



Somerset
Council

Mental Health Needs Assessment

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Executive Summary

Solutions to improve population mental health require systemwide commitment and coordination of services. This needs assessment reviews data linked to the socioeconomic, environmental and cultural determinants of mental health, alongside individual factors and health related data. This diverse approach provides evidence that will inform future commitments and actions that various parts of the system could adopt, to improve population mental health. The literature review explores the evidence for interventions which address the social determinants of mental health, to understand how effective these approaches are at improving mental health and wellbeing and can be used to guide future discussions around service provision and policy development.

In Somerset, the prevalence of common mental disorders is increasing, which is mirrored by an increase in anti-depressant prescriptions and demand for mental health services. Whilst wellbeing indicators are generally better in Somerset than nationally (life satisfaction, happiness, feeling things are worthwhile, loneliness), there has been a statistically significant decrease in happiness in Somerset between 2020-2021 (ONS). National data sets indicate that there has been a deterioration in all personal wellbeing measures since April 2017. Depression prevalence (2020/21) is higher in Somerset than nationally and regionally – Somerset is in the highest quintile nationally, with data currently showing an increasing trend. Similarly, the number of antidepressant prescriptions is also showing an increasing trend.

Modelled Common Mental Disorder (CMD) rates (16+) are lower than national but similar to regional figures. However, this is an estimate of true prevalence, and is likely an underestimate, the data is also outdated (2016/17). Prevalence of CMD in social care users in Somerset is the highest in the South West region and higher than national averages (2018/19). Long term mental health and depression prevalence data by GP indicates higher rates primarily around urbanised areas with a lower Indices of Multiple Deprivation score.

Demand for Mental Health services is increasing, particularly in the urban areas of Wells, Bridgwater, and Taunton and the coastal areas of West Somerset. Service call data from Mindline, Somerset's 24/7 listening service, also indicates an increasing trend in the number of calls received per week since April 2021. The top 5 presenting issues to Mindline are emotional support, eating disorders, anxiety, relationships, and isolation. Since April 2021, there has been an increase in the number of calls received from people who are actively suicidal with intent, plan and means.

Somerset is a consistent outlier for rates of suicide and self-harm. Suicide rates in Somerset are higher than nationally and are showing an increasing trend. Rates are consistently higher in males, in line with the trend seen globally. Hospital admission rates due to self-harm are consistently higher than nationally, with the rate in Somerset highest for young people aged 15-19. Although not mental health problems themselves, these issues are linked to mental distress, they often involve complex circumstances, driven by various interacting factors in people's lives. This highlights the need for a coordinated systems-based approach to mental health, one that understands and addresses the factors and environments that have an impact on mental health across the life course.

There is a firm consensus on known social inequalities and individual factors that are associated with an increased risk of poor mental health outcomes. This needs assessment explores data around the most influential social and individual factors. Somerset is a predominantly rural county with pockets of deprivation. We have an ageing population with three quarters of the population growth between 2011 and 2021 being in the 65+ age range. Information on ethnicity in the county is limited due to incomplete data sets; however, the percentage of ethnically diverse populations in Somerset is lower than national figures. The median gross annual income is slightly below the national average, although unemployment rates are lower. Housing availability and quality is an issue in Somerset. This needs assessment highlights where data is lacking, most notably surrounding individual factors linked to mental health including: ACES, ethnicity, substance misuse and physical health conditions. This limits our ability to map gaps in provision and effectively target resources, therefore, actions to improve data collection should be a priority.

We have identified social, economic and environmental factors which are likely to influence the wider determinants of health and subsequently the health of our population. These include: the cost-of-living crisis, Covid-19, global humanitarian crises resulting in displacement and climate change. Paramount is the impact of the cost-of-living crisis on people's wellbeing, given the links between mental health, money, debt and suicide. In the context of individuals, businesses and communities recovering from the pandemic, this additional pressure at a time of collective lowered resilience could be detrimental to the mental health and wellbeing of people living in Somerset.

A review of the literature on population-based interventions which address the social determinants of mental health found that mental health outcomes could be improved by working holistically across various sectors such as housing, education, employment and environmental planning. The literature provides evidence for the benefits of cross sector working between healthcare and social systems and it supports the need for a collaborative approach which is at the heart of the mental health in all policies initiative.

The findings of this needs assessment will be shared with partners across the system to help guide the development of a set of shared priorities which will form Somerset's Prevention Concordat for Better Mental Health. The concordat will provide a focus for cross-sector action to improve population mental health through the adoption of a public mental health approach across various sectors including; Somerset's local authority, integrated care system, the NHS, social care, public, private, and voluntary, community and social enterprise sector organisations, educational settings, employers, emergency services and justice systems.

1. Introduction

1.1 Background

Mental health is a fundamental element of health. It encompasses psychological, emotional and social wellbeing and it defines how we perceive ourselves, how we cope with life's ups and downs and how we engage with the world around us. The World Health Organisation (WHO) defines mental health as “a state of well-being in which every individual realises 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 their community” (2013).

Good mental health is associated with longer life expectancy, improved social functioning, better quality of life and improved physical health (gov.uk, 2018a). The impact of poor mental health is wide reaching, effecting not only the individual but also families, communities and society as a whole.

There is significant variation in the severity, duration and impact of mental illness and prevalence data alone is not sufficient for us to understand mental health and wellbeing. This needs assessment brings together data from other parts of the system including, housing, education and employment to provide a context to prevalence data, acknowledging that poor mental health has wide-reaching consequences. For this reason, the solutions to improve population mental health require systemwide commitment and coordination of services to better meet the needs in our communities.

1.2 Aim

The purpose of this needs assessment is to review and understand the mental health and wellbeing of the population in Somerset. It focuses on the potential changes to population mental health and wellbeing in light of the current and future social, economic and environmental climate. It aims to assist all stakeholders with an insight into current and future needs, which will help to coordinate and inform decision-making, commissioning and service provision across the system.

1.3 Scope

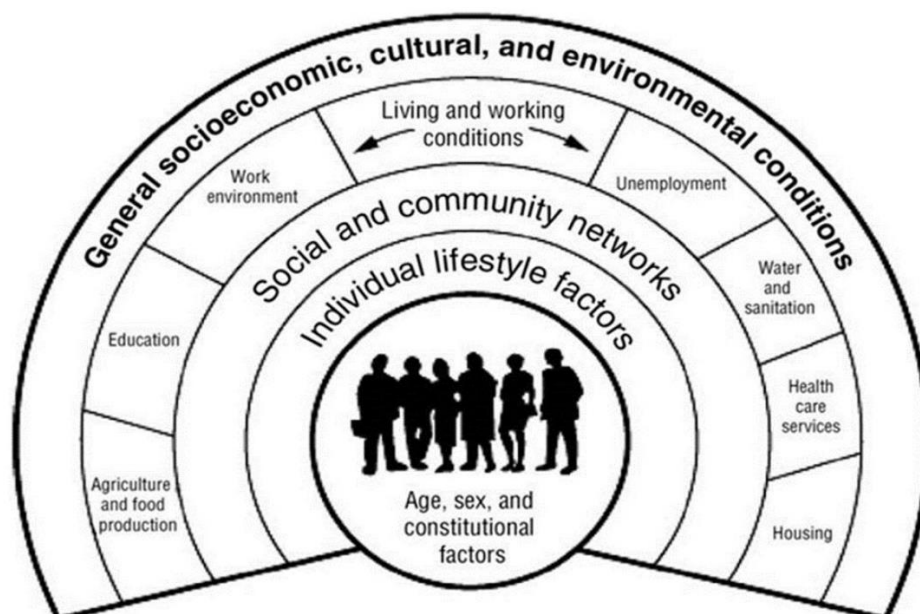
The focus is on population mental health and wellbeing; therefore, this document does not include a specific focus on children and young people, autism, learning disabilities, dementia or severe mental illness. These are complex areas which require a specific focus in their own right.

This is a working document, developing as more information and data is collected and collated. Secondary data and analyses have been collated from various databases and sources, including the Office of National Statistics (NOMIS, Census), NHS Digital, Office for Health Improvement and Disparities (OHID), GP Patient Survey and Open Prescribing.

1.4 The Social Determinants of Health

Health is not solely determined by genetics or healthcare. Social factors such as housing standards, employment, displacement, educational attainment, and poverty

also influence health. The wider factors that have the greatest impact on health outcomes are known as the social determinants of health (gov.uk, 2017).



Source: Dahlgren and Whitehead (1991)

Figure 1: The Dahlgren and Whitehead model of health determinants

The wider determinants of health, that is the conditions in which we are born, live, work, grow and age, as demonstrated in figure 1 by the Dahlgren and Whitehead model, are generally accepted to have the greatest influence on health. It is the interaction between these social, economic and environmental factors that influence our health and health behaviours and the systematic variation of these factors is a key contributor to health inequality.

In their 2014 report, Social Determinants of Mental Health, WHO states ' [some population] subgroups are at higher risk of mental disorders because of greater exposure and vulnerability to unfavourable [...] circumstances.' This exposure accumulates over a person's life course, increasing the risk of poorer mental health outcomes for some groups compared to the wider population. Practitioners and commissioners should, therefore, take a life course approach to mental health interventions, which takes into account the inequalities experienced from birth and throughout a person's life.

We know that some populations or communities are disproportionately affected by poorer mental health including:

- People living with disabilities
- People with drug and/or alcohol dependence
- Both offenders and victims of crime
- Carers
- People living with a sensory impairment
- People experiencing homelessness
- Refugees and asylum seekers
- People on lower incomes and with precarious livelihoods

- People from Black, Asian and minority ethnic communities
- People who identify as LGBTQIA+
- People who are geographically or socially isolated

It is important to consider how the social determinants of health are distributed and experienced in Somerset compared to nationally to ensure that our services are targeted and proportionate to need.

2. Somerset Data

2.1 Somerset Demographic Context

Somerset is a highly rural county with low levels of ethnic diversity and pockets of deprivation, particularly around more urbanised areas (Census, 2011; Gov.uk, 2015; Census 2021; ONS 2022a). Similar to the trends seen nationally, the 65+ age group has seen the biggest increase in population size between 2011 and 2021, however, Somerset has an exceptionally high number of older people equating to 25% of the population (Census, 2021). The demographic makeup of our residents, in particular our ageing population has implications for our economy, services and communities.

2.2 Mental Health and Wellbeing Data

This section uses health data to provide a picture of the population's mental health and personal wellbeing in Somerset.

Personal Wellbeing Measurement

Personal wellbeing measurement includes data on life satisfaction; it asks respondents to rate whether they feel that the things done in life are worthwhile, and to score their own levels of happiness and anxiety (ONS, 2022b). In Somerset, there has been no significant change in these measurements between 2019 – 2020, however, national data sets indicate that there has been a deterioration in all personal wellbeing measures since April 2017. Additionally, mean happiness scores indicated the first statistically significant decrease since local data was produced (ONS, 2022b).

Figure 2 demonstrates that between September 2020 and September 2021 there was a decrease in self-reported happiness in Somerset, with the largest decrease seen in Mendip. This mirrors the sudden deterioration in all personal wellbeing measures seen nationally during this time period and could be attributed to the impact of Covid restrictions on people's quality of life. A caveat to this data is that although measuring the same point, defined in the same way ("Overall, how happy did you feel yesterday, where 0 is 'not at all happy' and 10 is 'completely happy'?"), the data from each year comes from a different data set, therefore, we cannot be certain that the same methodology was used and that data is directly comparable.

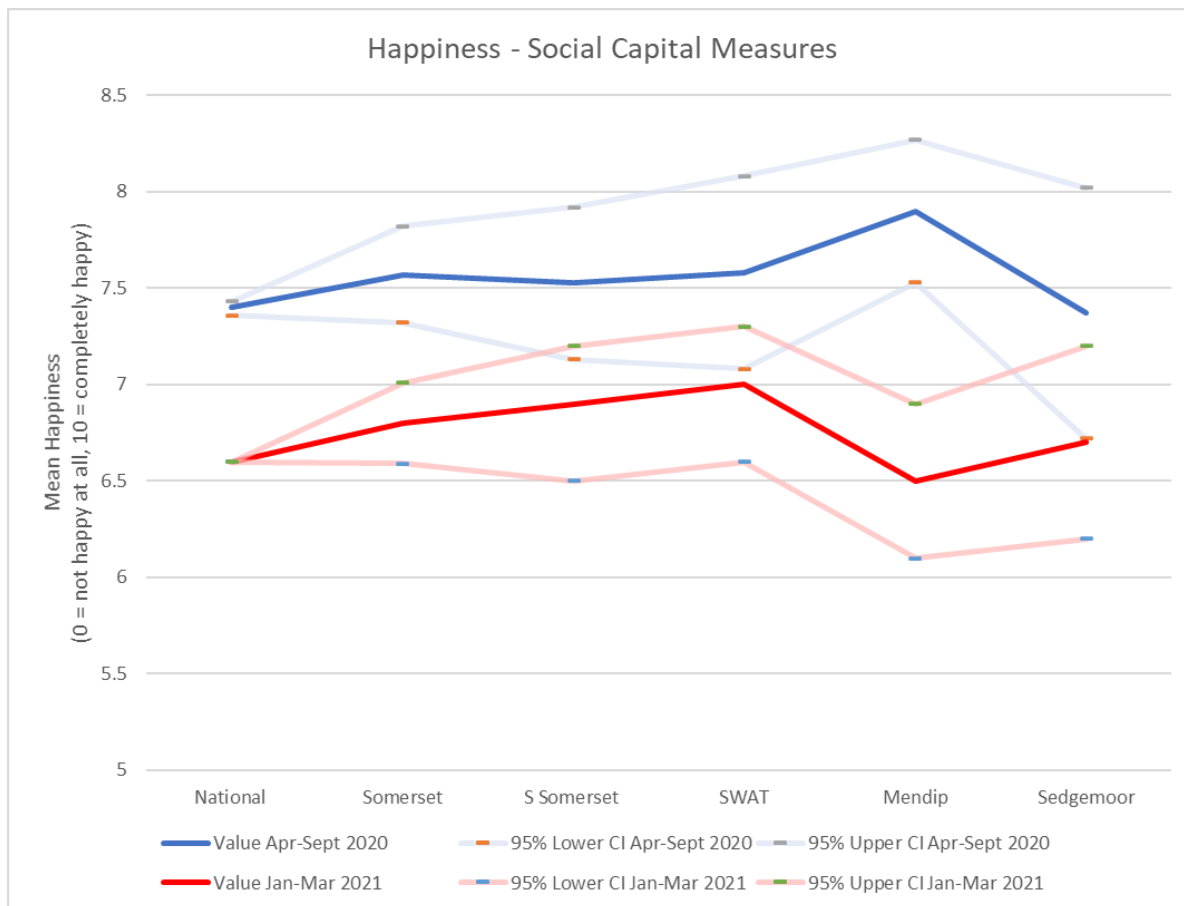


Figure 2: A comparison of mean Happiness Scores (self-reported) nationally, regionally and by district (ONS, 2021c)

Personal Wellbeing Data for Somerset – an explanation of how measures were defined and mean scores for Somerset wellbeing data (ONS, 2021c)

- Life satisfaction in Somerset (April 2020 – March 2021) was a mean of 7.6. This was higher than the national mean of 7.4, and regional mean of 7.5 (ONS Subnational indicators dataset, 2022). In Somerset there was no significant change for the period of April 2019 – March 2020. (Measurement definition: Mean satisfaction with your life nowadays scored 0 (not at all) - 10 (completely))
- Mean happiness in Somerset (April 2020 – March 2021) was 7.5, highest in South Somerset (7.6), lowest in Sedgemoor, and Mendip (7.4). This is higher than national scores (7.3) and similar to the regional figure (7.4) (ONS Subnational indicators dataset, 2022). In Somerset, there was no significant change for the period between April 2019 – March 2020. (Measurement definition: 0 = not happy at all, 10 = completely happy)
- Mean anxiety in Somerset (April 2020 – March 2021) was 3.2. The mean is lowest in South Somerset (2.7), highest in Mendip (3.5). (Measurement definition: Mean anxiety yesterday, scored 0 (not at all) – 10 (completely))
- Average feeling that that things done in life are worthwhile (April 2020 – March 2021). In Somerset, this was 7.92, highest in South Somerset (8.01), lowest in SWAT (7.87) (Measurement definition: 0 = not at all, 10 = completely) (ONS, 2022c)

Local figures reflect national trends except for anxiety which has deteriorated from April to June 2021-2022. A limitation of the local data is that the time period covered by the data sets only goes back as far as 2020, whereas the national dashboard allows comparison from 2011.

Common Mental Disorders (CMD)

Common Mental Disorders (CMD) include generalised anxiety disorder, mild, moderate and severe depression, phobias, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and panic disorder. These problems are referred to as 'common' as, when combined, they affect more people than other mental health problems (NICE, 2011)). Estimated prevalence of CMD is categorised for those aged 16+ and 65+. The indicator is designed to estimate local prevalence of CMD using national survey estimates (Adult Psychiatric Morbidity Survey (APMS)) applied to local demography (NHS Digital, 2016).

A caveat to this data is that it is likely an underestimate; estimates are calculated using CMD prevalence proportions based on individuals living in private households, which excludes those who are homeless and those living in institutional settings, who are likely to have poorer mental health (e.g. care homes); the method uses the latest Adult Psychiatric Morbidity Survey (APMS), 2014, to calculate reference prevalence which are applied to current local populations; it is likely that prevalence proportions have increased since 2014.

Predictive modelling indicates that 9.8% (13,198) of the population aged 65 and over in Somerset have a common mental disorder; this is similar to England (10.2%) and the South West average (9.9%) (2017). Additionally, modelling shows that 15.1% (69,234) of the population aged 16-65 in Somerset have a common mental disorder, this is lower than the England average (16.9%) and similar to figures for the South West (15.6%) (2017).

Figure 3 provides a breakdown of estimated CMD prevalence by district in Somerset. Although we cannot provide a reliable analysis due to the data set being incomplete, Sedgemoor appears to have the highest prevalence of CMD (15.5%) followed by Mendip (15.3%) and South Somerset (14.3%).

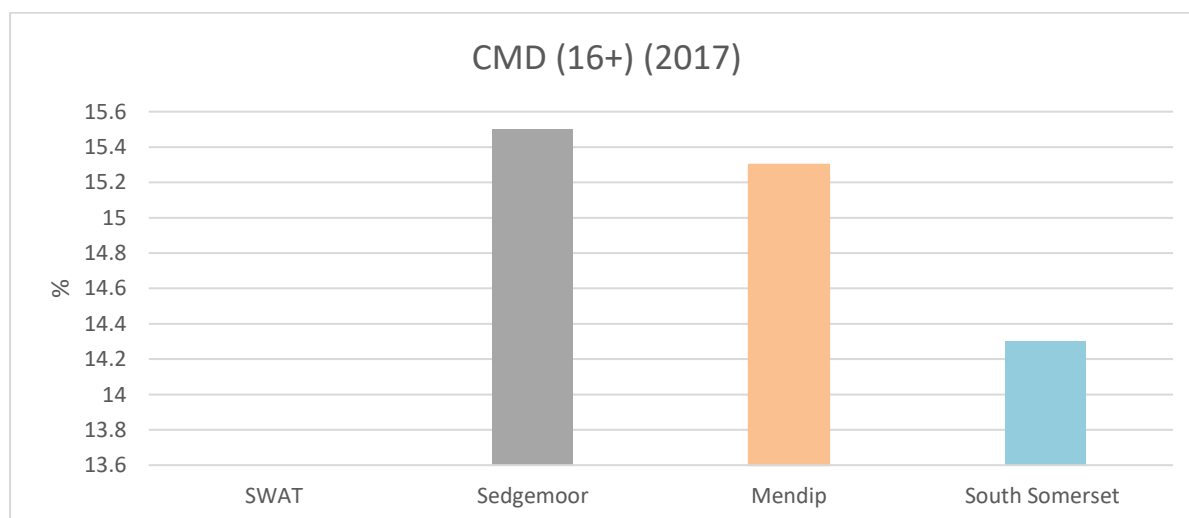


Figure 3: Estimated CMD prevalence by district, as a percentage of total population Source AMPS – No data available for Somerset West and Taunton (SWAT) due to

Depression/Anxiety Prevalence (GP patient survey, 2016/17)

When asked the question "What is the state of your health today?", figure 6 includes the percentage of respondents aged 18+ who answered, "moderately anxious or depressed," "severely anxious or depressed" or "extremely anxious or depressed." The questionnaire was sent to approximately 2.15 million patients, with a proportionally stratified, non-clustered sample being drawn at each practice; this led to approximately 700,000 respondents. Somerset has a prevalence of 12.5% (2016/17) this is lower than nationally (13.7%), with both Somerset and national data showing a slightly increasing trend (GP Patient Survey, 2018).

Figure 4 shows that, annually anxiety and depression in each district has fluctuated, however, in all districts there has been an increasing trend between 2014 and 2017. Data is not provided for SWAT, due to the merging of 2 district councils in 2018.

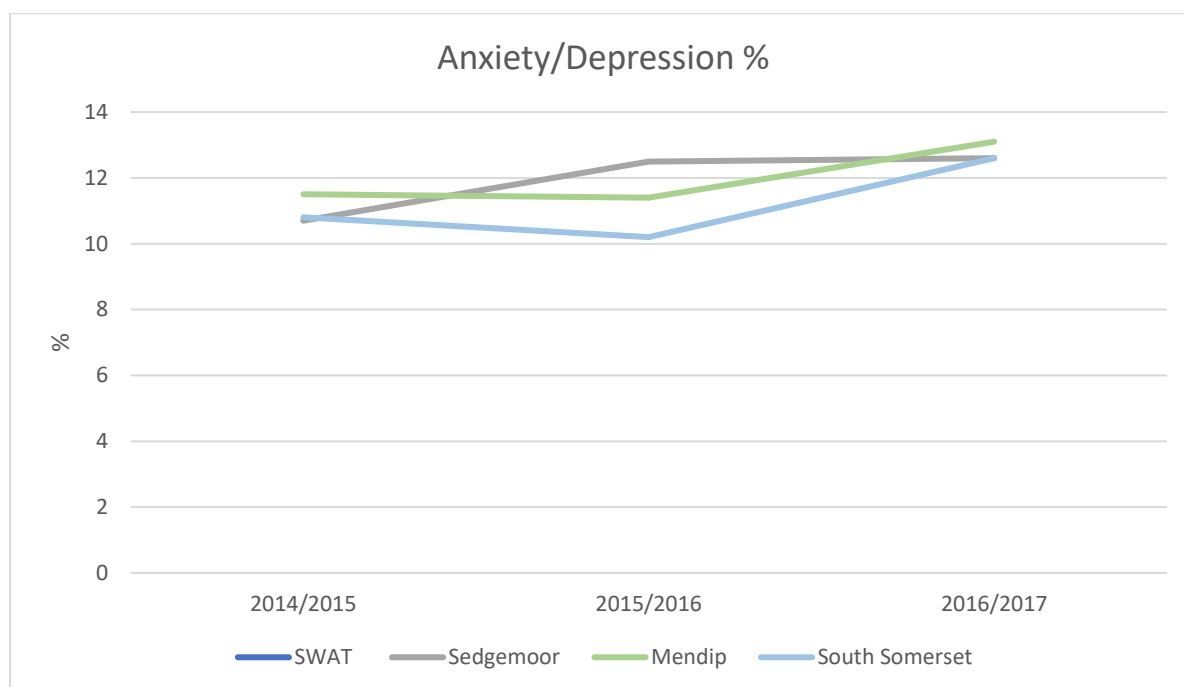


Figure 4: Prevalence of depression/anxiety (self-reported GP patient survey) in each district within Somerset over time. No data for SWAT available due to the merging of West Somerset and Taunton Deane District Council in 2018. Source GP Patient Survey, 2018

Depression/Anxiety among social care users (2018/19) (Personal Social Services Adult Social Care Survey, England, 2019). 53.1% of people supported by Adult Social Care in Somerset report having depression and/or anxiety (2018/19). Figure 5 demonstrates that Somerset has comparatively higher rates than other authorities in the South West and is higher than national rates (50.5%). However, the data has a quality warning, which is unspecified, therefore, we cannot be certain that information is reliable or totally comparable between geographical areas.

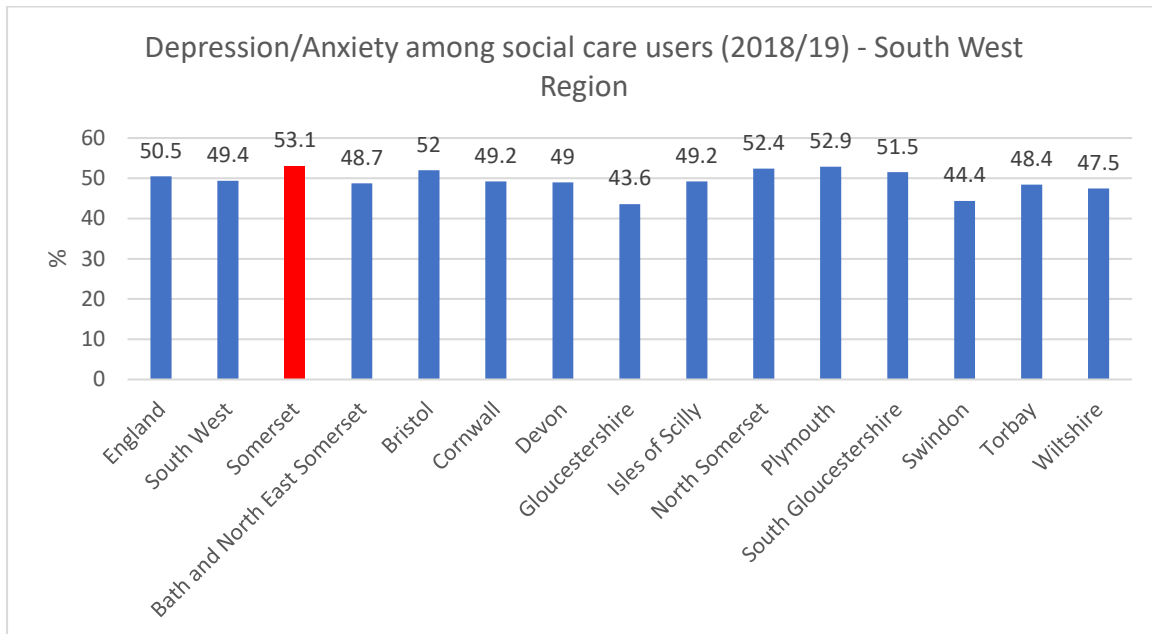


Figure 5: Proportion of adult respondents to the social care users survey who report that they feel moderately or extremely anxious or depressed when asked to choose a statement which describes the state of their health today. This indicator relates to all adult social care users, not just those with mental health conditions comparing National, South West regional and South West sub-regional areas. Source: Personal Social Services Adult Social Care Survey, England, 2019

Depression

The prevalence of depression (those with a formal diagnosis recorded by their GP) within the 18+ population in Somerset is increasing. Currently, it stands at 15.4% (Figure 6, 2021/22), this places Somerset in the highest quintile nationally. Prevalence is increasing in all counties/unitary authorities in the South West, however, prevalence of depression in Somerset is higher than the regional average (13.0%) and the national average (12.7%) and is joint highest in the region overall (as of 2021/22). Figure 7 provides a breakdown of prevalence by district. The highest prevalence is in South Somerset (15.9%) followed by Mendip (15.4%), Somerset West and Taunton (15.3%) and Sedgemoor (14.7%) (OHID, 2022a).

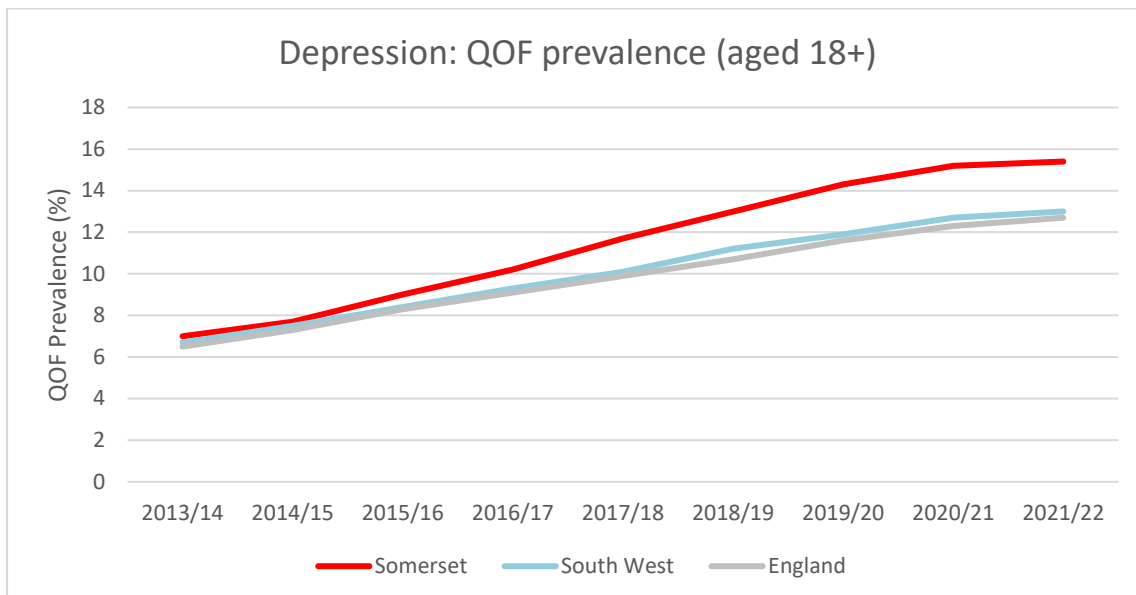


Figure 6: Depression: Recorded prevalence (aged 18+). Source: Quality and Outcomes Framework (QOF), NHS Digital, (OHID, 2022)

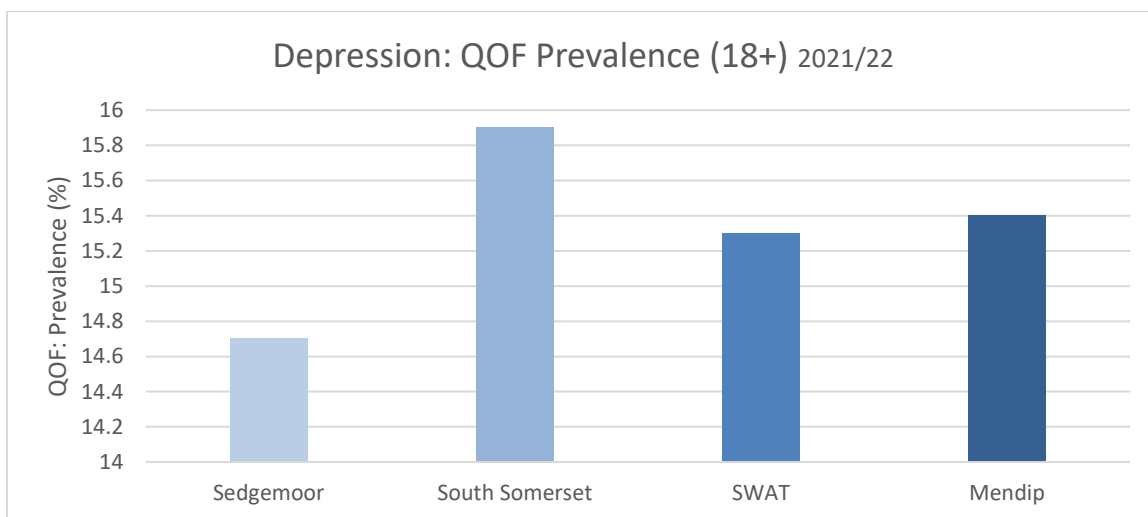


Figure 7: Depression prevalence by district in Somerset. Source Quality and Outcomes Framework (QOF), NHS Digital, (OHID, 2022)

The percentage of patients aged 18+ with depression recorded on practice disease registers for the first time (Depression QOF Incidence – New Diagnosis 18+) (2020/21) is 1.9% in Somerset, which shows a trend of no significant change. This is higher than nationally (1.4%), and equal to the South West regional average (1.9%). Somerset has the highest incidence rate in the South West region (2020/21) (OHID, 2022).

Somerset has consistently been an outlier with a higher prevalence of depression compared with regional and national levels as demonstrated in figure 6. In line with the increase in prevalence of depression since 2013, Open Prescribing data shows an increasing linear trend in the prescription of anti-depressants in Somerset from 2018 to 2021. This trend is demonstrated in figure 8. The linear trend indicates an increase of 74,535 prescriptions per year between 2018 and 2021.

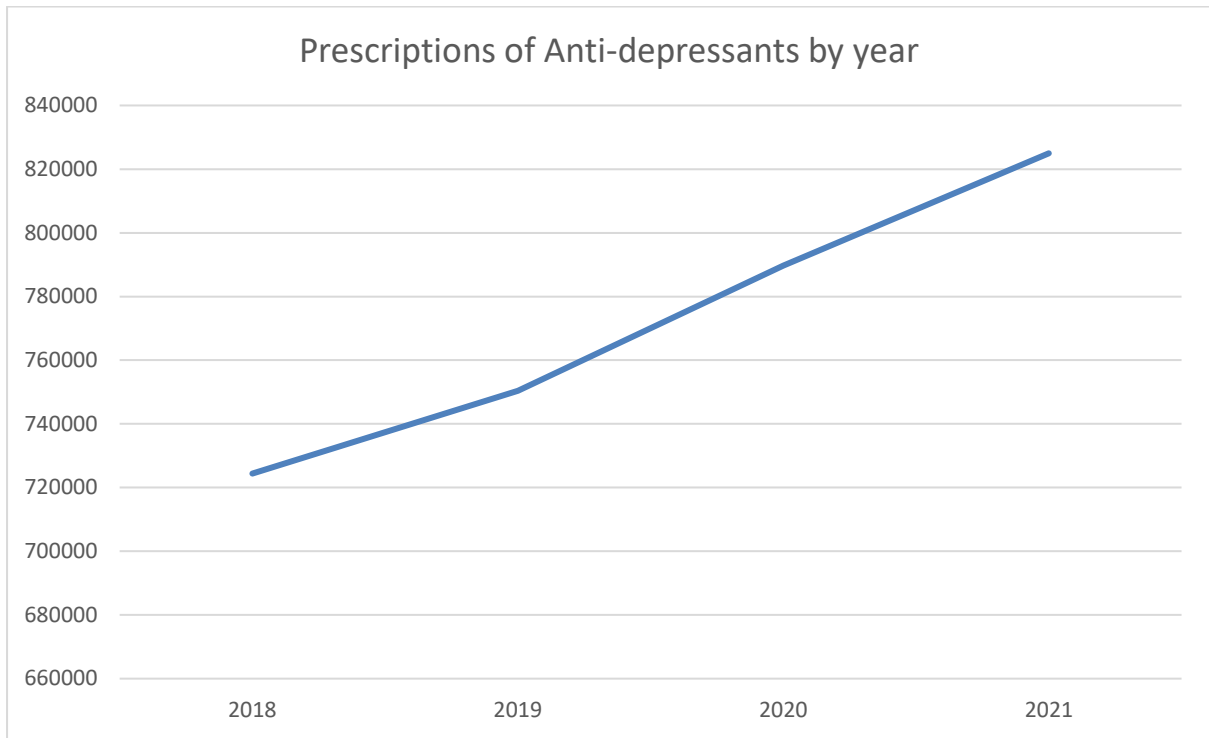


Figure 8: Prescription of Antidepressant drugs in Somerset CCG, with a linear trendline. Source: Open Prescribing. (Analyse | OpenPrescribing, 2023)

Long Term Mental Health Problems

There is an increasing trend in the proportion of the population, aged 16+ in Somerset reporting a long-term mental health problem, in 2022 it was 12.0% an increase of 3% since 2018. This is similar to the national figure at 12.3% (2022), a comparable increase has also been seen nationally during this time. This indicator was collected by asking: "Which, if any, of the following long-term conditions do you have?". The indicator value is the percentage of people who answered this question with "A mental health condition" from all responses to this question. The survey had approximately 720,000 responses and results are weighted for GPs (GP Patient Survey, 2022 & GP Patient Survey, 2018).

Figure 9 plots self-reported long term mental health problems onto a map of Somerset which also indicates areas of high or low deprivation. This highlights that there is a higher prevalence of self-reported long term mental health problems in areas with higher levels of deprivation; the increased prevalence is also noted to be concentrated in more urban areas (GP Patient Survey, 2022). Respondents were asked: "Which, if any, of the following long-term conditions do you have?". The indicator value is the percentage of people who answered this question with "a mental health condition" from all responses to this question.

Self Reported Long Term Mental Health Problem: Prevalence (aged 16+) by Somerset GP Practice

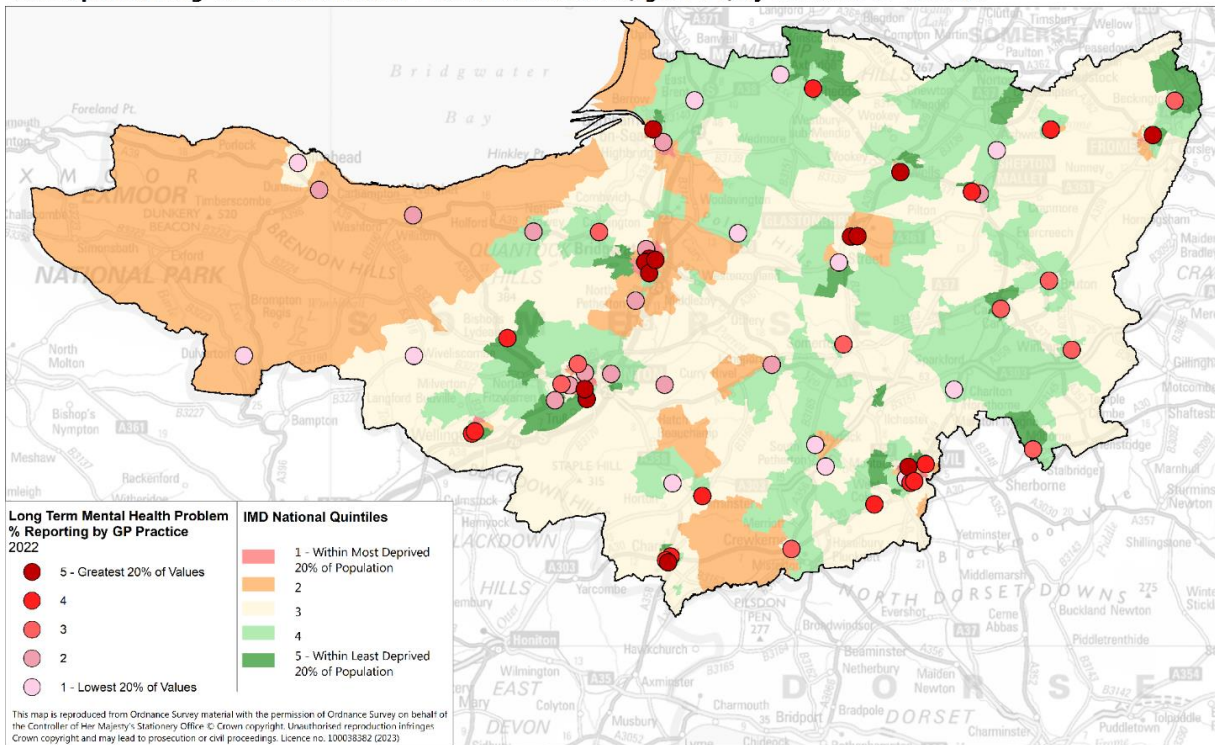


Figure 9: Self-reported long term mental health problem, by GP practice (2022)
 Source GP: Patient Survey, 2022

Severe Mental Illness

Severe Mental Illness (SMI) is defined as a psychological disorder that is often so debilitating, it severely impacts on an individual’s ability to engage in functional or occupational activities (Gov.UK, 2018b). Although not within the scope of this needs assessment, for a complete picture of population mental health in Somerset, SMI prevalence is presented for comprehensiveness.

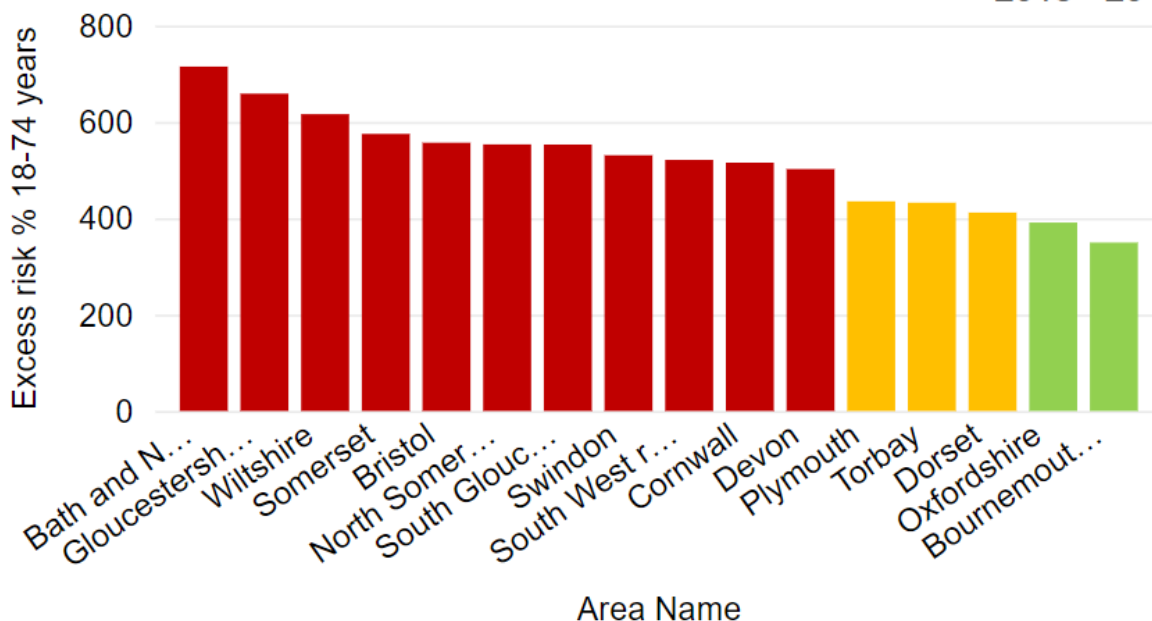
NHS Digital data defines Severe Mental Illness as patients with a diagnosis of Schizophrenia, Bipolar Affective Disorder and other psychoses as recorded on GP Practice registers. The prevalence in Somerset is 0.8% (proportion of all aged population) (2021/22) with a decreasing trend (NHS Digital, 2022).

SMI and Physical Health Checks

People living with an SMI face significant inequalities in health, with a life expectancy 15-20 years lower than the general population. There are several reasons why this disparity exists including, physical health needs being overlooked, a lack of support in accessing health information and opportunities to take up screening tests that reduce the risk of preventable conditions (NHS England, 2018a).

In Somerset, 42% (1,359) of individuals on the GP mental health register had all physical health checks between 30/06/21 and 30/06/22, compared to 43% in the South West region, and 44% nationally. Most individuals had completed a smoking physical health check (70%), followed by BMI weight (68%), blood glucose (66%), blood lipid (62%), alcohol (61%), and blood pressure (54%) (NHS Digital, 2022).

Excess under 75 mortality rate in adults with severe mental illness 2018 - 20



Premature mortality in adults with severe mental illness

2018 - 20

Figure 10: Measure of excess premature mortality experienced by adults with SMI over adults without SMI, where SMI is defined as having a referral to secondary mental health services in the five years preceding death. (NHS Digital Mental Health Statistics Data Set)

Excess premature mortality experienced by adults (aged 18-74) with SMI over adults without SMI (when SMI is defined as having a referral to secondary mental health services in the 5 years preceding death) is 490% excess risk (2018-2020) this is higher than nationally, and the fourth highest in the South West. Figure 10 compares this indicator across South West systems. This measure is calculated by identifying the difference between the directly age standardised rate of premature mortality in adults (aged 18-74) with SMI and without SMI (OHID, 2022b).

Service Demand

The increasing prevalence of common mental disorders in Somerset is reflected by data which demonstrates an increase in demand for mental health services across Somerset between 2019 and 2022. Figure 11 shows demand for mental health services across Somerset in the 12 months before the Coronavirus pandemic and Figure 12 shows demand for mental health services between September 2021 and August 2022. The increase in demand for services is greater in the more urban areas of Wells, Bridgwater, and Taunton and the coastal areas of West Somerset.

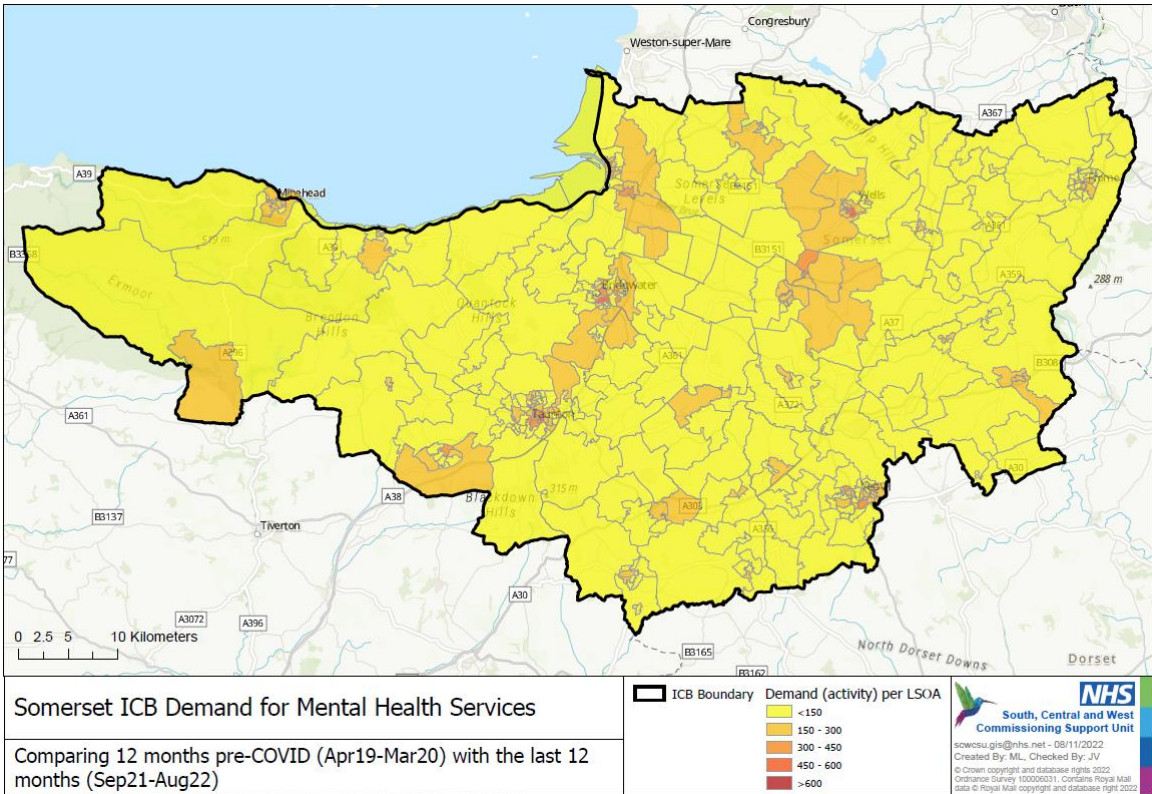


Figure 11: Somerset ICB demand for mental health services pre-COVID (April 2019 – March 2020)

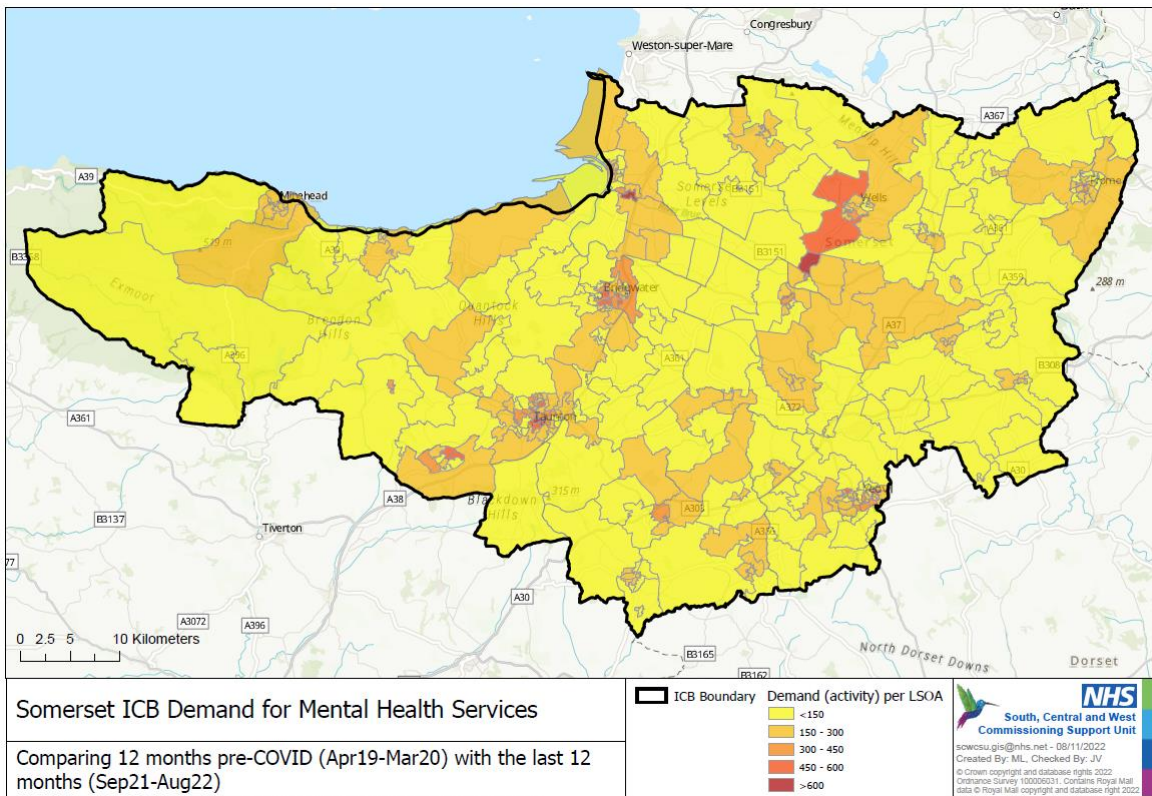


Figure 12: Somerset ICB demand for mental health services last 12 months (September 2021 – August 2022)

Crisis Service Calls

Mind in Somerset provide Somerset's 24/7 mental health helpline – Mindline. The service is manned by volunteers and now includes a web chat service accessed via the Mind in Somerset or Open Mental Health website 20:00 – 23:00 daily.

Conversations are confidential therefore the data is nonspecific; however, it is helpful to identify trends and emerging themes from calls. Mindline can introduce callers to a variety of support services in Somerset and also link with Emergency Services, Home Treatment Teams and Crisis Safe Space.

The number of calls to Mindline fluctuate week to week, with a peak of 880 in the week of 28.03.2022. The linear trend illustrated in figure 13 shows that call numbers have slightly increased between April 2021 and December 2022. During the period of March 2021 – December 2022 the top 5 presenting issues were emotional support, eating disorder, anxiety, relationship, and isolation, the frequency of these and other presenting issues are detailed in figure 14. Presenting issues can only be classified as specific conditions or concerns if they are disclosed by a caller, hence why emotional support appears to be the top presenting issue.

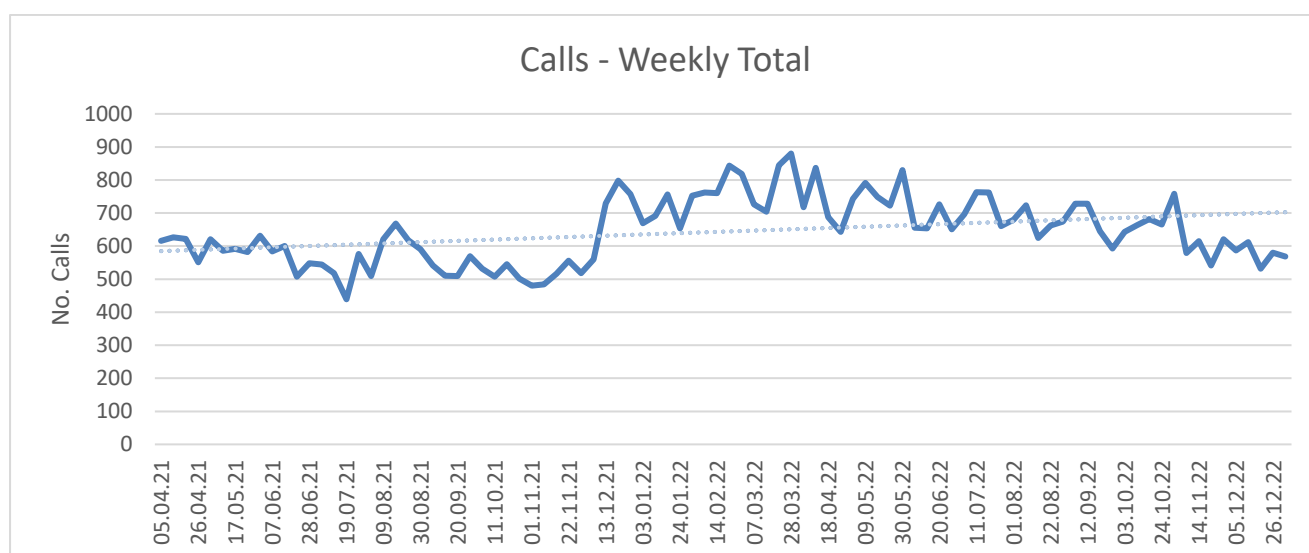


Figure 13: Number of service calls per week from April 2021 to January 2023 – with a linear trend line. Source: Mind in Somerset

It is notable that eating disorders are the second most common specified reason for calls to Mindline. Nationally, it has been reported that eating disorder services are stretched with demand for support outweighing service capacity ([Progress in improving mental health services in England - National Audit Office \(NAO\) press release](#)).

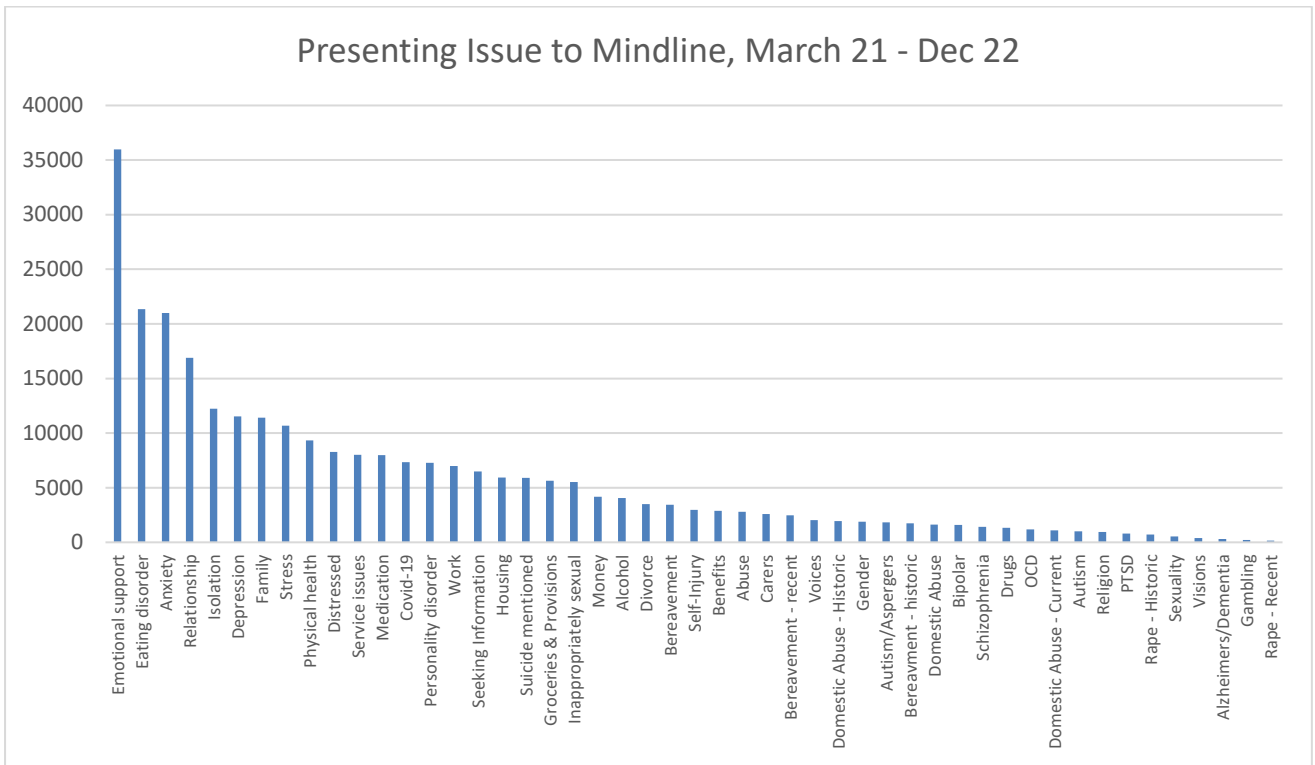


Figure 14: Presenting issue to Mindline, March 2021 – December 2022. Source: Mind in Somerset

Figure 15 demonstrates an increasing linear trend in Mindline calls with individuals who are actively suicidal with intent, plan and means, however, there are significant fluctuations within the data with a peak in the week of 18.04.2022 at 27 calls.

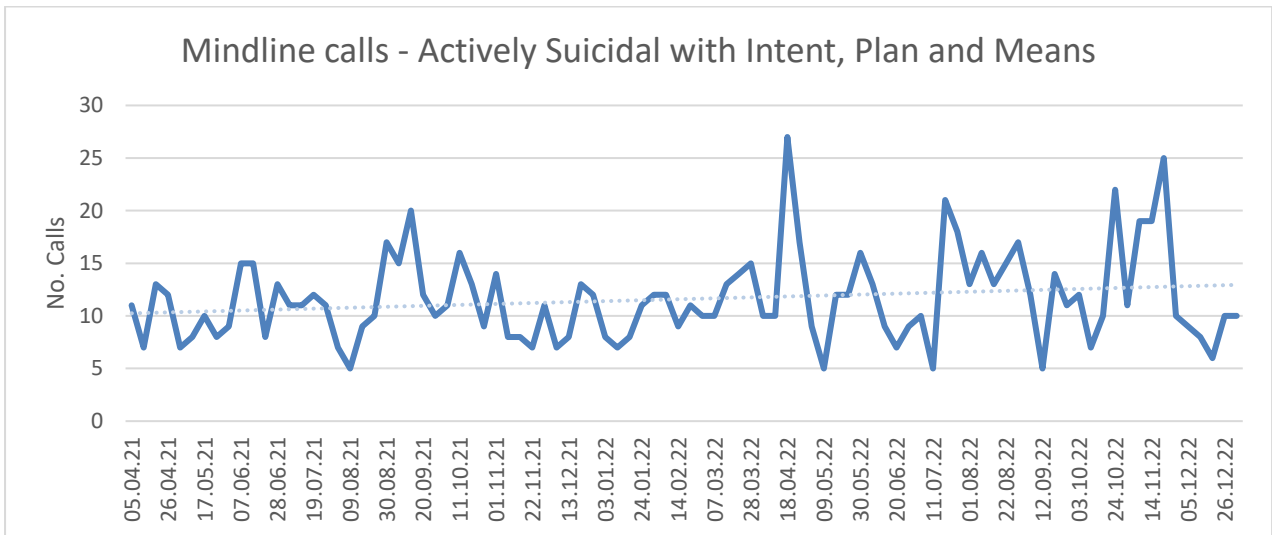


Figure 15: Mindline Red Card Calls – Actively suicidal with Intent, Plan and Means, calls per week from April 2021 to January 2023, with a linear trend line. Source: Mind in Somerset

Suicide and Self-Harm

Suicide and self-harm are not mental health problems, but they are linked with mental distress. Suicide is preventable but since 2007 rates have generally increased in England. Suicide is the leading cause of death for men under 50, young

people and new mothers (Gov.uk, 2019a). The circumstances leading to someone dying by suicide are often complex and for this reason work to reduce suicide relies on a multi-agency approach, in Somerset this work is led by the Suicide Prevention Partnership Forum.

Individuals with a history of self-harm are a high-risk group and therefore a priority for prevention. Self-harm rates are higher in some groups, such as young people (especially looked after children and care leavers), and gay and bisexual individuals. 22% of 15 year olds said that they had previously self-harmed, almost 3 times as many girls reporting self-harm than boys (Gov.uk, 2019b). Somerset is an outlier for both suicide and self-harm, with local rates above the national average.

Self-Harm

Self-harm is defined as an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent. However, following an episode of self-harm, there is a significant and persistent risk of suicide which varies markedly between genders and age groups.

In Somerset, the rate for hospital admissions for intentional self-harm (emergency) (2020/21) is 289.2 per 100,000 (OHID, 2022d). This is showing no significant change and is significantly higher than the rate nationally (181.2 per 100,000), and the South West regional average (249.4 per 100,000). Figure 16 demonstrates that since 2013/14 Somerset has consistently had a higher rate of hospital admissions as a result of self-harm compared to the South West region and England.

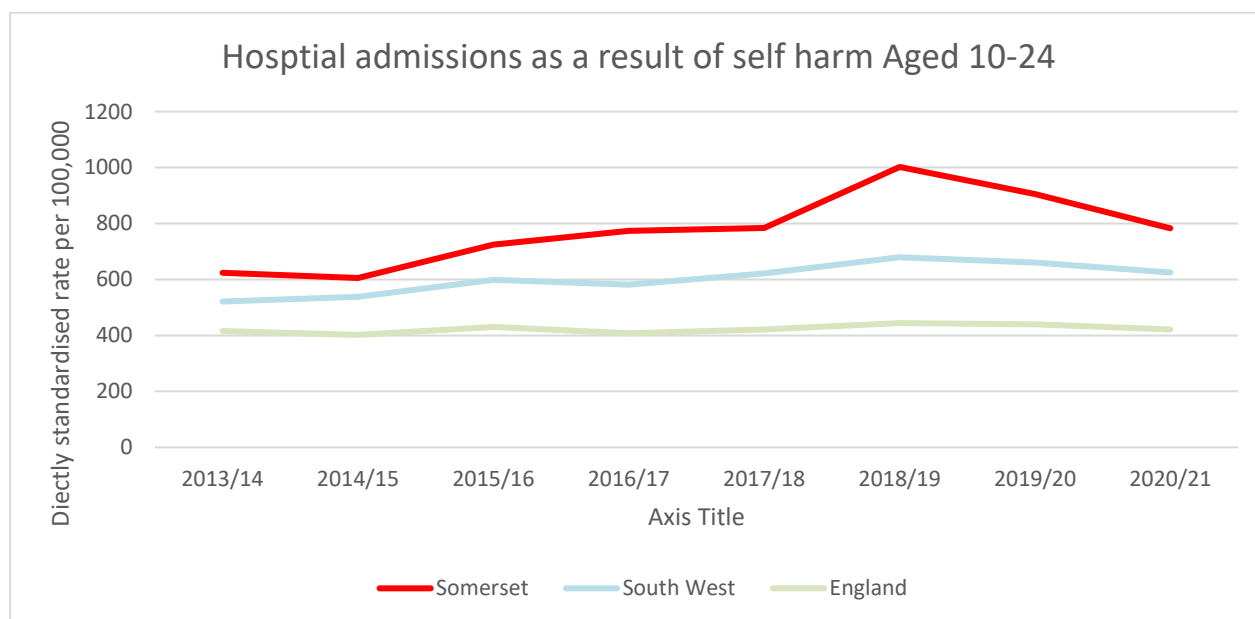


Figure 16: Hospital Admission rate as a result of self-harm in Somerset – trends over time. Source: OHID, 2022c

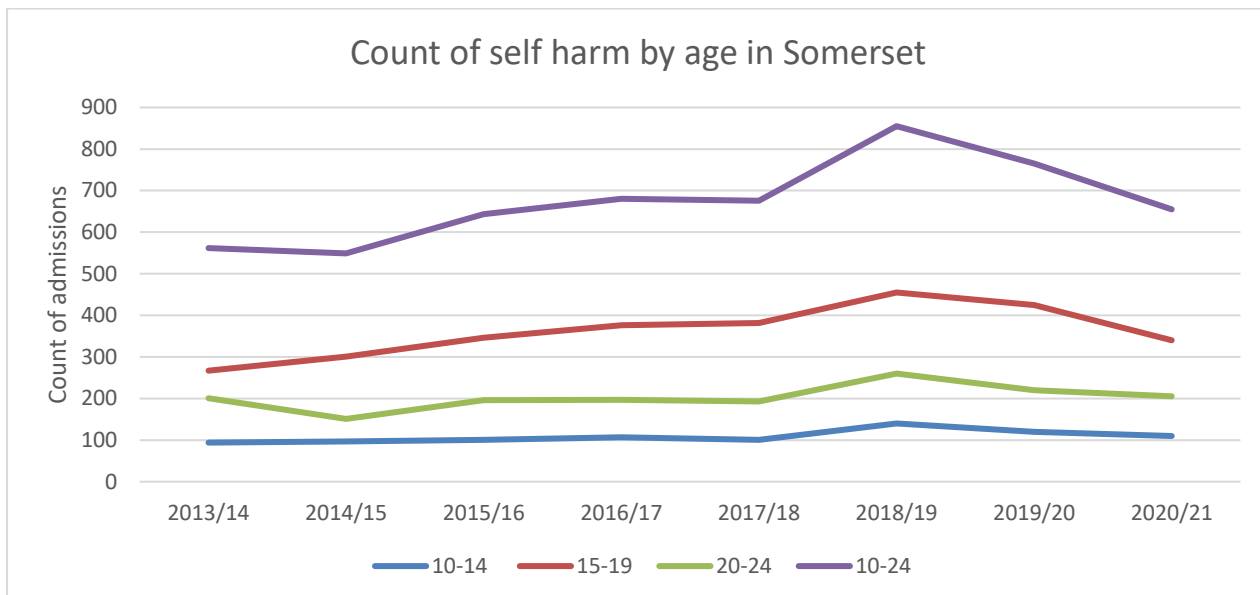


Figure 17: Count of admissions for self-harm by age group in Somerset (Hospital Admissions) Sources: OHID, 2022c

Figure 17 provides a breakdown of trends over time in admissions for self-harm by age category. This shows that the highest number of admissions to hospital for self-harm are seen in the 15-19 year old age category, followed by 20-24 year olds and 10 – 14 year olds, this trend has remained consistent since 2013/14.

Suicide

The suicide rate (persons) in Somerset is 15.1 per 100,000 (2019-2021). This is higher than nationally (10.4 per 100,000). The suicide rate in males is higher at 22.8 per 100,000, compared to females 7.8 per 100,000 (49) (2019-2021), this reflects the trend seen globally, highlighting that men are more than 3 times more likely to die by suicide (ONS, 2022d).

Figure 18 shows a comparison of the local, regional and national suicide rates per 100,000 between 2001 and 2021. The local rate fluctuates significantly but has been above the national average since 2015. Figure 19 provides a breakdown count by gender of suicides in Somerset from 2002 to 2021. The graph demonstrates an increasing trend in the number of deaths during this period and gender differences.

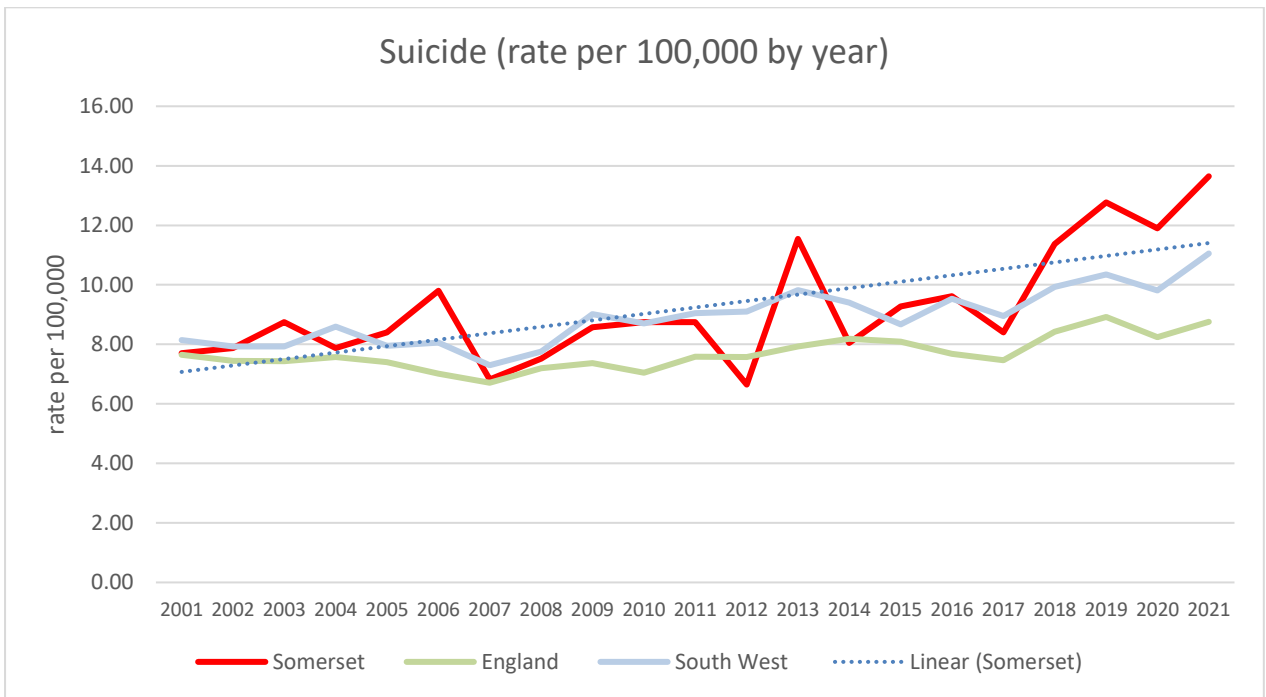


Figure 18: Comparison of the local, regional and national suicide rate by 100,000 over time. Source ONS, 2022d

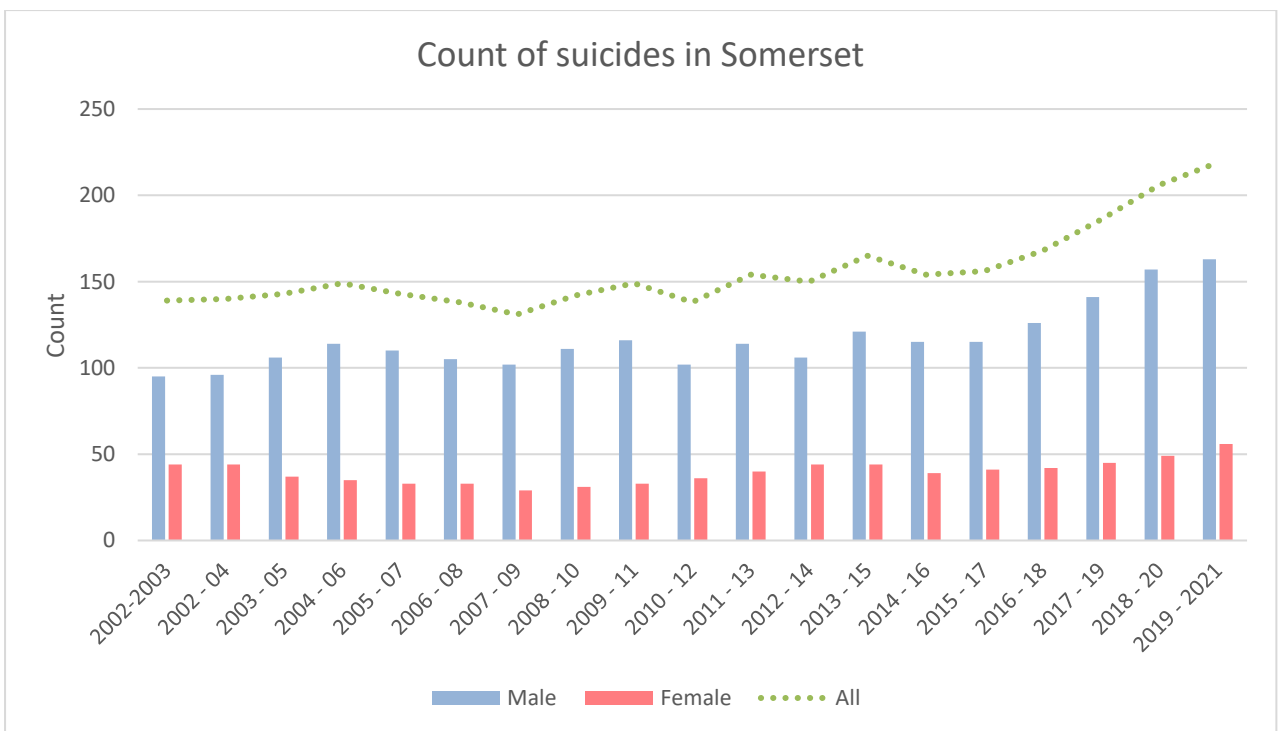


Figure 19: Count of suicides over time in Somerset. Source OHID, 2022c

3. Social Determinants of Mental Health

This mental health needs assessment takes an innovative approach by including data from other areas of the system including housing, education and employment, to build a picture of how the social determinants of health might impact mental health outcomes in Somerset. As discussed in section 1.4, social inequalities are associated with an increased risk of poor mental health outcomes and there is a firm consensus on known protective and risk factors for these (WHO, 2014). Only by looking at these wider social factors can we understand the interacting forces that shape individual and collective mental health and wellbeing in Somerset.

In this section, we present information on those social factors understood to have the greatest influence on mental health including: housing, education, employment, income and social connectedness (WHO, 2014). This information, alongside a review of the research into population-based approaches to improve mental health, will be used to identify actions that can be endorsed across the system, to protect and promote good mental health for all people living in Somerset.

A focus on these social factors also helps to predict how emerging societal issues such as international displacement, the rising cost of living and climate change may influence population mental health in the county, which will be imperative in ensuring that our approach is robust, universal and proportionate to the needs of our communities.

3.1 Housing

To lead healthy, independent lives we need warm, safe and secure homes (Shaw, 2004). Stable, good quality housing can act as a protective factor for mental health and can be a vital element of recovery from mental illness (gov.uk, 2019c).

The Marmot Review into the Health Impacts of Cold Homes and Fuel Poverty (2011) reported that unsuitable housing has negative impacts for mental health outcomes for both individuals and families (Marmot, 2011). There is no international consensus on how to measure fuel poverty however, in the Institute of Health Equity's report Health Impacts of Cold Homes and Fuel Poverty they define a household as living in fuel poverty if "the household cannot afford to adequately heat their home or meet basic energy requirements". Additionally, they state that fuel poverty is driven by 3 factors: household income, the affordability of energy, and the energy efficiency of a home. An estimated 28,651 households in Somerset are in fuel poverty according to latest figures (for 2020), representing 11.3% of all households. Fuel poverty is particularly prevalent in West Somerset, where one-in-seven households are considered 'fuel-poor'. Fuel poverty in Somerset is estimated to be lower than the national average rate (of 13.2%) (BEIS, 2022).

In Somerset, it is expected that the largest demand increases will be seen in single and adult couple households (from 2014-2039) (Somerset Intelligence, n.d.a). Meeting housing demand remains an issue, particularly for one bed properties. On average, approximately one-in-four applicants on the register are housed in any given year (Somerset Intelligence, n.d.a). As of 3rd January 2023 there were 11,628 households registered with an average of 112 bids being placed for each of the 485 homes advertised between 1 October and 31 December 2022; the highest number of bids received was 379 for a 1 bed flat in Bridgwater. Additionally, 52% of applicants

needed 1 bed accommodation yet only 42% of the homes let were 1 bed (Homefinder Somerset, 2023).

'A Decent Home' standard looks at housing in terms of state of repair, thermal comfort, and reasonably modern facilities (gov.uk, 2006). In Somerset 1 in 7 dwellings are classified as below the decent homes standard, this is higher than nationally (1 in 10) (Somerset Intelligence, n.d.a).

3.2 Homelessness

Homelessness is associated with severe poverty. To be deemed statutorily homeless a household must have become unintentionally homeless and must be considered to be in priority need (Gov.uk, 2023a). Consequently, statutorily homeless households are some of the most vulnerable members of our communities.

Actual, or fear of homelessness can itself create stress which affects people's physical and mental wellbeing. People experiencing homelessness are at an increased risk of developing depression and substance misuse compared to the general population (Crisis UK, n.d.). Studies have also shown the prevalence of mental health conditions in the homeless population is higher compared to the general population. Mental health is the second most prevalent health problem among homeless individuals with 53.6% experiencing this (Mental Health Foundation, n.d.a). There is however a range of estimates within these populations Homeless Links Health Needs Audit (2016) estimated that 44% of the homeless population have a mental health diagnosis compared to 23% of the general population. It is also estimated that these figures increase to approximately 80% prevalence of a mental health condition in individuals who are sleeping rough (Crisis UK, n.d.).

Extended interviews with people experiencing homelessness conducted in Somerset during 'Everyone In' (April 2020) revealed that, in addition to physical health concerns, 69% reported experiencing poor mental health, 79% reported substance misuse and 58% reported childhood abuse or neglect. Additionally, research of 61 individuals living in general needs accommodation or with no fixed abode in Somerset reported that 77% had medium/high mental health support needs from the agency.

397 households were accepted as statutorily homeless during 2017/18 (representing 61% of all homelessness applications). In Somerset, there has been a trend of no significant change in the rate of homelessness, at 1.6 per 1,000 (2017/18). This is significantly lower than rates seen nationally (2.4 per 1,000) and similar to the South West regional average (1.7 per 1,000) (Somerset Intelligence, n.d.b).

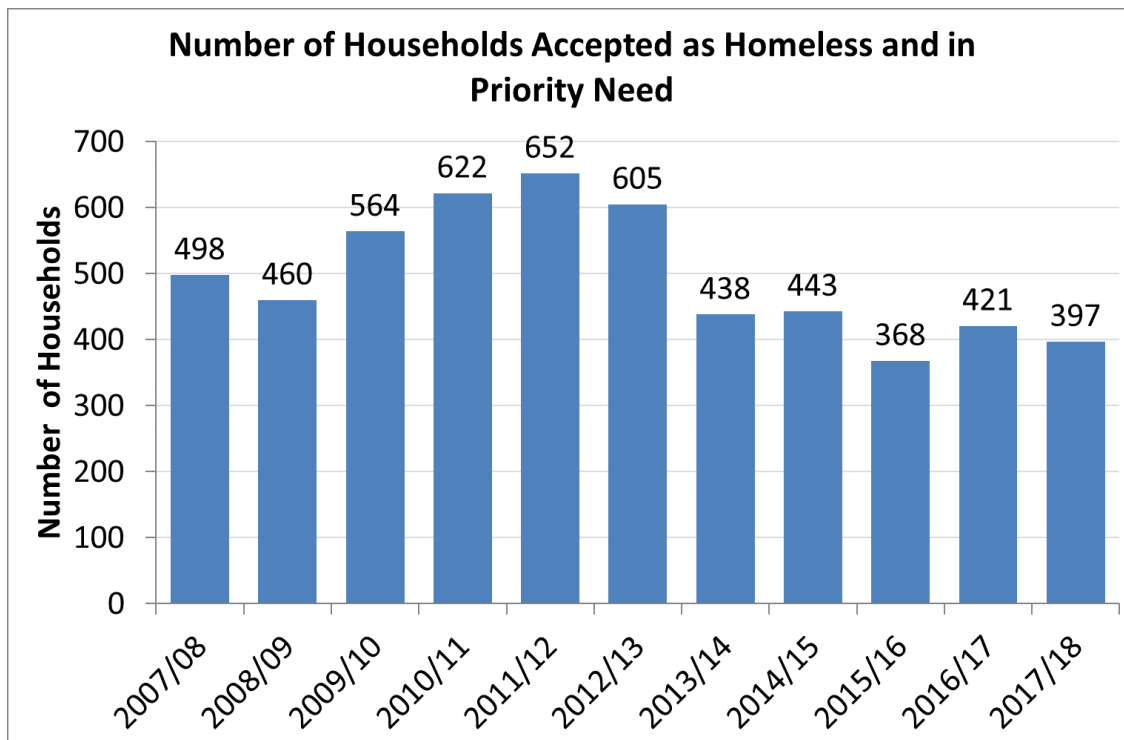


Figure 20: Number of households in Somerset accepted as homeless and in priority need over time between 2007 and 2018 (source: Somerset intelligence, n.d.)

Figure 20 shows the number of households accepted as homeless and in priority need annually between 2007 and 2018. Numbers fluctuate year on year, however, notably, the last increasing trend was seen between 2009 and 2013, this could be attributed to the global economic crisis in 2008.

In 2022, housing was identified as a priority focus area by the Somerset Health and Wellbeing Board. Particular challenges in Somerset include affordable housing availability and the quality of homes. Additionally, social factors as discussed in section 5 such as the rising cost of living, economic recession and international displacement and resettlement schemes, are likely to exacerbate these challenges and could result in an increase in numbers of households presenting as homeless over the coming years.

3.3 Income (ASHE, 2022)

There is a strong socioeconomic gradient in mental health, with those who are more economically disadvantaged at an increased risk of experiencing common mental disorders and their adverse consequences (Allen et al. 2014). People in the lowest socioeconomic group are two to five times more likely to suffer from a diagnosable mental health disorder compared to those in the highest socioeconomic group. Children living in poverty or in low income households have an increased risk of experiencing developmental delays, poor socioemotional functioning and behavioural problems (Weir, 2016). The average income in Somerset is below the national average and 14.5% of children were living in poverty in 2019.

In their 2014 report, *Social Determinants of Mental Health*, WHO include Health and Social Care data on the prevalence of common mental disorders by household income in England (2007). This supports that the distribution of common mental

disorders is observed as a social class gradient and is more marked in women than in men (WHO, 2014).

In Somerset, full-time median gross pay is £30,294, which has an annual percentage change of 4.3%. The full-time median gross pay for England is £33,111 (2022) (ASHE, 2022).

The percentage of children (under 16) living in Somerset in relative low income families (2020-21) is 13.9%. This is a decrease from 2014-15 (15.1%), and is lower than national figures (18.7%), which have increased across the same time period. 10.6% of children across Somerset are in absolute low income families (2020-21), this has also decreased since 2014-15 (15.0%), as well as being lower than nationally (15.1%).

The number of children living in low income families is highest in Sedgemoor for both relative (14.8%) and absolute low incomes (11.2%) Relative low income is defined as 'a family in low income before housing costs (BHC) in the reference year. A family must have claimed Child Benefit and at least one other household benefit at any point in the year to be classed as low income in these statistics'. Absolute low income is defined as 'a family in low income BHC in the reference year in comparison with incomes in 2010/11. A family must have claimed Child Benefit and at least one other household benefit at any point in the year to be classed as low income in these statistics' (DWP, 2022).

Indices of Multiple Deprivation (IMD) (2019), is a measure of relative deprivation for small areas in England (LSOAs). The 2019 version is based on 39 indicators, across 7 domains including income, employment, crime, health, education, barriers to housing & services, and living environment. Somerset has lower levels of deprivation compared to the national average, however since 2015 there has been a slight shift towards greater deprivation in Somerset relative to England, largely attributed to a decrease in housing quality (Gov.uk, 2019d) (Gov.uk, 2015). The number of 'highly deprived' (within the 20% most deprived in England) neighbourhoods in Somerset increased to 29 (2019) from 25 (2015) (out of 327 LSOAs). This puts approximately 47,000 Somerset residents living in an area classified as one of the 20% most deprived in England. The higher levels of deprivation are generally found in the urban areas of Bridgwater, Yeovil and Highbridge, with the most deprived area of Somerset being Highbridge South West in Sedgemoor. Comparatively the least deprived area in Somerset is Sampson's Wood in Yeovil, which falls within the 1% least deprived in England.

In addition to a social gradient in the distribution of common mental disorders, there is also a strong association between suicide rates and levels of deprivation nationally. For residents living in the 20% most deprived areas in the county, the rate of suicide and undetermined death is higher at 15.4 (per 100,000) than for the whole population of Somerset over this period at 14.6 (per 100,000), however this difference is not statistically significant.

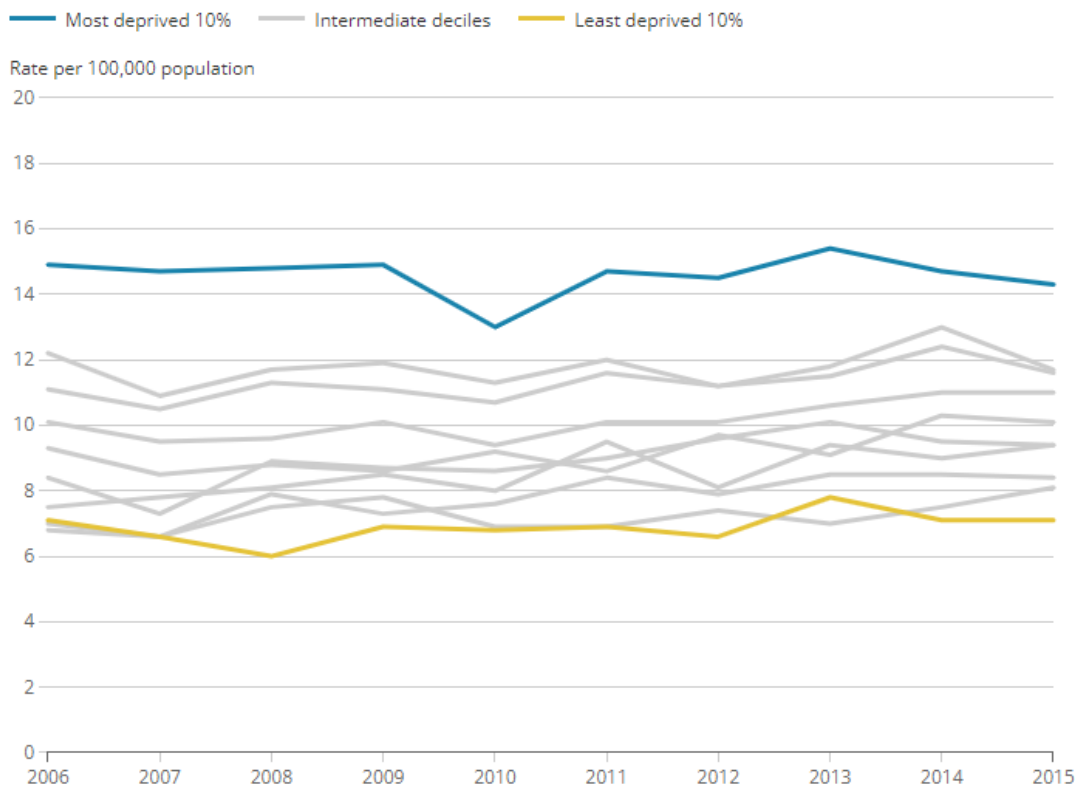


Figure 21: Suicide Rate per deprivation decile, England 2006 to 2015. Source: ONS, 2017b

The map in Figure 9 (section 2.2) demonstrates that there is a higher prevalence of long term mental health problems in more urban areas which experience higher levels of deprivation. Additionally, the income in Somerset is lower compared to nationally, and there is both an increasing trend in levels of deprivation and increasing demand for mental health services as demonstrated in section 2.2 (Figures 13 & 14). This is particularly apparent in the more urban areas of Taunton, Bridgwater and Wells which also contain the majority of the 9 LSOAs which are amongst the most deprived 10% nationally.

3.4 Education

Access to good education and educational attainment have been found to act as protective factors for mental health. This is supported by research which found that individuals with higher educational attainment are less likely to report themselves as experiencing anxiety or depression (Cutler, Lleras-Muney, 2006).

In their 2014 report, *The Social Determinants of Mental Health*, WHO comment on the important role that the education system plays in building emotional resilience in young people, which can affect a range of later life outcomes. These outcomes influence the risk of developing mental disorders – and includes things such as employment, income and community participation (WHO, 2014).

Approximately 4 in 10 people living in Somerset have Level 4 qualifications or above (undergraduate degree or equivalent) as their highest qualification level. Disparities across the county exist, with lower educational attainment rates in parts of urban areas such as Chard, Bridgwater, Taunton and Yeovil (Census, 2021 – ONS 2022a). 38.4% of individuals in the county have level 4 qualifications when compared to the

South West region (42.0%) and nationally (43.6%) (Jan 2021 – Dec 2021); 1 in 6 people in Somerset have no qualifications (Nomis, n.d.). In some areas, this increases to almost 1 in 3. At the end of 2019, 3.3% of young people aged 16 and 17 in Somerset were known to be not in education, employment or training (NEET), which was above the national average rate of 2.7%. In Sedgemoor 19.6% of the population have no qualifications, followed by South Somerset (16.5%), Somerset West and Taunton (16.4%) and Mendip (16.1%).

Somerset does not have a university, which could explain why educational attainment is lower than both the national and South West regional average, with many of those who continue into higher education choosing not to return to the county. Amongst individuals of university age (18-20) there was a net flow out of Somerset of 902 (year to June 2019) (ONS, 2021a) From 2011 to 2021 there was a reduction by 10.5% of the population aged 15-19, and a 7.3% reduction in those aged 20-24 (Census, 2021 – ONS 2022a). Somerset is an outlier for those who are NEET although it is not significantly higher than regional or national levels. Given the benefits of educational attainment in promoting young people’s emotional resilience, it is crucial that this is considered as a protective factor for mental health into adulthood.

3.5 Employment

Loss of employment and poor quality employment are risk factors for poor mental health and a significant driver of inequalities in mental illness. This is due to the strong links between employment risk factors, social class and skill level (WHO, 2014). In addition, people living with mental health problems are often over-represented in low-paid, high-turnover work (commonly part-time or temporary work) (Gov.uk, 2019e). The negative impact that unemployment has on mental health has been found to be greater in males than females (Kromydas, et al., 2021).

Between Jan 2021 – Dec 2021, 78.6% of Somerset’s working age population was economically active, with 76.1% of those between 16-64 in employment; 2.9% were unemployed. The unemployment rate in Somerset is lower than regionally (3.3%) and nationally (4.4%) (NOMIS, n.d.).

	2020 Employment rate, ages 16-64 (%)	2021 Employment rate, ages 16-64 (%)	Percentage change (%)
Mendip	80.7	79.4	-1.6
Sedgemoor	72.5	75.2	3.7
South Somerset	75.2	72.0	-4.3
Somerset West and Taunton	80.5	78.9	-2.0

Table 1: Employment by district in Somerset, percentage change 2020-21. Source: ONS, 2022c

In Somerset 0.3 people per 1,000 are long term claimants of job seekers allowance (2021). This is showing a trend of decreasing in Somerset, and is lower than regionally (0.9 per 1,000) and nationally (2.1 per 1,000) (NOMIS, n.d.).

Unemployment rates in Somerset are lower than both regional and national rates, however, what remains unclear is the quality of employment; for example, we have seen a rise in zero-hour contracts globally which have been found to negatively

impact mental wellbeing (Mental health foundation, n.d.b). Furthermore, whilst unemployment rates are low this doesn't guarantee that people are on a liveable income. Additionally, a large proportion of Somerset employers are Small Medium Enterprises (SMEs) who may have less resources to pay employees a living wage, and to promote and support employee wellbeing (HR Zone, 2019, Somerset Intelligence, n.d.c). Tourism and hospitality are key enterprises, particularly in coastal areas of West Somerset, leading to a higher proportion of low-skilled seasonal jobs available. Studies have found that higher rates of suicide are linked to certain job related features such a low pay and low job security, which are characteristic of seasonal work (ONS, 2017a)

3.6 Social and Personal Relationships

Loneliness is subjective, and is defined as 'negative emotion associated with a perceived gap between the quality and quantity of relationships that we have and those we want) Comparatively, social isolation is an objective state defined as 'quantity of social relationships and contacts between individuals, across groups and communities (MHSCP, n.d.)'. Social isolation and loneliness have been associated with poor mental wellbeing and have been found to have links to increased anxiety, depression and behavioural disorders (Cacioppo, et al., 2006). A systematic review which explored the impact of social isolation and loneliness on the mental health of children and adolescents found that social isolation in children can lead to increased social disorders and social anxiety (Loades, et al., 2020). Loneliness has also been linked to an increased risk of dementia in those over 50 (Lunaigh, Lawlor 2008). Additionally, social connections have important implications for mental health due to their ability to create a sense of collective meaning, purpose and support.

Older people have often been considered the most vulnerable to loneliness, however, research completed in 2019 found that levels of loneliness were highest in younger respondents (16-24) (BBC, n.d.). Subsequently, public mental health campaigns around loneliness have been targeted at young people, such as the current campaign "Lift Someone Out of Loneliness" which encourages young people to reach out to friends (NHS, n.d.a).

A mapping exercise on loneliness during the Covid-19 pandemic (October 2020 – February 2021) found that Somerset 5.60% of individuals often/always felt lonely (highest in SWAT – 7.25%; lowest in Mendip – 4.17%). This is lower than nationally, where 7.26% of individuals often/always felt lonely and regionally where the rate was 6.74%. Additionally, 17.06% of individuals in Somerset felt lonely some of the time (Also highest in SWAT – 20.78%; lowest in Sedgemoor – 14.25%) (ONS, 2021a).

The percentage of adult carers who describe themselves as having the amount of social contact they would like (18+) (2018/19) in Somerset is 21.6%. This is significantly lower than nationally (32.5%), but similar to regionally (28.1%). The number of adult social care users who have as much social contact as they would like (18+) in Somerset is 44.7%, this is similar to nationally (45.9%), and regionally (46.4%) (OHID, 2022e).

In the Reflect, Recover, Renew VCSE report which surveyed 270 Somerset residents, loneliness and isolation was identified by 64% of respondents as an issue worsened since the coronavirus pandemic and was the second highest priority after mental health and wellbeing (Spark Somerset, 2022).

The link between loneliness and health is well documented, social networks form an important aspect of our own identity and are a crucial form of informal support for mental wellbeing. A systematic review found substantial evidence from prospective studies that people with depression who perceive their social support as poorer have worse outcomes in terms of symptoms, recovery and social functioning (Wang et al., 2018).

Psychological research on some elements of social capital has found direct and indirect effects (i.e., moderating the effect of psychological stress) on mental and physical health by social trust, social support, and cohesive social identities (Uslaner, 2005) (Cobb, 1976) (Haslam et al., 2005).

Due to the rural nature of Somerset, the population is particularly vulnerable to geographical isolation which could lead to social isolation and increased loneliness for all ages. Rural public transport links within the county are poor and many Somerset residents rely on personal vehicles for transport (Census, 2021 - ONS 2022a). We might expect to see an increase in social isolation due to the impact of the rising cost of living limiting people's ability to travel to social events or clubs (Kelly et al., 2011).

3.7 Individual Factors

While there are a number of social determinants of health that put populations at greater risk of poorer mental health outcomes, individual risk factors can undermine development of individual level attributes and can reduce an individual's capabilities to thrive. This section will consider a number of these risks, which includes ACE (adverse childhood experience), substance misuse, long term conditions, and traumatic events challenging interpersonal relationships and financial worries/debt.

Adverse Childhood Experiences (ACES)

ACEs are potentially traumatic events which occur in childhood, these can include but are not limited to experiencing or witnessing violence, abuse or neglect, living in a household with substance abuse issues or instability due to parental separation or household members being in jail (CDC, n.d.). Bellis et al., (2013) found that in the UK (across a population sample) 47.1% of individuals reported at least 1 ACE.

Increasingly ACEs have been linked to adverse behavioural, health and social outcomes. Individuals with higher ACE scores have been found to be at a greater risk of poor educational and employment outcomes; low mental wellbeing and life satisfaction; recent violence involvement; recent inpatient hospital care and chronic health conditions (Bellis et al., 2013). In Somerset 46/10,000 of the population aged under 18 years, are 'Children in care'. This has shown a trend of no significant change, and is lower than nationally (67/10,000) and regionally (56/10,000) (2021). Additionally, the percentage of looked after children whose emotional wellbeing is a cause for concern in Somerset is 48.1%, showing a trend of no significant change. This is higher than nationally (36.8%), but similar to the South West regional average (42.0%) (2020/21) (OHID, 2022e).

- Based on the population of young people in Somerset we estimate that 4,090 young people between 16-24¹ will experience domestic abuse every year

Substance Misuse and Dual Diagnosis

Individuals with co-occurring mental health and alcohol/drug use conditions often have multiple needs, these can include poor physical health alongside social issues such as debt, unemployment or housing problems. These individuals are also more likely to be admitted to hospital, to self-harm, or die by suicide (NHS, 2022). Regular consumption of alcohol has been shown to cause mental ill health including depression, anxiety, and a connection to higher levels of self-harm and suicide in people with alcohol problems (Delgadillo et al., 2013). Mental health problems can also cause individuals to drink more, particularly as they may drink alcohol as a form of 'self-medication'.

In Somerset the proportion of people in contact with mental health services when they access services for alcohol misuse is 30.65%, and 30.08% for drug misuse. This is higher than the England average (24.26% for drug misuse, 22.67% for alcohol misuse), and the highest in the South West region for proportion in contact with alcohol misuse services, and second highest for drug misuse (2016/17) (OHID, 2022b). Dual diagnosis rates in Somerset are high amongst the homeless population, therefore a further exploration of SMI and drugs and alcohol is included in the Homelessness Needs Assessment.

Physical Health Conditions

Mental and physical health are inseparably linked (NHS England, 2016). Physical health problems substantially increase the risk of developing mental health problems and vice versa. People who experience chronic physical health problems are at an increased risk of developing common mental disorders such as depression and anxiety, this may be due to changes in their ability to carry out previously enjoyed activities, stress around a diagnosis, treatment or family and the impact of long-term pain (NIMH, 2021) (Fine, 2011). Similarly, those who have a diagnosed mental health condition are at an increased risk of being diagnosed with long term conditions such as cardiovascular disease, this is due to physical health needs being overlooked within care plans, a lack of support in accessing health information and opportunities to take up screening tests that reduce the risk of preventable conditions (NHS England, 2018b). Approximately one third of people with long term physical health conditions have a mental health problem, these are most commonly depression or anxiety (Mental Health Foundation, n.d.c). Individuals who have a long-term condition, such as diabetes, coronary artery disease, chronic obstructive pulmonary disease (COPD), or cardiac disease are two to three times more likely to have depression (Naylor et al., 2012).

In Somerset, 18.2% who report a long term musculoskeletal condition, such as arthritis, also report depression or anxiety, this is significantly lower than nationally which is 24.1%, and regionally which is 21.1% (OHID, 2022c).

¹ This is based on the number of young people in the population from the ONS (2020) mid-year estimates and the prevalence amongst young people in the Crime Survey for England and Wales (2020).

Lesbian, Gay, Bisexual, Transgender, Queer (or Questioning), Intersex, and Asexual (or Allies) (LGBTQIA+)

Studies have found that adults who self-reported as non-heterosexual (determined by both orientation and sexual partnership, separately) reported elevated levels of mental health problems and service usage (Chakraborty et al., 2011). Individuals identifying as LGBTQIA+ are more likely to develop problems such as: low self-esteem, depression, anxiety, misusing drugs and alcohol, self-harm, and suicidal feelings. Additionally, young people identifying as lesbian, gay and bisexual have been found to be at a greater risk of mental ill health – in 2018 rates in individuals aged 14-19 was 34.9% in LGBTQIA compared to 13.2% in heterosexual individuals (NHS Digital, 2018). Being LGBTQIA+ does not cause these problems, the reasons behind this are complicated and can include, but are not limited to: homophobia, biphobia, and transphobia, stigma/discrimination, difficult experiences coming out, social isolation, and exclusion (Mind, 2020).

In Somerset, 89.9% of individuals identified as being Straight or Heterosexual. The next largest groups were Gay or Lesbian (1.2%), Bisexual (1.1%), and Pansexual (0.2%). Approximately 12,000 Somerset residents selected a sexual orientation other than Straight or Heterosexual; around 1 in 40 people. 7.5% of the Somerset population did not respond to this question. Nationally, the proportion of people with a sexual orientation other than Straight or Heterosexual was slightly higher, at 3.2%; around 1 in 31 people (Census, 2021 – ONS, 2022a).

Over 1,600 individuals across Somerset stated that their gender identity differs from their sex as registered at birth; approximately 0.35% of the population (Aged 16+). Trans women and trans man were the most commonly identified with over 300 in each group. 5.7% did not respond to this question. Nationally proportion of individuals with a gender identity different from their sex at birth was higher than Somerset at 0.54% (Census, 2021 – ONS, 2022a).

2BU-Somerset conducted a 'Coming Out' survey (2016) to develop understanding of the impacts of homophobia and internalised oppression, and investigate the impacts of this on young people (Snowdon-Carr, 2016). 'Coming out' is a term used to refer to the point at which a person decides to tell another person about their gender identity or sexual orientation. 85% of respondents to the survey stated that they had either been bullied, witnessed bullying or both. 76% had personally experienced self-harm, 33% had been prescribed medication for depression, and 43% reported an eating disorder (n=52). Young people stated that they had experienced low mood and depression and considered this to be as a result of 'coming out' or their experiences of homophobia, biphobia and transphobia an individual surveyed stated "well I feel quite scared of what other people think, you could be quite confident in yourself but once someone tells you so many times that you are not worth anything you start believing it" and "I don't think it's all about being gay as such or LGBT its more about how LGBT people are treated, cos if they were treated in the same way as straight people it wouldn't cause us to self-harm or whatever".

People from Ethnic Minority Backgrounds

People from ethnic minority backgrounds are disproportionately experience poorer mental health. Evidence suggests that this is due to structural racism and marginalisation which can impact on the determinants of health including:

experiences of housing, employment, the criminal justice system, all of which can impact on the mental and physical health of individuals. This can also create barriers to individuals accessing health information and health care services (Raleigh and Holmes, 2021).

In Somerset, 96.4% of the population are 'White', compared to 81.1% nationally. The ethnic minority population in Somerset is comprised of, 1.5% who identify as 'Asian, Asian British, or Asian Welsh', 1.3% 'Mixed or Multiple Ethnic groups', 0.4% 'Black, Black British, Caribbean, or African', and 0.4% 'Other ethnic group' (Census, 2021 – ONS, 2022a). The greatest relative change since 2011 is amongst black ethnic groups, having more than doubled from 1,013 in 2011 to 2,436 in 2021. Poland is the most common non-UK country of birth for Somerset residents (1.3%), followed by Romania (0.75%), 91.5% of the Somerset population were born in the UK.

NHS Somerset have provided data on ethnicity and adult in-patient admissions for mental health (Figure 24) however, due to 1 in 4 responses being recorded as unknown (the second largest category after White British) we cannot use this as a proxy for ethnicity and mental illness. Across the health system there are concerns around the accuracy of ethnicity and health data, the ONS recently explained why these inaccuracies occur, they highlighted that there is not a single source of ethnicity data available to all analysts and the different sources that are available have various inconsistencies, which can result in one individual being recorded as a different ethnic group between different health related data sets. Other issues include sources with missing data and higher than expected proportions of people coded as 'other', which indicates that the categories available do not resonate with our population (ONS, 2023). Somerset ICB and the Population Health Transformation Board have confirmed that improving gathering of ethnicity data will be a priority work area over the coming years. Without this data it is hard to identify gaps in provision or understand how to adapt services to remove barriers to care.

Refugees and Asylum Seekers

Refugees and Asylum Seekers are at an increased risk of mental health issues, in particular, post-traumatic stress due to exposure to warfare, displacement, bereavement, unemployment, lack of family support and cultural differences (Giacco, Laxhman and Priebe, 2018). There are many barriers to refugees and asylum seekers seeking help for their mental health and accessing services including: uncertainty surrounding immigration status and permanency of placements amongst other factors such as language barriers and cultural differences (Sen, 2016).

To date over 1900 refugees and asylum seekers have been placed in Somerset since 2016. Before August 2021, the local authority participated in the Vulnerable Persons Resettlement Scheme (VPRS) and supported approximately 120 refugees impacted by the conflict in Syria, a breakdown of nationalities can be seen in table 2. Over the last 18 months there has been a 16x (+) increase in the number of displaced people in the county. This is linked with the evacuation of Afghan personnel and citizens, the war in Ukraine and the increase in small boat crossings.

Scheme/Nationality	Age	Number (rounded to nearest 10)
VPRS Scheme including (Syrian and Kurdish refugees)	Adults	50
	Under 18s	50
Community Sponsorship refugees (Syrian, Palestinian, and Kurdish refugees)	Adults	<20
	Under 18s	<10
ARAP/ACRS schemes (Afghans)	Adults	<20
	Under 18s	20
Homes for Ukraine (HfU) (Ukrainian Nationals)	Adults	880
	Under 18s	530
Unaccompanied Asylum Seeking Children (UASC) (Variety of nationalities primarily Kurds)	Care Leavers	Total to-date = 60
	Under 18s	Number of over 18s outside of Somerset: 20 Number outside under 18 outside of Somerset: <10 Numbers of Under 18s are continuing to grow with our current figure allocated by the Government as 120 * under 18's. *This is the number of UASC the LA could be allocated, not the number currently placed.
Adult Asylum 25-30 nationalities represented	Single adults, couples and families	Approx 280

Table 2: Number of Asylum Seekers and Refugees in Somerset to 2023

Unpaid Carers

Providing unpaid care can take a toll on carers' physical and mental health. Carers' week research from 2022 revealed 30% said their mental health was bad or very bad, with 77% stating that the impact of caring on their mental and physical health was one of the main challenges they were over coming that year (Carers UK, 2022).

Research suggests that young people providing care are less likely to be in employment, are more likely to have lower earnings and have poorer physical and mental health compared to those the same age who don't provide care (Brimblecombe et al., 2020). Estimating the number of people who provide unpaid care to friends, family members or others is notoriously difficult and the figure is constantly fluctuating. Nationally, 1 in 5 people who are 50-64 year-olds are unpaid carers and amongst 50-64 year-old women, the proportion is almost 1 in 4 (24%).

The 2021 Census reports that 4.65% of the population in Somerset provide 19 hours or less of unpaid care a week (age standardised rate – ASR). The highest

percentage is in SWAT and Mendip at 4.70%. Across the county, 1.70% (ASR) provide 20-49 hours per week of unpaid care (highest in SWAT and Sedgemoor – 1.80%). 50+ hours of unpaid care (ASR) is provided by 2.58% of the population across Somerset, with the highest rates found highest in Sedgemoor at 2.8% (ONS, 2022a).

Gender

There are significant gender differences in the number of men and women who access mental health support services, with women over-represented on caseloads, however, suicide rates are considerably higher in men. Since roughly 1990, men have been at least three times more vulnerable to dying by suicide, compared to women (ONS, 2017). Reasons behind this are complex, but it is suggested that they include a decline in traditionally male dominated industries and social expectations of masculinity (Samaritans, n.d.). In Somerset, the suicide rate in males is 22.6 per 100,000 (157), compared to females 6.5 per 100,000 (49), this reflects the trend seen globally (2018-2020) (ONS, 2022d). Mental health admissions in NHS Somerset were 58.9% female, and 41.1% male (2021-22). It is for this reason, that there are projects in Somerset specifically aimed at promoting mental wellbeing for people who identify as men, such as Stepladder and Unbreakable Men.

Under the Care of Mental Health Services

People living with a severe mental illness are considered to be vulnerable due to the impact their illness can have on their ability to make informed decisions. Additionally, they may also experience stigma and discrimination within community and workplace settings, which can impact their recovery and further compound their distress. People under the care of Mental Health services includes people with a diagnosed mental illness who have been treated in hospital through the NHS funded adult specialist mental health service. In Somerset the rate is 1,843 per 100,000 (2019/20 Q2), showing an increasing trend based on the 5 most recent time points. Rates in Somerset are lower than nationally (2,381 per 100,000), and regionally (1,968 per 100,000) (*there is an unspecified data quality warning on this information*) (OHID, 2022d).

The Mental Health Act is legislation that covers assessment, treatment, and rights of people with a mental health disorder. People detained under the Mental Health Act need urgent treatment for a mental health condition and are at risk of harm to themselves or others. The number of people in Somerset in receipt of inpatient care who had been sectioned under the Mental Health Act (aged 18+) is 18.9 per 100,000, showing a trend of no significant change (2019/20 Q2). This is lower than nationally (45.6 per 100,000), and similar to regionally (18.9 per 100,000) (*there is an unspecified data quality warning on this information*) (OHID, 2022d).

Persons detained under the Mental Health Act, is reported on as a proportion of people in contact with mental health services, this analysis can indicate variation and capacity within the service. A high rate may indicate a more serious case mix or it may reflect different local practice surrounding the use of the Mental Health Act. In Somerset, this is 0.86%, which is higher than regionally (0.60%) and similar to nationally (1.04%). In Somerset, there is a recent trend of no significant change, with national rates showing a decreasing trend (*there is an unspecified data quality warning on this information*) (OHID, 2022d).

4. Socioeconomic, Cultural and Environmental Influences on Population Mental Health

We have reviewed data and evidence on the social determinants of mental health and how these influence inequalities in the prevalence of mental disorders within the population, however, Dahlgren and Whitehead (2021) also highlight the importance of broader cultural, socioeconomic and environmental conditions on health, including factors such as disposable income, taxation and availability of quality work (Gov.uk, 2017). These socioeconomic, cultural and environmental factors, although less likely to have a direct impact on specific individuals, have the ability to disproportionately affect certain groups within the population, further driving health inequalities and poor health outcomes. For example, the current cost-of-living crisis is having a greater impact lower income households compared to higher income households (Statista, 2023). In addition, we know that Covid-19 disproportionately affected people from ethnic minority backgrounds (Morales and Ali, 2021).

This section explores the key socioeconomic, cultural and environmental factors likely to influence population mental health and wellbeing. Short term, these factors include financial pressure and the rising cost of living, Covid-19 and global humanitarian crises due to conflict. Long term, environmental factors such as climate change and an increase in extreme weather events are likely to influence population mental health. Although none of these factors are unique to Somerset, it is important to consider how these conditions will influence our population and whether these affects will be universal or disproportionately affect the mental health of certain groups.

4.1 Cost of Living Crisis and Economic Recession

The economic recession and rising cost of living is likely to influence various factors known to influence mental health including employment, income and housing. Specifically, these conditions are likely to cause:

- Long term financial stress
- Disposable income reduction
- Increase in numbers of people living in poverty
- Increase in numbers of people living in fuel poverty
- Increase in unemployment rates
- Housing instability and an increase in homelessness

The impact of the rising cost-of-living will be greater for the poorest UK households who typically spend a higher proportion of their income on food and household costs, 48.4% compared to 26.5% in the top income (Statista, 2023).

We can use data gathered after the economic crisis in 2008 to forecast what the likely impact could be of the cost-of-living crisis on mental health and suicide rates. A retrospective study revealed that there was an estimated 4.2% increase in suicide rates in European countries in 2009, which was attributed to the 2008 global recession (Chang et al., 2013).

In their report 'Deaths of Despair' Petterson et al. (2020) used quantifiable factors, identified from prior economic downturns to estimate the number of additional deaths of despair due to the COVID-19 impact on unemployment, isolation, and uncertainty. Deaths of despair refer to deaths as a result of alcohol, drugs or suicide. Analysis of the potential number of additional deaths relies upon assumptions of the economy, the relationship between deaths of despair and employment, and geographic variation of impacts, therefore we cannot assume direct comparisons to other geographical areas.

Across the nine different scenarios, the additional deaths of despair range from 27,644 (8.4/100,000) (quick recovery, smallest impact of unemployment on deaths of despair) to 154,037 (47.1/100,000) (slow recovery, greatest impact of unemployment on deaths of despair) – when considering the impacts of isolation and uncertainty the greatest impact scenarios may be the most accurate representations. If it is assumed that this rate will be similar in the UK, the best case scenario for Somerset will be 48 additional deaths, to 269 additional deaths as worst case scenario. There is significant demographic variation in rates of deaths of despair (reported by the CDC, in the USA), overall deaths of despair are most common in the 55-64 age group, with deaths of despair rising throughout the age groups to the point of 104.7 per 100,000 then declining. This is predominantly due to the rise and decline in alcohol-related deaths. Drug-related deaths are most common among 35-44 year-olds and suicide rates are relatively constant across ages. Additionally, deaths of despair are higher in males than females.

Citizens Advice Somerset reported a significant increase in client numbers between July 2021 and July 2022, largely attributed to the rising cost of living and the financial pressure that many people are currently experiencing. Ongoing money worries and financial stress have been linked to poor mental health and an increased risk of suicide (Bond and Holkar, 2018).

Citizens Advice Somerset Data:

- 1536% increase in count of clients with a financial issue regarding social welfare (374 to 6,119)
- 9700% increase in count of clients with a financial issue regarding fuel (1 to 98)
- 37700% increase in count of clients with a financial issue regarding food banks (1 to 378)
- 42699% increase in count of clients with a financial issue regarding charitable support (1 to 426)

Ability to save money in the next twelve months by local authorities in England and Wales, 7 January to 28 March 2021, is shown by table 3.

	Able to save money (%)	Not able to save money (%)	Don't know (%)
Somerset	44	35	20
Mendip	49	37	14
Sedgemoor	38	39	22
South Somerset	43	31	24
SWAT	47	32	21

Table 3: Self-reported ability to save money for each district of Somerset - Source ONS, 2021b

Kromydas et. al (2021) concluded in their research ‘Which is most important for mental health: Money, poverty, or paid work?’, using a sample representative of the UK population is that moving into poverty was strongly associated with the development of a Common Mental Disorder, with the effect having a greater impact on women (+2.3%) than men (+1.2%), however employment status transitions (moving from employed to unemployed) had more of an impact on men (+17.8%) than women (+13.5%) (Kromydas et al., 2021).

4.2 Fuel Poverty

In their report, ‘The Health Impacts of Cold Homes and Fuel Poverty,’ the Institute of Health Equity found that “Mental health is negatively affected by fuel poverty and cold housing for any age group and more than 1 in 4 adolescents living in cold housing are at risk of multiple mental health problems compared to 1 in 20 adolescents who have always lived in warm housing” (Marmot Review Team, 2011). The report also highlights how fuel poverty disproportionately affects some groups including; low-income households, families with dependent children but particularly lone parent and multigenerational households, households with people living with disabilities and minority ethnic households (Lee et.al, 2022).

Due to increasing energy bills many households will be unable to afford to heat their homes adequately over the winter, which will impact on both physical and mental wellbeing. This impact is likely to further the health inequalities already present within our population. Data from Citizens Advice South West supports this, between July 2021 and July 2022 they have seen a 9700% increase in clients approaching them for advice about a financial issue regarding fuel.

Fuel poverty is a complex social issue and a driver of health inequality due to the links between fuel poverty, health and socioeconomic status (Marmot Review Team, 2011). A study which explored the impact of fuel poverty on social housing tenants in Cornwall found that fuel poverty was associated with poor mental wellbeing and poor mobility; the study also highlighted challenges in measuring fuel poverty. Being able to appropriately measure fuel poverty is essential to ensure that targeted support is provided to the right people, at the right time, to minimise the impact on health (Tu et al., 2022). The paper also highlights the importance of holistic approaches to public health interventions, given the links between fuel poverty and poor mobility they suggest that public health measures incorporate physical activity interventions to help support fuel poor households to be more active and overcome mobility issues.

4.3 Covid-19

Psychologists and mental health professionals speculate that the pandemic is likely to impact on the mental health of the population globally with an increase in cases of depression, suicide, and self-harm, apart from other symptoms reported globally due to COVID 2019 (Kumar and Nayar, 2021). Social isolation leads to loss of social connection and cohesion. Although virtual communities have flourished, this is not accessible for all demographics, in particular elderly or those with learning disabilities meaning that the impact will be felt disproportionately. Furthermore, virtual community cannot totally replicate human contact and may not be enough to hold off the impact of isolation and loneliness. The magnitude and scale of social isolation in COVID-19 has been unprecedented, so the impact on mental health and illness is a prediction (Pettersen et al., 2020).

In the Somerset VCSE post pandemic report 'Reflect, Renew, Recover' mental health and wellbeing was the most common issue described by participants when asked about the impact of the Covid-19 pandemic and has significantly worsened in Somerset's communities. As such, it was ranked as the highest priority for the county by survey respondents (77% of 270) (Spark Somerset, 2022).

Research has also suggested that there is a relationship between gender and the impact of the pandemic on mental health and well-being. Women reported larger deterioration in mental health and worse symptoms than men, after the onset of the pandemic. There was however evidence of faster recovery among women than men in May/June 2020, but it has not returned to pre-pandemic levels (Gov.uk, 2021).

Unemployed adults and adults with lower incomes reported higher levels of psychological distress, anxiety, depression, and loneliness during the Covid-19 pandemic than adults with higher incomes. However, there is no evidence that the income-related gap has changed since pre-pandemic, all income groups, as well as adults with and without employment reported an initial deterioration in April 2020, followed by a period of recovery (OHID, 2022b). Petterson et al. (2020), suggest a 1 point increase in unemployment can lead to an increase of suicide rates by 1-1.6%.

Three years on from the start of the pandemic, the impact of Covid-19 continues to be felt, specifically within the NHS and Social Care. Waiting times for routine and emergency care are at an all-time high and missed opportunities for preventative care during the initial phase of the pandemic may have increased patient needs (Jefferies, 2023).

In the 'Marmot review 10 years on' it was reported that the amount of time people spend in poor health has increased across England between 2010 and 2020 (Marmot, 2020). This is likely to be confounded by the Covid-19 pandemic which had a significant impact on patient behaviour and the provision of routine NHS care services (BMA, 2020). We could therefore expect to see an increase in the number of people living with chronic long term conditions, which could in turn increase the prevalence of mental disorders and poor mental wellbeing, as we know that poor physical health is a significant risk factor. In addition, waiting times for elective care have also increased as a result of the pandemic, historically, increased waiting times in the NHS have led to an increased demand for private care (Besley, Hall, Preston, 1999). People from lower income households who cannot afford private health care are likely to be disproportionately impacted by increased waiting times, exacerbating existing inequalities in the receipt of healthcare and further exaggerating the health gap between wealthy and deprived areas (Propper, Stoye, Zaranko, 2020).

4.4 Increase in Refugee/Asylum Seeker Population in Somerset

There has been a 16x (+) increase in numbers of refugees and asylum seekers in Somerset over an 18-month period, increasing from approximately 120 in August 2021 to approximately 1900 in January 2023.

We can expect to see an increase in the population of refugees and asylum seekers in Somerset over the short term as the conflict in Ukraine continues. This could have an impact on individuals both hosts (Somerset residents who sponsor a Ukrainian

refugee(s)) and guests (Ukrainian refugees who have been matched to local sponsors), and demands for mental health services.

4.5 Climate Change and Extreme Weather Events

Over the medium to long term there are other factors such as extreme weather events, linked to climate change, which could have an impact on many rural/coastal communities within Somerset resulting in trauma and displacement. In all future climate change scenarios, direct and indirect flood risks are projected to rise over the course of the 21st century (Sayers et al. 2020).

The mental health impacts of flooding are well known and understood, ranging from effects on wellbeing and stress or anxiety, to more severe mental health impacts such as PTSD (Gov.uk, 2020). The report from 2013-2014 has led to the production of a guidance document to assist in the development of plans to manage public mental health in the event of flooding (Gov.uk, 2022). The report makes suggestions of how we can protect vulnerable communities from the mental health impacts of flooding including “supporting activities that promote social cohesion at local level are known to mitigate some of the mental health consequences caused by flooding where social action supports long-term preparedness.” Furthermore, a recent narrative synthesis and meta-analysis on the effect of extreme weather events on mental health (UK) concluded that due to the high prevalence of common mental health problems in those affected, the prevention of mental ill health in populations at risk or exposed to extreme weather events should be a UK public health priority (Cruz et al., 2020). A recommendation of the research is to promote mental health literacy to populations at risk via the delivery of training such as mental health first aid, this recommendation could be applied in Somerset via engagement with Community Flood Groups, who could nominate 2 members to complete training.

5. Other Considerations

We have explored social and individual factors linked to mental health and key socioeconomic, cultural and environmental factors likely to influence population mental health and wellbeing over the coming years. It is pertinent therefore to consider approaches which incorporate each of these elements, such as asset based community development and how we can utilise the physical/built environment to promote good mental health and wellbeing.

5.1 Communities and Social Capital

Evidence suggests that mapping out community assets can promote action, inform people and encourage a culture where people share stories, and use these stories to build stronger connections and relationships, both qualities known to enhance mental wellbeing (Go Well, 2010).

Asset based community development attempts to redress the balance between meeting demand and needs whilst nurturing the strengths and resources readily available in communities (Iriss, 2012). Every community is different and therefore this method requires a person centred approach, with coproduction at the centre. There are environmental aspects of Somerset that we could consider strengths – of that rurality and green space is one. We know that access to green space has a positive influence on mental wellbeing, therefore approaches that utilise this asset could be beneficial.

In Somerset, the Somerset Wildlife Trust run a popular nature for wellbeing course through their project Nature Connections – research by the Wildlife Trust found that there was a social return on investment value (SROI) of £6.88 for every £1 invested, for people with low wellbeing at baseline, who were part of a targeted nature for wellbeing programme (Wildlife Trust, 2019). With demand for anti-depressants continuing to rise, we must look to support projects such as these that promote mental wellbeing within communities before mental health deteriorates, capitalising on assets available within our county such as the natural environment.

Social capital has been found to be a key asset particularly within rural communities where geographical and social isolation may impact wellbeing (Boyd et al., 2008). Furthermore systematic reviews of the literature that link social capital to mental health outcomes conclude that there is strong evidence of a positive relationship between the two.

5.2 Physical Environment

Somerset is a highly rural county. Figure 22 demonstrates the proportion of rural versus urban areas in Somerset. Census data in 2011 identified that 48.2% of the population in Somerset live in rural areas (Census, 2011), which is significantly higher than the national average (18.5%).

Districts and Towns of Somerset

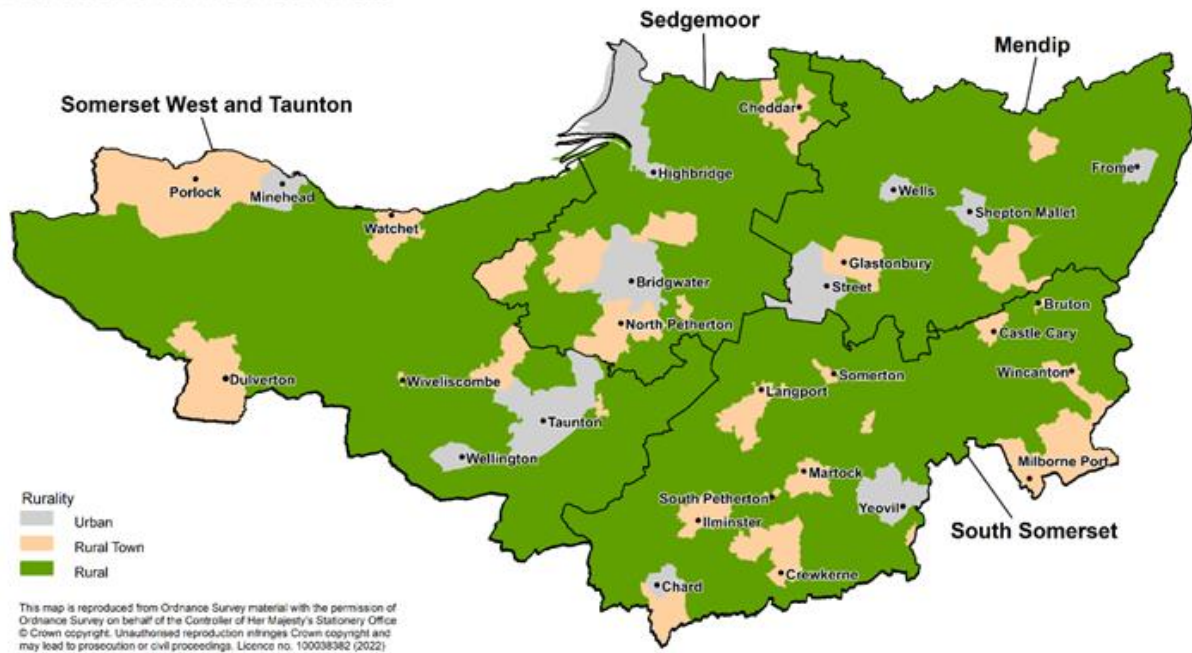


Figure 22: Rural, Rural Town and Urban area classifications in Somerset. Source: 2011 rural/urban classifications

Areas with more accessible green space have been associated with better mental and physical health, although it is difficult to draw clear conclusions from research due to the confounding factors surrounding higher levels of deprivation in more urbanised areas (Houses of Parliament, 2016).

A systematic review showed limited evidence for a causal relationship between surrounding greenness and mental health in adults, whereas the evidence was inadequate in children. The evidence was also inadequate for the other exposures evaluated (access to green spaces, quality of green spaces, and blue spaces) in both adults and children. The main limitation was the limited number of studies, together with the heterogeneity regarding exposure assessment (Gascon et al., 2015). However, a systematic review of evidence suggested a positive association between greater exposure to outdoor blue spaces and both benefits to mental health and well-being (Gascon et al., 2017).

6. Key Policies & National Guidance

The profile of mental health has increased significantly over the last 15 years, with mental health sitting high on the agenda for successive governments. In 2011, the Department of Health published the national public health strategy 'No Health without Mental Health: A cross government mental health outcomes strategy for people of all ages'.

This document identified six outcomes:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a good experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

In 2012, the government released a Suicide Prevention Strategy for England which aimed to reduce the suicide rate in England and provide better support for those bereaved or impacted by suicide. The strategy identified six key areas for action to support delivery of these objectives:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
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

We are awaiting a refresh of the national Suicide Prevention Strategy in June 2023.

Since then the government has released, The Mental Health Five Year Forward View (MH FTFV) (2015) which set out plans for improving and expanding mental health services and care, central to the NHS Long Term Plan. Highlighting a vision to put mental health on a par with physical health.

The NHS Long Term Plan outlines key aims (NHS, 2019):

- Transformation of mental health care, enabling more individuals to access treatment. Increasing national funding by at least £2.3 billion a year by 2023/24
- Making access easier for all to receive mental health crisis care through NHS 111
- Expansion of specialist mental health care for mothers
- Expansion of services (such as through schools, for an additional 345,000 children and young people (0-25) to get support
- Continuing to develop services in communities and hospitals, such as talking therapies and mental health liaison teams

For specifics on adults mental health see: [NHS Long Term Plan » Adult mental health services](#)

For specifics on children and young people's mental health see: [NHS Long Term Plan » Children and young people's mental health services](#)

In April 2022, the government launched a discussion paper: Mental health and wellbeing plan, to help inform a new, cross government mental health strategy (Gov.uk, 2023b) (Garratt, Laing, Parkin, 2022).

This focuses on 6 key areas:

- How can we promote positive mental wellbeing?
- How can we prevent the onset of mental health conditions?
- How can we all intervene earlier when people need support with their mental health?
- How can we improve the quality and effectiveness of treatment for mental health?
- How can we all support people with mental health conditions to live well?
- How can we all improve support for people in crisis?

The results of this discussion paper will be considered in the development of the new cross government Major Conditions Strategy, which will include Mental Health as one of the key themes.

NHS England Core20Plus

Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. Focussing on the most deprived 20% of the population, inclusion health groups, ethnic minority communities, and protected characteristics. Core20PLUS5 defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement. Approaches are outlined for children and young people, which include mental health targets (NHS, n.d.b):

1. Asthma
2. Diabetes
3. Epilepsy
4. Oral Health
5. Mental Health
 - a. Improving access rates to children and young people's mental health services (0 – 17 years old) for certain ethnic groups, age, gender and deprivation

Additionally for adults the '5' focus clinical areas are (NHS, n.d.c):

1. Maternity
2. Severe Mental Illness
 - a. Ensuring annual health checks for 60% of those living with SMI
3. Chronic respiratory disease
4. Early cancer diagnosis
5. Hypertension case-finding, optimal management, and lipid optimal management

NICE Guidance/Quality Standards

- [Overview | Depression in adults | Quality standards | NICE](#)
- [Overview | Depression in children and young people | Quality standards | NICE](#)
- [Overview | Self-harm | Quality standards | NICE](#)
- [Overview | Suicide prevention | Quality standards | NICE](#)
- [Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE](#)

7. Literature Review

7.1 Background

This section considers whole population mental health interventions which address the social determinants of mental health identified in section 3. This includes: education, social connectedness, housing, employment and physical environment. A literature review was completed to understand how effective population-based approaches are at improving mental health and wellbeing. Understanding the effectiveness of these interventions will enable the wider system to develop policies and practices to support those most vulnerable to mental disorders and poor mental wellbeing due to their social circumstances.

Due to resource limitations, the scope of the literature review has been limited to societal factors and does not include research on individual risk factors for poor mental health or future socioeconomic, cultural and environmental concerns. However, limiting the approach has avoided focusing on individual factors that might significantly vary between populations and subgroups (e.g. displaced people, LGBTQIA+ etc.). Instead focussing on the implications on the determinants that affect all (education, housing, employment etc.). The full inclusion and exclusion criteria is detailed in the method section.

7.2 Methods

Inclusion and Exclusion Criteria

Inclusion

- Adult population, involving a non-clinical intervention, focused on mental health, in a high income country, written/published in English, published within the last 10 years, focused on a population wellbeing approach, published as articles/papers

Exclusion

- Child population, published over 10 years ago, not published in English, focused on direct services to individual patients, clinical based intervention, in low/middle income countries, focussing on very specific populations (such as maritime personnel, and Inuit), published as a book

Search Strategy:

Searches were carried out using PubMed. Core search terms were developed which are outlined in 7.2. The core terms were used in all searches; this was then amended for each search based on the social determinant examined. The title and abstract were searched but not the full body of the text as this brought back results which were much more specific to the topics to the selected social determinant and mental health.

Search Terms

Core search:

(poor mental health [Title/Abstract] OR poor emotional wellbeing [Title/Abstract] OR poor mental wellbeing [Title/Abstract] OR mental health crisis [Title/Abstract] AND

intervention*[Title/Abstract] OR activity*[Title/Abstract] OR population based intervention*[Title/Abstract] AND improve* mental health [Title/Abstract] OR population health [Title/Abstract])

Housing:

- AND (housing [Title/Abstract] OR homeless*[Title/Abstract])

Employment:

- AND (unemployment [Title/Abstract] OR low paid work [Title/Abstract] OR stable income [Title/Abstract])

Physical Environment:

- AND (green space [Title/Abstract] OR blue space [Title/Abstract])

Social:

- AND (social connectedness [Title/Abstract] OR social isolation [Title/Abstract])

Education:

- AND (education* attainment [Title/Abstract])

Study Selection

Initial searching using the terms above produced 508 results across the 5 categories (table 4). Results were downloaded into a table and then screened based on titles and abstract. Screening was based on the inclusion and exclusion criteria in 7.2. and initially completed by one person. A second person screened these results to ensure relevance. Consultation between both parties was undertaken where there was disagreement for inclusion/exclusion with a third party consulted if no decision could be reached. Once this initial screening was completed there were 82 results.

Further screening was carried out based on the full text, with papers primarily being excluded based on the following criteria: they did not cover the specific focus topic, there was no intervention, the intervention was in a low or middle income country, it was not a population approach, and the research did not have a focus on mental health. This led to a final number of 43 papers. During the full text screening most papers were excluded based on having no intervention, not being relevant to the specific topic, not being focussed on mental health and being too niche interventions focussed on specific groups.

	Housing	Employment	Physical Environment	Social	Education	Total papers
No. results produced by initial search	183	90	51	102	82	508
No. results left when screened on title/abstract	18	16	19	19	10	82
No. results after full read – (included studies)	6	7	9	13	5	41

Table 4: Number of results produced by each search

T i t l e	A u t h o r	C o n t r i b u t i o n	Publication Year	Inclusion based on Abstract /Title	Reason for exclusion	Exclusion after full read	Key Themes	Intervention /Approach	Findings/ conclusions	L i m i t a t i o n s	Quality of Evidence (1-7, see figure 25)

Table 5: Column headings for synthesis of evidence, and process of exclusion/inclusion

Quality Assessment

Quality of the included papers was based on the Hierarchy of scientific evidence:

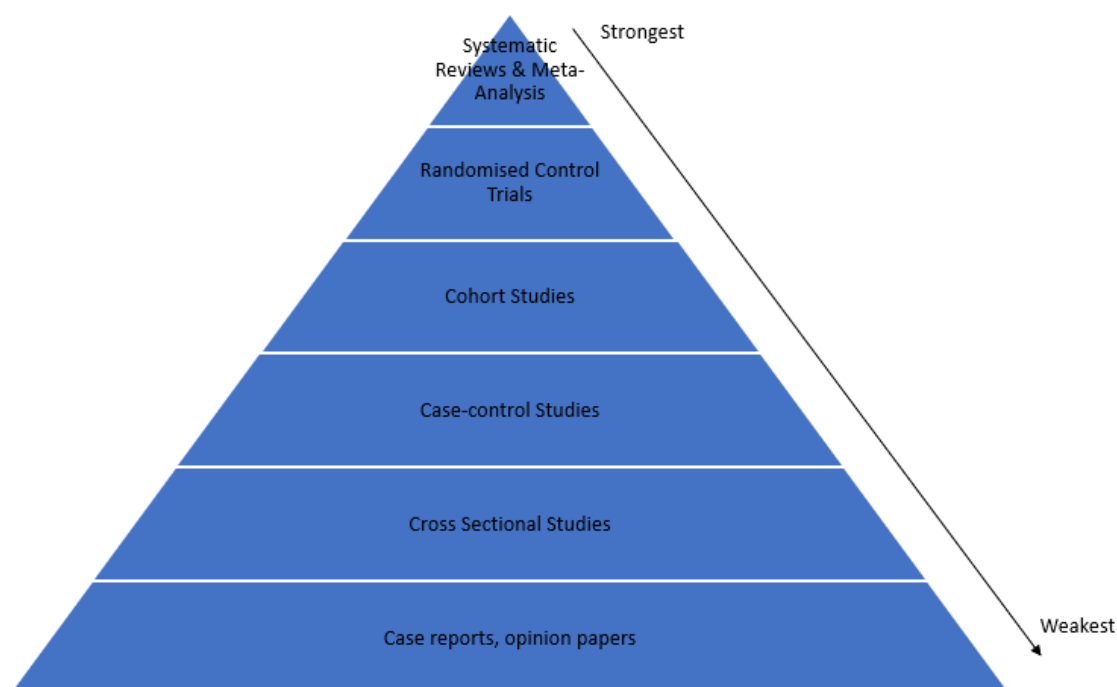


Figure 23: The hierarchy of Scientific Evidence Source – Greenhalgh (1997)

Summary of quality of the evidence

Quality of Evidence/Topic	Housing	Employment	Physical Environment	Social	Education
1 - Meta analysis & systematic reviews	2	2	2	3	1
2	3	1	1	1	
3	1	1		6	1
4		3	1		
5			3		1
6 – Case reports, opinion papers			2	3	2

Table 6: Numbers of studies based on the hierarchy of scientific evidence

7.3 What interventions are used for mental health and wellbeing, and how effective are these?

A summary of the findings from the literature search of population mental health interventions are below.

Social Connections

Social factors such as loneliness and isolation have a significant impact on the mental health of populations. Social interventions, such as peer-led support groups and intergenerational activities, have been found to be effective in promoting mental health and wellbeing.

In a study by Webber and Fendt-Newlin (2017), it was found that social participation interventions, such as volunteering and peer mentoring, can help people with poor mental health to better manage symptoms and improve their quality of life; there is however limited evidence, as the intervention is under-evaluated. Furthermore, Anderson, Laxhman, and Priebe, (2015) conducted a systematic review that found that psychosocial interventions designed to increase social networks can also leading to symptom reduction and increases in personal strengths. The use of Time Credits programmes found these enabled individuals to develop a sense of purpose through making a positive contribution to their community (Burgess, 2017). Subsequently, this was associated with improved mental health and wellbeing outcomes, including reduced social isolation, improved access to services, and improved quality of life. Weziak-Bialowolska et al. (2021) also found that character strengths interventions involving an orientations to promote good (having thoughts and taking actions which contribute to the good of oneself and others) can help to improve health and wellbeing. Additionally, Bains and Turnbull (2019) highlighted the potential role of understanding and cultivating prosocial purpose; this study however has no clear conclusions but may lead to self-efficacy, and behavioural change.

Social prescribing in the form of “creative green prescription”; Thomson et al. (2020) found that their program involving artmaking and horticulture as a grouped activity was effectual in promoting mental health, decreasing social isolation, and improving self-esteem/happiness.

Community interventions were found to be helpful in promoting mental health and wellbeing. Mawani and Ibrahim (2021) found that their peer-led, community-based walking and rolling (with mobility aids) program was successful in promoting inclusion and mental health, highlighting lived experiences of improved mental health. Additionally, Chan, Yu, and Choi (2017) also found physical activity with a social aspect to be beneficial for mental well-being; through a tai chi-based intervention. This led to significantly larger improvement on loneliness scale and social support in the trial group compared to the control. There were also improvements seen on the MHI-18 score, however, it is unclear if these results were due to the tai chi practice or the social support. The HANS KAI project (Henteleff & Wall, 2018) also found a peer-led community-based approach was successful in promoting health and wellbeing. This project aimed to encourage peer support and personal empowerment, based of social learning theory and empowerment theory, and led to statistically significant mental health improvements pre- to post-program.

Social network interventions (GENIE™ Intervention², within MH services was shown to be efficacious in improving outcomes for service users, but more research is needed (Brooks et al., 2022).

Intergenerational activities have also been found to be effective in promoting mental health and wellbeing. Canedo-García et al., (2021), found that intergenerational face-to-face activities were beneficial for the mental health and wellbeing of participants, with improvements in mood, professional wellbeing, social participation, and self-determination as well as mental health more generally. Finally, Cherniack and Cherniack, (2014) found that the physical and psychological benefits of animal-assisted therapy can lead to modest benefits to mental health, social functioning, and quality of life of older adults, by alleviating loneliness, and manifestations of cognitive disorders.

Community interventions for improving adult mental health explored the types of interventions being used to improve adult mental health in England. The study found that the most used interventions included training and education, support services, and preventive measures, whilst also highlighting the need for better collaboration and coordination between services in order to improve outcomes – due to a lack of funding evaluations of the efficacy of the interventions was not collected (Duncan et al., 2021).

Overall, social interventions have been shown to be beneficial for improving mental health and wellbeing. They can help individuals to build connections, find support, and access mental health services. These interventions can also help to reduce symptoms of depression, anxiety, and social isolation, and improve social functioning.

Education

The relationship between education and health has been well documented, with a review of the literature suggesting that educational interventions can help to reduce disparities in health outcomes between different socio-economic groups. Research shows that a multigenerational approach is most effective.

Zajacova and Lawrence, (2018) examined the relationship between education and health, finding that educational interventions had the potential to improve mental health and wellbeing, particularly among marginalised populations. This has been further supported by research from Littlecott et al., (2018), which showed that health improvement and educational attainment are complementary rather than competing priorities in secondary schools. This study considers school-based interventions which increase connectedness and reduce absenteeism, while also highlighting the importance of educational interventions and the time which they occur as a critical period across a life course. Interventions which focus on both health and educational outcomes had a greater impact than those which focus solely on educational outcomes. This suggests that a more holistic approach to improving mental health and wellbeing is needed.

WHO's Health Promoting Schools (HPS) framework considers 2 projects: the Gatehouse Project, a primary prevention programme which includes both institutional and individual focused components to promote the emotional and

² Generating Engagement in Network Involvement

behavioural, outcomes and beyond blue intervention, which used a comprehensive classroom curriculum program, enhancements to school climate, improvements in care pathways, and community forums. These interventions are associated with improvements in student self-esteem, school attendance and academic performance, as well as reductions in school dropout rates. However, there is little to no evidence that these interventions were effective in reducing depression (Langford et al., 2015).

Dotson et al., (2022), found that education-based interventions were successful in addressing population health equity. Health Equity management model (HEM) - Education prescription intervention creates a pathway for systematic improvement in the quality of life for individuals with low educational attainment prospects, helps to reduce healthcare costs by increasing health literacy, and has a positive impact on society by creating more economic opportunities within communities. This study also highlighted the importance of considering contextual factors when designing and implementing such interventions, however, it focuses more on the theoretical model rather than the effectiveness.

Finally, Younes et al., (2015) explored the use of e-mental health care among young adults and their help-seeking behaviours. The study found that digital interventions could be used to improve physical and mental health outcomes, particularly among young adults who may be reluctant to seek help from traditional source. Educational level did not impact the efficacy of this intervention, thus this could be valuable to decrease inequalities mental health outcomes.

In conclusion, research has demonstrated that education-based interventions can improve mental health and wellbeing. Such interventions should be tailored to the needs of individuals and the contexts in which they are implemented. Furthermore, interventions should be holistic, combining both health and educational outcomes in order to have the greatest impact.

Housing

Housing is an important factor in mental health and wellbeing. Poor housing can have a significant impact on mental health and can contribute to development of mental health problems. Poor housing can lead to feelings of isolation, depression, and anxiety, as well as physical health problems. Poorly maintained housing can have a direct effect on mental health, such as increased stress levels, feelings of insecurity, and feelings of helplessness. In contrast, good housing can provide a sense of security, stability, and support, which can help to improve mental health. Good housing can also provide access to services and amenities that can help to improve mental wellbeing.

A community engagement and planning (CEP), multisector community coalition approach which encouraged network building and collaboration among/across community and service agencies was found to be more advantageous than individual program technical assistance to individual agencies, at improving mental health (MHRQL), and mental wellness in multiple groups. However, these outcomes were self-reported and retention within these studies was relatively low (Izquierdo et al., 2018, Wells et al., 2013).

Housing mobility interventions, such as public housing programs, which involve moving individuals from areas of deprivation to middle-income neighbourhoods, are associated with better self-reported health. Over a decade later, mobility programs were associated with improved mental health and wellbeing, increased physical activity, and decreased risk of severe obesity/diabetes. These interventions had little impact on children, however, with increased mental health issues among boys (Thornton et al., 2016).

Housing quality was also discussed. Bird et al., (2018) consider the importance of the natural and built environment on general wellbeing and health, identifying the provision of affordable rental housing as improving mental health among adolescents and adults. Provision of housing to homeless individuals also improved mental health. Additionally, medium quality evidence showed energy efficient homes and developments in housing quality improved population mental health. The importance of warm housing interventions and housing quality was also highlighted by Shah et al., (2020). McCartney et al., (2017), who also comment on the impact of housing quality. They observe that housing-led regeneration programmes involving refurbishments and other specific housing improvements in Glasgow had results of self-reported improvements in mental health.

In conclusion the evidence indicates that the quality of dwellings, and housing standards as well as affordability of housing can impact mental health and wellbeing. Collaboration and network building for planning, including engaging with the community are also important in improving mental health outcomes.

Physical Environment

There has been an increasing amount of research examining the role of the physical environment in improving health and wellbeing. Studies have looked at the potential for green spaces, inland waterways, wetlands and nature-based interventions to influence health outcomes. For this review the studies have been divided into green space and blue space.

Green space is represented by grasslands and forests. A systematic review found evidence for access to green space and time spent in green space (increased urban greening) as a protective factor for loneliness, especially in individuals living alone; however, the evidence is weak, and more research is needed (Astell-Burt et al., 2022). Green prescribing in outdoor nature-based interventions were found to improve mental health outcomes in adult populations, including those with SMI and long-term conditions. This reports only short-term benefits due to the study ending thus the overall benefits were unclear (Coventry et al., 2021) Quantifiable mental health improvements due to access to green space were also found by Jimenez et al., (2021). Comparatively Thompson et al. (2019) conducted a quasi-experiment in Scotland to investigate the efficacy of Woods in and Around Towns (WIAT) interventions in deprived urban communities. This involves small scale physical change, such as footpath surfacing and clearing rubbish and overgrown vegetation. Interventions were associated with increased stress when compared to control sites, reasons for this outcome were unclear.

Müller-Riemenschneider et al., (2020) conducted a randomized controlled trial to investigate the effectiveness of prescribing physical activity in parks in improving health and wellbeing. Findings demonstrated improvements in some wellbeing

measures, especially psychological wellbeing; no improvements were seen relating to psychological distress.

Integrated university infrastructure was explored to understand how nature can improve mental health. The results of the study suggest that such interventions can be beneficial in improving mental health and wellbeing, as well as attainment (Boyd, 2022).

Blue space encompasses inland water ways, wetlands, lakes and seas. Maund et al., (2019) investigated the impact of engaging individuals with wetland nature for the treatment of anxiety and/or depression. The study demonstrated a significant improvement in mental health across indicators including mental wellbeing, anxiety, stress, and emotional wellbeing; benefits to physical wellbeing and social isolation were also seen. This study had a small sample size so may lack generalisability.

Afentou et al., (2022) investigated the impact of using inland waterways on population health and wellbeing. Self-reported results showed that frequent use for recreation or leisure was beneficial to life satisfaction and physical activity. This study also suggested that policy designed to ameliorate health inequalities linked to unequal access could prioritise interventions to target disadvantaged populations.

Generally real-world nature (both blue and green) access is more advantageous for improving emotional and physical wellbeing, but virtual (VR) access can be used as an alternative for individuals where this is not possible, such as those who are housebound or mobility constrained (White et al., 2018).

In conclusion, there is a growing body of research suggesting that access to nature in terms of green and blue space can have significant benefits to mental health and wellbeing. However, further research is needed in this area to gain a better understanding of the relationship between the physical environment and mental health, and to understand the potential negative impacts that may also arise from these types of interventions such as increased stress.

Employment

The relationship between employment and mental health and well-being is complex and multidimensional. Employment can provide a sense of purpose and social connections as well as financial security – all of which are important for mental health. Nonetheless employment can be a source of stress depending on type and quality of work, especially in situations of low pay, long-hours, poor working conditions.

An Umbrella review investigating population level interventions found that higher quality evidence indicates that more generous welfare benefits may reduce socioeconomic inequalities in mental health outcomes. Lower quality evidence suggests unemployment insurance, warm housing interventions, neighbourhood renewal, paid parental leave, gender equality policies, community-based parenting programmes, and less restrictive migration policies are associated with improved mental health outcomes (Shah et al., 2021).

A quasi-experiment comparing interdisciplinary re-employment programmes with regular re-employment programmes among individuals with mental health problems

found this was not productive in increasing re-employment (Carlier, Schuring, & Burdorf, 2018). Psychoeducation on return to work for individuals who have been on sick leave did not decrease the level of psychological symptoms or improve mental health-related quality of life (Pendersen et al., 2015).

Provision of physical activity during work time found improved mental health and productivity, reduction in sick leave, and employees having more favourable perceptions of their employer. This was however from a homogenous sample, and it is acknowledged that there are significant barriers to this being implemented (Ryde, Atkinson & Gorely, 2020). The possibility of part-time and flexible working hours instead of retirement was beneficial. It was found that extending working life, particularly part-time, may have benefits or a neutral effect for some but adverse effects for others in high demand or low reward jobs which could widen health inequalities (Baxter et al., 2021). Overall, it was found that an increase in working life had mixed effects on mental health and beneficial or neutral effects on overall health status. Many studies were excluded from this review due to focusing on impact of retirement rather than extended working.

Additionally, Kaufman et al. (2020) used a difference of differences model to identify that an increase by US\$1 of minimum wage led to a 3.4-5.9% decrease in suicide, this model does rely upon the parallel trends assumption, which depends upon both groups being exposed to the same variables (excluding the independent variable) so that treatment effect can be effectively measured. Curnock, Leyland and Popham, (2016) used a difference of differences approach to understand the impacts of employment and welfare transition. Results of this study found that transitions from disability benefits to employment were associated with an improvement in the SF12 mental health score, and transitions to unemployed status were also associated with a significant improvement in mental health. This study also relies upon the parallel assumptions trend in identifying differences.

In summary, to promote mental health and wellbeing, it is important for employers to provide secure, meaningful work, fair pay, flexible working and support for employees. Increases to minimum wage and benefits can also help to improve mental health and wellbeing.

8. Conclusion

This needs assessment provides a picture of the mental health and wellbeing of people living in Somerset. It explores wider social, economic and environmental factors known to influence mental health. Since the last needs assessment was completed in 2014, the profile of mental health has increased significantly. The Covid-19 pandemic substantially contributed to this shift, with the unprecedented experience of lockdowns, isolation, illness, uncertainty and collective grief. This impacted on the mental health and wellbeing of the entire population but also exposed and amplified social inequalities and their influence on health. It is vital that we recognise and work together across the system to prevent mental illness by promoting the links between physical health, mental health and social connection.

A key finding of the needs assessment is that the prevalence of common mental disorders and the demand for mental health services is increasing. This need and demand for services is greater in certain areas, including urban and coastal areas and those which have higher levels of deprivation. However, the needs of those in more rural areas is not to be ignored. Geographical isolation is linked to loneliness which has featured in both local and national reports on the impacts of the pandemic. The age groups most vulnerable to loneliness are people aged 65+ and young people aged 16-25. Loneliness is a silent ailment and a risk factor for mental health and suicide, therefore, actions to reduce loneliness and isolation across the life course are crucial.

There are several areas in which Somerset is an outlier including, suicide, self-harm, dual diagnosis and the mental health of social care users. Although self-harm and suicide are not in themselves mental disorders, they are associated with mental distress. Suicide, self-harm, dual diagnosis and social care users all have a common theme; they often involve complex circumstances, driven by various interacting factors in people's lives. It is these areas which highlight the need for a coordinated systems-based approach to mental wellbeing, one that understands and addresses the factors and environments that have an impact on mental health across the life course.

Data collection and measurements are essential to ensure that we commission appropriate services and target support to those who need it the most. The needs assessment highlights a lack of rigorous data available on individual factors linked to mental health, particularly surrounding ACES, ethnicity, substance misuse and physical health conditions. Without this data, it is difficult to map gaps in provision and target resources effectively. Therefore, actions to improve data collection and outcome measurements across these areas are essential.

We must continue to bridge the divide between physical and mental health. Despite the profile of mental health increasing significantly, we are still a long way off parity of esteem. Interventions which take a holistic community strength-based approach should be encouraged and opportunities to work collaboratively across various sectors including health, care, education and housing should be sought. This holistic cross system approach would support the mental health in all policies initiative and promote to our communities that mental wellbeing is a shared priority for all services in Somerset. The Prevention Concordat for Better Mental Health will provide an excellent opportunity to utilise the insights from the needs assessment and generate a system wide commitment to improving mental health in Somerset.

9. Abbreviations

Abbreviation	Meaning
ACE	Adverse Childhood Experience
AMPS	Adult Psychiatric Morbidity Study
BHC	Before Household Costs
CCG	Clinical Commissioning Group
CMD	Common Mental Disorder
DCLG	Department for Communities and Local Government
DWP	Department for Work and Pensions
ESA	Employment Support Allowance
HES	Hospital Episodes Statistics
ICB	Integrated Care Board
IMD	Index of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer (or Questioning), Intersex, and Asexual (or Allies)
LSOA	Lower Layer Super Output Area
MH	Mental Health
NEET	Not in Education, Employment or Training
NHS/E	National Health Service/England
NICE	National Institute for Health and Care Excellence
OHID	Office for Health Improvement and Disparities
ONS	Office of National Statistics
QOF	Quality Outcomes Framework
SCC	Somerset County Council
SEND	Special Educational Needs and Disability
SMI	Serious Mental Illness
SWAT	Somerset West and Taunton
UA	Unitary Authority
UASC	Unaccompanied Asylum Seeking Children
VCSE	Voluntary community and social enterprise
WHO	World Health Organisation

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