.5	33
	2009-11	81.1	79.3	78.9	38
	2010-12	81.4	79.7	79.2	36
Females	2007-09	83.7	82.9	82.3	61
	2008-10	84.2	83.2	82.5	41
	2009-11	84.5	83.6	82.9	49
	2010-12	84.8	83.8	83.0	33

Note: Figures presented to one decimal place. The rankings in this table reflect differences in the unrounded numbers. 1 = Highest and 346 = Lowest Data based on deaths registered in calendar years and mid-year population estimates.

Source: Office of National Statistics, 2013

In 2010-12, the life expectancy at age 65 was also higher in Kingston than the London and England averages with men living in Kingston on average 0.7 and 1 year more than their counterparts in London and England respectively. Among women, the life expectancy during the same period was 1 year higher than those women living in London and England (Table 12).

The ranking of life expectancy at 65 was slightly worse in 2010-12 than 2009-11 among men as it moved from the 55th highest life expectancy in England to the 56th rank. For women life expectancy at 65 moved up to the 60th highest rank from the 62nd rank it occupied in 2009-11.

Table 12: Male and Female life expectancy (in years) at 65 for Kingston, London and England, 2007-12

Gender	Year	Kingston	London	England	Rank (Kingston)
Males	2007-09	18.8	18.1	17.9	72
	2008-10	19.3	18.4	18.1	46
	2009-11	19.5	18.7	18.4	55
	2010-12	19.6	18.9	18.6	56
Females	2007-09	21.3	20.5	20.5	102
	2008-10	21.8	20.7	20.7	63
	2009-11	22.0	21.1	21.1	62
	2010-12	22.1	21.1	21.1	60

Note – Life expectancy figures presented to one decimal place. The rankings in this table reflect differences in the unrounded numbers. 1= Highest, 346= Lowest. Data based on deaths registered in calendar years and mid-year population estimates. Source: Office for National Statistics, 2013

The healthy life expectancy is also called disability-adjusted life expectancy and represents the average number of years that a person can expect to live in 'full health'. This measure of full health is based on contemporary mortality rates and the prevalence of self-reported good health. The prevalence of good health is derived from responses to a survey question on general health.

The healthy life expectancy is higher in Kingston (63.5 for males and 64.4 for females) than the regional (63.0 for males and 63.8 for females) and national (63.2 for males and 64.2 for females) averages (Table 13).

Globally, the highest healthy life expectancy at birth is seen in Japan (75 years), followed by Iceland, Sweden, Australia and Switzerland where the recorded healthy life expectancy is 73 years².

Table 13: Life Expectancy (LE) and Healthy Life Expectancy (HLE) for males and females at birth in Kingston, London and England, 2009-11

	Gender	Life expectancy	Healthy life expectancy
Kingston	Males	81.1	63.5 (60.7 to 66.3)
	Females	84.5	64.4 (61.5 to 67.2)
London	Males	79.3	63.0 (62.5 to 63.4)
	Females	83.6	63.8 (63.3 to 64.3)
England	Males	78.9	63.2 (63.1 to 63.4)
	Females	82.9	64.2 (64.0 to 64.3)

Note: Values in brackets denote 95% confidence intervals. Excludes residents of communal establishments except NHS housing and students in halls of residence where inclusion takes place at their parents' address.

Source: Office for National Statistics, 2013

Health Inequalities

The length and quality of people's lives differ substantially according to their socio-economic status, education and the quality of their living environment and this leads to large inequalities in life expectancy. This is illustrated by the data in Table 14 which shows that there is a gap in life expectancy between the most and least deprived tenths (deciles) of the population in Kingston. In 2010-12 the gap in the life expectancy between men living in the most and least deprived deciles was 5.8 years for Kingston. During the same time period the gap for women was 3.7 years. Data is also presented for the 2008-10 and 2009-11 time periods. No significant changes can be observed as the confidence intervals for this data are very wide.

Table 14: Slope index of inequality in life expectancy at birth within Kingston, based on local deprivation deciles in Kingston, 2008-10, 2009-11, 2010-12

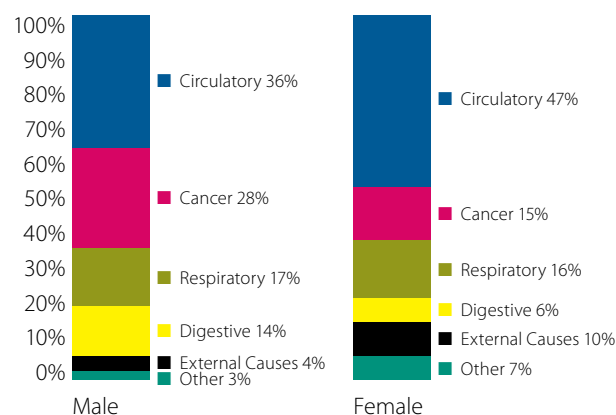
Gender	Year	The slope of inequality in life expectancy
Men	2008 – 2010	6.3 (2.6 – 10.0)
	2009 – 2011	6.7 (1.1 – 12.3)
	2010 – 2012	5.8 (1.3 – 10.2)
Women	2008 – 2010	3.8 (1.2 – 6.4)
	2009 – 2011	2.9 (0.7 – 5.2)
	2010 – 2012	3.7 (1.1 – 6.2)

Values in brackets denote 95% confidence intervals.

Source: Public Health England, accessible via Public Health Outcomes Framework.

Figure 5 illustrates the main health conditions that contribute to the gap in life expectancy between the most and least deprived sections of the community in Kingston. Circulatory diseases provide the largest contribution (36% for men and 47% for women), followed by cancer (28% for men and 15% for women). The third main contribution is provided by respiratory diseases (17% for men and 16% for women).

Figure 5: The life expectancy gap between the most and least deprived quintiles in Kingston, by cause of death, 2009-11



Source: Life Expectancy Segment Tool, 2013 Accessible via Public Health England. An external cause of death, is a death due to accidents and violence including environmental events, circumstances and conditions as the cause of injury, poisoning, and other adverse effects. Broad categories of these include, but are not limited to, homicide, injury from war activities, suicides, and accidents

Morbidity

General practice records are recognised as a potentially rich source of morbidity data that can be used for assessing local health needs. However, it is important to note the limitations with using this data source as the main indicator for the prevalence of many conditions in the community. These are:

- The data relating to some conditions may not be comparable to other sources of prevalence data mainly because of the very specific criteria set for the inclusion of cases on the register. For example the asthma register excludes patients who have not been prescribed asthma-related drugs in the previous twelve months
- It is also important to understand the definitional differences, for example when comparing prevalence in general practice (obtained from practice registers) with expected prevalence rates using public health models. To take one example the smoking indicator in general practice relates to the smoking status of people with one or more selected chronic conditions and as such it does not record the overall prevalence of smoking in the community
- Year-on-year changes in the size of QOF registers are influenced by various factors including:
 - Changes in prevalence of the condition within the population
 - Demographic changes, such as an ageing population
 - Improvements in case finding by practices
 - Changes to the definitions used to populate the registers

Table 15 presents the prevalence of the main conditions identified in general practice.

Table 15: Prevalence of main conditions in general practice, 2014

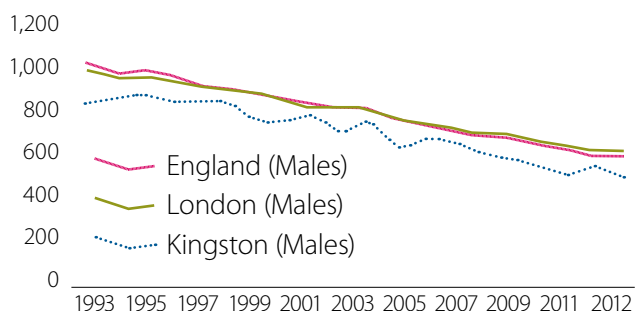
Condition	Number on disease register	% Prevalence
Palliative Care	364	0.2%
Dementia	774	0.4%
Heart Failure	894	0.5%
Epilepsy (aged 18 and over)	901	0.6%
Severe Mental Illness	1,590	0.8%
Stroke	2,068	1.0%
Atrial Fibrillation	2,172	1.1%
Chronic Obstructive Pulmonary Disease	2,209	1.1%
Cancer	3,227	1.6%
Chronic Kidney Disease	3,890	2.0%
Coronary Heart Disease	4,377	2.2%
Hypothyroidism	4,940	2.5%
Asthma	9,226	4.7%
Diabetes (aged 17 and over)	7,739	4.9%
Depression (aged 18 and over)	8,267	5.3%
Obesity (aged 16 and over)	9,991	6.2%
Hypertension	20,730	10.5%

Source: Disease Prevalence – Practice Focus Report, QMS, March 2014
Practice Population by age group – PCSS, March 2014

Mortality

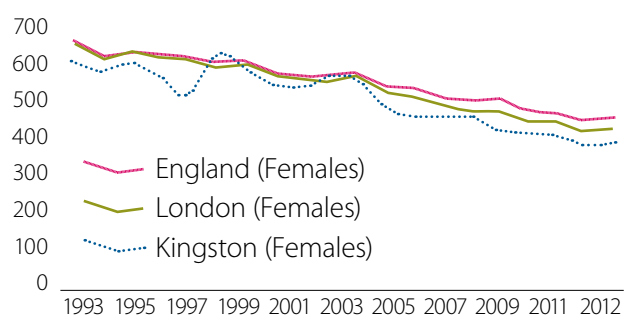
There were 1,020 deaths in Kingston during 2012, nine deaths less than the previous year. From 1993 to 2012 there was a marked decrease in the local mortality rates which have remained lower than the regional and national averages for males and females since 2004 (Figures 6 and 7).

Figure 6: Directly age standardised mortality rates from all causes, all ages for males in Kingston, London and England, 1993 to 2012



Source: The NHS Indicator Portal, 2014

Figure 7: Directly age standardised mortality rates from all causes, all ages for females in Kingston, London and England, 1993 to 2012



Source: The NHS Indicator Portal, 2014

The main causes of deaths at all ages in Kingston were (Figure 8):

- Diseases of the circulatory system (including heart disease and stroke) comprising 27.5% of all deaths (281 individuals)
- Malignant neoplasm (cancers) making up 26.4% of the total (269 individuals)
- Diseases of the respiratory system accounting for 17.7% of all deaths (181 individuals)

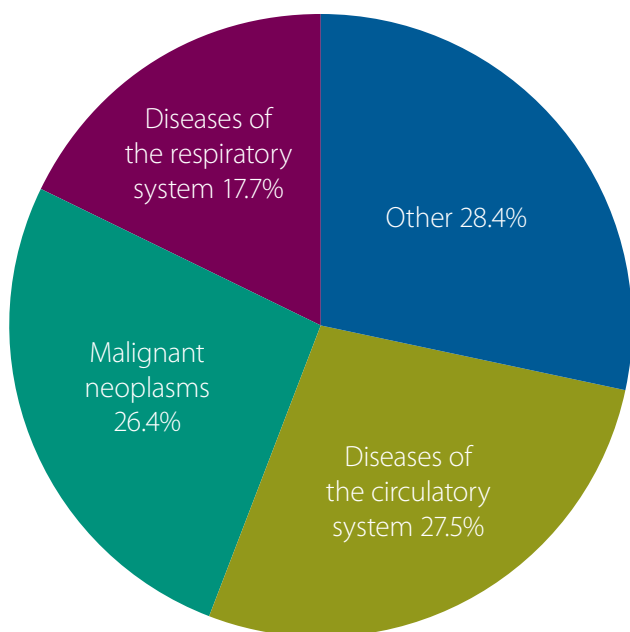
The commonest single cause of death in men of any age was ischaemic heart disease (16.1%) followed by cancer of the digestive system (9.2%) and pneumonia (7.5%).

The commonest single cause of death in women of any age was cerebrovascular disease (9.2%) followed by ischaemic heart disease (9.0%) and pneumonia (8.3%).

Of the 292 people who died prematurely (under 75 years of age) (Figure 9), the main causes of deaths were:

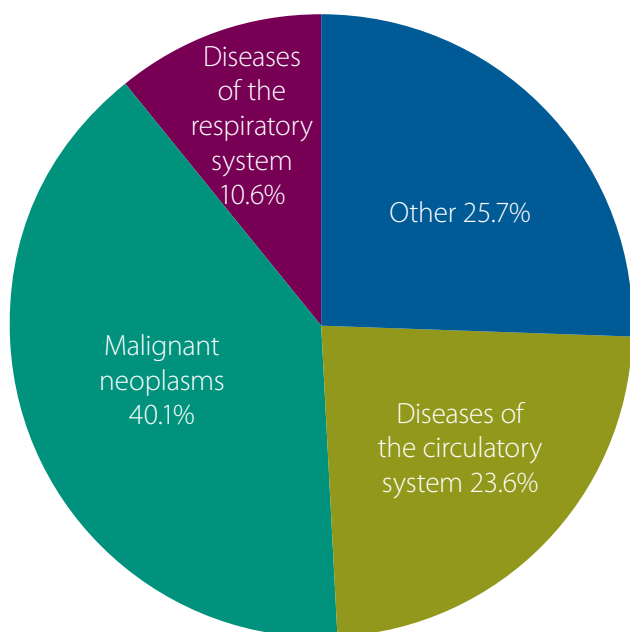
- Malignant neoplasms (cancers) 40.1%
- Diseases of the circulatory system (23.6%)
- Diseases of the respiratory system (10.6%)

Figure 8: The commonest causes of deaths, all ages, Kingston 2012



Source: ONS 2012 Vital Statistics Tables (VS3)

Figure 9: The commonest causes of deaths, under 75 years of age, Kingston 2012



Source: ONS 2012 Vital Statistics Tables (VS3)

Economic Indicators

Socio-economic differences in health exist. People in the lowest income quartile are more likely to suffer from ill health than people in the highest.

Several mechanisms may cause this correlation. Firstly, socio-economic status influences health, due to mediating processes like health related behaviour, social support, possibilities to invest in health and access to health care. Secondly, ill health may inhibit the individual's advancement in the social hierarchy, for instance due to limiting his or her work capacity or education. This results in a vicious circle with poverty and/or unemployment generating ill health and ill health generating further poverty and unemployment³.

Unemployment

Unemployment is associated with poor health and long term unemployment is even more detrimental to health⁴. Research indicates that the impact of unemployment on psychological health seems to be at least partly mediated through poverty and financial anxiety⁵. Some data suggest that stigma and social isolation also play an independent role⁶. Financial problems act partly by increasing the frequency of stressful life events associated with debt and possibly by the effect on diet, the quality of the home environment and social support.

Unemployment Benefit

The GLA claimant count shows the percentage of the economically active population who are claiming Job Seekers Allowance (JSA) and National Insurance Credits. This data indicates that in February 2014 there were 1,420 unemployed people in Kingston. Of these, slightly more men were claiming unemployment

benefits (1.8%) than women (1.7%). This can be seen in Table 16 whilst Table 17 illustrates the unemployment rates by age and electoral ward. The highest rates were in people aged 16 to 24. The ward with the highest percentage of claimants was Norbiton, followed by Chessington South.

Table 16: Claimant counts and rates by gender and geographical area in Kingston, April 2014

April 2014 (2012 base)	Claimant Count			Claimant count rate (%)		
	Persons	Men	Women	Persons	Men	Women
Alexandra	75	45	30	1.5%	1.7%	1.3%
Berrylands	80	50	30	1.6%	1.9%	1.3%
Beverley	100	60	45	2.0%	2.2%	1.9%
Canbury	105	65	40	1.6%	1.9%	1.4%
Chessington North and Hook	80	45	35	1.8%	1.8%	1.8%
Chessington South	110	60	55	2.1%	2.2%	2.2%
Coombe Hill	80	45	30	1.9%	1.9%	1.6%
Coombe Vale	60	30	30	1.2%	1.1%	1.4%
Grove	105	55	50	1.7%	1.6%	1.8%
Norbiton	145	75	70	2.8%	2.7%	3.1%
Old Malden	80	35	45	1.8%	1.5%	2.1%
St. James	70	40	30	1.8%	1.9%	1.6%
St. Mark's	95	65	30	1.9%	2.4%	1.4%
Surbiton Hill	90	50	40	1.5%	1.6%	1.4%
Tolworth and Hook Rise	95	60	35	1.9%	2.2%	1.5%
Tudor	50	20	30	1.1%	0.9%	1.4%
Kingston upon Thames	1,420	800	620	1.8%	1.8%	1.7%

Notes:

1. Data are based on administrative counts of people in receipt of unemployment-related benefits (ie Jobseeker's Allowance and National Insurance credits)
2. Percentage rates are GLA estimates and express the claimant count as a percentage of the resident labour force (the economically active population). The labour force denominators used here exclude economically active full-time students
3. All ONS count data are rounded to the nearest five. For this reason, rates based on very low counts are less reliable and should be treated with a degree of caution

Source: Office for National Statistics (Jobcentre Plus administrative system) and GLA estimates

Table 17: Claimant counts and rates by age and geographical area in Kingston, April 2014

April 2014 (2012 base)	Claimant count				Claimant count rate (%)			
	All ages	16-24	25-44	45-59/64	All ages	16-24	25-44	45-59/64
Alexandra	75	15	30	30	1.5%	3.3%	1.2%	1.5%
Berrylands	80	15	35	30	1.6%	3.0%	1.2%	1.9%
Beverley	100	15	50	40	2.0%	3.5%	1.7%	2.4%
Canbury	105	20	50	35	1.6%	3.8%	1.2%	2.0%
Chessington North and Hook	80	20	30	30	1.8%	5.1%	1.2%	1.9%
Chessington South	110	20	50	40	2.1%	4.9%	1.7%	2.2%
Coombe Hill	80	15	45	20	1.9%	3.2%	2.1%	1.3%
Coombe Vale	60	15	30	20	1.2%	3.8%	1.2%	1.0%
Grove	105	15	55	35	1.7%	2.4%	1.3%	2.7%
Norbiton	145	35	75	35	2.8%	5.6%	2.3%	2.8%
Old Malden	80	10	45	25	1.8%	2.7%	2.0%	1.4%
St. James	70	10	30	30	1.8%	3.8%	1.8%	1.5%
St. Mark's	95	10	50	30	1.9%	1.6%	1.6%	2.9%
Surbiton Hill	90	15	45	30	1.5%	2.4%	1.2%	2.1%
Tolworth and Hook Rise	95	20	45	35	1.9%	4.2%	1.6%	1.9%
Tudor	50	10	20	20	1.1%	4.1%	0.9%	1.1%
Kingston upon Thames	1,420	250	680	490	1.8%	3.4%	1.5%	1.9%

Source: Office for National Statistics (Jobcentre Plus administrative system) and GLA estimates

Key out of work benefits

These are the benefits that were chosen to represent a count of all those working age benefit recipients who cannot be in full-time employment as part of their condition of entitlement. Table 18 shows that of the 6,560 people who received out of work benefits in August 2013, 57% (3,740 claimants) received ESA

and Incapacity benefits and 27% (1,770 claimants) received Job Seeker's allowances. As can be seen from the table the total percentage of key out-of-work benefit claimants is less in Kingston than the London and national averages.

Table 18: Key out-of-work benefit claimants in Kingston, London and Great Britain, August 2013

By statistical group	Kingston (number)	Kingston (%)	London (%)	Great Britain (%)
Job seekers	1,770	1.6%	3.4%	3.2%
Employment and Support Allowance (ESA) and incapacity benefits	3,740	3.4%	5.5%	6.1%
Lone parents	830	0.7%	1.4%	1.3%
Carers	740	0.7%	1.0%	1.3%
Others	220	0.2%	0.3%	0.4%
Disabled	780	0.7%	0.9%	1.2%
Bereaved	170	0.2%	0.1%	0.2%
Key out of work benefits	6,560	5.9%	10.6%	10.9%

Note: % – represents the percentage of claimants of the resident population of area who are aged 16 to 64
Source: DWP benefit claimants – working age client group.

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Abbreviations

AFH	Action for Happiness	LEAH	Learn English at Home
APHO	Association of Public Health Observatories	LEAP	London Exercise & Pregnant Smokers Project
BAPEN	British Association for Parenteral and Enteral Nutrition	LGBT	Lesbian, Gay, Bisexual & Transgender
BMI	Body Mass Index	LTC	Long Term Condition
BAME / BME	Black and Minority Ethnic	LSCB	Local Safeguarding Children's Board
CAB	Citizens Advice Bureau	LSE	London School of Economics
CAMHS	Child and Adolescent Mental Health Services	MBCT	Mindfulness-Based Cognitive Therapy
CASSR	Council with Adult Social Services Responsibility	MDT	Multidisciplinary Team
CBT	Cognitive Behavioural Therapy	MSM	Men who have Sex with Men
CCG	Clinical Commissioning Group	MUST	Malnutrition Universal Screening Tool
CDH	Community Development and Health Course	NCSTC	National Centre for Smoking Cessation and Training
CDOP	Child Death Overview Panel	NEA	New Enterprise Allowance
CHD	Coronary Heart Disease	NEET	Not in Education, Employment or Training
CHIMAT	The Child and Maternal Health Intelligence Network	NICE	National Institute for Health and Clinical Excellence
CIL	Community Infrastructure Levy	NPPF	The National Planning Policy Framework
CMHT	Community Mental Health Teams	NRT	Nicotine Replacement Therapy
COSMIC	Co-morbidity Of Substance Misuse and Mental Illness Collaborative	ONS	Office for National Statistics
CPN	Community Psychiatric Nurse	PCSS	Primary Care Support Service
CQC	Care Quality Commission	PH	Public Health
CQUIN	Commissioning for Quality & Innovation	PHE	Public Health England
CRCID	Centre for Research, Communities, Identity and Difference at Kingston University	PHOF	Public Health Outcomes Framework
CSC	Children's Social Care	PIP	Personal Independence Payment
CSPAN	Community Sport and Physical Activity Network	PSHE	Personal Social and Health Education
DLA	Disability Living Allowance	QOF	Quality & Outcomes Framework
DH	Department of Health	RAK	Refugee Action Kingston
DSM V	Diagnostic and Statistical Manual of Mental Disorders – 5	RAID	Rapid Assessment Interface and Discharge
DPH	Director of Public Health	RISE	Recovery Initiative Social Enterprise
DWP	Department for Work and Pensions	RoSPA	Royal Society for the Prevention of Accidents
ECET	Equalities and Community Engagement Team	SAMCAT	Safeguarding Adults and Mental Capacity Act team
ESA	Employment and Support Allowance	SCA	Smoking Cessation Advisers
ESOL	English for Speakers of Other Languages	SCIE	Social Care Institute for Excellence
EYFS	Early Years Foundation Stage	SDQ	Strength and Difficulties Questionnaire
FASS	Family Advice Support Service	SEN	Special Education Needs
GKV	Go Kingston Volunteering	SENCO	Special Educational Needs Coordinator
GLA	Greater London Authority	SHEU	The Schools Health Education Unit
GFR	General Fertility Rate	SPD	Supplementary Planning Document
HES	Hospital Episode Statistics	SRE	Sex and Relationships Education
HIA	Health Impact Assessment	STI	Sexually Transmitted Infection
HLW	Health Link Workers	SWL	South West London
HPA	Health Protection Agency	SWLStG	South West London and St George's Mental Health Trust
HSE	Health Survey for England	TAG	Teenage Action Group
IAPT	Improving Access to Psychological Therapies	TOP	Termination of pregnancy
IMD	Index of Multiple Deprivation	TPFR	Total Period Fertility Rate
JSA	Jobseeker's Allowance	WHO	World Health Organization
KCCG	Kingston Clinical Commissioning Group	WEMWBS	Warwick Edinburgh Mental Well-being Scale
KCN	Kingston Carers' Network	WoW	Walk once a Week
KHT	Kingston Hospital Trust	YHC	Your HealthCare
KPI	Key Performance Indicator		
LA	Local Authority		
LAC	Looked After Children		
LARC	Long Acting Reversible Contraception		
LDF	Local Development Framework		

Glossary

Achieving for Children

A social enterprise providing social, educational and community services for children and young people in Kingston and Richmond.

Action for Happiness (AFH)

A charity promoting action to create a happier society. It is part of 'The Young Foundation'.

Active travel

Active travel refers to journeys that use physical activity, such as walking and cycling.

Acute care

A branch of health care usually provided in a hospital where a patient receives active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery.

Adult Social Care

Care and support for adults who need extra help to manage their lives and be independent. It includes residential care, home care, personal assistants, day services, the provision of aids and adaptations and personal budgets.

Advanced Care Planning

The process of discussing with individuals their preferences regarding the type of care they would wish to receive and where they wish to be cared for in case they lose capacity or are unable to express a preference in the future.

Alzheimer's disease

The most common type of dementia. On its own it accounts for an estimated 62 percent of cases.

Anorexia nervosa

A serious, potentially life-threatening eating disorder characterized by self-starvation and excessive weight loss.

Asperger syndrome

An autistic spectrum disorder considered to be on the "high functioning" end of the spectrum.

Assessment and Care Planning Team

A team including senior social workers and family liaison workers who provide support to disabled children and their families.

Asset Based Community Development

A methodology to discover and utilise strengths within communities as a means to meet community needs.

Attendance Allowance

A sum of money that helps to pay for personal care for older, or disabled, people.

Attention Deficit Hyperactive Disorder (ADHD)

A group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness.

Autistic Spectrum Disorder (ASD)

A condition that affects social interaction, communication, interests and behaviour. It includes Asperger syndrome and childhood autism.

Bariatric surgery

A surgical procedure performed on people who are obese to promote weight loss by changing the digestive system's anatomy.

Bibliotherapy

The use of the written word in the treatment of mental or psychological disorders.

Bike polo

A competitive sport where players riding a bike use a mallet and ball to score goals against their opponents.

Binge Eating Disorder (BED)

A condition in which a person consumes an amount of food which would definitely be in excess of that consumed by an average person, this occurs on multiple occasions and does not involve compensatory behaviour such as in bulimia.

Bipolar disorder

A condition in which a person's mood can swing from one extreme to another. People with this can have episodes of depression (low mood) or episodes of mania (happy and overactive).

Body Mass Index (BMI)

An indirect measure of adiposity, it is calculated taking a person's weight in kilograms divided by the square of their height in metres (weight (kg) ÷ height (m²)).

Booking appointment

First appointment when pregnant mothers attend for antenatal care.

Bulimia Nervosa

A serious, potentially life-threatening eating disorder characterized by a cycle of bingeing and compensatory behaviours such as self-induced vomiting.

Carbon sink

A natural (or artificial) reservoir that accumulates and stores carbon-containing chemical compounds for an indefinite period.

Care Act 2012

An Act to reform the law relating to care and support for adults, and the law relating to support for carers.

Care Programme Approach

A particular way of assessing, planning and reviewing someone's mental health care needs. This should involve a shared decision with the particular person involved to devise a plan for care and support.

Case management

A treatment plan for a specific patient to ensure they receive the most appropriate and co-ordinated treatment.

Child eligible for free school meals

Those aged 5-16 years old with parents who are on Employment and Support Allowance, Job Seekers Allowance or Income Support.

Child poverty

Defined as growing up in a household in which the standard of living is well below that considered acceptable by most people in Britain today, i.e. family income below 60% of median income.

Children's Centre

A centre where informal support is available for parents of children under 5 or expectant mothers and fathers. There are 10 centres across Kingston.

Children's Social Care

The body responsible for social services for children. In Kingston, children's social care is delivered by Achieving for Children.

Clinical Commissioning Group (CCG)

NHS organisation led by local GPs responsible for the commissioning of local NHS services including hospital and community services. They replaced PCTs in April 2013.

Cognitive Behavioural Therapy (CBT)

A talking therapy that can help people manage their problems by changing the way they think and behave.

Common mental health problems

Common mental health problems include depression, generalised anxiety disorder, panic disorder, obsessive compulsive disorder, post-traumatic stress disorder and social anxiety disorder.

Community Engagement

Utilising the assets of communities; helping communities to have control over their health, through working in partnership with them or delegating power to them, in order to improve health outcomes.

Community (health) services

Health services provided in the community which include health visitors, community matrons, community hospitals and clinics. The community health service provider in Kingston is called 'Your Healthcare'.

Community Mental Health Team

A group of different mental health professionals from health and social care backgrounds that work together to help people recover from mental illness.

Community Infrastructure Levy

A levy that local authorities in England and Wales can choose to charge on new developments in their area.

Conduct disorder

A serious behavioural and emotional disorder that can occur in children and teenagers. A child with this illness may display a pattern of disruptive and violent behaviour and have problems following rules.

Coproduction

Working collaboratively with communities to identify the outcomes that matter most to them and to jointly evaluate, design and achieve these outcomes.

Core Strategy

The core strategy is the key development plan document within the Local Development Framework. In Kingston it includes land use policies and guidance that is used in deciding planning applications and guides future development in the borough up until 2027.

Commissioning for Quality and Innovation (CQUIN)

Introduced in 2009 this makes a proportion of a healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.

Dementia Care and Support Compact

Supports the delivery of the National Dementia Strategy to improve care and support for those with dementia, their carers and families.

Early Year (EY) providers

All childcare providers for preschool children, excluding mothers, toddler groups, nannies, and short term crèches.

Edinburgh Postnatal Depression Screening tool

A 10 question self-rating questionnaire proven to be an efficient and effective way of identifying postpartum (after birth) depression.

Equalities and Community Engagement Team

A team in the Council working to address health inequalities.

Essential amino acids

Amino acids that cannot be made in the body and therefore can only be consumed through the diet.

Excess Winter Deaths (EWDs)

The increased number of deaths that occur during the winter months compared with the non-winter months of the year.

Fuel Poverty

Under the government's new 'Low Income High Cost' definition a household is considered to be fuel poor where there are fuel costs that are above average and, were they to spend that amount, they would be left with a residual income below the official poverty line.

General Fertility Rate

Number of live births per 1000 women ages 15 – 49 in a given year.

Greenways

Traffic-free routes for walking, cycling and other non-motorised uses, often built along other forms of transport infrastructure.

Health inequalities

Preventable and unfair differences in a population group's health status e.g. avoidable differences in health between different socioeconomic groups, genders and ethnic groups.

Health Link Workers

Health link workers are responsible for the delivery of targeted interventions to young people in schools in Kingston and play a key role in the delivery of training, support and advice to school staff, parents and young people regarding Personal, Social and Health Education provision and health promotion. They deliver targeted prevention and education to young people around emotional health and wellbeing, obesity, smoking, drug, alcohol and substance misuse, sexual health and teenage pregnancy.

Health Visitors

Professionals that advise on all aspects of development and health promotion until a child is 5 years old.

Housing Resettlement Team

The team's role is to provide advice and practical support to clients with mental health and/or drug and alcohol problems, young vulnerable people, people fleeing domestic violence and people with physical disabilities during the period of transition between homelessness and settlement into secure accommodation.

Hyperkinetic disorder

An enduring disposition to behave in a restless, inattentive, distractible and disorganised fashion with diagnostic feature of overactivity, inattentiveness and impulsiveness. This would encompass a severe form of attention deficit hyperactivity disorder (ADHD).

Improving Access to Psychological Therapy (IAPT) service

A NHS programme of psychological therapies.

Index of Multiple Deprivation (IMD)

A composite measure made up of seven domains which, when combined, give a score indicating the estimated deprivation experienced by the population in any given area.

Infant Mortality Rate

An estimate of the number of infant deaths for every 1,000 live births in a given area.

Joint Strategic Needs Assessment (JSNA)

A statutory duty set out in the Local Government and Public Involvement in Health Act (2007). It requires local authorities to assess the health and wellbeing needs of the local population. It takes a broad look at health and wellbeing in an area and draws attention to topics that need attention.

Kingston Carers' Network (KCN)

An organisation providing information, support and advocacy to young people and adults who provide long-term unpaid care to a relative, partner or friend within the borough.

Kingston Centre for Independent Living (KCIL)

A user-led organisation for disabled people.

Kingston Lifestyle Survey

A survey that was carried out by the Council's Public Health directorate in 2014 to learn more about the health and lifestyles of Kingston's residents.

Kingston Race Equalities Council

An organisation that aims to acquaint organisations, agencies and employers with the nature and extent of racial discrimination and inequality experienced by minority racial groups in different areas of life.

Kingston Welcare

A charity offering local families support with parenting issues from experienced support workers.

Kingston Youth Council (KYC)

A group of young people (aged 11 – 19) who actively represent the views, interests, concerns and aspirations of young people in Kingston.

Leaving Care Team

Kingston Council's looked after and leaving care team provides a specialist service to children and young people who are under the care of the Council on a permanent or long term basis or those who have left care and require ongoing advice and/or assistance.

Liaison psychiatry

A branch of psychiatry that specialises in the interface between medical healthcare and psychiatry.

Local Development Framework

The collection of local development documents produced by a local authority which collectively deliver the spatial planning strategy for its area.

Looked after children

Children who are cared for by the local authority.

Low decision latitude

Lack of freedom of action or choice. For example not having the authority to make a decision within a group of people or business.

Mental health

A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. In this the absence of mental disorder does not necessarily mean the presence of good mental health. (WHO definition)

Mental disorder

See mental illness.

Mental illness

Mental illness refers to a diagnosable condition that significantly interferes with an individual's cognitive, emotional or social abilities, such as depression, anxiety, schizophrenia, or bipolar disorder. Also sometimes called a mental disorder.

Mental Health Cluster

A Mental Health Care Cluster is part of a currency developed to support the National Tariff Payment System for Mental Health Services. Mental Health Care Clusters are 21 groupings of Mental Health patients based on their characteristics, and are a way of classifying individuals utilising Mental Health Services that forms the basis for payment.

Mental Health Parliament

The Kingston Mental Health Parliament is an independent collective advocacy movement designed and implemented by service users and ex-service users from Kingston.

Mental wellbeing (also mental health)

Having a positive state of mind and body and feeling safe and able to cope. It also involves having a sense of connection with the people and the environment around you. People can have good mental wellbeing, even if they have a mental illness.

Mind

A national mental health charity. Mind in Kingston is the local branch.

Mindfulness-based cognitive therapy (MBCT)

Combines mindfulness techniques like meditation, breathing exercises and stretching with elements from cognitive behaviour therapy (CBT) to help break negative thought patterns.

Morbidity

The frequency of disease or other health disorders within a population. Morbidity indicators include chronic disease incidence/ prevalence, rates of hospitalisation, primary care consultations, disability-days (i.e. days of absence from work), and prevalence of symptoms.

National Institute for Health and Care Excellence (NICE)

The independent organisation responsible for providing national guidance on the promotion of good health and the treatment of ill health.

National Patient Safety Agency

A special health authority of the National Health Service in England created to monitor patient safety incidents, including medication and prescribing error reporting.

Needs Assessment

An assessment of the needs of a population or group of people, based on a review of data and trends and a comparison of local care against best practice. The needs assessment may also include surveys, focus groups and workshops, and the mapping of local services.

Office for National Statistics

Independent producer of official statistics and is the recognised national statistical institute for the UK.

One Kingston

A programme set up by the Council to deliver front line services with an evidence based approach to reshape action undertaken.

One Norbiton

A partnership programme between statutory, voluntary and community stakeholders delivered in the ward of Norbiton.

Payment by Results

A form of payment that is dependant on the independent verification of results.

Perinatal

The time period in a pregnancy commencing at 22 completed weeks of gestation and ending seven completed days after birth.

Personal budgets

A sum of money allocated to a person as a result of an assessment of their needs.

Personal Independence Payments (PIP)

The government has replaced Disability Living Allowance for eligible people aged 16 to 64 with Personal Independence Payment (PIP) from 8 April 2013. PIP is based on an assessment of individual need and considers how their impairment affects their life and their ability to carry out a range of everyday activities.

PHQ-9 questionnaire

A self-administered questionnaire used to monitor the severity of disease and response to treatment in those with depression. This can also be sometimes used to indicate a diagnosis of depression may be present.

Prevalence

The proportion of individuals in a population having a disease or characteristic.

Primary care

Healthcare given as the primary point of consultation with patients. This is usually a general practitioner (GP) but may also be provided by other health professionals as first point of contact, such as pharmacists.

Primary prevention

Taking measures to prevent disease or ill health.

Psychiatric disorder

Another term used for mental illness.

Psychological treatment

Sometimes referred to as talking therapies, these can include one-to-one counselling, bibliotherapy or encouragement of lifestyle changes. They aim to change patterns of thinking and behaviour through different methods with the aim of helping a person manage problems in their life.

Psychosis Physical Health CQUIN

This scheme established for 2014 – 15 provides incentives for Mental Health Trusts to monitor and improve the health of people with psychosis as a Commissioning for Quality and Innovation payment.

Pupil Referral Unit

A service provided by local authorities which give specialist support for pupils aged 11 to 16 years old and who are out of mainstream schools. This might be because they have emotional and behavioural difficulties, medical issues, or difficult home or personal situations.

Quality and Outcomes Framework (QOF)

A voluntary annual reward and incentive programme for General Practice (GP) surgeries across the UK.

Recovery

Recovery refers to the experience of people as they accept and overcome the challenge of a disability or long term health condition, including mental illness.

Refugee Action Kingston (RAK)

A local charity, providing advice and support for refugees and asylum seekers in the Kingston area.

Relateen

Relateen counselling is a service provided by Relate (Richmond, Kingston and Hounslow) which provides one to one support for young people who are experiencing difficulties as a result of family breakdown, family conflict or issues with step families.

Respite care

Care provided for ill or disabled individuals to enable a temporary break for carers.

Safeguarding

The process of protecting vulnerable adults or children from abuse or neglect and putting plans in place to prevent harm in the future.

Safer Kingston Partnership

A group made up of public, private and voluntary sector organisations working in Kingston. The partnership works with residents of, visitors to, and businesses in Kingston to identify priorities, target resources and ensure safety.

Schizophrenia

A psychotic disorder. Common symptoms include false beliefs, unclear or confused thinking, auditory hallucinations, reduced social engagement and emotional expression, and inactivity.

School Health Education Unit (SHEU)

A specialist provider of local survey data regarding children and young people's health and wellbeing.

Secure attachment

Secure attachment is the presence of an emotional bond between children and caregivers.

Service user

Anyone who is a patient or other user of health and/or social services.

Severe mental illness

These describe psychotic illnesses such as schizophrenia and bipolar disorder.

Singing for the Brain

A group singing activity facilitated by the Alzheimer's Society.

Smoking Cessation Advisor (SCA)

Advisers who are trained to help people stop smoking.

The Social Care Institute for Excellence (SCIE)

The organisation, funded by the Department of Health, which aims to identify and disseminate the knowledge base for good practice in social care.

South West London and St Georges Mental Health Trust (SWLStG)

This NHS trust provides community and hospital mental health services to Kingston, Merton, Richmond, Sutton and Wandsworth.

Spatial planning

The process to promote sustainable development which goes beyond traditional land use planning to bring together and integrate policies for the development and use of land with other policies and programmes (including health) which influence the nature of places and how they function.

StayWell Kingston

The new name for Age Concern Kingston

The Noble Centre

The Noble Centre in Kingston is the location for a number of services including Kingston Carer's Network, Mind in Kingston's Wellbeing Wednesdays and the Council's 'Promoting Independent People Service' where residents with physical disabilities can try out and buy equipment to help them make their lives easier.

The Samaritans

A UK charity aimed at providing support to people in emotional distress or at risk of suicide, often through their telephone helpline.

Time Bank

A reciprocity based work trading system in which hours are the currency. With time banking, a person with one skill set can bank and trade hours of work for equal hours of work in another skill set instead of paying or being paid for services. In these arrangements all time is considered equal.

Triple P programme

Triple P is an evidence based positive parenting programme which gives parents simple and practical strategies to help them confidently manage their children's behaviour, prevent problems developing and build strong, healthy relationships.

Vascular dementia

Caused by problems with the supply of oxygen to the brain following a sudden stroke or over time, through a series of small strokes or small vessel disease. Vascular dementia constitutes the second most common cause of dementia after Alzheimer's disease.

Voluntary and Community Sector (VCS) Strategy

The local VCS Strategy aims to recognise and capitalise on the role the voluntary and community sector play in the delivery of services and projects in the community.

Warwick Edinbrough Mental Wellbeing Scale (WEMWBS)

This is a scale of 14 items for assessing a population's mental wellbeing. There is also a shorter version of this limited to 7 items called the Short WEMWBS.

Wellbeing

See mental wellbeing.

Your Kingston, Your Say

A tool used by the Council to involve residents in the choices they make. The feedback received is then used to improve the services provided.





Statistical Annex

Table 1A : Kingston, London and England Population Age and Gender Structure, 2013 Mid Year Population Estimates

Usual residents		Age Group												
		0-4	5-14	15-24	25-44	45-64	65-74	75-84	85+	All Ages				
Kingston	Gender													
	Male	5,900	9,444	11,238	26,726	18,735	5,580	2,959	1,092	81,674				
	Female	5,736	9,329	12,086	26,729	19,062	6,004	3,940	2,233	85,119				
London	Person	11,636	18,773	23,324	53,455	37,797	11,584	6,899	3,325	166,793				
	Male	318,064	504,058	526,387	1,503,424	888,510	240,183	140,562	44,147	4,165,335				
	Female	303,217	482,599	523,930	1,482,560	923,450	271,300	179,503	84,641	4,251,200				
England	Person	621,281	986,657	1,050,317	2,985,984	1,811,960	511,483	320,065	128,788	8,416,535				
	Male	1,748,820	3,155,709	3,500,026	7,231,408	6,712,115	2,418,603	1,348,062	419,226	26,533,969				
	Female	1,665,310	3,008,603	3,358,464	7,295,016	6,885,167	2,604,970	1,695,677	818,641	27,331,848				
	Person	3,414,130	6,164,312	6,858,490	14,526,424	13,597,282	5,023,573	3,043,739	1,237,867	53,865,817				

Notes and Definitions

1. The estimated resident population of an area includes all people who usually live there, whatever their nationality. People arriving into an area from outside the UK are only included in the population estimates if their total stay in the UK is 12 months or more. Visitors and short term migrants (those who enter the UK for 3 to 12 months for certain purposes) are not included. Similarly, people who leave the UK are only excluded from the population estimates if they remain outside the UK for 12 months or more. This is consistent with the United Nations recommended definition of an international long-term migrant. Members of UK and non-UK armed forces stationed in the UK are included in the population and UK forces stationed outside the UK are excluded. Students are taken to be resident at their term time address. Source – ONS Mid-year population estimates for 2013. © Crown Copyright 2014

Table 1B : Kingston, London and England Population Age and Gender Structure, 2012 Mid Year Population Estimates

Usual residents		Age Group												
		0-4	5-14	15-24	25-44	45-64	65-74	75-84	85+	All Ages				
Kingston	Gender													
	Male	5,830	9,084	11,323	26,198	18,330	5,323	2,977	1,045	80,110				
	Female	5,670	9,042	12,205	26,201	18,764	5,677	3,928	2,309	83,796				
London	Person	11,500	18,126	23,528	52,399	37,094	11,000	6,905	3,354	163,906				
	Male	312,776	491,413	538,116	1,481,467	868,795	232,896	137,464	42,644	4,105,571				
	Female	299,058	471,085	536,594	1,467,242	904,412	263,239	177,337	83,831	4,202,798				
England	Person	611,834	962,498	1,074,710	2,948,709	1,773,207	496,135	314,801	126,475	8,308,369				
	Male	1,736,916	3,118,327	3,519,015	7,232,186	6,673,866	2,331,158	1,315,285	406,695	26,333,448				
	Female	1,656,440	2,973,126	3,388,842	7,300,677	6,837,826	2,513,332	1,676,227	813,811	27,160,281				
	Person	3,393,356	6,091,453	6,907,857	14,532,863	13,511,692	4,844,490	2,991,512	1,220,506	53,493,729				

Notes and Definitions

1. The estimated resident population of an area includes all people who usually live there, whatever their nationality. People arriving into an area from outside the UK are only included in the population estimates if their total stay in the UK is 12 months or more. Visitors and short term migrants (those who enter the UK for 3 to 12 months for certain purposes) are not included. Similarly, people who leave the UK are only excluded from the population estimates if they remain outside the UK for 12 months or more. This is consistent with the United Nations recommended definition of an international long-term migrant. Members of UK and non-UK armed forces stationed in the UK are included in the population and UK forces stationed outside the UK are excluded. Students are taken to be resident at their term time address. Source – ONS Mid-year population estimates for 2012. © Crown Copyright 2014

Table 3 : Kingston & Greater London Authority 5 Year Population Projections, 2018

Usual residents		Age Group													
		0-4	5-14	15-24	25-44	45-64	65-74	75-84	85+	All Ages					
Kingston	Gender														
	Male	5,900	10,700	12,700	27,400	19,900	6,000	3,300	1,400	87,300					
	Female	5,600	10,400	12,400	27,200	20,400	6,600	4,000	2,300	88,900					
Greater London	Person	11,500	21,100	25,100	54,600	40,300	12,700	7,200	3,600	176,100					
	Male	331,700	548,400	546,700	1,591,800	959,800	257,700	144,600	56,700	4,437,400					
	Female	312,600	526,300	546,800	1,585,100	991,200	291,600	183,300	94,500	4,531,400					
	Person	644,400	1,074,800	1,093,600	3,176,900	1,951,000	549,300	327,900	151,300	8,969,200					

Source: © GLA 2013 Round Demographic Projections

Table 4 : Office for National Statistics Subnational Population Projections for 2019

Usual residents		Age Group																	
		0-4	5-14	15-24	25-44	45-64	65-74	75-84	85+	All Ages									
Kingston	Gender																		
	Male	6,300	11,500	11,900	28,700	20,700	6,500	3,500	1,400	90,700									
	Female	6,000	11,200	12,300	28,100	21,400	7,100	4,200	2,500	92,600									
London	Person	12,300	22,600	24,300	56,800	42,100	13,600	7,700	3,900	183,300									
	Male	337,200	570,100	532,000	1,622,400	993,300	268,600	151,600	58,200	4,533,300									
	Female	321,100	544,300	523,500	1,560,600	1,015,300	305,400	190,300	94,500	4,554,700									
England	Person	658,300	1,114,300	1,055,500	3,183,000	2,008,500	574,000	341,800	152,500	9,088,000									
	Male	1,781,600	3,447,800	3,320,000	7,434,500	7,023,200	2,681,100	1,558,600	560,000	27,806,600									
	Female	1,696,600	3,283,800	3,155,800	7,335,700	7,230,400	2,879,400	1,864,000	946,200	28,391,700									
	Person	3,478,100	6,731,700	6,475,800	14,769,900	14,253,600	5,560,600	3,422,600	1,506,200	56,198,300									

Source – 2012-based Subnational Population Projections for Local Authorities in England, Office of National Statistics, 2012.

Table 5 : Key Birth Statistics, 2012

Area	Female Population aged 15-44	Number of live births	General Fertility Rate*	Total Period Fertility Rate**	% Mothers under 20 Years	% Mothers 40 Years & over	% Live Births in NHS Hospitals
Kingston	38,406	2,328	60.6	1.7	1.6%	6.7%	98.0%
London	2,003,836	134,186	67.0	1.8	2.5%	5.5%	96.9%
England	10,689,519	694,241	64.9	1.9	4.6%	4.1%	97.2%

* The general fertility rate is the number of live births per 1,000 females of childbearing age between 15-44.

** The total period fertility rate (TPFR) calculated as the sum of the age-specific fertility rates between ages 15-44.

Brackets denote 95% confidence intervals

Source: The NHS IC Indicator Portal, 2013; Office of National Statistics 2012 mid year population estimates; Office of National Statistics 2012 Vital Statistics Tables VS1 and VS2.

Table 6 : Infant Mortality Statistics, 2012

Area		Livebirths	Stillbirths	Perinatal Mortality	Neonatal Mortality	Post-Neonatal Mortality	Infant Mortality
Kingston	Number	2,328	5	12	*	*	11
	Rate	n/a	2.1	5.1	*	*	4.7 (2.6 to 8.5)
London	Number	134,186	755	1,039	354	165	519
	Rate	n/a	5.6 (5.2 to 6.0)	7.7 (7.2 to 8.2)	2.6 (2.4 to 2.9)	1.2 (1.1 to 1.4)	3.9 (3.5 to 4.2)
England	Number	694,241	3,357	4,886	1,985	885	2,870
	Rate	n/a	4.8 (4.7 to 5.0)	7.0 (6.8 to 7.2)	2.9 (2.7 to 3.0)	1.3 (1.2 to 1.4)	4.1 (4.0 to 4.3)

* Figures less than 5 and adjacent figures were suppressed

Stillbirths: Fetal deaths occurring after 24 weeks gestation. Rate per 1,000 total live and still births

Perinatal Mortality: Stillbirths and deaths of infants at ages under 7 days. Rate per 1,000 total live & still births

Early Neonatal Mortality: Deaths of infants at ages under 7 days. Rate per 1000 live births.

Neonatal Mortality: Deaths occurring under 28 days. Rate per 1000 live births.

Post-neonatal Mortality: Deaths of infants at ages 28 days to 1 year. Rate per 1000 live births.

Infant mortality: Deaths to infants at various ages: (<7 days, <28 days & 28 days to 1 year). Rate per 1000 live births.

Source: The NHS IC Indicator Portal, May 2013 and Office of National Statistics 2012 Vital Statistics Tables (VS5)

Table 7 : Infant Mortality Statistics, 2010 – 12 Pooled

Area		Early Neonatal Mortality	Neonatal Mortality	Infant Mortality
Kingston	Number	*	21	29
	Rate	*	3.0 (2.0 to 4.6)	4.2 (2.9 to 6.0)
London	Number	900	1,159	1,693
	Rate	2.2 (2.1 to 2.4)	2.9 (2.7 to 3.1)	4.2 (4.0 to 4.4)
England	Number	4,734	6,113	8,822
	Rate	2.3 (2.2 to 2.4)	3.0 (2.9 to 3.0)	4.3 (4.2 to 4.4)

* data for 2010-12 is not available currently

Early Neonatal Mortality: Deaths of infants at ages under 7 days. Rate per 1000 live births.

Neonatal Mortality: Deaths occurring under 28 days. Rate per 1000 live births.

Infant mortality: Deaths to infants at various ages; (<7 days, <28 days & 28 days to 1 year) under 1 year. Rate per 1000 live births.

Values in brackets denote 95% confidence intervals

Source: The NHS IC Indicator Portal, May 2014

Table 8: All cause mortality; numbers – All Ages and Under 75

Area		Number of deaths (All ages) 2012	Number of deaths (Under 75) 2012
Kingston	Male	465	162
	Female	555	130
	Person	1,020	292
London	Male	23,720	10,355
	Female	24,178	6,886
	Person	47,898	17,241
England	Male	224,460	87,986
	Female	242,319	60,721
	Person	466,779	148,707

Source: Office of National Statistics, 2012 Vital Statistics (VS3)

Table 9: All cause mortality; Numbers and Rates – All Ages

Area		Number of deaths	Crude Death Rate per 100,000 (2012)	Directly Standardised Death Rate * (2010-2012)	Indirectly Standardised Ratios (2010-2012)
Kingston	Male	465	580.45 (530.15 to 635.50)	522.3 (494.66 to 551.00)	83.7 (79.40 to 88.26)
	Female	555	662.32 (609.60 to 719.57)	384.2 (363.71 to 405.51)	87.9 (83.71 to 92.20)
	Person	1,020	622.31 (585.37 to 661.56)	446.1 (429.33 to 463.27)	86.0 (82.93 to 89.05)
London	Male	23,720	577.75 (570.47 to 585.13)	603.5 (599.00 to 608.05)	95.8 (95.05 to 96.46)
	Female	24,178	575.28 (568.10 to 582.56)	419.8 (416.52 to 423.11)	92.9 (92.19 to 93.54)
	Person	47,898	576.50 (571.38 to 581.67)	503.2 (500.48 to 505.91)	94.3 (93.79 to 94.76)
England	Male	224,460	852.38 (848.87 to 855.89)	624.9 (623.35 to 626.43)	100.0 (99.76 to 100.24)
	Female	242,319	892.18 (888.65 to 895.73)	449.5 (448.35 to 450.66)	100.0 (99.77 to 100.23)
	Person	466,799	872.59 (870.10 to 875.08)	529.5 (528.54 to 530.41)	100.0 (99.83 to 100.17)

* Rate per 100,000 European Standard Population
Source: The NHS IC Indicator Portal, May 2014

Table 10: All Cause Mortality (ICD10 A00-Y99, ICD9 001-E999) , Directly Standardised Rate Per 100,000 European Standard Population, All Ages, Persons, 2002 – 2012

Area	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Kingston	619.29	630.10	547.03	545.88	544.78	519.74	489.13	469.31	452.83	453.08	433.00
London	660.26	663.76	622.41	602.93	581.18	562.37	557.08	530.20	519.86	594.11	495.96
England	663.67	662.72	627.87	614.94	593.94	582.00	577.74	550.60	541.76	523.04	523.91

Source: The NHS IC Indicator Portal, May 2014

Table 11: All Cause Mortality (ICD10 A00-Y99, ICD9 001-E999) , Indirectly standardised ratios (SMR), All Ages, Persons, 2002 – 2012

Area	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Kingston	118.86	122.45	105.98	106.16	102.02	99.78	95.44	89.88	86.56	87.06	85.28
London	123.65	125.35	117.38	113.77	108.78	105.59	104.97	99.77	97.82	93.16	93.76
England	125.97	126.39	119.54	116.98	112.34	110.20	109.51	104.06	102.53	98.95	100.00

Source: The NHS IC Indicator Portal, May 2014

Table 12: Key Abortion Statistics 2012

Area	Crude Rate per 1,000 Women All Ages	Crude Rate per 1,000 Women Under 18 years	Crude Rate per 1,000 Women 18-19 years	Crude Rate per 1,000 Women 20-24 years	Crude Rate per 1,000 Women 25-29 years	Crude Rate per 1,000 Women 30-34 years	Crude Rate per 1,000 Women 35+ years	% of all NHS funded abortions under 10 weeks in Kingston CCG	Total NHS Funded Abortions
Kingston	15.5	11.0	22.0	18.0	22.0	18.0	10.0	86.0 (83.1 to 88.7)	580
London	22.8	14.0	34.0	38.0	28.0	22.0	12.0	83.0 (82.5 to 83.2)	43,605
England	16.6	11.7	25.1	28.7	22.7	16.6	7.2	79.0 (79.2 to 79.6)	173,043

Source: Department of Health, Abortion Statistics for England & Wales, 2013

Table 13 : Main Causes of deaths in Kingston during 2011 & 2012 (Numbers and Percentages)

Cause of death	2011						2012						Difference in numbers of deaths between 2011 and 2012
	Males	% of All Cause Mortality	Females	% of All Cause Mortality	Total	% of All Cause Mortality	Males	% of All Cause Mortality	Females	% of All Cause Mortality	Total	% of All Cause Mortality	
Diseases of the circulatory system (ICD10 I00-I99)	143	30%	163	30%	306	30%	129	28%	152	27%	281	28%	-25
Ischaemic heart disease (ICD10 I20-I25)	79	16%	59	11%	138	13%	75	16%	50	9%	125	12%	-13
Hypertensive disease (ICD10 I10-I15)	5	1%	6	1%	11	1%	*	*	*	*	6	1%	-5
Cerebrovascular disease (ICD10 I60-I69)	29	6%	58	11%	87	8%	19	4%	51	9%	70	7%	-17
Malignant neoplasms (ICD10 C00-C97)	154	32%	130	24%	284	28%	131	28%	138	25%	269	26%	-15
Stomach cancer (ICD10 C16)	*	*	*	*	7	1%	*	*	*	*	6	1%	-1
Digestive system cancer (ICD10 C15-C26)	44	9%	34	6%	78	8%	43	9%	36	6%	79	8%	*
Lung cancer (ICD10 C33-C34)	34	7%	30	6%	64	6%	28	6%	27	5%	55	5%	-9
Malignant melanoma of skin (ICD10 C43)	*	*	*	*	6	1%	*	*	*	*	5	0%	-1
Female Breast cancer (ICD10 C50)	-	-	18	3%	18	2%	-	-	22	4%	22	2%	4
Cervix uteri cancer (ICD10 C53)	-	-	*	*	*	*	-	-	0	0%	0	0%	*
Prostate cancer (ICD10 C61)	21	4%	-	-	21	2%	15	3%	-	-	15	1%	-6
Leukaemia (ICD10 C91-C95):	*	*	*	*	7	1%	*	*	*	*	11	1%	4
Diseases of the respiratory system (ICD10 J00-J99)	63	13%	83	15%	146	14%	81	17%	100	18%	181	18%	35
Asthma (ICD10 J45-J46)	*	*	*	*	*	*	*	*	*	*	6	1%	*
Bronchitis and emphysema (ICD10 J40-J44)	22	5%	19	3%	41	4%	31	7%	29	5%	60	6%	19
Pneumonia (ICD10 J12-J18)	24	5%	47	9%	71	7%	35	8%	46	8%	81	8%	10
Accidents (ICD10 V01-X59)	13	3%	9	2%	22	2%	*	*	*	*	15	1%	-7
Suicide and undetermined injuries (ICD10 X60-X84, Y10-Y34 exc. Y33.9)	6	1%	6	1%	12	1%	*	*	*	*	10	1%	-2
Falls (ICD10 W00-W19)	*	*	*	*	6	1%	*	*	*	*	*	*	*
All causes, all ages deaths	484	100%	545	100%	1,029	100%	465	100%	555	100%	1,020	100%	-9

* data suppressed as less than 5, '-' not applicable, percentages are rounded
Source: Office of National Statistics 2012 Vital Statistics Tables (V53)

Table 14 : Main Causes of deaths in Kingston, All ages and under 75 years of age, 2012

Cause of death	Under 75						All ages					
	Male	% of all causes deaths	Female	% of all causes deaths	Person	% of all deaths	Male	% of all causes deaths	Female	% of all causes deaths	Person	% of all causes deaths
Diseases of the circulatory system (ICD10 I00-I99)	46	28%	23	18%	69	24%	129	28%	152	27%	281	28%
Ischaemic heart disease (ICD10 I20-I25)	33	20%	8	6%	41	14%	75	16%	50	9%	125	12%
Hypertensive disease (ICD10 I10-I15)	0	0%	0	0%	0	0%	*	*	*	*	6	1%
Cerebrovascular disease (ICD10 I60-I69)	*	*	*	*	8	3%	19	4%	51	9%	70	7%
Malignant neoplasms (ICD10 C00-C97)	52	32%	65	50%	117	40%	131	28%	138	25%	269	26%
Stomach cancer (ICD10 C16)	*	*	*	*	*	*	*	*	*	*	6	1%
Digestive system cancer (ICD10 C15-C26)	17	10%	21	16%	38	13%	43	9%	36	6%	79	8%
Lung cancer (ICD10 C33-C34)	11	7%	12	9%	23	8%	28	6%	27	5%	55	5%
Malignant melanoma of skin (ICD10 C43)	*	*	*	*	*	*	*	*	*	*	*	*
Female Breast cancer (ICD10 C50)	-	-	14	11%	14	5%	-	-	22	4%	22	2%
Cervix uteri cancer (ICD10 C53)	-	-	0	0%	0	0%	-	-	0	0%	0	0%
Prostate cancer (ICD10 C61)	*	*	-	-	*	*	15	3%	-	-	15	1%
Leukaemia (ICD10 C91-C95):	*	*	*	*	*	*	*	*	*	*	11	1%
Diseases of the respiratory system (ICD10 J00-J99)	19	12%	12	9%	31	11%	81	17%	100	18%	181	18%
Asthma (ICD10 J45-J46)	*	*	*	*	*	*	*	*	*	*	6	1%
Bronchitis and emphysema (ICD10 J40-J44)	12	7%	6	5%	18	6%	31	7%	29	5%	60	6%
Pneumonia (ICD10 J12-J18)	*	*	*	*	5	2%	35	8%	46	8%	81	8%
Accidents (ICD10 V01-X59)	9	6%	0	0%	9	3%	*	*	*	*	15	1%
Suicide and undetermined injuries (ICD10 X60-X84, Y10-Y34 exc. Y33.9)	*	*	*	*	8	3%	*	*	*	*	10	1%
Falls (ICD10 W00-W19)	0	0%	0	0%	0	0%	0	0%	*	*	*	*
All causes deaths	162	100%	130	100%	292	100%	465	100%	555	100%	1,020	100%

* data suppressed as less than 5, '-' not applicable, percentages are rounded
Source: Office of National Statistics 2012 Vital Statistics Tables (VS3)

Table 15 : Mortality from coronary heart disease (ICD9 410-414 adjusted, ICD10 I20-I25), DSR, 2000-2014

Period	All Ages			Under 75		
	Kingston	London	England	Kingston	London	England
2000	109.05	130.09	134.60	53.33	69.59	68.57
2001	87.95	121.35	128.54	34.80	63.40	64.57
2002	99.53	116.92	123.05	47.87	60.95	60.51
2003	90.42	113.19	117.95	41.69	58.48	56.76
2004	86.54	103.85	108.36	34.90	51.56	51.69
2005	76.12	96.81	101.03	33.24	47.50	47.90
2006	76.39	87.34	93.43	34.24	43.14	44.53
2007	73.58	85.95	88.39	33.46	42.40	41.63
2008	65.86	83.09	83.88	29.70	41.42	39.69
2009	68.47	75.26	77.25	31.49	35.49	36.06
2010	56.24	70.22	73.94	26.00	33.41	34.79
2011	60.44	63.39	67.67	28.29	30.41	32.06
2012	55.23	63.10	65.64	27.93	30.89	30.48

Rate per 100,000 population
Source: The NHS Indicator Portal, 2014

Table 16 : Mortality from stroke (ICD9 430-438 adjusted, ICD10 I60-I69), DSR, 2000-2014

Period	All Ages			Under 75		
	Kingston	London	England	Kingston	London	England
2000	60.85	51.86	59.42	25.59	20.49	19.76
2001	62.57	54.69	58.85	20.97	20.69	19.12
2002	51.78	51.50	58.71	17.08	19.14	18.63
2003	60.14	53.10	57.03	18.96	18.61	17.69
2004	54.20	47.95	51.88	19.36	17.35	16.10
2005	44.05	44.57	48.54	13.13	15.62	14.90
2006	37.93	41.09	45.14	9.17	14.49	13.63
2007	43.19	37.61	42.47	13.13	13.49	12.82
2008	32.37	36.76	41.42	5.66	12.48	12.07
2009	35.51	34.67	38.13	6.79	11.52	11.09
2010	35.93	33.63	37.33	10.34	11.98	11.06
2011	34.19	31.11	34.29	10.97	10.38	10.57
2012	25.27	30.50	33.27	5.30	11.23	10.06

Rate per 100,000 population
Source: The NHS Indicator Portal, 2014

Table 17 : Mortality from all cancers (ICD9 140-208 adjusted, ICD10 C00-C97), DSR, 2000-2014

Period	All Ages			Under 75		
	Kingston	London	England	Kingston	London	England
2000	164.64	186.55	189.37	105.36	125.71	128.66
2001	163.91	187.41	187.51	111.19	126.86	126.07
2002	179.28	184.66	186.84	122.86	123.89	124.79
2003	178.45	180.27	183.06	114.17	119.01	121.34
2004	150.11	175.88	179.66	99.69	116.70	118.78
2005	163.54	172.27	177.42	99.24	113.90	116.77
2006	166.68	170.94	175.96	111.04	112.61	115.45
2007	160.47	166.13	174.23	107.08	108.47	113.89
2008	155.70	164.57	172.55	96.26	106.80	111.98
2009	152.77	163.87	169.48	103.62	106.40	109.67
2010	140.25	158.54	167.60	93.62	101.38	107.76
2011	144.87	160.51	166.66	88.36	102.10	107.04
2012	130.45	157.25	165.54	79.64	99.92	105.33

Rate per 100,000 population
Source: The NHS Indicator Portal, 2014

"If you are unable to read this document because of disability or language, we can assist you. Please call the Kingston Council Helpline on 020 8547 5000 or ask someone to call on your behalf."

"당신이 신체적인 불편함 혹은 언어 문제로 인해 이 서류를 읽지 못할 경우, 저희들이 돕겠습니다. 킹스톤 의회 상담전화 (Kingston Council helpline) 020 8547 5000 로 직접 전화하시거나 혹은 다른 사람에게 전화를 부탁하십시오"

چنانچه قادر نیستید این نامه را به دلیل ناتوانی یا مشکل زبان بخوانید ما میتوانیم به شما کمک کنیم. لطفا خود یا شخص دیگری با شماره کمک شهرداری کینگستون تماس بگیرید.
تلفن 020 8547 5000 ۰۲۰۸۵۴۷۵۰۰۰

Jeśli nie są Państwo x stani zapoznać się z treścią tego dokumentu z powodu niepełnosprawności lub nieznajomości języka, służymy pomocą. Prosimy o telefon na linię pomocy Kingston Council 020 8547 5000 lub o poproszeni kogoś innego by zadzwonił w Państwa imieniu.

உங்களால் இந்த கடிதத்தை படிக்க இயலவில்லை என்றால் தயவு கூர்ந்து கிங்ஸ்டன் உதவி மையத்தை நீங்களோ அல்லது உங்களை சார்ந்த எவராவது தொடர்பு கொள்ளவும். தொடர்பு கொள்ள வேண்டிய எண் 020 8547 5000

"إن لم تكن قادراً على قراءة هذا النص بسبب اللغة أو أي عائق آخر، اتصل بنا فنحن نستطيع مساعدتك. الرجاء الاتصال بخط مجلس كنجستون للمساعدة (Kingston Council helpline) على الرقم 020 8547 5000 أو اطلب من أي شخص آخر الاتصال بنا نيابة عنك."

- کرینگے مدد کو آپ ہم تو ہیں ناقابل سے وجہ کسی پڑھنے کو دستاویز اس آپ اگر فون 020 8547 5000 ۰۲۰۸۵۴۷۵۰۰۰ لائن ہیلپ کاونسل کنگسٹن مہربانی برائے کروائے۔ سے کسی یا کیجئے

Caso você nao consiga ler este documento devido a disabilidade ou idioma, nós podemos ajudar. Por favor, lique para o canal de atendimento Kingston Council no telefone 020 8547 5000, ou solicite a alguém para ligar por você.

“ਜੇਕਰ ਤੁਸੀਂ ਅਪਹਜਤਾ ਜਾਂ ਭਾਸ਼ਾ ਦੇ ਕਾਰਣ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਅਸਮਰਥ ਹੋ, ਤਾਂ ਅਸੀਂ ਤੁਹਾਡੀ ਸਹਾਇਤਾ ਕਰ ਸਕਦੇ ਹਾਂ। ਕਿਰਪਾ ਕਰਕੇ 020 8547 5000 'ਤੇ ਕਿੰਗਸਟਨ ਕੌਂਸਲ ਦੀ ਹੈਲਪਲਾਇਨ 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਵੱਲੋਂ ਕਿਸੇ ਨੂੰ ਕਾਲ ਕਰਨ ਲਈ ਕਹੋ।”

Haddii aadan awoodin akhrinta dokumentigan sabab naafada ama luqadda ah, waan ku caawin karnaa. Fadlan soo wac Khadka caawimada ee Kawnsalka Kingston 020 8547 5000 ama qof ku matalaya ka codso inuu na soo waco

我们可以协助您，如果您因语言障碍或残疾不能阅读此文件。请拨打金斯敦市议会热线服务电话 020 8547 5000 或请求他人来代表您通话。

نہ گھر توانای خویندنه وهی نهم نوسراوت نیه له بهر په ککه وتهی/ بن توانای یا خود له بهر زمان تینه گه یشتن ، نهوا نیمه نه توانین یارمه تیت بدین . تکایه په یوهندی بکه به هیلی یارمه تی شاره وانی کینگستونه وه (Kingston Council) به ژماره ته له فوننی 020 8547 5000 بیان به که سی بلن که به ناوی تووه په یوهندی بکات .

Worried about mental health?

Mental health problems are more common than many people think. Almost everyone feels overwhelmed or that they can't cope with things at least once in their life and many feel like that a lot more frequently.

At times like that, you may need to talk to someone and shouldn't be afraid to ask for help.

Only you can decide who you feel most comfortable talking to. It may well be someone in your family or a friend, but your GP is often the best person to help guide you through problems and the services that are available to help.

There are also information pages, discussion forums, phone lines and support groups that can be helpful. They include:

- Mind in Kingston – www.mindinkingston.org.uk
- YoungMinds (specialise in supporting young people and parents) – www.youngminds.org.uk
- Samaritans – www.samaritans.org/kingston
- Royal College of Psychiatrists – www.rcpsych.ac.uk/expertadvice.aspx



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www.kingston.gov.uk