WOKINGHAM BOROUGH COUNCIL

CHAPTER 3: SEVERE AND ENDURING MENTAL HEALTH ILLNESS

Table of contents

3 SEVERE AND ENDURING MENTAL HEALTH ILLNESS

3.1 Introduction

This chapter focuses primarily on schizophrenia, psychosis, bipolar disorder, and eating disorders in adults aged 18 years or older but some of the data in the chapter may cover those in the younger age group as we do not have all data separately reported for those aged 18 years or older.

Eating disorders have been included as even though they are not a severe mental illness (SMI) under the Quality and Outcomes Framework (QOF), they have debilitating and sometimes life-threatening consequences for those who live with them.

The causes and risk factor section will look at what the current evidence shows about causes and contributing factors to SMI. Prevalence data is limited in terms of telling us the true picture of SMI among Wokingham residents. Where data is available it is provided with a comparison to the South East and England. Where local data is not available, national prevalence estimates (where available) are applied to the local population to derive local estimates where appropriate.

Finally, there is a section on services which aims to capture and share what is currently available which either directly or indirectly supports the prevention, early intervention and or management of SMI for Wokingham residents.

3.2 Definitions

Serious (or severe) mental illness (SMI) is a term used to describe psychological conditions in people which can have a debilitating effect to the point where it impacts their ability to function normally both in their personal and professional lives. For the Quality and Outcomes Framework (QOF) it includes schizophrenia and other psychoses, and affective disorders (including bipolar disorder) (Reilly S, 2015). SMI is often used in some contexts when another condition has a debilitating mental health impact, for example, when severe depression has become treatment-resistant or has features of psychosis (National Mental Health Intelligence Network, 2018). The commonality between these is their severe impact on a person's ability to live their life as they normally would without the condition.

3.2.1 Schizophrenia and psychosis

Schizophrenia is a severe and long-term mental health condition causing a range of different symptoms, including hallucinations, delusions, and the unclear and muddled thinking which are a result of the hallucinations and delusions. Without treatment this can lead to the person becoming withdrawn from normal life affecting personal and professional relationships. The cause of schizophrenia is not known but it is thought to be due to a combination of genetic and environmental factors. Some people may be more vulnerable to developing schizophrenia, with certain triggering factors, such as drug misuse, suspected to play a role (NHS, Overview - Schizophrenia, November 2019).

Characteristic symptoms of psychosis include hallucinations (including auditory hallucinations or hearing voices) paranoia and delusions. It is possible to experience

psychosis but not have a diagnosis of schizophrenia. Psychosis can occur in people who have bipolar disorder, severe depression, or it can be due to several triggering factors such as stress, drug and alcohol misuse, medication side effects, trauma, or a neurological condition such as a brain tumour or Parkinson's disease (NHS, Overview - Pyschosis, December 2019).

3.2.2 Bipolar disorder

Bipolar disorder is a mental health condition which causes changes to the mood of a person. This means that people with bipolar disorder have times when they experience depression, followed by episodes of mania (very high mood and overactivity), and vice versa. Symptoms of bipolar disorder vary depending on which state of mood the person is currently in. It is important to note that these are not just 'mood swings', but rather extreme states of mood which can last for weeks and have significant impact on life (NHS, Overview - Bipolar disorder, March 2019).

During a phase of depression, a person might have feelings of worthlessness, low mood, low appetite, and feel disinterested in any activities and hobbies, as well as other symptoms of depression. During a phase of mania, a person might feel very happy and in high spirits, with lots of energy, making ambitious plans and having grand ideas. This can mean the person in a manic state is vulnerable to spending a lot of money on things. In some cases, this may be items which they may not usually buy or, may not be able to afford. A person may also not sleep a lot, talk very fast, and feel constantly creative and the need to do something. People diagnosed with bipolar disorder can often experience their manic phases as positive experiences and may also experience symptoms of psychosis (as described above) (NHS, Overview - Bipolar disorder, March 2019).

3.2.3 Eating disorders

An eating disorder is a condition where a person uses their control of food to cope with their feelings or in response to life situations. These behaviours can range from eating too little or too much, to worrying about body shape or weight. Eating disorders can affect anyone, but they are most common in young people aged 13-17 years. With support and treatment, it is possible to recover from an eating disorder.

The most common eating disorders are:

- **Anorexia nervosa**: attempting to control weight by reducing food intake, over-exercising, or a combination of both.
- **Bulimia**: loss of control of food intake amount, and drastic or extreme actions to avoid putting on weight.
- **Binge eating disorder**: eating large amounts until full to the point of discomfort.

If a person has disordered eating with symptoms not concordant with a clear diagnosis, they are said to have Other specified feeding or eating disorder (OSFED) (NHS, Overview - Eating Disorders, February 2021).

3.3 Causes and risk factors

The exact causes of severe and enduring mental health conditions largely remain unknown in many cases. The following sections outline what is broadly known about causes and some of the contributory risk factors to developing or having these conditions. For many conditions, it is thought that there are many individual factors which combine to contribute to the increased risk.

There are several risk factors which broadly contribute to a person's mental health. These are covered in the respective chapters outlined in Chapter 1: Introduction.

3.3.1 Schizophrenia

The exact causes of schizophrenia remain unknown however it is likely that a combination of physical, genetic, psychological, and environmental factors all play a role in making someone more susceptible of developing schizophrenia. A person who is prone to schizophrenia may develop it following a stressful or emotional situation or life event which triggers an initial psychotic episode.

Schizophrenia is known to run in families but there is no evidence showing there is one specific gene which is responsible for it, rather it is thought that a combination of genes might make someone more vulnerable to developing the condition. Studies have suggested that schizophrenia may in part be a disorder of brain structure, and it is thought that neurotransmitters (the chemicals which carry messages between brain cells) may be imbalanced, or the brain being overly sensitive to them, in people with the condition. Some research has shown that people who go on to develop schizophrenia are more likely to have suffered from birth complications such as low birthweight, premature labour, or lack of oxygen during birth. These factors may influence brain development (NHS, November 2019).

Drug misuse has been shown to increase the risk of developing schizophrenia and/or psychosis. Aside from the natural effects which come from some drugs, cannabis, cocaine, LSD, and amphetamines may trigger additional typical symptoms in susceptible persons however, they are not the direct cause of schizophrenia (NHS, November 2019).

3.3.2 Bipolar disorder

The exact causes of bipolar disorder also remain unknown. It is likely that there are numerous different physical, environmental, and social factors which play a role in making someone more susceptible to developing the disorder. It is thought that bipolar disorder results from chemical imbalances in the brain, specifically relating to the neurotransmitters which relay messaging within the brain. Certain imbalances may result in either the depression or mania typical of bipolar disorder. As bipolar disorder seems to run in families, genetics are also thought to play a part. There is increased probability of more than one family member being diagnosed with bipolar disorder, however, as with schizophrenia, no specific gene is thought to be responsible, but rather a mix of several genes and environmental factors (NHS, March 2019).

Environmental triggers which may also contribute to increase risk include stressful events such as relationship breakdowns, abuse (physical, sexual, or emotional),

death of a loved one, as well as physical illness, sleep disturbances, or overwhelming life problems such as money or work issues (NHS, March 2019).

3.3.3 Eating disorders

It is not known what exactly causes eating disorders. Risk factors include (NHS, Overview - Eating Disorders, February 2021) :

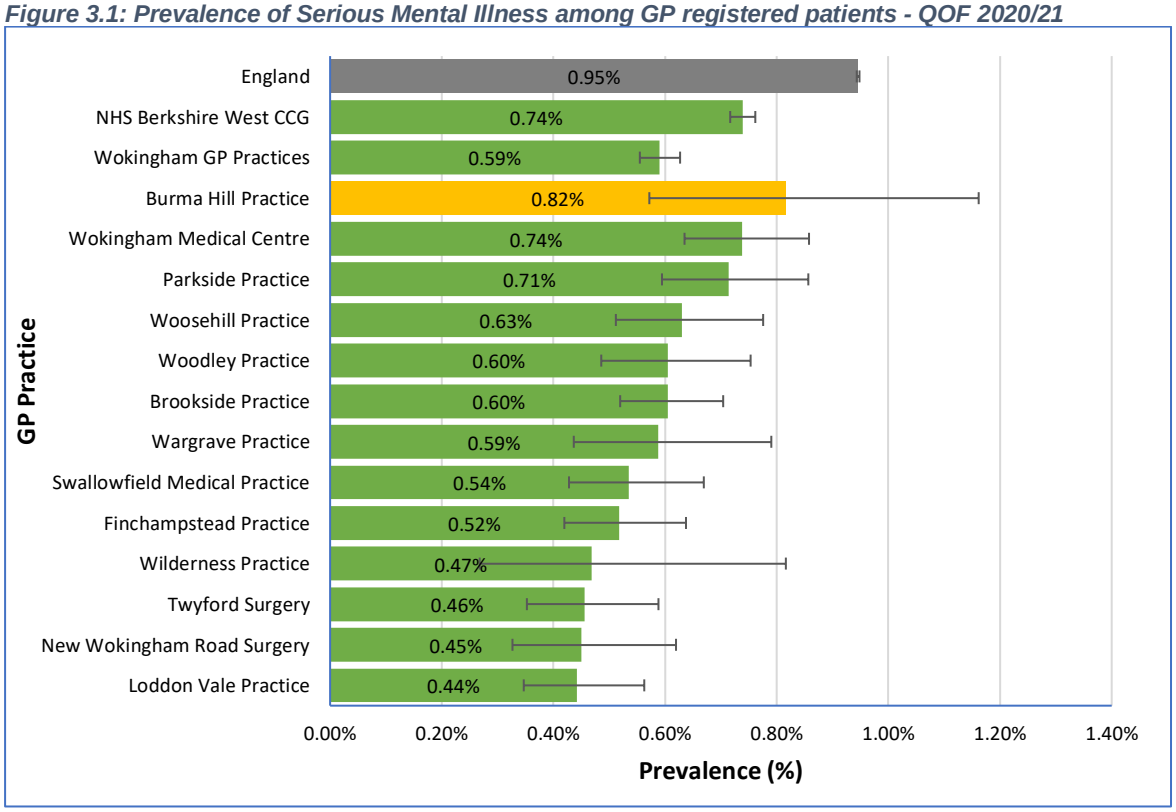
- A family history of eating disorders
- Depression, anxiety, low self-esteem, obsessive personality trait
- Alcohol or drug misuse
- Being criticised for body shape or weight or eating habits
- Excessive worry about being slim including societal pressure
- History of abuse, being a victim of sexual abuse

3.4 Prevalence

3.4.1 SMI Quality and Outcomes Framework (QOF) prevalence

The SMI QOF data includes all patients on a GP register who have a diagnosed with schizophrenia, bipolar affective disease, and other psychoses. Overall, Wokingham practices recorded 0.59% SMI prevalence which was significantly lower than Berkshire West CCG and England averages in 2020/21 (Figure 3.1). The highest prevalence of 0.82% was recorded among Burma Hill Practice patients which was similar to the national average. All other practices had significantly lower prevalence than the national average and the lowest prevalence of 0.44% was in Loddon Vale Practice patients (Figure 3.1).

Figure 3.1: Prevalence of Serious Mental Illness among GP registered patients - QOF 2020/21



***Source:** NHS Digital and Quality Outcomes Framework (2021)*

Overall, there were 1,022 patients with SMI among GP-registered patients across Wokingham practices in 2020/21 compared with 994, in 2019/20, an increase of 28 (2.8%). This represents only 0.01%-point change between 2019/20 and 2020/21 across GP practices in Wokingham, similar to the change in prevalence across NHS Berkshire West GP practices. The biggest increase of 0.06% points was among Swallowfield patients while New Wokingham Road Surgery recorded the biggest decline of 0.06% points (Table 3.1).

It is important to note that QOF data may not reflect the true prevalence in Wokingham or within a Practice as this will only show those who have been diagnosed. Differences among practices can also be impacted on by people who present to their GP. Furthermore, not all the patients registered with Wokingham GPs would be Wokingham residents while some Wokingham residents may be registered with GPs outside Wokingham.

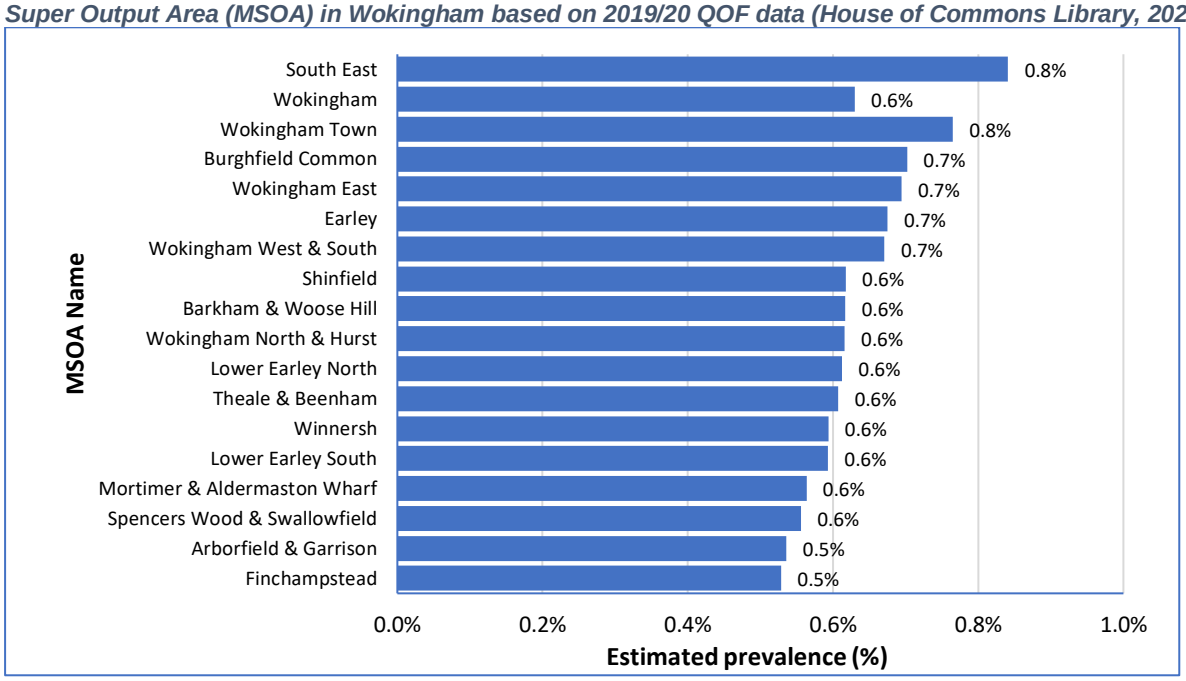
Table 3.1: QOF Serious Mental Illness Register (Wokingham) – numbers and prevalence 2019/20 to 2020/21

Practice name	2019/20		2020/21		%-point change
	Number	Prevalence	Number	Prevalence	
Brookside Practice	161	0.58%	165	0.60%	0.02%
Burma Hill Practice	29	0.86%	30	0.82%	-0.04%
Finchampstead Practice	85	0.52%	87	0.52%	0.00%
Loddon Vale Practice	61	0.41%	65	0.44%	0.03%
New Wokingham Road Surgery	40	0.51%	37	0.45%	-0.06%
Parkside Practice	105	0.66%	114	0.71%	0.06%
Swallowfield Medical Practice	71	0.53%	76	0.54%	0.00%
Twyford Surgery	61	0.47%	58	0.46%	-0.01%
Wargrave Practice	46	0.64%	43	0.59%	-0.05%
Wilderness Practice	11	0.44%	12	0.47%	0.02%
Wokingham Medical Centre	165	0.73%	168	0.74%	0.01%
Woodley Practice	72	0.57%	79	0.60%	0.04%
Woosehill Practice	87	0.63%	88	0.63%	0.00%
Wokingham GP Practices	***994***	***0.58%***	***1,022***	***0.59%***	***0.01%***
NHS Berkshire West CCG	***3,994***	***0.73%***	***4,119***	***0.74%***	***0.01%***

Source: (NHS Digital and Quality Outcomes Framework, 2021)***NHS Digital and Quality Outcomes Framework (2021)***

Modelled Middle Super Output Area (MSOA) estimates based on 2019/20 QOF data shows that Wokingham Town has the highest prevalance of schizophrenia, bipolar disorder & psychoses (0.8%) while Finchampstead has the lowest (0.5%) (Figure 3.2).

Figure 3.2: Modelled estimate of schizophrenia, bipolar disorder & psychoses prevalence by Middle Super Output Area (MSOA) in Wokingham based on 2019/20 QOF data (House of Commons Library, 2021)



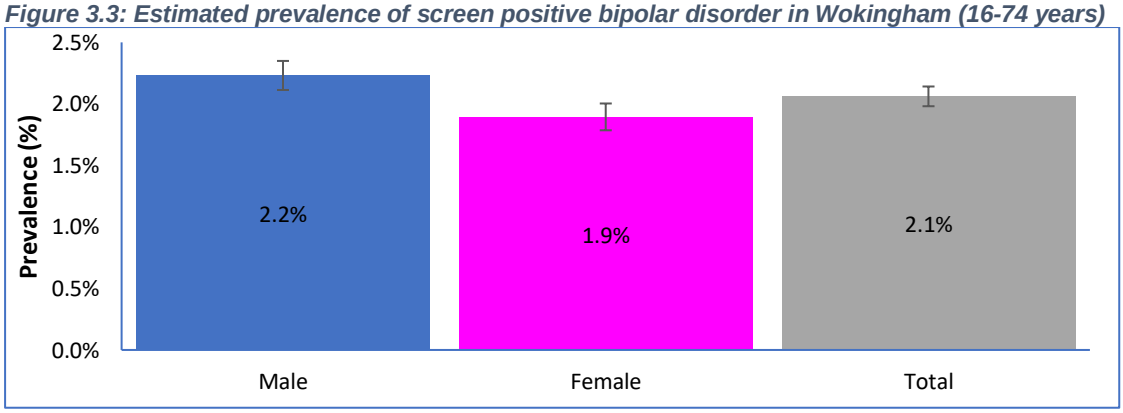
Source: ***House of Commons Library Constituency Data: Health Conditions***

3.4.2 Bipolar, psychotic, and anti-social and borderline personality disorders

The 2014 Adult Psychiatric Morbidity Survey (APMS) (NHS Digital, 2016) used the 15-item Mood Disorder Questionnaire to assess the presence of bipolar disorder. A positive screen required endorsement of at least 7 lifetime manic/hypomanic symptoms, as well as several co-occurring symptoms, together with moderate or serious functional impairment. A positive screen indicated the likely presence of bipolar disorder, and that fuller assessment would be warranted. Overall, 2.0% of the population screened positive for bipolar disorder; the rate for men and women aged 16 years or older was 2.1% and 1.8% respectively.

Using the age and sex specific rates from the 2014 APMS and 2020 ONS Mid-year estimates for Wokingham, the local prevalence was estimated. Overall, there were 2,476 people aged 16-74 years with screen positive bipolar disorder in Wokingham in 2020 – the respective estimates for men and women were 1,339 and 1,137. The equivalent percentage prevalence by sex is shown in Figure 3.3.

Figure 3.3: Estimated prevalence of screen positive bipolar disorder in Wokingham (16-74 years)



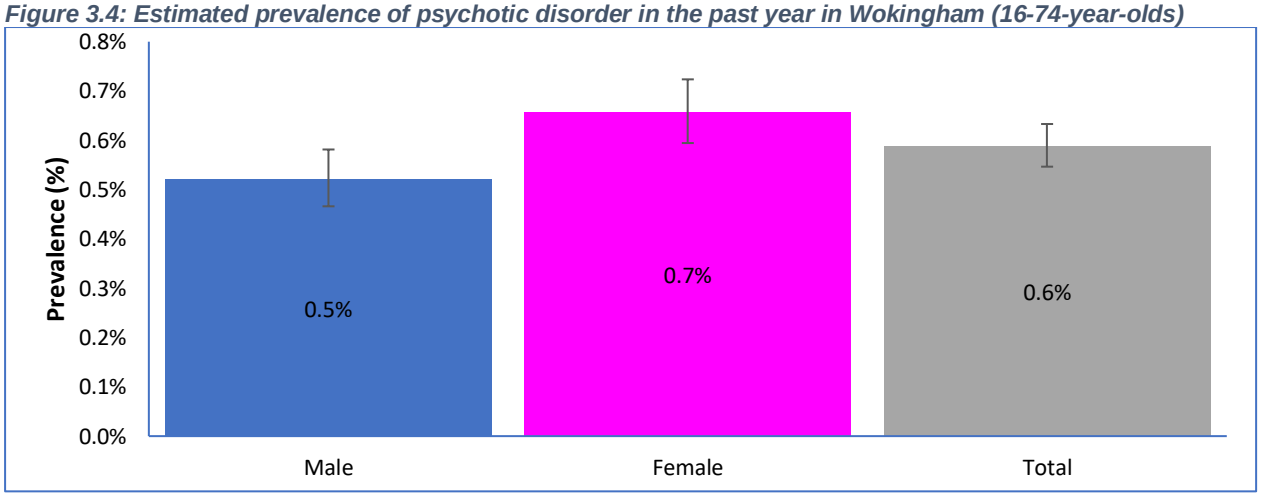
Source: 2014 APMS (NHS Digital, 2016) ***& ONS mid-year 2020 population***

Psychotic disorders consist of two main types: schizophrenia and affective psychosis. The APMS identified 'psychotic disorder in the past year' if they completed a phase two Schedule for Clinical Assessment in Neuropsychiatry (SCAN) interview and it was positive.

Because psychotic disorder has a low prevalence, data from APMS 2007 and 2014 was combined to increase the number of positive cases for analysis. Overall, the prevalence of psychotic disorder in the past year has remained broadly stable at less than one adult in a hundred (0.4% in 2007, 0.7% in 2014). Using data pooled from the 2007 and 2014 surveys, the prevalence was 0.54% - the respective figures for men and women were 0.46% and 0.61% which did not show a statistically significant difference.

Using the pooled age and sex specific rates from the 2007 and 2014 APMS, and 2020 ONS Mid-year estimates for Wokingham, the local prevalence was estimated. Overall, there were 707 people aged 16-74 years would have been identified as having psychotic disorder in the past year in Wokingham in 2020 – the respective estimates for men and women were 313 and 394. The equivalent percentage prevalence by sex is shown in Figure 3.4.

Figure 3.4: Estimated prevalence of psychotic disorder in the past year in Wokingham (16-74-year-olds)



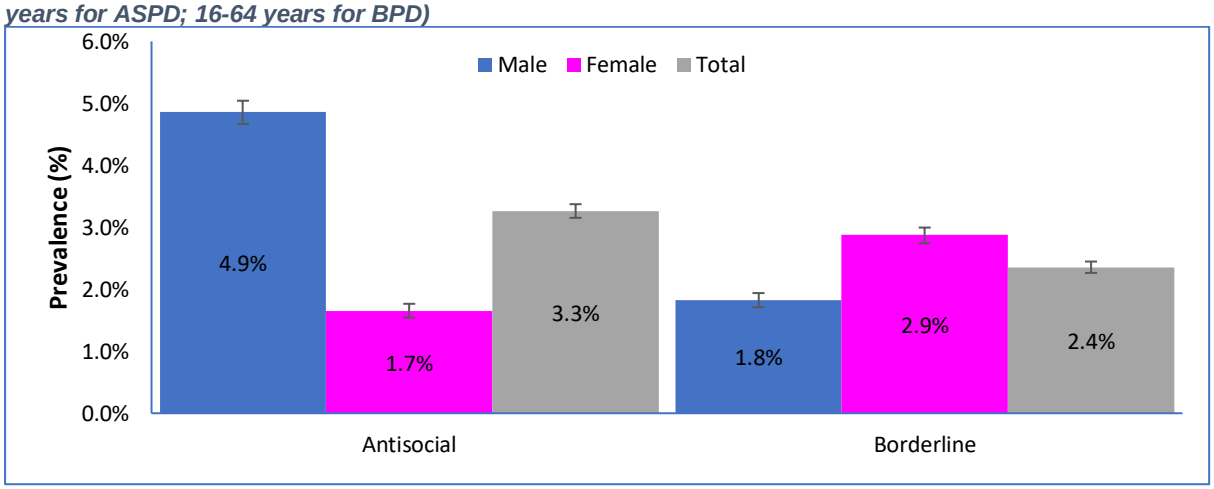
Source: 2007 and 2014 APMS (NHS Digital, 2016) ***& ONS mid-year 2020 population***

For the 2014 APMS the self-completion Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II) was used to screen for antisocial personality disorder (ASPD) and borderline personality disorder (BPD). ASPD was characterised by a pervasive pattern of disregard for and violation of the rights of others in people aged at least 18, which has persisted since the age of 15 and a result the results were presented for those aged between 18 and 64 years. BPD was characterised by high levels of personal and emotional instability associated with significant impairment and the results were presented for those aged between 16 and 64 years.

Overall, 3.3% of participants aged 18 to 64 years screened positive for ASPD on the SCID-II – the respective figures for men and women were 4.9% and 1.8% with a statistically significant difference. 2.4% of adults aged 16 to 64 years screened positive for BPD on the SCID-II - the respective figures for men and women were 1.9% and 2.9% with no statistically significant difference.

Using the age and sex specific rates from the 2014 APMS and 2020 ONS Mid-year estimates for Wokingham, the local prevalence was estimated. Overall, there were 3,274 people aged 18-64 years would have screen positive for ASPD in Wokingham in 2020 – the respective estimates for men and women were 2,449 and 825. The total for those who would have screened positive for BPD was 2,476 – the respective figures for men and women were 961 and 1,514. The equivalent percentage prevalence by sex and disorder type is shown in Figure 3.5.

Figure 3.5: Estimated prevalence of anti-social and borderline personality disorders in Wokingham (18-64 years for ASPD; 16-64 years for BPD)



Source: 2014 APMS (NHS Digital, 2016) ***& ONS mid-year 2020 population***

3.4.3 Eating disorders

Beat estimate that around 1.25 million people in the UK have an eating disorder. There is currently insufficient research or data to provide details about the estimate prevalence of this condition in England (Beat, 2022).

The Health Survey for England is used to monitor trends in health and care of those living in private households in England. The findings from the 2019 survey by age group and gender were applied to the Wokingham Borough 2020 mid-year population estimates (Office for National Statistics, 2021) to estimate the local prevalence figures (Table 3.2). Assuming England estimates are applicable locally, we expect around 21,377 adults to be experiencing possible eating disorders with around 5,727 of them with possible eating disorder with significant impact. This equates to 15.6% of the population aged 16 or older having possible eating disorders and 4.2% with a possible eating disorder with significant impact (Figure 3.6).

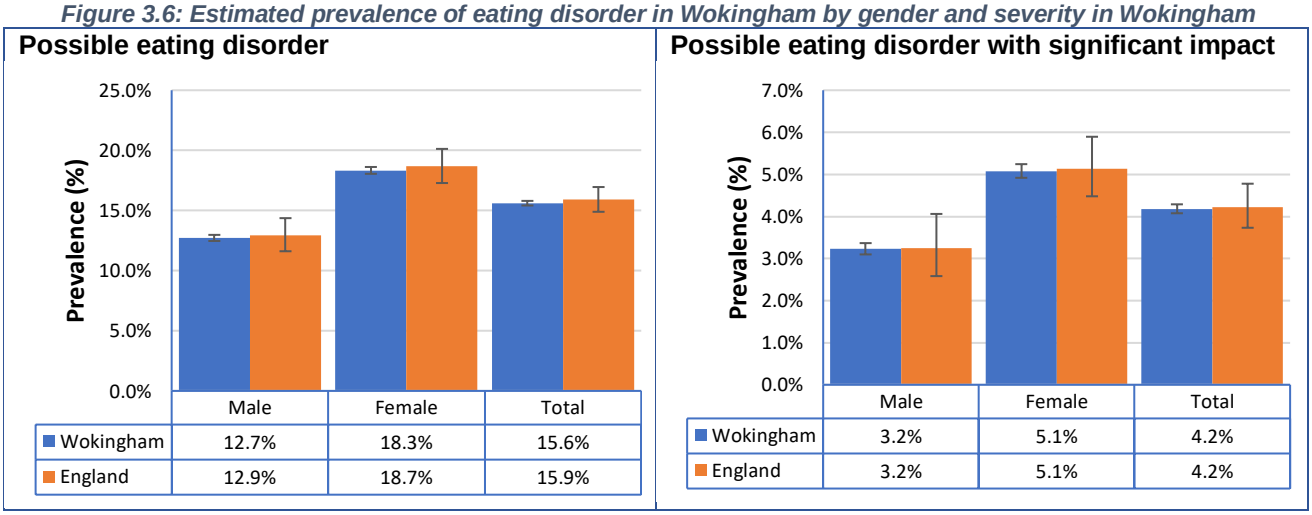
Women are significantly more likely to report a possible eating disorder than men and the proportion increases as household income decreases (NHS England , 2019).

Table 3.2: Estimated numbers of adults with possible eating disorder in Wokingham by gender and severity in Wokingham.

	16-24	25-34	35-44	45-54	55-64	65-74	75+	Total
Women with possible eating disorder	2,136	2,543	2,824	2,743	1,583	710	380	**12,919**
Men with possible eating disorder	1,096	1,699	1,953	1,781	947	611	371	**8,458**
Total with possible eating disorder	***3,232***	***4,242***	***4,777***	***4,524***	***2,530***	***1,321***	***751***	***21,377***
Women with possible eating disorder with significant impact	508	810	1,000	761	292	172	36	**3,579**
Men with possible eating disorder with significant impact	278	352	752	342	187	165	72	**2,148**
Total with possible eating disorder with significant impact	***786***	***1,162***	***1,752***	***1,103***	***479***	***337***	***108***	***5,727***

Sources: ONS Mid-Year Population Estimates (June 2020) for Wokingham and Health Survey for England 2019.
NB: Numbers are rounded up so may be different from exact estimates without rounding up

Figure 3.6: Estimated prevalence of eating disorder in Wokingham by gender and severity in Wokingham



Sources: ONS Mid-Year Population Estimates (June 2020) for Wokingham and Health Survey for England 2019.

3.5 Health needs associated with SMI

3.5.1 SMI and physical health

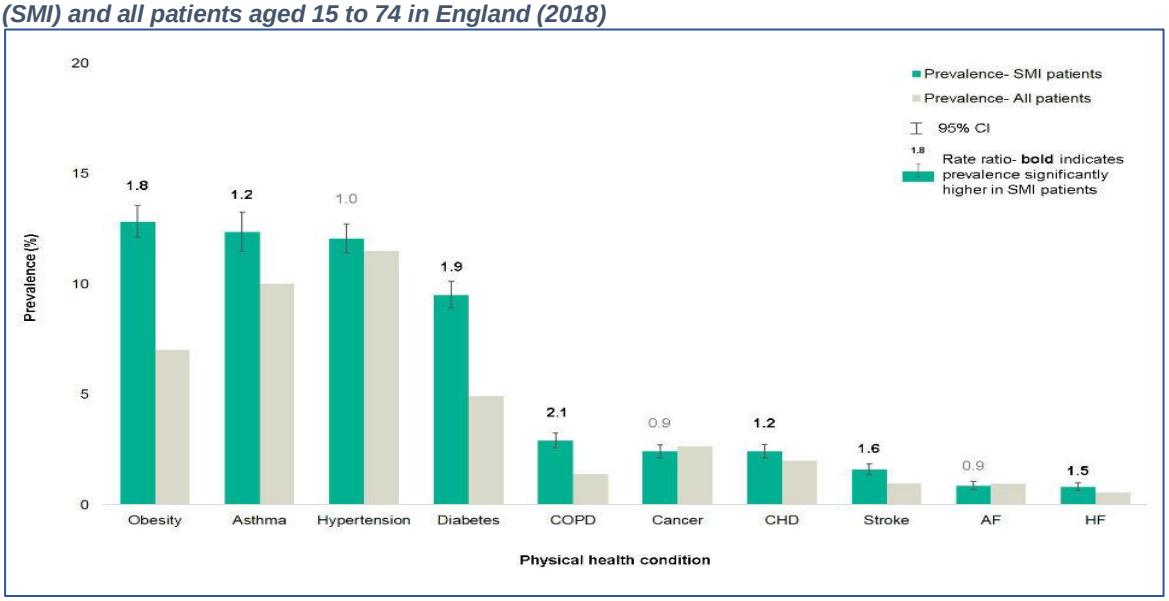
Where at least one physical health condition and mental health condition exist at the same time, this is known as co-morbidity. Multi-morbidity is when there is frequent diagnosis of more than one physical health condition at the same time as a mental health illness (Mental Health Taskforce , 2016).

It is known that poor physical health is a common problem in people with a SMI condition (National Mental Health Intelligence Network, 2018). Those who are living with SMI are likely to have at least one physical health problem concurrently with their SMI (De Hert M. et al., 2011).

In England, compared with the general population, those with SMI have a higher prevalence of chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), stroke, heart failure (HF), obesity, asthma, and diabetes, and similar prevalence of hypertension, cancer, and atrial fibrillation. The significantly higher rates of prevalence in SMI compared to all patients are in bold in Figure 3.7.

People in England with SMI living in more deprived areas are more likely to have one or more physical health conditions, and SMI itself is more common in more deprived areas with the health inequalities being higher for younger age groups - adjusting for deprivation does not level off the inequalities.

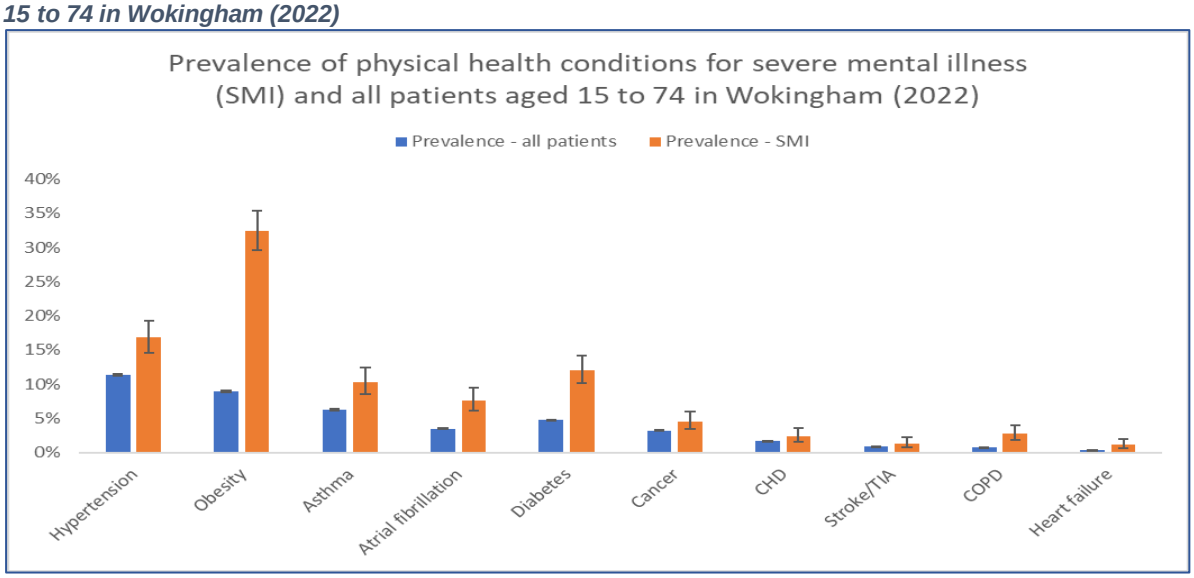
Figure 3.7: Prevalence (age and sex standardised) of physical health conditions for severe mental illness (SMI) and all patients aged 15 to 74 in England (2018)



Source: *Severe mental illness (SMI) and physical health inequalities: briefing* (Public Health England, 2018)

The national pattern for comorbid conditions is broadly mirrored locally. Those with SMI in Wokingham have significantly higher prevalence of e.g., hypertension, obesity, asthma, diabetes, and cancer (Figure 3.8). These patterns may be due to those with SMI being more likely to be in contact with health services hence are more likely to have diagnoses of other health conditions than the general population.

Figure 3.8: Prevalence of physical health conditions for severe mental illness (SMI) and all patients aged 15 to 74 in Wokingham (2022)



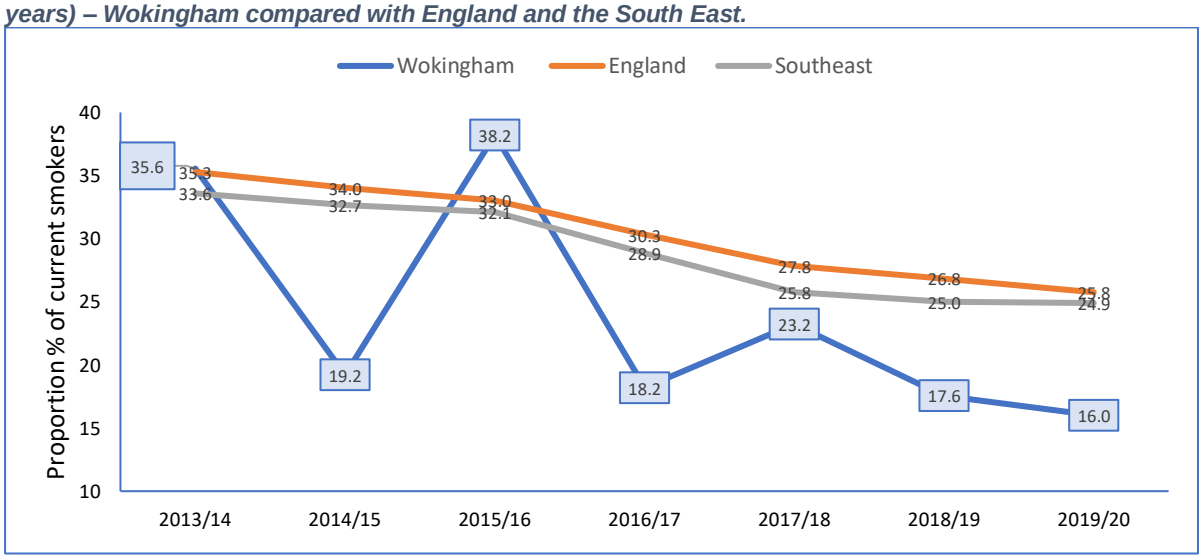
Source: (Insights, [Accessed 16/03/2022])

3.5.2 Smoking and long-term mental Health conditions

Smoking remains one of the important causes of preventable ill health and premature mortality in the UK. It increases a person's risk of developing many diseases including lung cancer, COPD, and heart disease. It increases the risk of the types of cancers a person may develop including lip, mouth, throat, bladder, kidney, stomach, liver and cervix. Evidence shows that people with mental health conditions are more likely to smoke than those without and are more likely to smoke more.

There has been a significant decrease in the estimate prevalence of smokers in England and Wokingham over the last decade, but the prevalence of smoking in adults with long-term mental health conditions remains double that of the general population. It is estimated in 2020 that 16% of adults with a long-term mental health condition was a current smoker in Wokingham – this was three times higher than the 5.5% among the general adult population (Figure 3.9).

Figure 3.9: Trends for smoking prevalence (%) in adults with a long-term mental health condition (18+ years) – Wokingham compared with England and the South East.



Source: (Office for Health Improvement & Disparities (2), 2022)

3.6 Outcomes for people with SMI

3.6.1 National picture

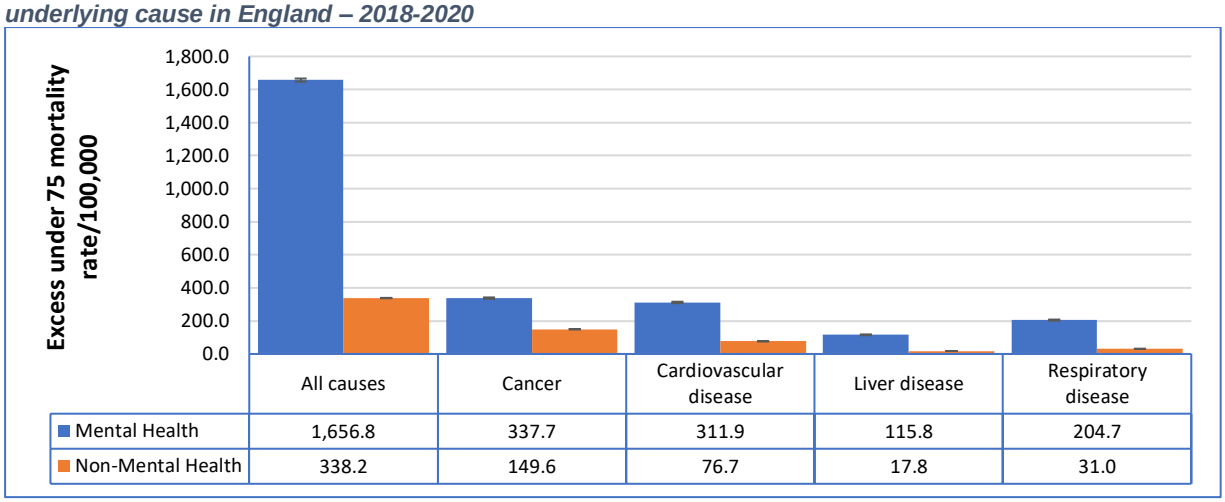
People in England with an SMI have an average lifespan 15-20 years shorter than the general population, and a 3.7 times higher death rate aged under 75 years old compared with the general population (the gap in death rates increases over time). Importantly, it is thought that for people with SMI, two out of three deaths are from physical illnesses which could be prevented, including a range of common chronic physical conditions (Mental Health Taskforce , 2016).

Excess under-75 mortality rate in adults with serious mental illness is a measure of the extent to which adults with a serious mental illness die younger than adults in the general population (NHS Digital, 2019).

In England during the 2018-2020 period, compared with people under 75 years without SMI, those with SMI have excess death rates which are 4.9 times higher for all causes, 2.3 times higher for cancers, 4.1 higher for cardiovascular diseases, 6.5

higher for liver diseases, and 6.6 times for respiratory diseases (Figure 3.10) (NHS Digital, 2022).

Figure 3.10: Excess under 75 mortality rate in adults with SMI compared with those without SMI by underlying cause in England – 2018-2020

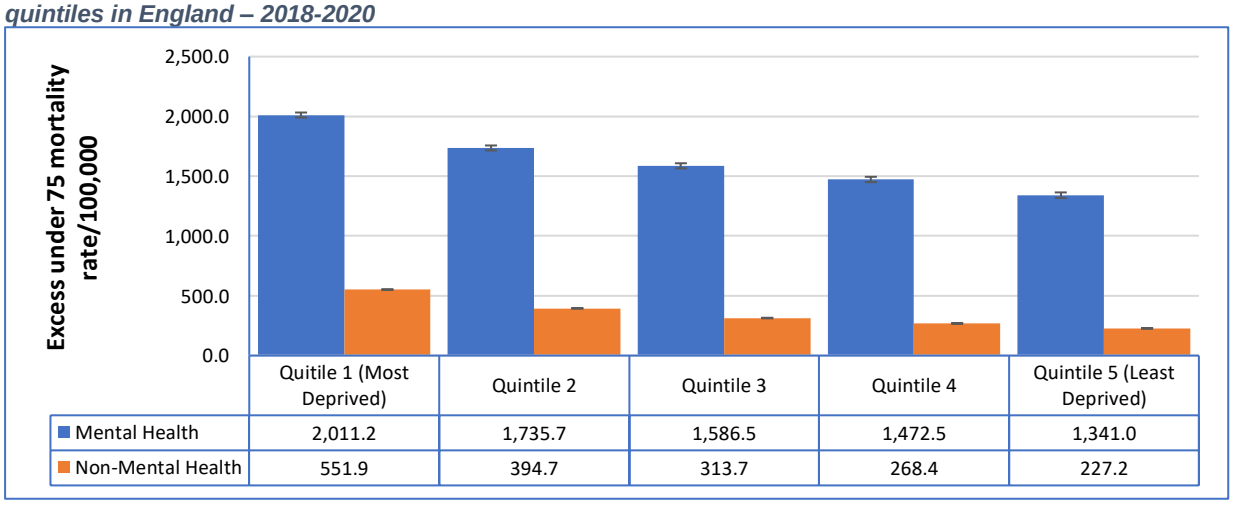


	All causes	Cancer	Cardiovascular disease	Liver disease	Respiratory disease
Mental Health	1,656.8	337.7	311.9	115.8	204.7
Non-Mental Health	338.2	149.6	76.7	17.8	31.0

Source: ***NHS Digital 2022*** *

Though excess death rates were higher the more deprived an area is, the relative impact of SMI seemed to be higher the less deprived an area is. Compared with those without SMI, those with SMI from the most deprived areas had 3.6 times the excess death rate while those in the least deprived areas had 5.9 times the excess death rate (Figure 3.11). This may be explained by the relatively lower levels of excess deaths in the less deprived areas.

Figure 3.11: Excess under 75 mortality rate in adults with SMI compared with those without SMI by IMD quintiles in England – 2018-2020



	Quitile 1 (Most Deprived)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (Least Deprived)
Mental Health	2,011.2	1,735.7	1,586.5	1,472.5	1,341.0
Non-Mental Health	551.9	394.7	313.7	268.4	227.2

Source: ***NHS Digital 2022***. *

3.6.2 Outcomes for people with SMI in Wokingham Borough

There are no data on the outcomes related to the various SMI. Figure 3.12 shows selected outcomes for Wokingham. Two of these (Excess under-75 mortality rate in adults with SMI and Excess under-75 mortality rate due to cancer in adults with SMI)

* NHS Digital have uncovered an issue with the underlying data previously published in this publication. The issue impacts all of the data included in this publication and as such the data has been removed. This data has been reissued on May 4, 2022. Previous versions of the data held for the 2018-20 reporting period should be disregarded.

were significantly worse than national averages – they will be examined further in this section. The others were similar or better than national averages.

Figure 3.12: Severe Mental Illness outcomes profile for Wokingham Borough (2018-2020)

Indicator	Period	Wokingham			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Premature mortality in adults with severe mental illness (SMI) New data	2018 - 20	–	275	79.6	83.4	103.6	212.4		52.2
Premature mortality due to cancer in adults with severe mental illness (SMI) New data	2018 - 20	–	80	22.2	16.1	20.2	53.0		10.0
Premature mortality due to cardiovascular diseases in adults with severe mental illness (SMI) New data	2018 - 20	–	35	10.6	14.5	18.9	46.9		8.7
Premature mortality due to liver disease in adults with severe mental illness (SMI) New data	2018 - 20	–	10	3.5	5.5	7.6	21.0		3.0
Premature mortality due to respiratory disease in adults with severe mental illness (SMI) New data	2018 - 20	–	25	6.8	9.5	12.2	30.6		4.7
Excess under 75 mortality rate in adults with severe mental illness (SMI) New data	2018 - 20	–	-	549.6%	436.1%	389.9%	615.1%		
Excess under 75 mortality rate due to cancer in adults with severe mental illness (SMI) New data	2018 - 20	–	-	302.8%	128.9%	125.8%	302.8%		19.7%
Excess under 75 mortality rate due to cardiovascular disease in adults with severe mental illness (SMI) New data	2018 - 20	–	-	277.3%	353.5%	306.6%	548.6%		3.3%
Excess under 75 mortality rate due to liver disease in adults with severe mental illness (SMI) New data	2018 - 20	–	-	587.0%	558.7%	550.2%	1,323.3%		197.6%
Excess under 75 mortality rate due to respiratory disease in adults with severe mental illness (SMI) New data	2018 - 20	–	-	858.7%	642.1%	559.5%	998.2%		1%

Source: Severe Mental Illness Area Profiles (OHID) – accessed 04 May 2022

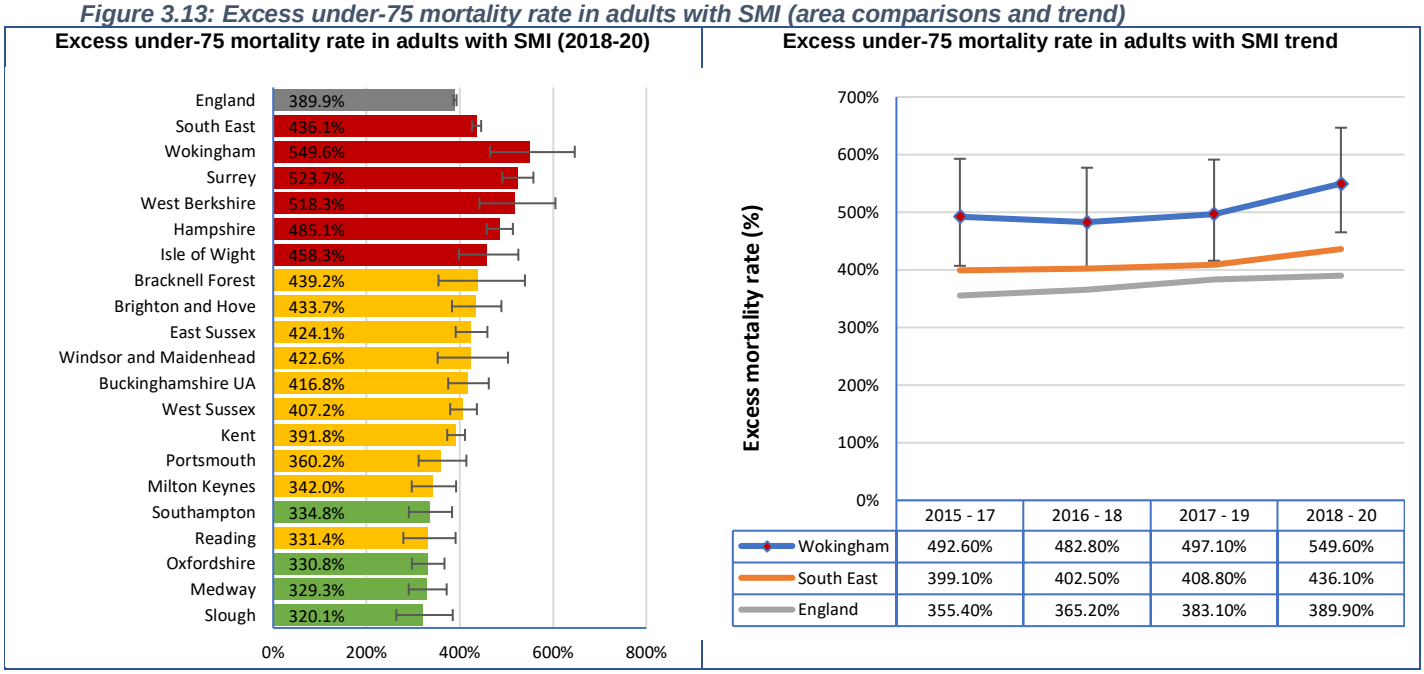
On average the death rate among under-75 adults with SMI in Wokingham was 5.5 (i.e., 549.6%) times higher than among the general population in the period spanning 2018 to 2020 and was significantly higher than the South East and England averages of 436.1% and 389.9% respectively. The rate was the highest in the South East over the period and has seen a year-on-year rise over the past few years (Figure 3.13).

Cancer is the highest cause of death in England in under 75s. Though people with SMI have similar rates of cancer to the rest of the population (Figure 3.7), the case fatality rates are higher and survival rates are lower for the cohort with SMI (Office for Health Improvement and Disparities, 2022).

On average the death rate due to cancer among under-75 adults with SMI in Wokingham was 3 times (i.e., 302.8%) higher than the rate due to cancer among the general population and was the worst in England during the period spanning 2018 to 2020. The corresponding regional and national figures were 128.9% and 125.8% respectively. Over the recent years the rate in Wokingham has seen a year-on-year increase (Figure 3.14).

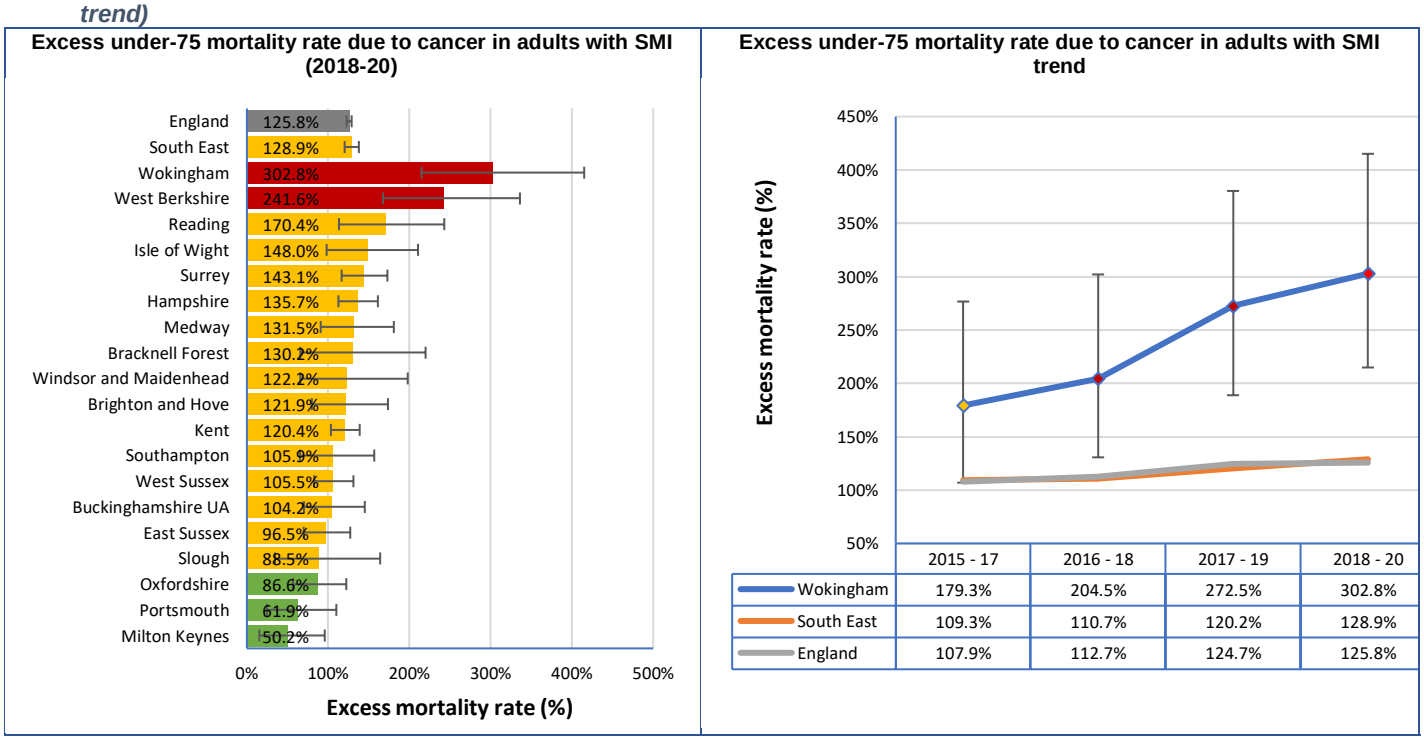
The foregoing may be indicators of local factors influencing inequalities observed in these outcomes which local partners should work to identify and address.

Figure 3.13: Excess under-75 mortality rate in adults with SMI (area comparisons and trend)



Source: Severe Mental Illness Area Profiles (OHID) – accessed 04 May 2022

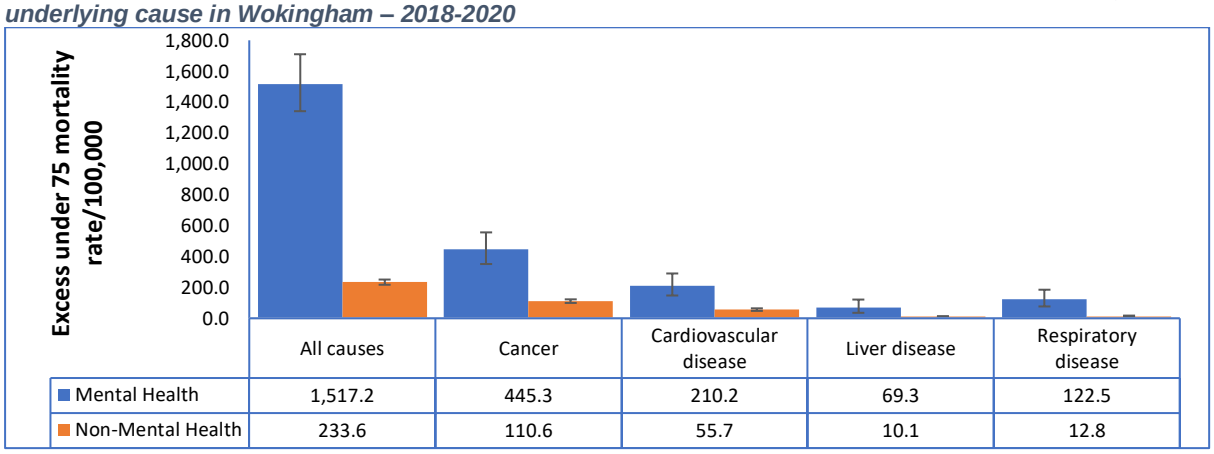
Figure 3.14: Excess under-75 mortality rate due to cancer in adults with SMI (area comparisons and trend)



Source: Severe Mental Illness Area Profiles (OHID) – accessed 04 May 2022

In Wokingham, during the 2018-2020 period, compared with people under 75 years without SMI, those with SMI have excess death rates which are 6.5 times higher for all causes, 4.0 times higher for cancers, 3.8 higher for cardiovascular diseases, 6.9 higher for liver diseases, and 9.6 times for respiratory diseases (Figure 3.15) (NHS Digital, 2022)

Figure 3.15: Excess under-75 mortality rate in adults with SMI compared with those without SMI by underlying cause in Wokingham – 2018-2020



	All causes	Cancer	Cardiovascular disease	Liver disease	Respiratory disease
Mental Health	1,517.2	445.3	210.2	69.3	122.5
Non-Mental Health	233.6	110.6	55.7	10.1	12.8

Source: ***NHS Digital 2022*** *

3.7 Service provision and indicators of demand and outcomes

3.7.1 Service use and unmet needs – national profile from APMS

3.7.1.1 Bipolar disorder

Of those who screened positive for bipolar disorder, 59.2% were not in receipt of any current medication or treatment. Those who screened positive were considerably more likely to report receiving some form of psychotropic medication (39.2%) or psychological therapy (16.4%) than those who screened negative (10.7% and 2.6% respectively).

Those who screened positive were also more likely to report using the other types of service asked about. For example, half of those screening positive for bipolar disorder reported having used a health care service in the past year (50.0%), compared with a tenth of those who screened negative (11.8%.).

12.7% of those who screened positive reported they had requested but not received a particular mental health treatment in the 12 months preceding the survey compared with 1.4% of those who screened negative.

3.7.1.2 Psychotic disorder

The combined 2007 and 2014 data showed 82.4% of adults with a psychotic disorder in the past year were receiving some form of treatment (psychotropic medication and/or psychological therapy) at the time of the interview (compared with 9.8% of those without a psychotic disorder).

In the 2014 survey, participants were asked whether they had requested, but not received, a particular mental health treatment in the past 12 months. Unmet treatment requests were about seven times more likely among people with a psychotic disorder than in the rest of the population (12.2% of people with psychotic disorder, compared with 1.8% of those without).

3.7.1.3 Antisocial and borderline personality disorders

Those screening positively for a personality disorder on any of the measures used, were more likely to be in receipt of mental health treatment than those who did not. 26.6% of 18- to 64-year-olds who screened positive for ASPD, 43.1% of screen

positives for BPD, and 28.9% of screen positives for any personality disorder reported receiving psychotropic (mental health) medication, psychological therapy or both.

People screening positive were more likely to be in receipt of medication than counselling. Psychotropic medication was being taken by 24.5% of individuals screening positive for ASPD and any personality disorder (25.6%), and 38.3% of those screening positive for BPD.

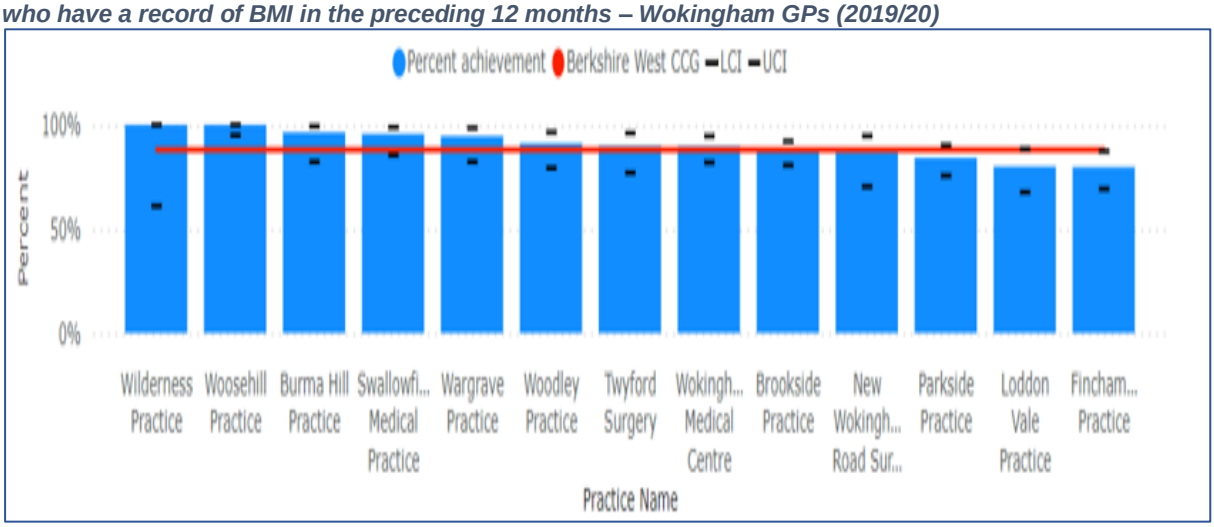
Though people screening positive for personality disorders were more likely to be in receipt of mental health treatment, they were more likely to have requested a particular treatment which they did not receive. 16.6% of screen positives for BPD, 9.1% of screen positives for ASPD, and 7.3% of screen positives for any personality disorder had requested some kind of mental health treatment in the past 12 months which they had not received, compared with 0.8% of people not screening positive for any personality disorder.

3.7.2 Physical health checks for people with SMI

People diagnosed with SMI registered with a GP are invited for an annual physical health check to detect and treat physical health problems and prevent other serious problems from occurring. These arrangements are made by Berkshire West Clinical Commissioning Group (CCG). Due to the impact of the Covid-19 pandemic, QOF implementation was changed in the 2020/21 reporting year and therefore data from these years is unreliable. The following charts used 2019/20 data for Wokingham GPs, and they show a comparison against Berkshire West CCG average (displayed as a red line).

In England, 85% of patients on SMI registers have had their BMI recorded in the previous 12 months, the rate in the South East was 84% and it was 88% in Berkshire West CCG. As shown below (Figure 3.16), there was little variation overall between Wokingham GPs with the vast majority of practices being similar to the CCG average, with Wilderness practice significantly higher and Finchampstead lower.

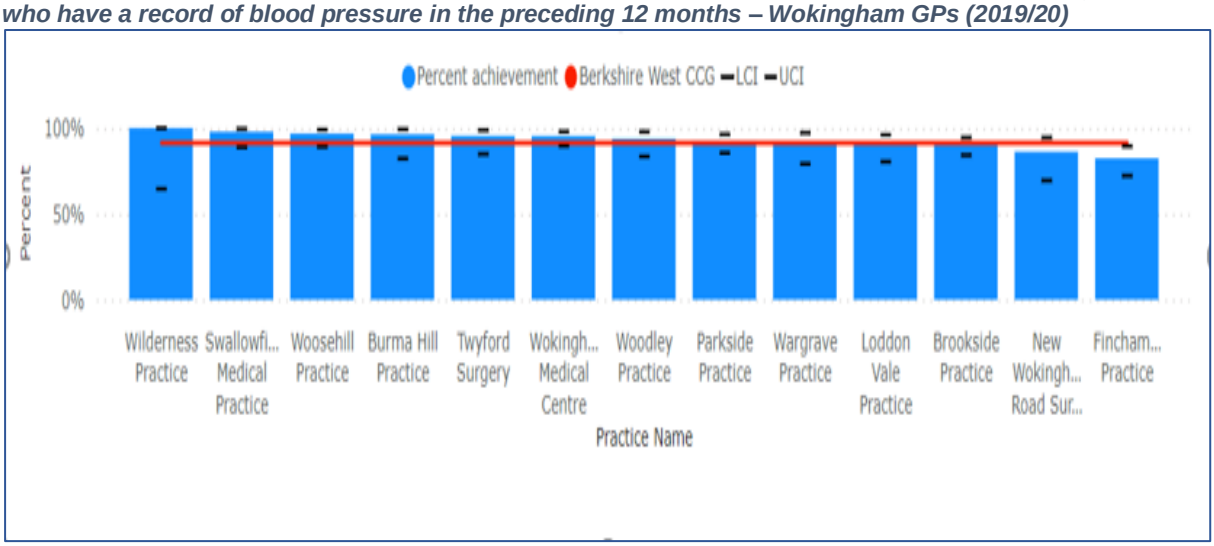
Figure 3.16: Percentage of patients with schizophrenia, bi-polar affective disorder and other psychoses who have a record of BMI in the preceding 12 months – Wokingham GPs (2019/20)



Source: (NHS Digital and Quality Outcomes Framework, 2021)***NHS Digital and Quality Outcomes Framework (2021)***

In England, 90% of patients on SMI registers have had their blood pressure recorded in the previous 12 months in 2019/20, the rate in the South East was 89% and was 91% in Berkshire West CCG. Similar to BMI checks, records of blood pressure in Wokingham showed little variation among Wokingham GP Practices with the vast majority of practices having similar coverage as the CCG average with only one practice significantly lower (Figure 3.17).

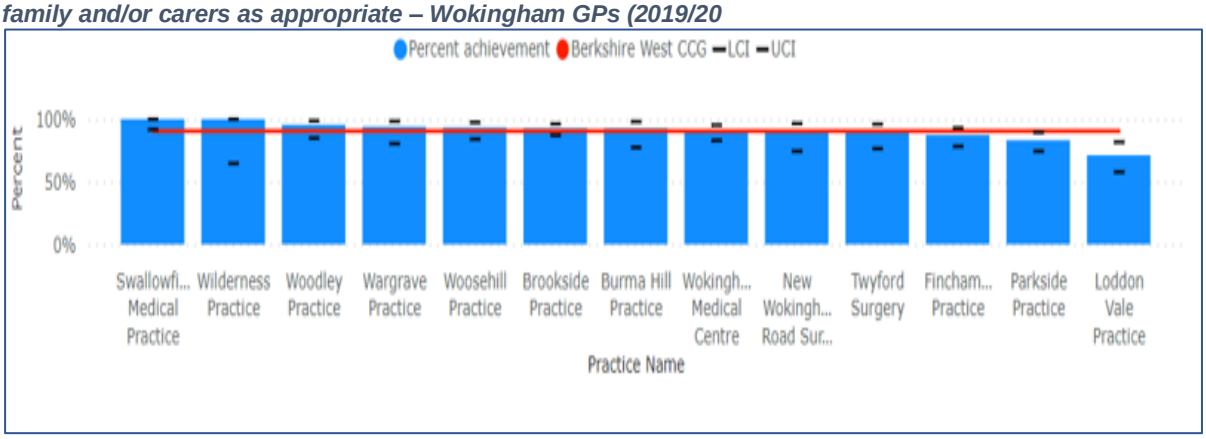
Figure 3.17: Percentage of patients with schizophrenia, bi-polar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months – Wokingham GPs (2019/20)



Source: (NHS Digital and Quality Outcomes Framework, 2021)***NHS Digital and Quality Outcomes Framework (2021)***

In England, 85% of patients on SMI registers have a comprehensive care plan documented in their records in the previous 12 months in 2019/20, the rate in the South East was 86% and is 90% in Berkshire West CCG. There was little variation among Wokingham GP Practices with the vast majority of practices being the same as the CCG average - Swallowfield Medical Practice was significantly higher, and Parkside and Loddon Vale Practice was significantly lower (Figure 3.18).

Figure 3.18: Percentage of patients with schizophrenia, bi-polar affective disorder and other psychoses who had a comprehensive care plan documented in the preceding 12 months, agreed by individual, their family and/or carers as appropriate – Wokingham GPs (2019/20



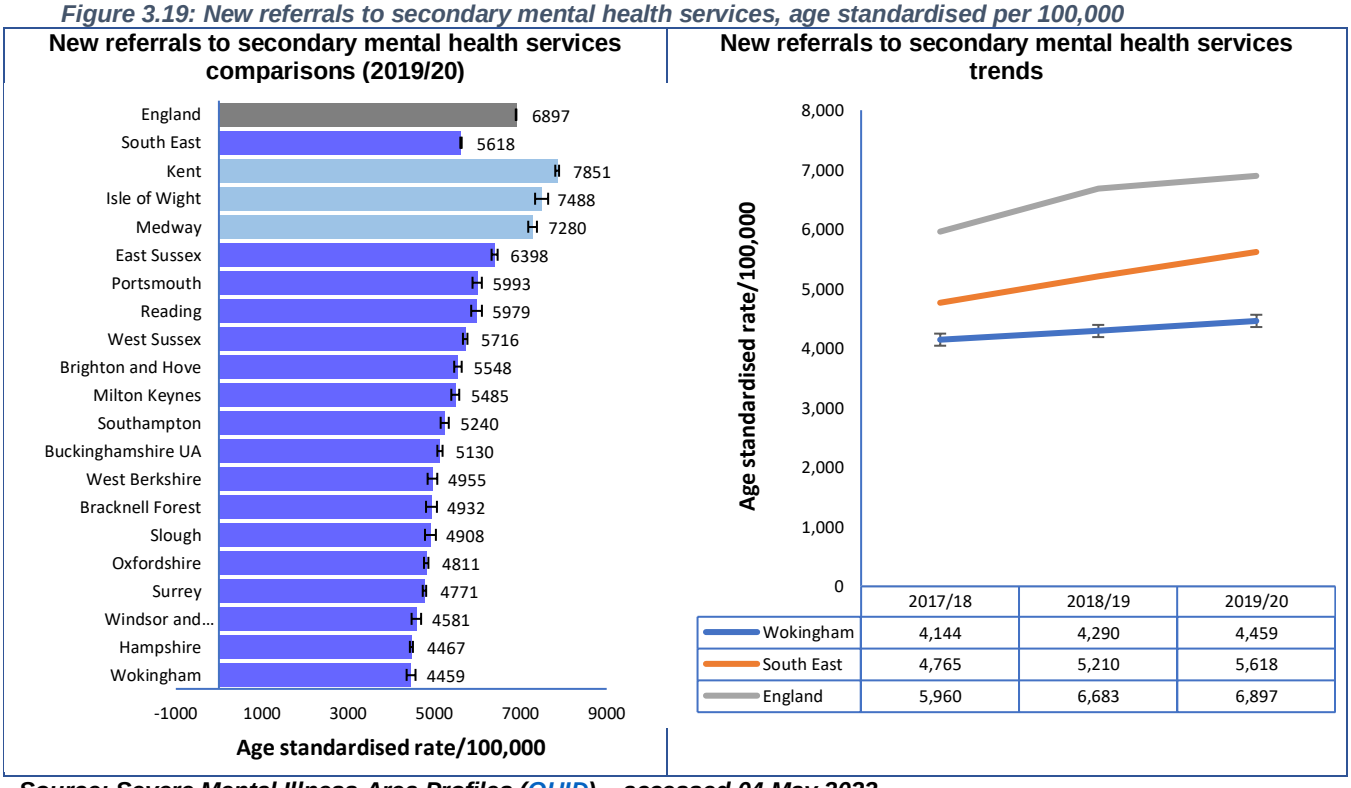
Source: (NHS Digital and Quality Outcomes Framework, 2021)***NHS Digital and Quality Outcomes Framework (2021)***

3.7.3 Referrals to secondary care mental health services, inpatient stays and community and outpatient mental health service contacts

Rates of new referrals to secondary mental health services, attended contacts with services, and inpatient stays provide local health and care systems with an important measure of demand. They contribute to assessing how these demands reflect the mental health needs of the local population and if these demands can be met by current service provisions (Office for Health Improvement and Disparities, 2022).

New referrals to secondary mental health services have increased year-on-year but has been significantly below the South East and England averages between 2017/18 and 2019/20 (Figure 3.19). With the rate of 4,459 per100,000 in 2019/20, Wokingham had the lowest referral rate among local authorities in the South West (Figure 3.19). It is not possible to make any judgements based on this relating to how well local residents with mental health needs requiring secondary care are being referred into these services – the increasing trend, which is similar to regional and national trends, may be a reflection of increasing demands for secondary mental health services.

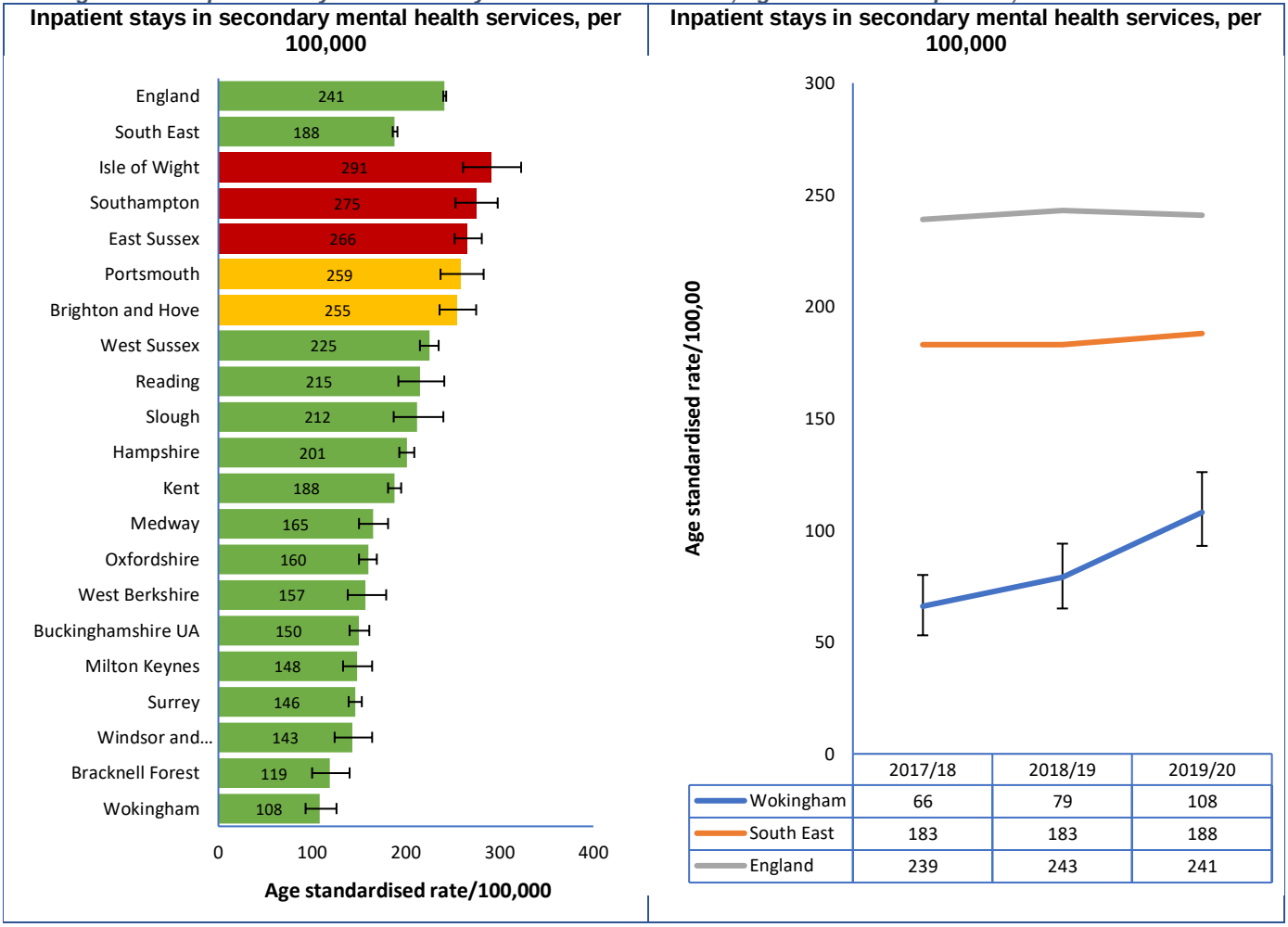
Figure 3.19: New referrals to secondary mental health services, age standardised per 100,000



Source: Severe Mental Illness Area Profiles (OHID) – accessed 04 May 2022

Similarly, inpatient stays in secondary mental health services have seen a year-on-year increase locally over the same period but the rate of increase has been higher than regional and national averages though significantly below the regional and national averages (Figure 3.20). With a rate of 108 per 100,000 in 2019/20, Wokingham had the lowest inpatient stay rate among local authorities in the South West (Figure 3.20). This may be a reflection of the quality support being received preventing inpatient admissions among local resident with SMI.

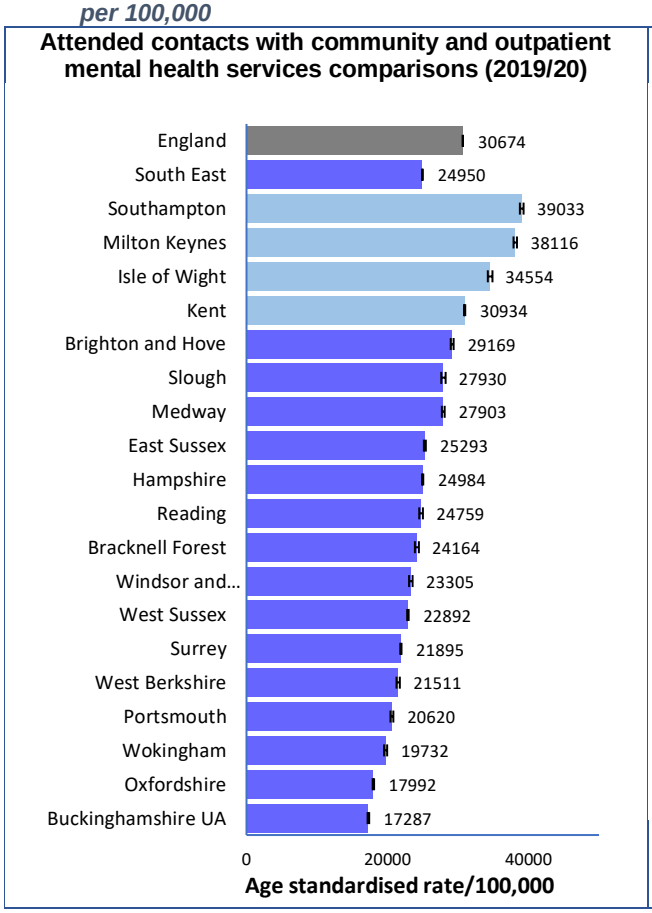
Figure 3.20: Inpatient stays in secondary mental health services, age standardised per 100,000

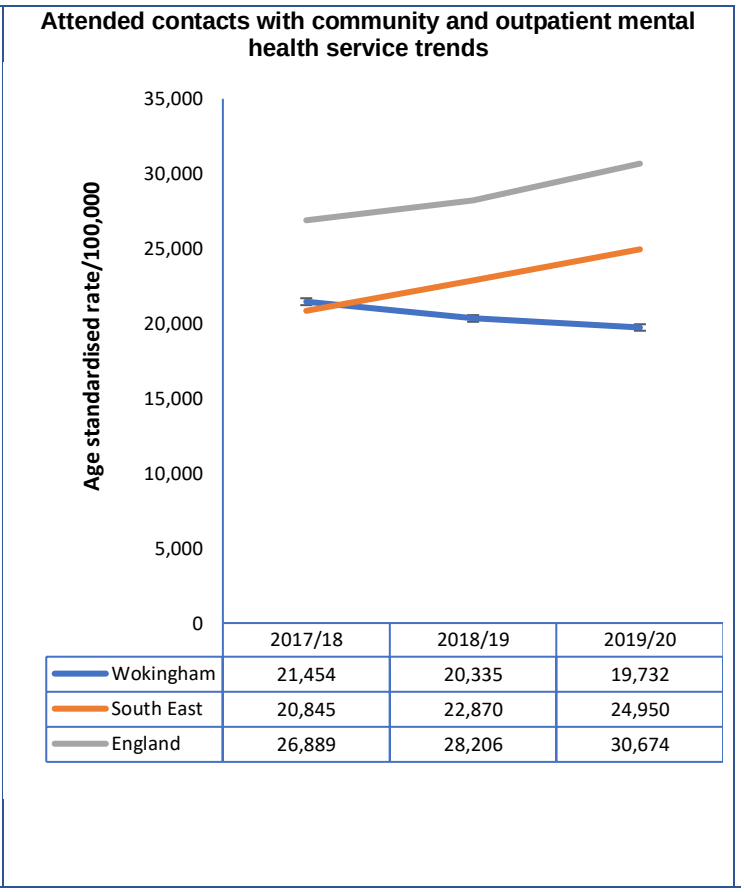


Source: Severe Mental Illness Area Profiles (OHID) – accessed 04 May 2022

Attendance at community and outpatient mental health services has declined significantly in Wokingham between 2017/18 and 2019/20 while it increased, on the average, in the South East and England (Figure 3.21). With a rate of 19,732 per 100,000 in 2019/20, Wokingham had the 3rd lowest rate in the South East (Figure 3.21). Though no definite conclusions can be drawn from this, it may be an indication that local factors may be impeding attendance at community and outpatient mental health appointments over the period.

Figure 3.21: Attended contacts with community and outpatient mental health services, age standardised per 100,000





	2017/18	2018/19	2019/20
Wokingham	21,454	20,335	19,732
South East	20,845	22,870	24,950
England	26,889	28,206	30,674

Source: Severe Mental Illness Area Profiles (OHID) – accessed 04 May 2022

3.7.4 Specific local services

3.7.4.1 Inpatient service provision

The main site for people in Berkshire with mental health conditions that require inpatient care are admitted into Prospect Park Hospital in Reading. Admission can be voluntary or admission on a Section 136 or 135. They have a specialist ward for dementia and a specialist ward for people with learning disabilities.

In 2020/21 there were an average of 40 admissions to Prospect Park Hospital each month with an average length of stay of 50 days. Around 8% of those discharged tend to be re-admitted within 28 days.

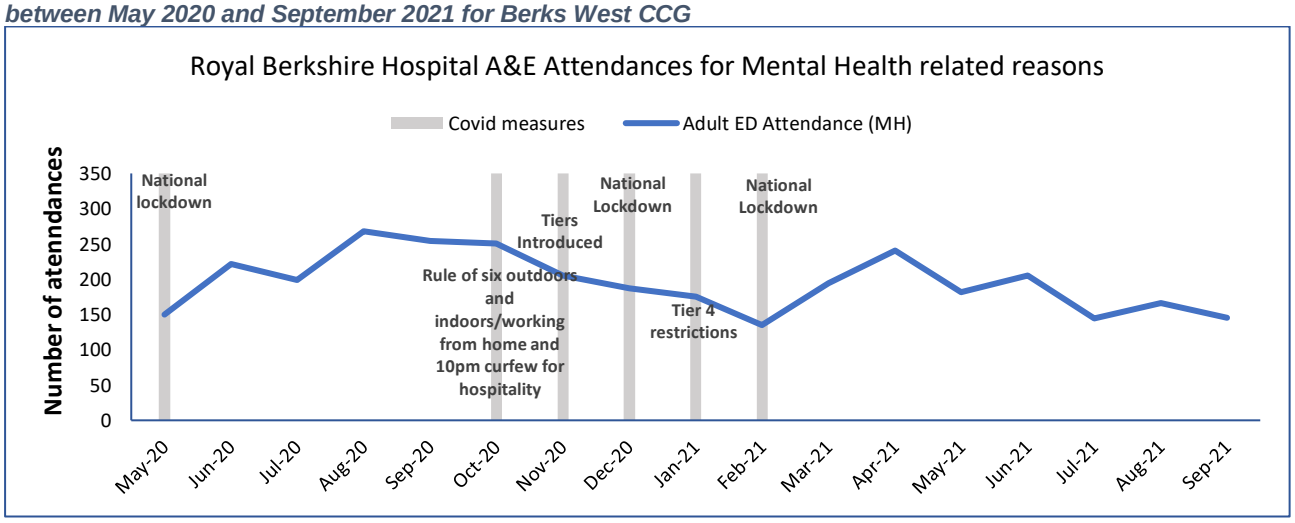
A delayed transfer of care from acute or non-acute care occurs when a patient is ready to be discharged from such care but could not be discharged due non-medical reasons. On average, there were a total of 120 delayed days each month for patients in Prospect Park Hospital. The main reason for delay was a lack of appropriate housing for clients to be discharged to.

3.7.4.2 Hospital Accident and Emergency (A&E) service utilisation

People with acute mental health problems or crisis often present as an emergency attendee at Accident and Emergency Departments. The Royal Berkshire Hospital is the main Acute Hospital providing services to Berkshire West patients.

Figure 3.22 shows the monthly number of attendances presenting with mental health problems by both adults and children between May 2020 and September 2021. Overall, 3,323 attendances were recorded over the period. Between April and September 2021, there were 1,300 attendances at A&E by people presenting with mental health problems suggesting COVID-19 control measures might have reduced contacts with A&E departments. It should be noted that the figures presented are counts of attendances and not unique individuals in contact with services - an individual may present more than once over the period.

Figure 3.22: Number of attendances presenting with mental health problems by both adults and children between May 2020 and September 2021 for Berks West CCG



Source: (Hub, 2020/21)***(Berkshire West CCG Mental Health Services Performance Report 2020/21)***

3.7.4.3 Community Health Team - Common Point of Entry

The Adult Community Mental Health Team (CMHT) supports those with severe and complex mental health difficulties. CMHT in Wokingham have a Common Point of Entry (CPE) team. The team provide support and advice, and conduct the initial assessment, following which a person will be directed to the most appropriate support or services to meet their needs.

Berkshire Healthcare NHS Foundation Trust (BHFT) is the provider of secondary mental health services in Berkshire West. The CPE is the main access point for specialist mental health support. People can self-refer or be referred by a healthcare professional.

In 2020/21 there were on average almost 500 referrals to the CPE each month with over 300 contacts† made. Around 50% are urgent referrals who are offered an assessment within 24 hours; a further 30% require routine assessments which are offered with 28 days (Hub, 2020/21)(*Berkshire West CCG Mental Health Services Performance Report 2020/21).*

† Contacts include - phone calls, assessments (contact over 30mins on the phone) and any form of appointment including face to face

3.7.4.4 Crisis Services

A Crisis Support Service for those suffering from acute mental health conditions or crisis (not requiring an emergency a 999 call) is provided by BHFT. The service operates 24 hours a day, 7 days a week. Where possible treatment is provided in a person's own home. People can self-refer via 111 or through the CPE line or be referred by a healthcare professional.

On average Crisis Service responds to 580 calls/month in activity in 2020/21. 25% are new contacts, 22% are older adults (those aged 75 years or older), 3% are CYP. Of these 59% are self-referrals.

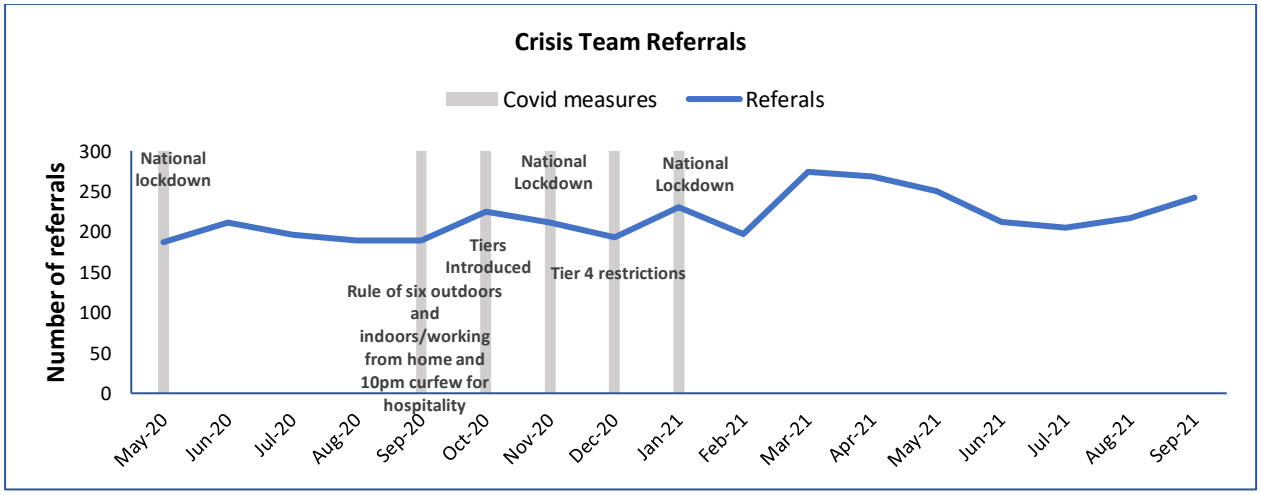
Figure 3.23 shows monthly referrals into the Crisis Team between May 2020 and September 2021. Periods of increased COVID-19 restrictions are indicated on the chart. Increase in referrals can be seen during and after these restrictions. There was a particularly sharp increase in referrals after the third national lockdown seen in March 2021.

There has been a significant increase in people seeking mental health crisis support over the recent period with increased complexity of presentations during the COVID-19 control measure. Calls to the crisis line averaged at almost 600 per month between June and September 2021. During September 2021, there were 471 unique clients accessing the service, the highest since the service started. Only 41% of clients were known previously to mental health services. This proportion has increase since the service started.

Over the period, majority (over 60%) self-referred into the service followed by referrals form 111 (18%) and carers (11%). 52% of referrals are for people resident in Reading, 28% are resident in West Berkshire, and 20% in Wokingham.

There has also been a sharp rise in the number of referrals to the service that were for those aged over 75 years of age (Hub, 2020/21)(*Berkshire West CCG Mental Health Services Performance Report 2020/21).*

Figure 3.23: Monthly referrals into the Crisis Team between May 2020 and September 2021 for Berks West CCG



Source: (Hub, 2020/21)***(Berkshire West CCG Mental Health Services Performance Report 2020/21)***

3.7.4.5 Wokingham Recovery College

The Wokingham Recovery College offers free mental health and wellbeing training courses. They provide support to everyone, particularly those who are on the recovery journey and those who wish to learn more about mental health and wellbeing. Courses are co-produced, devised and delivered by people with personal experience of mental illness working together with mental health professionals.

3.7.4.6 Street Triage

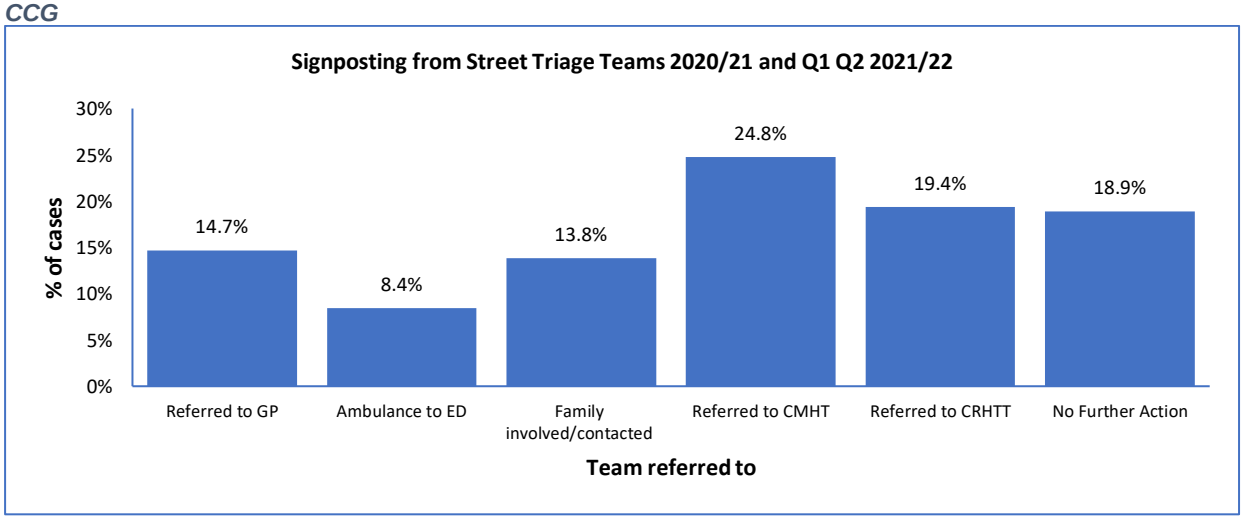
Street Triage service aims to reduce the number of individuals who are detained inappropriately in police custody at Police Stations and reduce the use of Section 136. Section 136 of the Mental Health Act allows a person to be taken to a place of safety if a police officer is concerned that a person has a mental health disorder that requires immediate care. This service provides mental health professionals to accompany/assist the police at incidents where the possible mental health of an individual gives rise for concern and consider and offer alternatives to Section 136 if in the patient's best interest.

During 2020/21 and the first 2 quarters of 2021/22, 140 cases were handled by the Street Triage team. This included those requiring face-to-face support, phone support, as well as those requiring information and advice only. Over this period 28 Section 136s were avoided and 12 cases required Section 136s.

Figure 3.24 shows onward signposting from the Street Triage team to further services over the period. 25% of cases were referred to Community Mental Health Team. 20% were referred to the Crisis Resolution and Home Treatment Team (CRHTT). 19% require no further action.

Generally, there has been a steady decline in the number of people being placed on Section 136, with improved access of Mental Health professionals (via Professionals Line), increased hours of Street Triage Team and improved partnership working.

Figure 3.24: Signposting % of cases from Street Triage Team 2020/21 & Q1-Q2 2021/22 for Berks West CCG



Source (Hub, 2020/21)***(Berkshire West CCG Mental Health Services Performance Report 2020/21)***

3.7.4.7 Other services

Mental health cannot be supported in isolation by one organisation or group of professionals. There are several roles that various organisations can play. Key organisations include local authorities, national and local health services, and voluntary and community sector (VCS) to name a few.

For people with SMI, Wokingham Borough Council and Berkshire Healthcare Foundation Trust jointly provide services and support to adults with mental health conditions. The responsibilities are partly outlined in Section 117 of the Mental Health Act (MHA) and requires councils to provide after-care services and support to people moving out of hospital. Approved Mental health Practitioners (AMHPs) are responsible for contributing to statutory mental health assessments and any MHA tribunals that need to occur. This may relate to guardianship, or duties to authorise deprivation of liberty safeguards.

3.8 Conclusion

Wokingham overall has relatively low prevalence of SMI compared with our neighbours and England. It is likely that local pockets of health inequalities exist relating to SMI and identifying these in order to target interventions to those that need them most would help alleviate the total burden of SMI, both in terms of mental health and physical health, in the most effective manner.

Some of the obvious inequalities identified in the needs assessment relate to premature mortality which is the worst for those with SMI co-existing with cancer diagnoses and access to physical health checks.

The following considerations should be given to supporting residents with SMI:

- Improve uptake of annual physical health assessments for those who live with SMI in accordance with NICE guidelines
- Local partners to work to understand the apparent inequalities relating to excess mortality among those with SMI
- Ensure access to key interventions including smoking prevention and cessation, weight management, substance misuse reduction, and support in leading healthy lifestyles.
- Ensure treatment is holistic and integrated between different care pathways – particularly physical health and mental health.
- Local services should be designed to consider the needs of residents living with SMI, ensuring there is appropriate access or support so as not to exacerbate any inequities which exist as a result
- As population increase local partners should work to increase capacity to support those with SMI to ensure adequacy to support in the future.

3.9 References

Beat. (2022). *How many people have an eating disorder in the UK?* Retrieved March 11, 2022, from https://www.beateatingdisorders.org.uk/get-information-and-support/about-eating-disorders/how-many-people-eating-disorder-uk/

De Hert M. et al. (2011). Physical illness in patients with severe mental disorders: Prevalence, impact of medications and disparities in health care. *World Psychiatry, 10*(1), 52-77.

Global Burden of Disease Collaborative Network. (2021). *Global Burden of Disease Study 2019.* Seatle, United States: Institute for Health Metrics and Evaluation.

House of Commons Library. (2021, April 27). *Constituency data: health conditions*. Retrieved from https://commonslibrary.parliament.uk/constituency-data-how-healthy-is-your-area/

Hub, B. W. (2020/21). *Berkshire West CCG Mental Health Service Performance Report.*

Insights, C. C. ([Accessed 16/03/2022]).

Mental Health Taskforce . (2016). *Five Year Forward View for Mental Health.* London: NHS England .

National Institute for Health and Care Excellence. (2020). *Clinical Knowledge Summaries: Self-harm - What are the risk factors?* Retrieved March 11, 2022, from https://cks.nice.org.uk/topics/self-harm/background-information/risk-factors/

National Institute for Health and Care Excellence. (February 2014). *Pyschosis and schizophrenia in adults: prevention and management Clinic Guidelines [CG178]*. Retrieved March 11, 2022, from https://www.nice.org.uk/guidance/cg178/chapter/1-Recommendations#care-across-all-phases

National Mental Health Intelligence Network. (2018, September 2018). *Severe mental illness (SMI) and physical health inequalities: briefing.* Retrieved March 22, 2022, from https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing#authors-and-acknowledgements

NHS. (2022). *Self-harm*. Retrieved March 11, 2022, from https://www.nhs.uk/mental-health/feelings-symptoms-behaviours/behaviours/self-harm/

NHS. (December 2019). *Overview - Pyschosis*. Retrieved March 11, 2022, from https://www.nhs.uk/mental-health/conditions/psychosis/overview/

NHS Digital. (2016, September 29). *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014.* Retrieved from Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014.: https://digital.nhs.uk/data-and-information/publications/statistical/adult-

psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014

NHS Digital. (2019, May). *NHS Outcomes Framework Indicator Specification*. Retrieved from Excess under 75 mortality rate in adults with serious mental illness (formerly indicator 1.5): https://files.digital.nhs.uk/69/92C9C6/NHSOF_Domain_1_S.pdf

NHS Digital. (2022). *Excess under 75 mortality rates in adults with serious mental illness - 2018 to 2020*. Retrieved June 15, 2022, from https://digital.nhs.uk/data-and-information/publications/statistical/excess-under-75-mortality-rates-in-adults-with-serious-mental-illness/2018-to-2020

NHS Digital and Quality Outcomes Framework. (2021).

NHS England . (2019). *Health Survey for England* . Retrieved March 11, 2022, from https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2019

NHS England. (2021). *NHS Outcomes Framework: 1.5.i Excess under 75 mortality rates in adults with serious mental illness 1 Jan 2015 to 31 Dec 2017*. Retrieved March 11, 2022, from https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-1-preventing-people-from-dying-prematurely-nof/1.5.i-excess-under-75-mortality-rate-in-adults-with-serious-mental-illness-formerly-indicator-1

NHS England. (n.d.). *Mental Health Bulletin 2020-21 Annual report - NHS Digital.* Retrieved 03 16, 2022, from https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2020-21-annual-report

NHS. (February 2021). *Overview - Eating Disorders*. Retrieved March 11, 2022, from https://www.nhs.uk/mental-health/feelings-symptoms-behaviours/behaviours/eating-disorders/overview/

NHS. (July 2020). *Why people self-harm*. Retrieved March 11, 2022, from https://www.nhs.uk/mental-health/feelings-symptoms-behaviours/behaviours/self-harm/why-people-self-harm/

NHS. (March 2019). *Causes - Bipolar disorder*. Retrieved March 11, 2022, from https://www.nhs.uk/mental-health/conditions/bipolar-disorder/causes/

NHS. (March 2019). *Overview - Bipolar disorder*. Retrieved March 11, 2022, from https://www.nhs.uk/mental-health/conditions/bipolar-disorder/overview/

NHS. (November 2019). *Causes - Schizophrenia* . Retrieved March 11, 2022, from https://www.nhs.uk/mental-health/conditions/schizophrenia/causes/

NHS. (November 2019). *Overview - Schizophrenia*. Retrieved March 11, 2022, from https://www.nhs.uk/mental-health/conditions/schizophrenia/overview/

Office for Health Improvement & Disparities . (2022). *Public Health Profiles*. Retrieved March 11, 2022, from https://fingertips.phe.org.uk/search/Mortality#page/4/gid/1000044/pat/6/par/E12000008/ati/402/are/E06000041/iid/93582/age/181/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-do-0

Office for Health Improvement & Disparities (2). (2022). *Local Tobacco Control Profiles* . Retrieved March 11, 2022, from https://fingertips.phe.org.uk/profile/tobacco-control/data#page/4/gid/1938132900/pat/6/par/E12000008/ati/301/are/E06000041/iid/93454/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

Office for Health Improvement & Disparities Public Health Profiles - Child and Maternal Health. (n.d.). Retrieved from https://fingertips.phe.org.uk/profile/child-health-profiles/data

Office for Health Improvement and Disparities (2021). (n.d.). *Office for Health Improvement and Disparities. (2021). Substance misuse treatment for adults: statistics 2020 to 2021. Available: https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021. Last accessed 28th No.*

Office for Health Improvement and Disparities. (2022). *Severe Mental Illness Profile*. Retrieved from Fingertips Public Health Data: https://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/data#page/1

Office for National Statistics. (2021, June 25). *Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland*. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

Public Health England. (2018). *Severe mental illness (SMI) and physical health inequalities: briefing.* Public Health England. Retrieved June 15, 2022, from https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing

Reilly S, O. I. (2015). Inequalities in physical comorbidity: a longitudinal comparative cohort study of people with severe mental illness in the UK. . *British Medical Journal (BMJ) Open*.