Croydon Joint Strategic Needs Assessment

2012/2013

An overview of mental health and well-being in Croydon

Part 1 of five JSNA 2012/2013 chapters

NHS

South West London

Croydon Borough Team

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Croydon Joint Strategic Needs Assessment 2012/2013

An overview of mental health and well-being in Croydon

Part 1 of five JSNA 2012/2013 chapters

April 2013

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The **Croydon Joint Strategic Needs Assessment 2012/2013** is published in five parts:

- An overview of mental health and well-being in Croydon
- Key Topic 1: Depression in adults
- Key Topic 2: Schizophrenia
- Key Topic 3: Emotional health and well-being of children and young people aged 0-18 years
- Croydon Key Dataset

All parts of the JSNA are published on the Croydon Observatory at:
http://www.croydonobservatory.org/jsna/chapters201213/

Acknowledgements

Many individuals and organisations have contributed to the development of this chapter and our thanks are extended to all involved. To ensure that the recommendations are taken forward, it is important that this engagement continues.

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Contents

Executive summary 3

1. Introduction 6
2. What is mental health and well-being? 7
   - 2.1 Policy overview.. ..... ….9
3. Why is it important to improve mental health? 10
   - 3.1 Improving mental health contributes to additional positive outcomes 11
   - 3.2 Effective public mental health approaches 12
4. Factors that influence mental health and well-being 13
   - 4.1 The overview structure and framework 14
5. Croydon's population characteristics and implications for mental health 16
   - 5.1 A growing population - results of the 2011 census 17
   - 5.2 Migration from within and outside the UK 18
   - 5.2.1 Migration within the UK 18
   - 5.2.2 Migration from outside the UK 19
   - 5.3 Asylum seekers and refugees 20
   - 5.4 Migration and mental health 20
   - 5.4.1 Why were previous population estimates much lower than the census? 21
   - 5.5 A culturally diverse population 21
   - 5.5.1 Ethnic groups 21
   - 5.6 Implications of population changes for mental health services 22
6. Equality and social justice factors 25
   - 6.1 Increasing deprivation and inequalities 25
7. Wider determinants and the impact on mental health and well-being 30
   - 7.1 Income, financial security and debt 30
   - 7.2 Expected impact of changes to welfare reform 31
   - 7.3 Employment and working lives 32
   - 7.3.1 Unemployment 33
   - 7.3.2 Young people 16-18yrs Not in Education, Employment or Training (NEET's) 33
   - 7.3.3 Employment of people with mental health conditions 34
   - 7.4 Fear of Crime 36
   - 7.5 Housing and physical security 36
   - 7.5.1 Homelessness 37

7.5.2 Housing for adults with mental health conditions 38
7.6 Education and lifelong learning 39
8. Enhancing mental health and well-being through stronger, resilient communities and the civil society 40
8.1 Social relationships and the core economy 40
8.1.1 Increasing resilience, social participation and inclusion 41
8.2 Croydon's civil society 42
8.3 Croydon's green spaces and parks 44
8.3.1 Community participation in Croydon's green spaces 45
9. Enhancing mental health and well-being across life stages 47
9.1 Evidence-based actions to improve individual well-being 47
9.1.1 Children and young people 48
9.1.2 Parents with mental health problems 50
9.1.3 Children in poverty 50
9.1.4 Children and Adolescents 51
9.1.5 Working age population 53
9.1.6 Older People 53
10. Enhancing mental health and well-being by considering the relationship with physical health 57
10.1 People with diagnosed mental illness 57
10.2 Smoking and mental health 58
10.3 Obesity and mental health 58
10.4 Substance abuse, alcohol problems and mental health 59
10.5 People with long term conditions 59
11. Measuring mental well-being and data limitations 63
11.1.1 Warwick Edinburgh Mental well-being scale (WEMWBS) 64
11.1.2 Mental well-being impact assessment (MWIA) 64
12. Conclusion and key messages 65
13. Appendices 66

Executive Summary

Background

- Joint Strategic Needs Assessment (JSNA) is the **process** by which local areas review and describe the health and well-being needs in their local area.
- The 2012/13 Croydon JSNA focuses on **mental health.**
- The following summarises the first part of the 2012/13 Croydon JSNA, namely the **Overview Chapter** on Mental Health and Well-being.
- Other chapters from the 2012/13 Croydon JSNA (chapters on depression in adults, schizophrenia in adults, and the emotional health and well-being of children, as well as the Croydon Key Dataset) can be found on the Croydon Observatory website once completed:
  http://www.croydonobservatory.org/jsna/chapters201213/

What is mental health and well-being?

- Mental health is more than just the absence of mental illness; it is about resilience and well-being.
- Mental health is a **spectrum**. In a population like Croydon's, a small number will have a mental illness, and a similar number will be 'flourishing' at the other end of the spectrum. The bulk will be somewhere in the middle of these two extremes and have either 'moderate' mental health or be 'languishing'.
- The aim of mental health interventions should be to shift as many people as possible from one end of the spectrum, where people are languishing or have mental health problems, towards the other – in other words, to **improve population mental health**. This is the public mental health approach.
- Croydon has many **assets** for mental health promotion in terms of a thriving voluntary sector and many parks and open spaces, although this is more challenging in the north of the borough.
- The Overview Chapter focuses on how Croydon protect and promote good mental health and well-being in the population.

Why is it important to improve mental health and well-being?

- Mental health problems are extremely **common** and can affect anyone.
- Mental health problems are linked to **risk behaviours** like substance misuse and teenage pregnancy.
- The impact of mental health problems go beyond the individual.
- Mental health problems are **costly**.
- Improving mental health can improve community **resilience**.
- Improved mental health contributes to additional **positive outcomes** for people and communities such as reduced sickness and improved productivity.
- Mental health is **not just an issue for the NHS**. Several of the most important levers for improving well-being, for example planning, transport, education, leisure and housing, are the remit of **local government**.

What factors influence mental well-being?

- **Population characteristics** such as size, age, ethnic make-up and levels of physical health are important factors affecting mental health in any community. **Changes in the population size and structure of Croydon** mean that the numbers experiencing mental health problems is likely to rise, which means the numbers seeking help may also rise.
- It is very **difficult to predict** increased demand accurately. However, using the best model currently available, local information has been used to make **projections** of the impact of these changes in terms of mental health.
- In Croydon, the **population has grown** more quickly in the last ten years than was at first thought, and it is thought that some of this is due to internal and international migration, although data on migration is very unreliable.
- **Migration** can have positive and negative effects on mental health. Being reunited with family members after time apart can improve mental health, however, asylum seekers and refugees are often fleeing persecution, violence, disaster or disease and therefore have a greater risk of serious mental health problems.
- There is also a relationship with **ethnicity** and mental health. For example, people from black and minority ethnic populations have a three-fold increased risk of psychosis. The relationship is complex. Ethnicity interacts with other characteristics and differences in the levels and prevalence of mental health across ethnic groups are due to a number of factors, including socio-economic deprivation, diagnostic bias, racism and variation in access to culturally appropriate services.
- Another way in which Croydon is changing is that it is becoming increasingly deprived. **Deprivation** is strongly linked to some areas of mental health (such as schizophrenia and addictive behaviours). There is an association with less severe conditions such as depression, but this is less strong.
- The projections made in the chapter are likely to be an underestimate of demand for mental health services since the impact of the **recession** on mental health is difficult to quantify. There is however a known link between (for example) debt and mental health problems. **Unemployment** is also a risk factor for mental illness and is a key challenge facing Croydon, particularly for its young people.
- Mental health and housing are also closely connected. In the last year Croydon has seen an increase of 45% in the number of households accepted as being **homeless**.

What next?

- The chapter describes the **evidence based actions** needed to improve mental health across the '**lifecourse**', from birth to old age, and compares this with what Croydon is already doing. Gaps are highlighted in a series of recommendations, including
    - Croydon's health and well-being board adopting a number of mental health champions to the board, from elected members and senior managers.
    - Non-mental health professionals receiving appropriate mental health awareness training.
    - Promotion of the 'five ways to well-being' across Croydon (connecting with people, being active, giving, learning, and taking notice).

- Prioritising the health of pregnant women, particularly to identify and reduce post natal depression.
- Consideration of a package of measures to improve perinatal mental health.
- Prioritising parenting interventions with families with children at risk of conduct disorder and those experiencing behavioural problems.
- Increasing social connectedness and educational programmes for older adults e.g. Information Technology to overcome the memory effects of dementias and to reduce isolation.
- Raising awareness and explore access to social interventions in primary and community care pathways through social prescribing which are often delivered by the voluntary sector.
- Raising awareness of healthy ageing programmes for older people, particularly amongst GPs, and taking action to measure improvements in well-being.
- Targeting workplaces in Croydon to ensure employers are maximising opportunities to improve the mental well-being of their employees.
- Exploring the feasibility of developing 'play streets', particularly in the North of the Borough and maximise the benefits of the environment on mental health and well-being.

- The chapter goes on to consider the evidence **for integrating physical and mental health** and describes what is already being done in Croydon.
- The chapter concludes by summarising the ways in which mental health can be **measured** locally.

1. Introduction

What is a JSNA?
Joint Strategic Needs Assessment (JSNA) is a process that identifies current and future health and well-being needs in light of existing services. It provides information for future service planning by identifying the 'big picture' in terms of local health and well-being needs.

Joint: it is a partnership between statutory bodies, agencies, patient and public representative bodies and communities
Strategic: it looks across a broad time frame - both medium term (3 to 5 years) and longer term (5 to 10 years)
Needs: it examines needs, not wants or demands. Its focus is on the needs of the population, rather than the needs of the individual
Assessment: it attempts to assess needs, and to place them appropriately in context.

Thus JSNA is a **crucial tool for commissioners** and other decision makers.

The approach taken to the Croydon JSNA in recent years has been to combine one, broad 'overview' chapter on health and well-being with a small number of in-depth chapters on specific, key topic areas. Topic areas are prioritised from a long list of suggestions to the JSNA Steering Group, using a systematic prioritisation process. The final decision on key topic chapters is taken by the Health and Well-being Board.

Croydon JSNA 2012/13
This year's JSNA focuses entirely on **mental health**. This is because of the high demand that was demonstrated by stakeholders across Croydon for in depth consideration of specific mental health issues.

The 2012/13 JSNA is made up of **five separate sections**, each of which are or will be made available on the Croydon Observatory website. This chapter, the **Overview Chapter**, describes the big picture of health and well-being in Croydon and considers the impact of demographic change on population mental health in Croydon. It should be read in conjunction with separate and forthcoming chapters on the following:

- **Depression** in adults
- **Schizophrenia** in adults
- **Emotional health and well-being of children** aged 0-18 years

These four chapters should also be viewed in conjunction with the updated **Key Dataset for Croydon**. This is published separately from the Overview Chapter this year since it is broader than mental health. The Key Dataset describes Croydon's position relative to London and England for over 200 indicators relating to health and well-being.

2. What is mental health and well-being?

"How people feel is not an elusive or abstract concept, but a significant public health indicator; as significant as rates of smoking, obesity and physical activity." [1]

Mental health is a term which is used in a number of different ways. It has often focussed on mental illness. However, a main aim of this Overview Chapter is to shift the focus away from mental illness to **consider how good mental health and well-being can be protected and promoted in Croydon.**

Mental health is not simply the absence of mental illness. It is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity.[2]

The main terms that will be used in the Overview Chapter to describe mental health are defined in Box 1.

Box 1 – Glossary of mental health terms

Mental illness refers to common **mental disorders** such as depression and anxiety and more serious mental illness such as schizophrenia and bipolar disorder.

Well-being includes feeling happy and satisfied but goes beyond this to feeling fulfilled, developing as a person, and making a contribution to society.

Resilience is a term that is linked to mental well-being and is the ability to cope with change, challenge and adversity. It can include, but is more than, 'bouncing back' from difficulties.

Mental capital is related to resilience and can be built up throughout life, especially during infancy and childhood. It can also be reduced if not protected. Mental capital is an asset and a core element of resilience for individuals, families, organisations and communities.

Public mental health focuses on the wider prevention of mental illness and promotion of mental health and well-being across the life course.

Figure 1 visually describes how mental health tends to be 'distributed' in our society, from 'flourishing' at one end of the spectrum, to having a mental disorder at the other. In a population like Croydon, approximately 17% of people are said to be 'flourishing', and this is comparable to the proportion with a mental disorder. Between these two

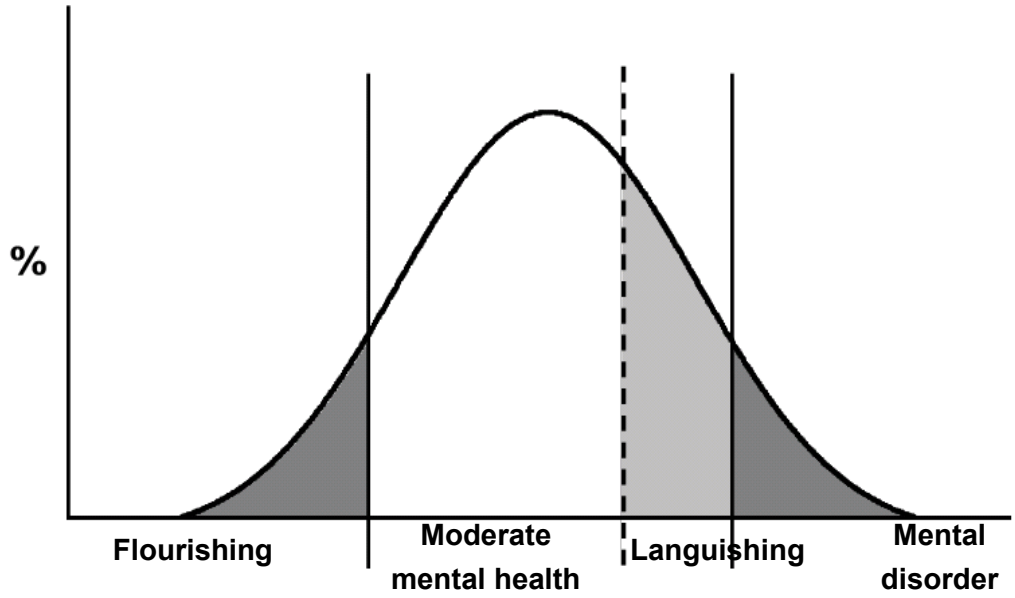
[1] Department of Health (2001) Making it Happen: a guide to delivering mental health promotion. London:DH.

[2] Friedli,L. (2009) Mental Health, Resilience & Inequalities. World Health Organisation

extremes, the bulk of the population have 'moderate' mental health, and many (about another 11%) are 'languishing' i.e. not reaching their full potential.

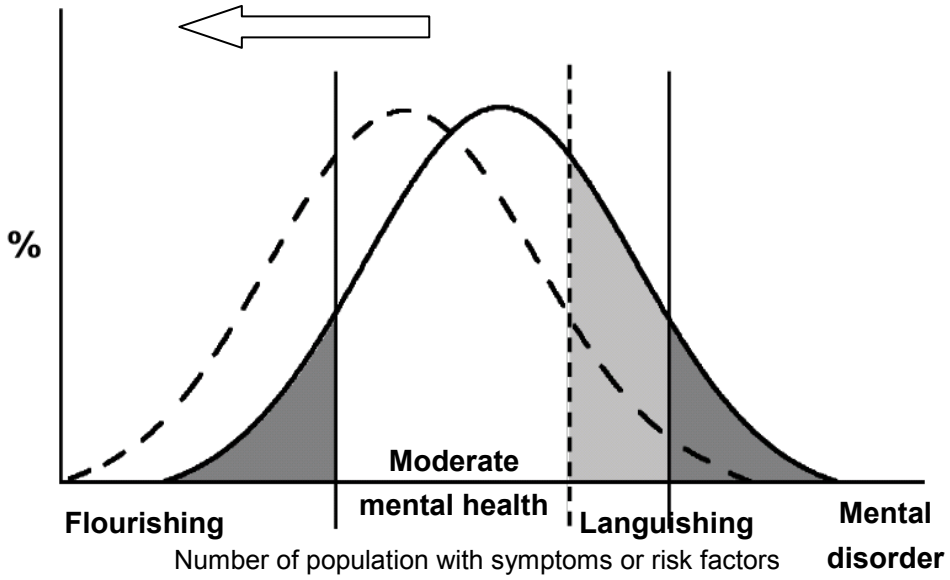
As well as providing an approximation of the different states of mental health, this serves to highlight that **the absence of mental illness does not necessarily imply a presence of good mental health.** Any state of mental health less than 'flourishing' is associated with increased impairment and burden to self and society.

Figure 1: The mental health spectrum[3]



By promoting mental health in the population, the aim is that more people will move from the 'languishing' and 'mental disorder' segments into the 'flourishing' and moderate sections and have a better state of mental health (Figure 2).

Figure 2: The effect of shifting the average of the mental health spectrum



[3] From: Huppert Ch.12 in Huppert et al. (Eds) The Science of Well-being

2.1 Policy overview

There has been a significant shift in policy on mental health in the last few years. This has been strengthened by a developing evidence base around how to promote and protect mental health and well-being. Publications include:

- Foresight Report: Mental Capital and Well-being (2008)
- New Horizons: A Shared Vision for Mental Health (2009)
- Confident Communities, Brighter Futures: A framework for developing well-being (2010)
- No health without mental health: a cross-government mental health outcomes strategy (2011)[4]

Within these policy documents there is a strong **emphasis on promoting good mental health** across local populations, taking **preventative action and intervening earl**y, improving the well-being, quality of life and health of those living with and recovering from mental illness, and addressing the key **social determinants of health**.

NICE Guidance

The National Institute for Health and Clinical Excellence (NICE) has published a range of evidence based guidance on promoting and protecting mental health and well-being which underpins national policy. The Marmot Review - Fair society, Healthy Lives (2010) also supports the public mental health and well-being agenda through six recommendations to:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of prevention

It is across all these policy areas that there is the strongest evidence for intervening around public mental health and well-being, examples of which will be outlined throughout the chapter, alongside the relevant NICE guidance.

[4] Mental health foundation has produced useful guides on the government strategy for Local Authorities, CCGs, Health and Wellbeing boards and Health watch

3. Why is it important to improve mental health?

"Improving mental health benefits everyone. There is a clear association between good mental health and better societal outcomes: life expectancy, physical health, educational achievement, criminality and employment status."[5]

Mental health problems are extremely common and can affect anyone.
One in four people will experience at least one mental health condition at some point in their life.[6] They can affect anyone in Croydon, regardless of age, race, gender or social background, although some groups have a higher risk of mental disorder and lower levels of well-being. Mental health problems can start early in life and last a lifetime, particularly if inadequately treated.

Mental health is linked to risk behaviours.
Poor mental health is often the underlying factor behind risk behaviours (including smoking and substance abuse) and health outcomes, including teenage pregnancy, eating disorders, injuries, bullying and violent behaviour, including domestic violence.[7]

Mental health and well-being is everyone's business.
Mental health problems do not only affect the individual involved, but also impact on families, employers and communities.

Mental health problems are costly to society.
One pound out of every £8 spent by the NHS in Croydon goes on the treatment of mental health problems. Mental health is the biggest single area of spend in the NHS.[8] A large proportion of the money spent on mental health goes into high end services for the relatively small number of people with more serious mental health problems. The majority of people with mental health problems have less serious conditions, but these still impact on services. Most people with mental health problems are supported solely by GPs and other professionals working in primary care. Around ten per cent of patients with mental health problems are referred on to specialist teams. Around one in three GP consultations concern mental health problems.[9]

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[5] World Health Organization (2004) Prevention of mental disorders: effective interventions and policy options: summary report Geneva: Prevention Research Centre of the Universities of Nijmegen and Maastricht.
[6] No health without mental health: a cross-government mental health outcomes strategy for people of all ages.HM Government, Feb 2011.
[7] No health without Royal College of Psychiatrists Position statement: public mental health the case for action
[8] B Alves (2011) Croydon mental health PBMA review: final report and recommendations
[9] R Jenkins, A McCulloch, L Friedli and C Parker, (2002) Developing a National Mental Health Policy, Maudesley Monograph 43, Hove, The Psychology Press

Improving mental health can improve community resilience
Focusing only on those people labelled with mental health problems or 'at risk' or 'vulnerable' (see appendix 1) can undermine the mental health and well-being of those individuals and their communities. A helpful comparison is to use the principle of **'herd immunity',** i.e. the more people in a community (such as a school, workplace or neighbourhood) who have **high levels of good mental health**, the more likely it will be that those with both acute and long term problems can be supported because the **community is resilient.**[10]

As this chapter outlines, through effective promotion, prevention, early identification and intervention, the impact of poor mental health can be reduced and well-being enhanced.

3.1 Improving mental health contributes to additional positive outcomes

Action to improve mental health and well-being will contribute to a wide range of positive outcomes for individuals and communities in addition to the prevention of mental health problems, for example:

- Improved educational attainment and outcomes
- Increased quality of life and overall well-being
- Safer communities with less crime
- Reduced health inequalities – both physical and mental health-related and lower health care utilisation
- Reduced sickness absence
- Improved productivity and employment retention. [11]

Recommendation 1
It is recommended that Public Health Croydon prioritise public mental health in Croydon based on the available evidence of what works in the short, medium and long term. Encourage the mainstreaming of well-being in as wide a range of settings and organisations as possible by co-ordinating awareness raising and appropriate training across organisations and sectors.

Recommendation 2
To promote a wider perspective of mental health including awareness raising of the protective factors, it is recommended that the health and well-being board adopt a number of mental health champions to the board, from elected members and senior managers.

[10] Stewart- Brown 1998; Blair et al 2003 p.143.
[11] CSIP (2005) Making it Possible: Improving Mental Health and well-being in England

3.2 Effective public mental health approaches

An effective public mental health approach requires:

- **Universal interventions**: actions to promote mental well-being and reduce the risk factors for poor mental health across the whole population of Croydon.
- **Targeted** interventions towards those groups who are less likely to benefit from universal approaches or are at risk of developing mental illness, including the most socially excluded groups and those with protected characteristics (Box 2) e.g. through children centres and schools, workplaces, local communities.
- Support for recovery and better outcomes for **people who have mental health problems** and other vulnerable groups. These groups may need additional support to enable them to participate in activities that improve mental well-being. This might include providing peer support or buddies to help with motivation for exercise or extra assistance to get back into employment, for example.

The final level will be explored in more depth in the relevant key topic chapters on depression, schizophrenia and the emotional health and wellbeing of children.

Recommendation 3

To ensure that the recommendations in this Chapter are taken forward, there is a need for local action plans for public mental health to be developed, based on each of the 2012/13 JSNA chapters. Public Health Croydon should work with commissioners and other stakeholders to develop a clear strategy and action plan for public mental health based on each of the chapters of the JSNA.

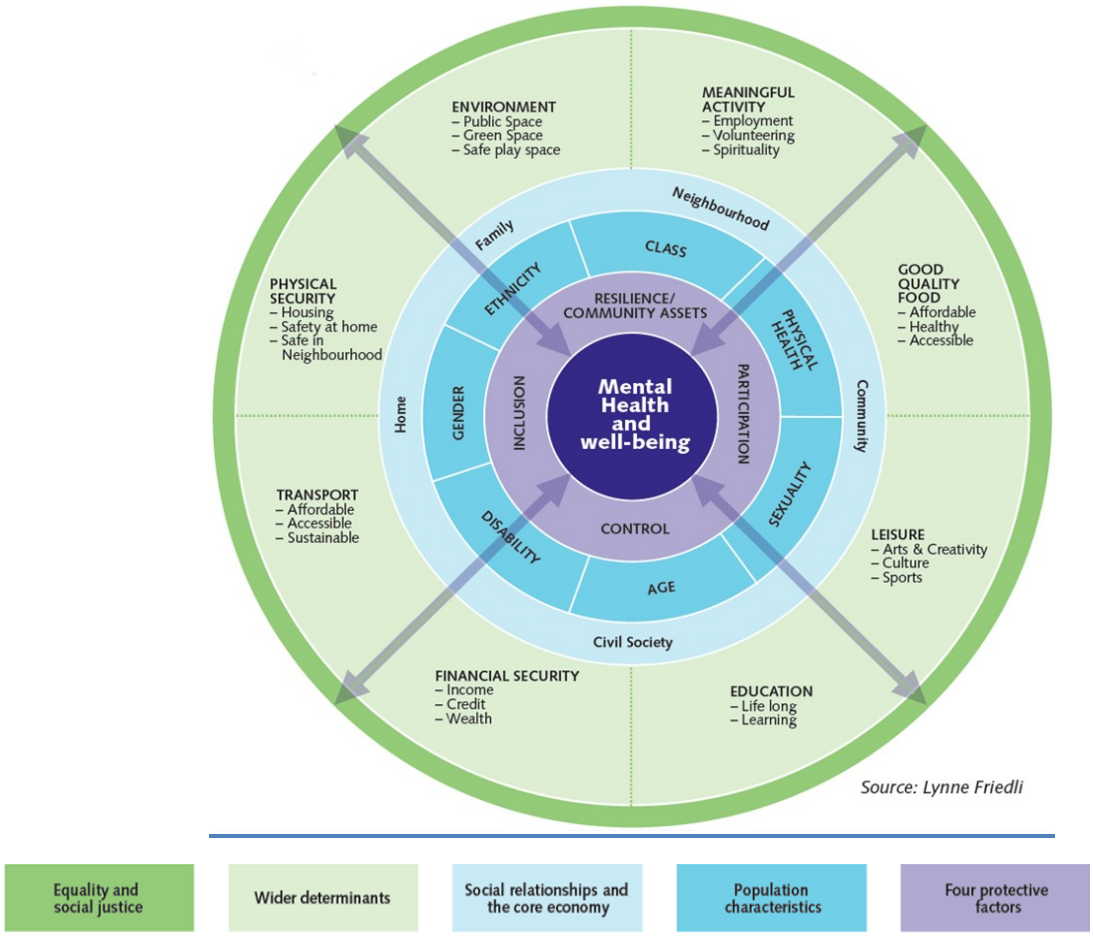
4. Factors that influence mental health and well-being

> ***"Many of the risk and protective factors for good mental health lie well outside of mental health services: they are in family, friends, workplaces, community and wider society."***[12]

Factors that influence mental health and well-being are **interrelated**. At any one time, a mix of social, psychological, and biological factors determine the level of mental health of a person.[13]

All of the factors that influence well-being demonstrate that improving mental health is **not just an issue for the NHS**. As public health moves into the local authority in April 2013 **Croydon Council will have a new responsibility for health and well-being**. There are opportunities to influence several of the most important levers for improving well-being, for example planning, transport, education, leisure and housing, which are under the remit of the Local Authority.

Figure 3: A dynamic model of mental well-being and framework for the JSNA Overview Chapter



Source: The Mental Well-being Impact Assessment Toolkit, National Mental Health Development Unit

[12] No health without mental health: a cross-government mental health outcomes strategy (2011)
[13] Rogers, A. and Pilgrim, D. 2005. A Sociology of Mental Health and Illness. Maidenhead: Open University Press.

4.1 The overview structure and framework

Figure 3 shows the key factors that influence mental health and well-being. The Overview Chapter will use this model to look at Croydon specific data (where it is available) and the implications for mental health and well-being for our population. To improve mental health and well-being in Croydon, each part of the model needs to be addressed in a systematic and co-ordinated way.

An individual's mental health must be understood in the context of the circumstances of their life. For example, employment can provide financial security, a purpose and a social network (protective factors for good mental health), but working very long hours can cause stress (risk factor for mental illness).

There are **five layers to the framework** which will be considered in turn in this chapter:

i) Population characteristics and considerations for mental health
This section looks at how population characteristics such as age, gender, disability, physical health and ethnicity influence mental health and well-being, which in turn are influenced by wider determinants. Using the best model currently available, local information has been included in this section to make projections of the impact of these changes in terms of mental health.

ii) Equality and social justice and the impact on mental health
Particular groups who suffer disadvantage and discrimination may be at risk of higher rates of mental ill health and poorer mental well-being. Specific issues around fairness or inequalities to mental health and well-being[14] will be outlined in **blue boxes** throughout this chapter.

Alongside those characteristics that are protected by law (see Box 2), **deprivation level** is an important factor to mental health and will be considered within this section.

iii) Wider determinants that impact on mental health
The chapter will assess the impact of the wider determinants of health such as financial security, education, employment, housing and access to green spaces and services.

iv) Enhancing mental health through social relationships and the core economy.
The chapter will consider how the core economy of home, family and community relations contributes to mental health and well-being.

v) Promoting the four core protective factors
There are **four core protective factors** that have a significant influence on mental health and well-being: enhancing control, increasing resilience, facilitating participation and promoting inclusion[15].

[14] Friedli, 2009 Mental health, resilience and inequalities (WHO)
[15] http://www.apho.org.uk/default.aspx?RID=70494

It is possible to strengthen these factors at an **individual level** (e.g. providing flexible working can enhance individual control), and also at a **community level** (e.g. a credit union may enhance financial control within a community).

In addition to the five layers of the framework described above, the chapter will look at the following:

vi) Enhancing mental health over the life course
The evidence of effectiveness of interventions that protect mental health at different life stages will also be assessed, and gaps highlighted.

vii) Enhancing mental health by considering the relationship between mental and physical health
The chapter will assess the relationship between physical health and mental well-being and the implications of this.

Recommendation 4
All Croydon strategies and commissioning decisions need to consider each aspect of the framework to ensure that they enhance the protective factors for good mental health. This could be taken forward through mental well-being impact assessment or health impact assessment.

Box 2 – Protected characteristics and mental health

The Equality Act 2010 provides protection from discrimination for people's individual characteristics (termed protected characteristics). The Equality Act requires public bodies to take account of nine protected characteristics:

- Age
- Disability
- Race
- Religion or belief
- Sex
- Sexual Orientation
- Gender Reassignment
- Marriage and civil partnership
- Pregnancy and maternity

Many people will have more than one protected characteristic and therefore may experience multiple discrimination. There is a particular need to reduce risk factors and promote the protective factors of mental health in these groups.

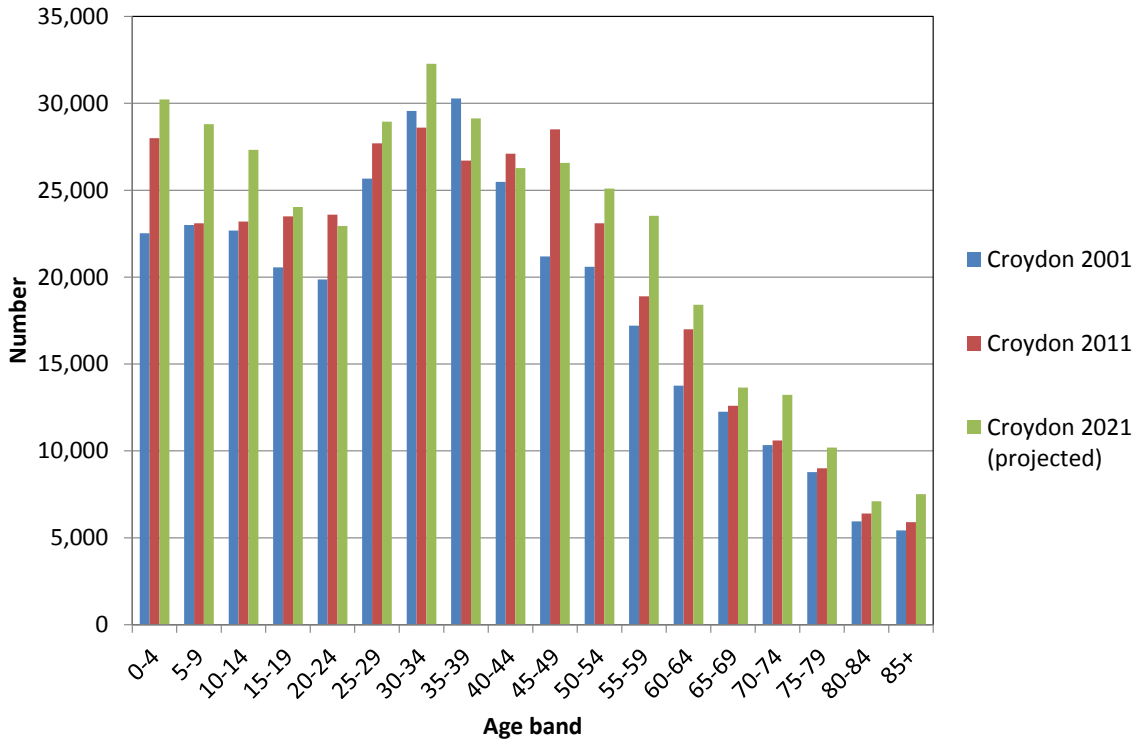
5. Croydon's population characteristics and implications for mental health

Figure 3 demonstrated that population characteristics such as age, gender, ethnicity and physical health are important factors in affecting mental health. Nationally, the population is ageing as life expectancy increases and the baby boomer generation approaches older age. **Compared to other areas, however, Croydon has a relatively young population.** The present high birth rate and effects of migration are expected to result in growth in some of the younger as well as older age groups in coming years.

By 2011, Croydon had a larger number of children aged under five and a larger number of people aged 45 to 64 than in the previous ten years.

By 2021, the highest growth is projected to be in the age groups 0 to 14, 30 to 39 and the over 55s.

Figure 4: Change in age structure of Croydon's population, 2001, 2011 and 2021 (projected)



Source: 2011 Census: Population and household estimates for England and Wales, published 16/07/2012; local population projections for 2021 based on 2011 Census and GLA 2011 SHLAA Projections

Box 3 – Age, sex and mental health considerations

Age and mental health

- Half of lifetime mental illness (excluding dementia) starts by the age of 14[16] and early intervention to treat childhood mental illness will reduce the risk of mental health problems in adulthood. The JSNA chapter on Emotional Health and Wellbeing of Children considers this in more detail and section 9 of the overview chapter will look at the importance of promoting mental well-being in children.

- Age should not play a part in allowing or restricting access to the most appropriate care and treatment for anyone with mental health problems.

Sex and mental health

- There are differences in the way mental health presents between men and women. Recorded rates of anxiety and depression are between 1.5 and two times higher in women than in men.[17] Rates of self-harm are two to three times higher in women than in men.[17] Three quarters of suicides are male.[18] Men are less likely than women to seek help for emotional health problems, and more likely to express emotional distress in behavioural and conduct disorders.[18]

5.1 A growing population - results of the 2011 census

The first results of the 2011 census show that Croydon's population has grown more quickly in the last ten years than was projected by the Office for National Statistics (ONS). The usual resident population[19] of Croydon was estimated to be **363,400** on 27th March 2011[20]. This is **13,600 more people** (or 3.9% higher) than was estimated by ONS in projections for 2011 based on the previous census (349,800) and 28,000 more people (or 8.4% higher) than in 2001 (335,100)[21].

Figure 5 shows the population estimates and projections that were in use prior to the release of the first results from the 2001 Census (blue line), compared with the population estimates from the 2001 and 2011 census (purple dots).

[16] Kessler, R.C., Berglund, P, Demler, O. et al. (2005) Lifetime prevalence and age-of onset distributions of DSM-IV disorders in the National Comorbidity Survey replication. Archives of General Psychiatry; 62(6): 593–602;

[17] Department of Health (2002). Women's mental health: into the mainstream. London: Department of Health.

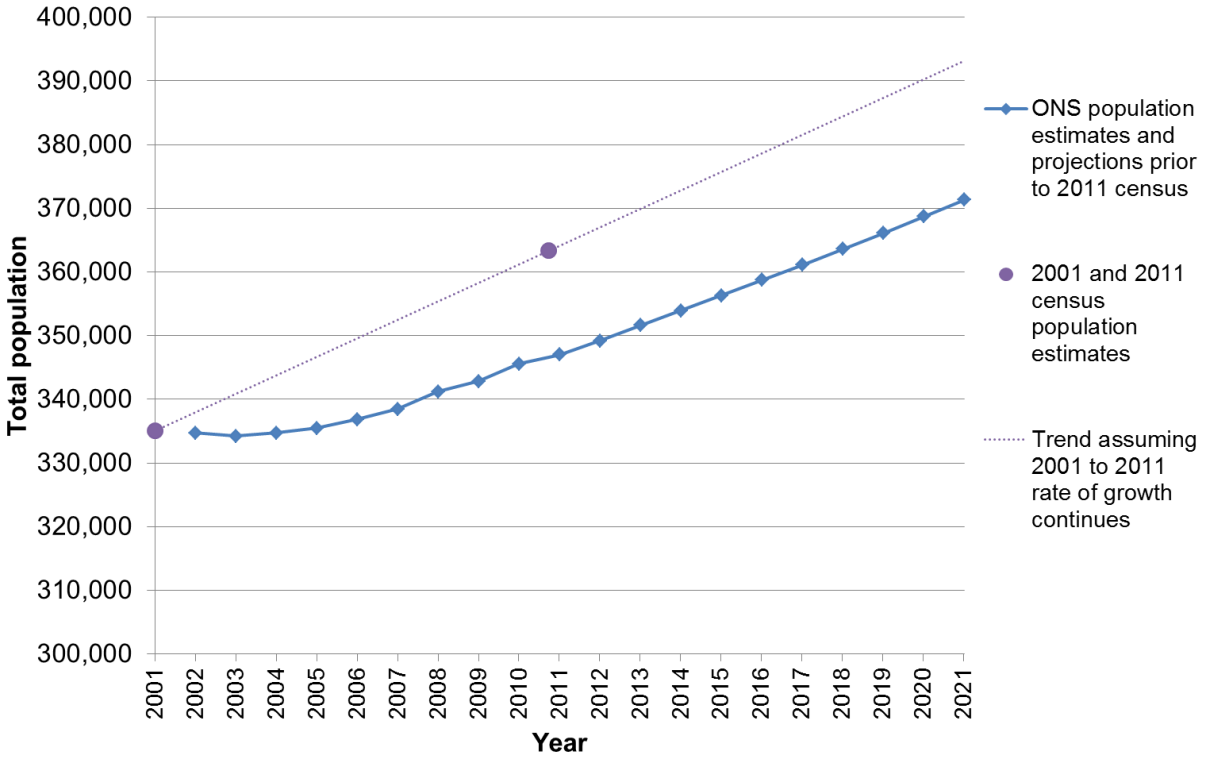
[18] Wilkins D (2010). Untold problems: a review of the essential issues in the mental health of men and boys. London: Men's Health Forum

[19] A usual resident is defined as a person who has stayed or intends to stay in the UK for more than 12 months. The 2011 census also counted 1,000 short-term residents from outside of the UK who were living in Croydon at the time of the census.

[20] 2011 Census: Population and household estimates for England and Wales, published 16/07/2012

[21] Office for National Statistics mid-2001 population estimates. ONS recommend comparing with mid-year population estimates rather than the 2001 Census population count as additional changes were made to the mid-year estimates methodology following the 2001 Census.

Figure 5: 2011 Census compared with previous population estimates[22]



Source: Mid-year population estimates and projections, Office for National Statistics; 2011 Census: Population and household estimates for England and Wales, published 16/07/2012

5.2 Migration from within and outside the UK

5.2.1 Migration within the UK

Each year, approximately **18,000 people move into Croydon and 20,000 people move out of Croydon** to elsewhere within the UK[23]. Croydon's population is subject to a north to south flow of people migrating from Inner South London to Outer South London and from Outer South London to Surrey (Figure 6).

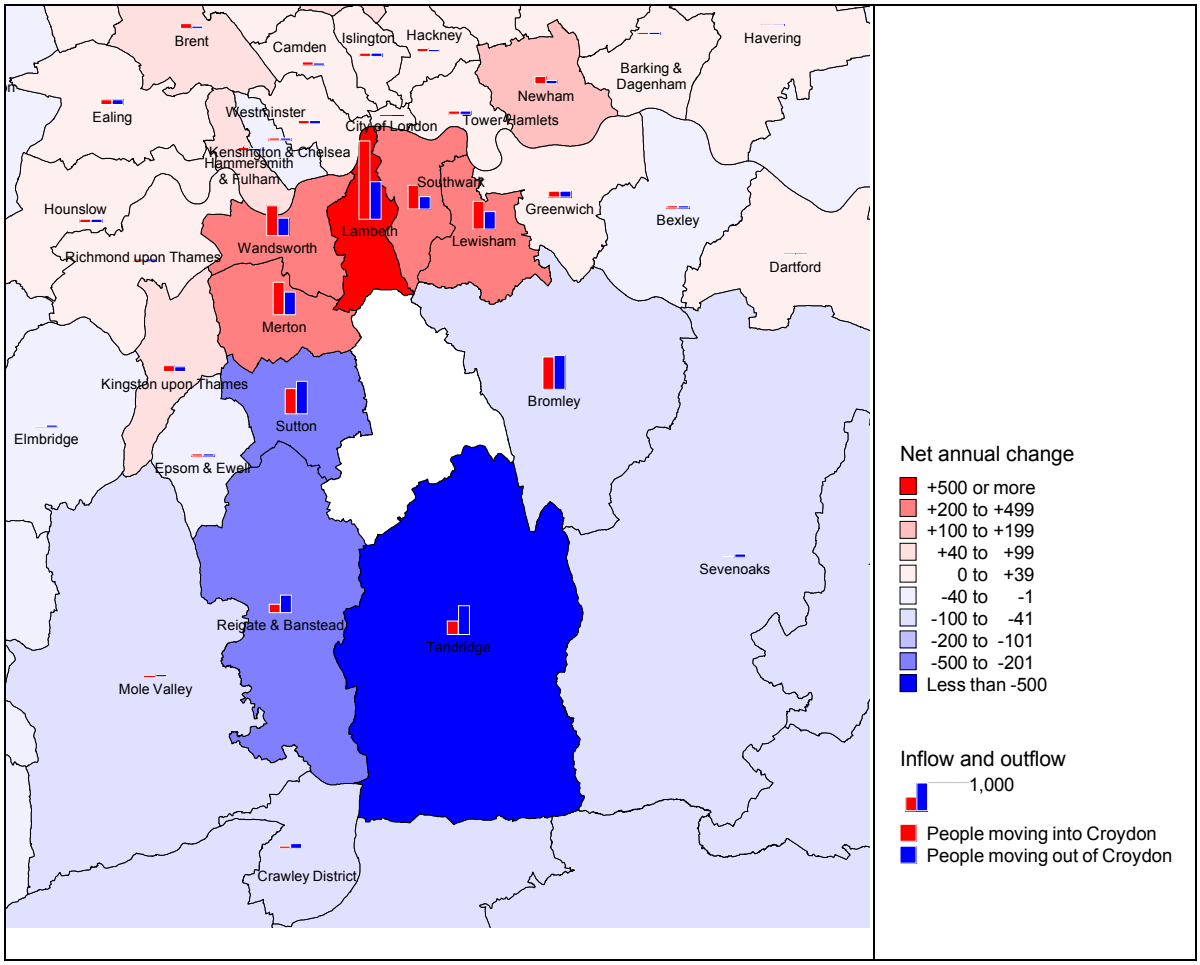
This means there is a net inflow of people from more deprived areas than Croydon and a net outflow of people to more affluent areas. Over time, these **migration flows** are likely to **result in Croydon's population becoming more deprived.**

The data shows a net inflow to Croydon of approximately 3,000 people per year from other London boroughs, and a net outflow of approximately 3,000 people per year to local authorities outside of London. The largest inflow/outflow to any local authority is between Croydon and Lambeth. These are estimates produced by the Office for National Statistics, based mainly on transfer of GP registrations data.

[22] ONS recommend comparing with mid-year population estimates rather than the 2001 Census population count as additional changes were made to the mid-year estimates methodology following the 2001 Census.

[23] Average annual internal migration during 2007 to 2010, taken from Local Area Migration Indicators, Office for National Statistics. Note: these data do not include short-term residents who live in an area for less than 1 year.

Figure 6: Map of migration estimates for Croydon showing inflow, outflow and net migration from surrounding local authorities



Source: Internal migration by local authorities in England and Wales, mid-2010 to mid-2011, Office for National Statistics

5.2.2 Migration from outside the UK

Croydon has 6,000-7,000 new immigrants from outside the UK per year and at least 3,000 emigrants[24]. The main areas immigrants have been coming from in recent years are South Asia (India, Pakistan and Sri Lanka: 2,300 people per year), Eastern Europe (Poland, Romania, Lithuania, Bulgaria, Hungary: 1,100 people per year) and certain countries in Africa (Ghana and Nigeria: 500 people per year).

It is important to note that migration data is currently very **unreliable** and it will not be possible to reliably compare Croydon with elsewhere until the publication of the census data in 2013.

[24] Immigrants data is based on new patient GP registrations and new national insurance number allocations for the last 3 years and emigrants data is based on estimates for the last 3 years, taken from the Local Area Migration Indicators, Office for National Statistics.

5.3 Asylum seekers and refugees

Croydon Council provides housing and subsistence to a relatively small number of adult asylum seekers (110 in March 2012[25]) compared to other London boroughs, but is responsible for a very high number of unaccompanied asylum seeking children (UASC) (440 in March 2011, which is 43% of UASC in London[26]). Although a large number of refugees and asylum seekers come into Croydon as a result of the location of the Home Office UK Border Agency in Croydon, the Home Office is responsible for housing adult asylum seekers, whereas Croydon Council is responsible for placing unaccompanied asylum seeking children. Many children are placed in Croydon, some outside. See 2010-11 JSNA chapter on Looked After Children for more information:

The health needs of the migrant population are very heterogeneous, reflecting the diversity of where people come from, the circumstances of their migration and the condition in which they live post migration e.g. housing, employment status.

5.4 Migration and mental health

Migration can have positive and negative effects on mental health. At an individual level, being reunited with family members after time apart can improve mental health and overall well-being. However, asylum seekers and refugees are often fleeing persecution, violence, disaster or disease and therefore have a greater risk of serious mental health problems.[27] Female refugees and asylum seekers have high rates of post-traumatic stress disorder and other mental illness.[28]

Frequent household moves may be a symptom of multiple social and health problems; children in such families can suffer from disruption to their education, and may also be more at risk of violence and sexual abuse if services are unable to track them.[29]

The stress arising from moving home and associated aspects such as adapting to a new culture can all increase the risk of poor mental health. Access to health services is restricted if people are not registered with GPs.

Recommendation 5

All frontline workers coming into contact with those who have recently arrived in the UK should encourage them to register with a GP in order be able to access mental health services, should it be required.

[25] Immigration Statistics, Home Office (http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/immigration-asylum-research/immigration-q1-2012/?view=Standard&pubID=1024555)

[26] Children looked after by local authorities in England, year ending March 2011, Department for Education (http://www.education.gov.uk/rsgateway/DB/SFR/s001026/index.shtml)

[27] Department of Health (2010): Understanding health needs of migrants in the South East region.

[28] Department of Health (2002). Women's mental health: into the mainstream. London: Department of Health.

[29] Travers, Tunstall, & Whitehead, 2007

5.4.1 Why were previous population estimates much lower than the census?

The most difficult component of population change to estimate is migration, as there is no compulsory system within the UK to record movements of the population. It is likely that population estimates prior to the 2011 census **underestimated net migration into Croydon**.

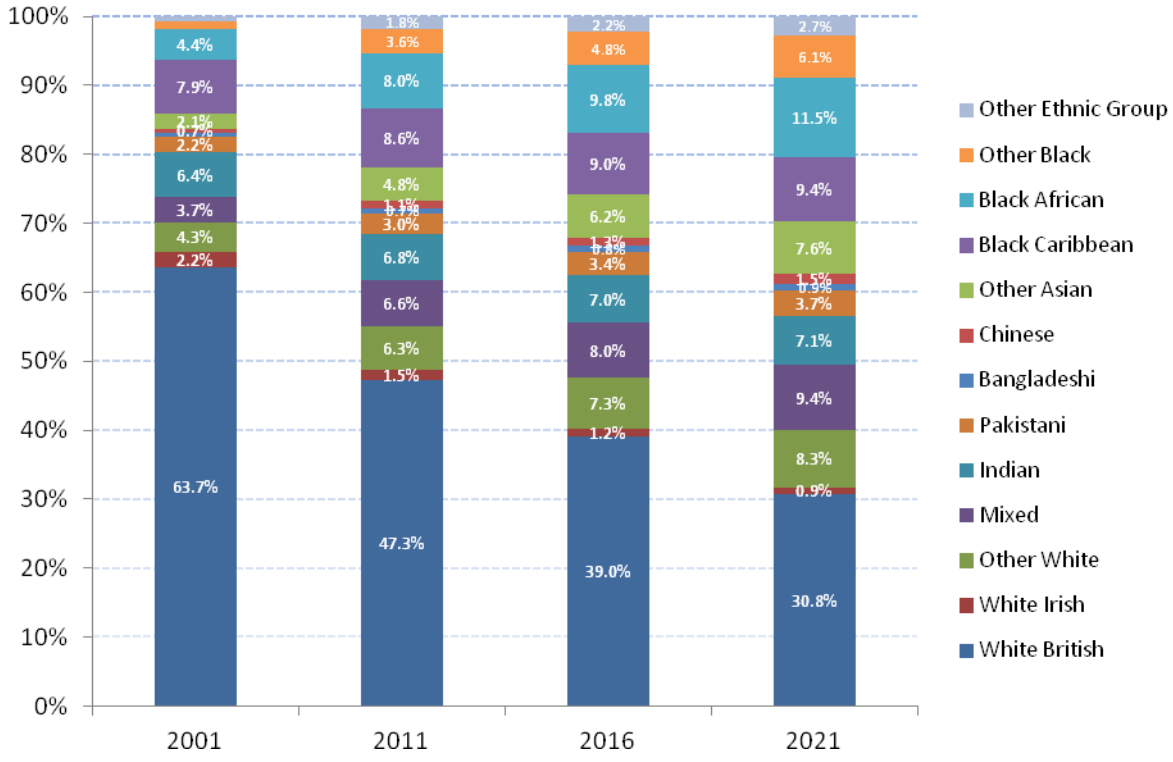
In addition to population estimates, the Office for National Statistics publishes data on new GP registrations and national insurance registrations for immigrants into the UK. These are much higher than the international migration component of the population estimates, which are based on the International Passenger Survey. Based on these figures, it is possible that the difference may be entirely due to underestimating **international migration**. Alternatively, **internal migration** within the UK may also be underestimated.

5.5 A culturally diverse population

5.5.1 Ethnic groups

Over half of Croydon's population are now from black, Asian and minority ethnic groups, and the proportion has been increasing over time (Figure 7). The relationship between ethnicity and mental health is complex, with well-documented inequalities at a national level with respect to mental health. Figure 7 shows projections based on data from the censuses.

Figure 7 Ethnicity* distribution for Croydon's population based on trends in the the last two census'



Source: Data from 2001 and 2011 Census

* Records with White and Black African, White and Black Caribbean, and White and Black Asian are included in the Mixed category.

Box 4 – Ethnicity and mental health considerations

- Individuals from a black and minority ethnic (BME) background do not form a homogeneous group. There is a need to recognise both the differences in the way inequalities affect different ethnic groups and also the interplay between race and other protected characteristics.

- Differences in the levels and prevalence of mental health across ethnic groups are due to a number of factors, including socio-economic deprivation, diagnostic bias, racism and variation in access to culturally appropriate services.

- Higher rates of suicide; self-harm and eating disorders are found among Asian adolescent girls, compared with the general female population.[30]

- People from Black and minority ethnic populations have a three-fold increased risk of psychosis[31] (seven-fold increased risk in African–Caribbean groups[32]) and a two- to three-fold increased risk of suicide.[33]

- Psychiatric inpatients from Black population groups are more likely to enter the mental health system via the criminal justice system or social services, rather than primary care or specialist community teams. They are also more likely to be detained under the Mental Health Act.[34]

- BME groups (mixed/multiple ethnic groups and Black/African/Caribbean/Black British) report significantly lower than average ratings for 'life satisfaction' compared with the UK average[35]

5.6 Implications of population changes for mental health services

The above has outlined some of the important population changes that have been and are taking place in Croydon, particularly in terms of its growing population. Demand for services is partly driven by changes in the number of people who need them. However,

[30] Department of Health (2002). Women's mental health: into the mainstream. London: Department of Health.
[31] Kirkbride JB, Barker D, Cowden F, et al (2008) Psychoses, ethnicity and socio-economic status. British Journal of Psychiatry, 193, 18–24
[32] Fearon P, Kirkbride J, Morgan C, et al (2006) Incidence of schizophrenia and other psychoses in ethnic minority groups: results from the MRC AESOP Study. Psychological Medicine, 36, 1541–1550.
[33] Bhui K, Mckenzie K (2008) Rates and risk factors by ethnic group for suicides within a year of contact with mental health services in England and Wales. Psychiatric Services, 59, 414–420.
[34] See Count Me In census reports 2005–2009 http://www.cqc.org.uk/guidanceforprofessionals/mentalhealth/countmeincensus.cfm
[35] ONS, 2012

demand is difficult to predict accurately. This is partly because some of the information underpinning our understanding of the structural changes taking place (such as around migration) is unreliable and at the time of writing the full release of the 2011 Census data is not yet available. In addition, not all of those who have a particular health problem (particularly a mental health problem) will recognise this, or seek help. Finally, not all of those with a risk factor for mental health will develop mental health problems.

However, using available data, projections have been made of the number of people in Croydon with mental health conditions for the years leading to 2021. The methods used (summarised in Box 5) are complex and more information is contained in Appendix 1. In summary, different methods have been used for different indicators based for example on whether data on prevalence are available nationally or locally, and for undiagnosed as well as for diagnosed cases. In all cases it has been possible to factor in changes in age and sex. Changes in deprivation level have been factored in where possible. The 'best' available method has been used in each case.

It is important to note that each method has been based on the assumptions that growth in Croydon's population will continue at the same rate as between the 2001 and 2011 Censuses, which may or may not be the case.

The resulting projections are shown in Table 1.

Box 5 Methods used in calculation of projections

A. **National** prevalence data from surveys of diagnosed and undiagnosed cases has been applied to population projections by **age and sex,** not including an adjustment for deprivation.

B. **Local** prevalence data from GP diagnosed cases has been applied to population projections by **age and sex**, including an adjustment based on recent trends in **deprivation**[36].

C. Projecting forward as a **linear trend** the number of GP diagnosed cases of the condition[37].

Projections for **children's services** have also been made and will be included in the chapter on Emotional Health and Wellbeing of Children.

[36] The adjustment assumes that changes in deprivation in Croydon will continue at the same rate as between 2001 and 2008.

[37] This method was used for conditions where prevalence rates appeared to be increasing over time rather than remaining stable.

Table 1: Estimated numbers of adults with mental health conditions in Croydon, projected to 2021

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
1) Dementia (diagnosed+undiagnosed)	3,250	3,291	3,337	3,387	3,443	3,514	3,587	3,663	3,738	3,821
2) Dementia (diagnosed)	1,540	1,575	1,653	1,732	1,812	1,890	1,970	2,050	2,131	2,214
3) Mild alcohol dependence (diagnosed+undiagnosed)	16,404	16,512	16,615	16,702	16,780	16,809	16,845	16,892	16,944	16,993
4) Moderate or severe alcohol dependence (diagnosed+undiagnosed)	1,407	1,413	1,420	1,427	1,434	1,435	1,438	1,443	1,449	1,455
5) Drug dependence including cannabis (diagnosed+undiagnosed)	10,385	10,446	10,508	10,552	10,585	10,594	10,617	10,653	10,694	10,735
6) Drug dependence excluding cannabis (diagnosed+undiagnosed)	2,745	2,761	2,777	2,791	2,802	2,807	2,815	2,826	2,838	2,850
7) Problem gambling (diagnosed+undiagnosed)	2,230	2,245	2,260	2,272	2,284	2,290	2,297	2,306	2,315	2,325
8) Serious mental illness (diagnosed)	3,922	3,985	4,094	4,203	4,314	4,418	4,523	4,630	4,738	4,847
9) Schizophrenia (diagnosed)	1,735	1,764	1,812	1,861	1,910	1,957	2,004	2,053	2,102	2,152
10) Bipolar disorder (diagnosed)	856	869	893	916	940	963	985	1,008	1,032	1,055
11) Other psychoses (diagnosed)	1,331	1,352	1,389	1,426	1,464	1,498	1,534	1,569	1,605	1,641
12) Depression at a point in time (diagnosed+undiagnosed)	6,949	6,995	7,041	7,084	7,126	7,148	7,171	7,195	7,223	7,250
13) Depression in last 5 years (diagnosed)	19,969	20,120	20,288	20,445	20,575	20,686	20,786	20,890	21,007	21,131
14) Mixed anxiety and depressive disorder (diagnosed+undiagnosed)	26,715	26,923	27,121	27,304	27,478	27,586	27,698	27,817	27,940	28,059
15) Generalised anxiety disorder (diagnosed+undiagnosed)	12,811	12,903	12,994	13,083	13,172	13,228	13,284	13,345	13,409	13,471
16) Phobias (diagnosed+undiagnosed)	4,289	4,315	4,343	4,373	4,401	4,420	4,440	4,461	4,483	4,504
17) Obsessive compulsive disorder (diagnosed+undiagnosed)	3,398	3,420	3,440	3,457	3,470	3,475	3,483	3,494	3,505	3,516
18) Panic disorder (diagnosed+undiagnosed)	3,207	3,229	3,252	3,275	3,297	3,311	3,328	3,345	3,363	3,380
19) Any common mental disorder (diagnosed+undiagnosed)	47,824	48,178	48,522	48,848	49,159	49,354	49,560	49,779	50,009	50,230
20) Postnatal depression (incidence, diagnosed+undiagnosed)	717	738	759	781	800	820	841	868	892	918
21) Post-traumatic stress disorder (diagnosed+undiagnosed)	8,922	8,980	9,036	9,085	9,127	9,143	9,161	9,185	9,213	9,239
22) Eating disorder (diagnosed+undiagnosed)	4,887	4,922	4,950	4,973	4,989	4,993	4,998	5,007	5,017	5,025
23) Personality disorder (diagnosed+undiagnosed)	2,550	2,572	2,591	2,606	2,618	2,624	2,630	2,636	2,642	2,647
24) Autism (diagnosed+undiagnosed)	3,156	3,180	3,204	3,227	3,250	3,267	3,284	3,304	3,324	3,345
25) Autism (diagnosed)	464	494	536	578	621	663	706	750	794	839
26) Learning disability (diagnosed+undiagnosed)	6,376	6,420	6,465	6,508	6,549	6,575	6,604	6,639	6,675	6,712
27) Learning disability (diagnosed)	1,376	1,422	1,462	1,502	1,542	1,580	1,618	1,658	1,699	1,740

Source: Croydon Public Health Intelligence Team (C-PHIT)

(Information on data sources can be found in Appendix 1).

Recommendation 6

As new Census data and deprivation indices are published, it is recommended that Public Health Croydon undertake further analysis to show the impact of the recession and welfare reforms on Croydon's population and to estimate more accurately the future prevalence of mental health conditions.

6. Equality and social justice factors

6.1 Increasing deprivation and inequalities

"Deprivation causes mental and physical health problems. The chronic low level stress of coping with daily deprivation and disadvantage 'gets under the skin', affecting the way the body reacts and therefore impacting on people's physical health through cholesterol levels, blood pressure and heart disease."[38]

The preceding section has projected the likely increase in numbers of those with mental health problems based on changes to the population structure. Where it was possible to incorporate information on deprivation into these projections, this has been done. However, for most of the indicators this was not possible. As such, the figures above are likely to **underestimate** the numbers with mental health problems in Croydon, where deprivation is increasing.

Mental health problems are more common in areas of deprivation. Poor mental health is both a cause and a consequence of the experience of social, economic and environmental inequalities. People with mental health problems tend to have lower incomes and are more likely to live in areas of high social deprivation and be affected by increases in the cost of food and fuel. The most deprived communities in the country have the poorest mental and physical health and well-being[39]. Those people in lower income groups are less cushioned against risk and hardship.[40]

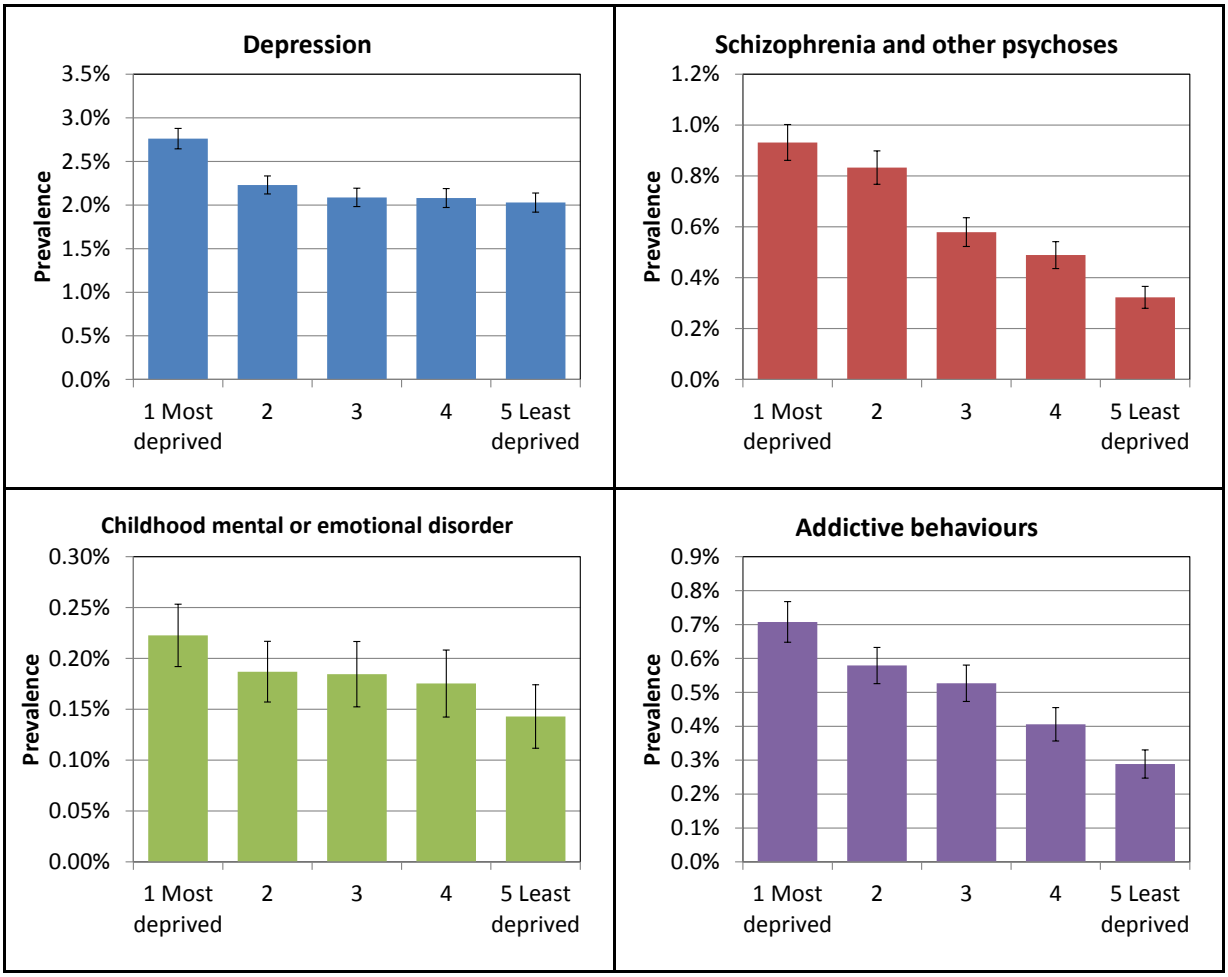
The bars on the graphs in Figure 8 each represent a fifth of Croydon's population, living in the 20% most deprived areas to the 20% least deprived areas in Croydon. There is a clear relationship between mental health and deprivation. This is much stronger for severe mental illness and addictive behaviours – for example, in Croydon the prevalence of schizophrenia is around three times as high in the most deprived as the least (Figure 8). There is also a clear social gradient with common mental disorders such as depression, however this is less strong.

[38] [17] Friedli,L. (2009) Mental Health, Resilience & Inequalities World Health Organisation

[39] HM Government/Department of Health. No health without mental health: a cross-government mental health outcomes strategy for people of all ages. February 2011. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

[40] Green Well Fair: Three Economies of Social Justice (2009) New Economics Foundation (NEF)

Figure 8: Prevalence of selected mental health conditions diagnosed by GPs in the last 5 years by deprivation quintile



Source: Data from Croydon general practices, March 201

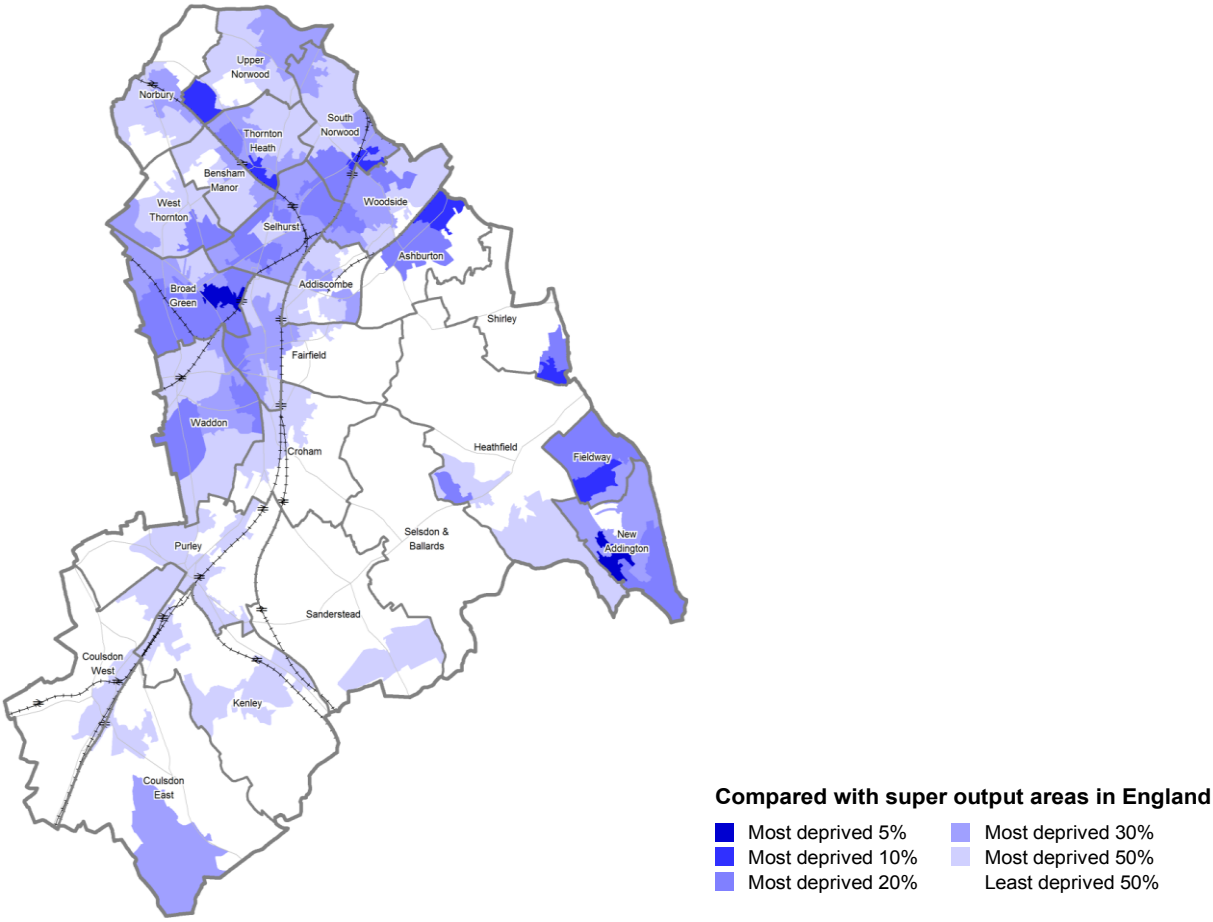
Figure 18 also shows a clear link between the most deprived wards in Croydon and levels of well-being. The following data highlight that **to improve mental health and well-being in Croydon there is a need to address inequalities.**

In recent years, outer London has been becoming increasingly deprived compared with England as a whole, while inner London has been becoming increasingly affluent. Croydon is more deprived in the north of the borough than in the south, and there are also areas of high deprivation in the east of the borough in Fieldway, New Addington and the Shrublands estate in Shirley (Figure 9). Croydon is currently[41] the **19th most deprived borough in London out of 33**. Between 2004 and 2010, levels of deprivation increased in Croydon more than in any other borough in the south of London. If Croydon continues to grow more deprived at the same rate as recent years, **by 2020 it will be the 12th most deprived borough in London[42].**

[41] The most recent Index of Multiple Deprivation is for 2010, based on data for 2008.

[42] Projections are based on a continuation of the trend by lower super output area between 2001 and 2008, using the Index of Multiple Deprivation 2004, 2007 and 2010.

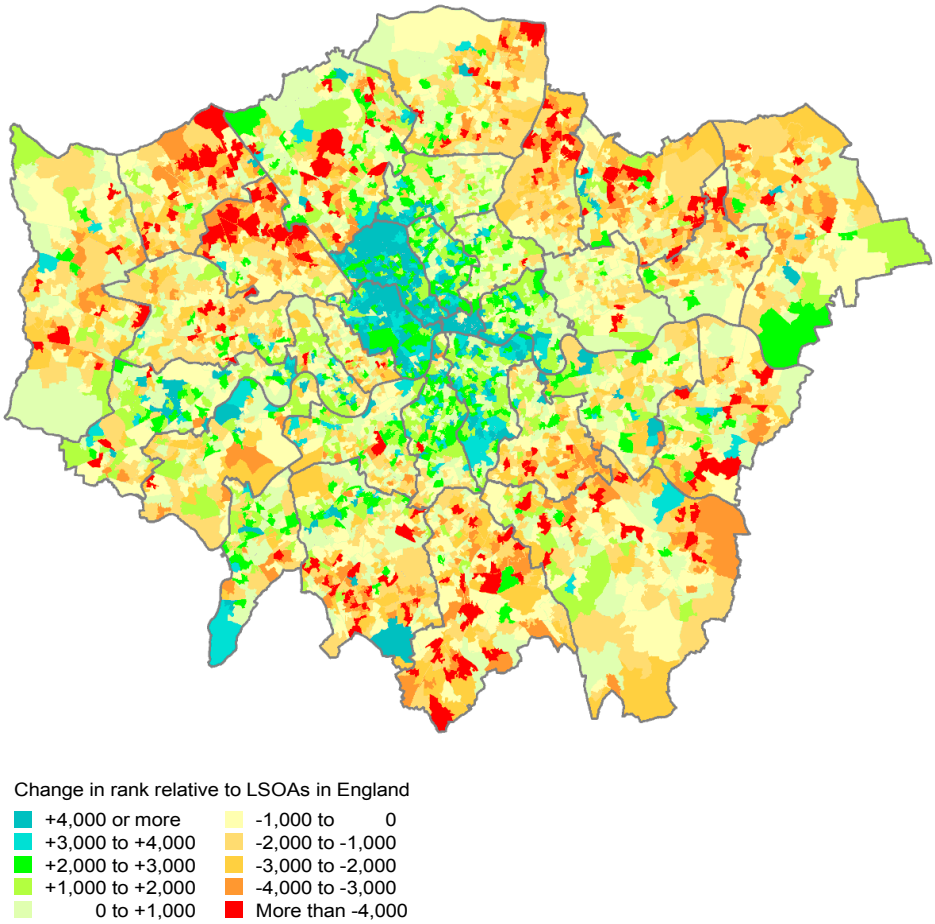
Figure 9: Deprivation in Croydon compared to England, 2010



Source: Indices of Deprivation, Department of Communities and Local Government

The Index of Multiple Deprivation (IMD) is made up of seven domains which reflect different aspects of deprivation. Figure 11 illustrates how each domain changed between 2004 and 2010 for Croydon and London compared with England as a whole. For three of the seven domains (employment, health deprivation and disability, and education, skills and training) the average deprivation level in Croydon increased over this time period, in contrast to the overall trend for London. For another three of the seven domains (income, crime and disorder, and living environment) both Croydon and London as a whole have become more deprived, however the changes in Croydon have been greater than the London average.

Figure 10: Map of London showing change in deprivation compared to England, 2004 to 2010



Source: Indices of Deprivation, Department of Communities and Local Government

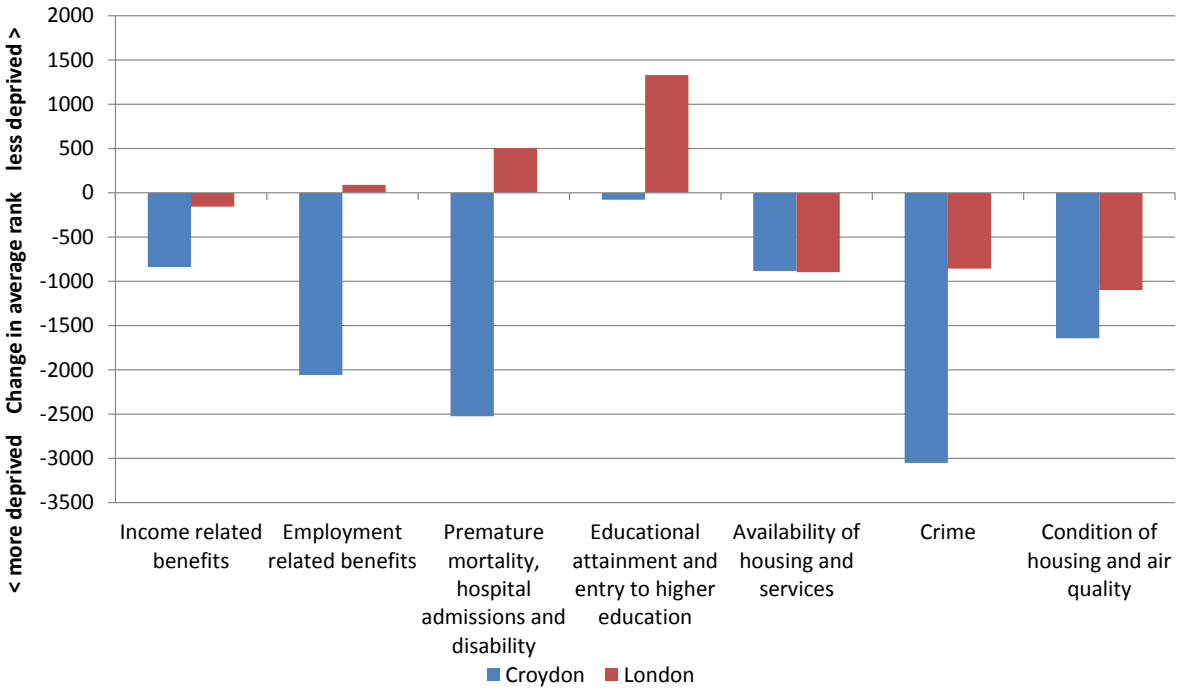
What does this mean for mental health? Increasing deprivation means that **more people in Croydon are being exposed to many of the associated risk factors for mental health problems including unemployment, poverty and low levels of education achievement**.

In Croydon, the increasing deprivation is partly due to the consequences of the recession on aspects such as employment (i.e. many of those living in Croydon becoming unemployed), but it is also a product of **population shift** as people move into and out of Croydon. These risk factors and the implications for Croydon's population will be discussed further in the section on wider determinants for mental health.

Figure 12 shows how lower super output areas[43] in Croydon will become more deprived relative to England by 2015 and 2020 if current trends in deprivation continue.

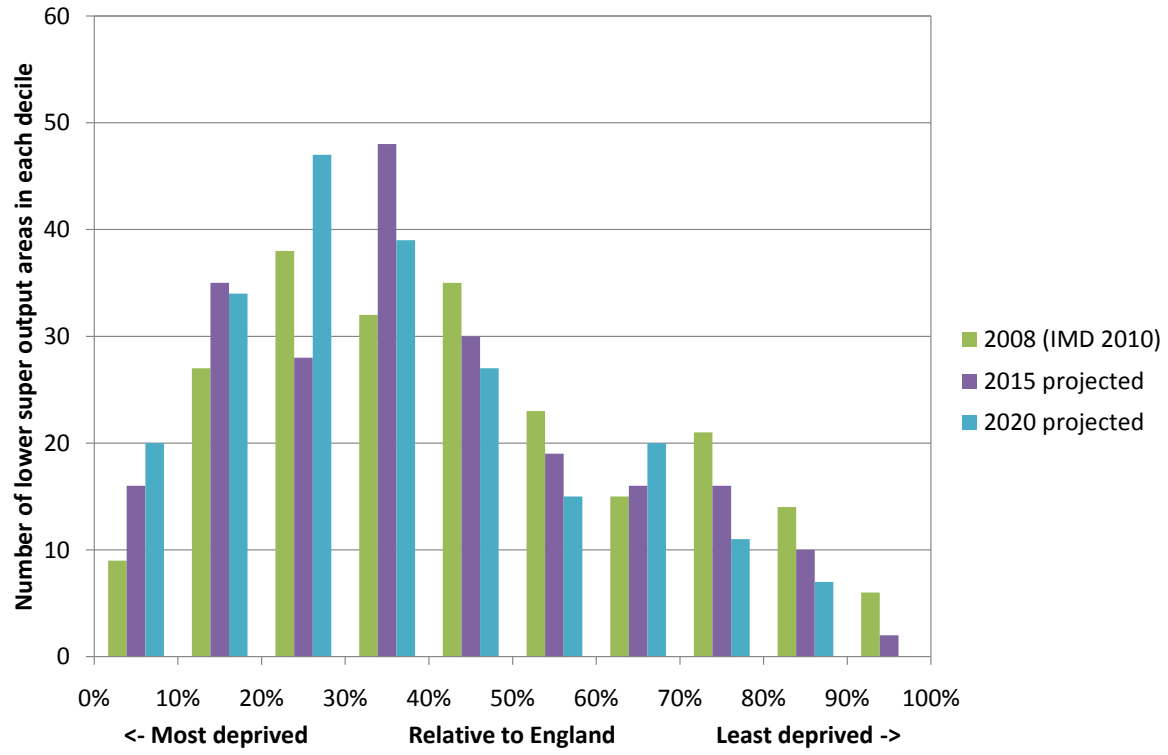
[43] Lower super output areas are geographical areas defined by the Office for National Statistics with an average population of 1,500 people. There are 220 lower super output areas in Croydon.

Figure 11: Change in the Index of Multiple Deprivation by domain, 2004 - 2010, Croydon and London relative to England



Source: Indices of Deprivation, Department of Communities and Local Government

Figure 12: Change in deprivation decile for Croydon lower super output areas, projections based on current trends to 2015 and 2020



Source: Indices of Deprivation, Department of Communities and Local Government

7. Wider determinants and the impact on mental health and well-being

Preceding sections have highlighted the likely impact on services of important changes taking place to the population of Croydon. On top of the demographic and structural changes there are also the economic challenges of the recession to consider. The full impact of the recession, welfare reform and changes to public services on the mental health of Croydon residents are not yet fully understood. The data that we currently have on the projected prevalence of mental illness may change as the effects of the recession become fully realised in the next few years.

Despite the difficulties in forecasting the future prevalence of mental illness, it is critical that all commissioners and policy makers responsible for delivering public services in Croydon work to tackle the wider determinants that can impact on mental health to promote well-being. As Figure 1 and Figure 2 show there is good evidence that protecting mental health and reducing risk factors can result in less mental illness and improved mental well-being, with associated positive outcomes.

7.1 Income, financial security and debt

Research shows a clear link between debt and mental health; individuals who initially have no mental health problems but find themselves having unmanageable debts within a 12-month period have a 33% higher risk of developing depression and anxiety-related problems compared to the general population who do not experience financial problems.[44]

Debt may be a cause and a consequence of mental health problems. Debt is a risk factor for mental illness with evidence showing a three-fold increase in common mental disorder, alcohol dependence and drug dependence and a four-fold risk of psychosis.[45]

People with a mental illness are 3-4 times more likely to have a debt problem than the general population, **while people in debt are 2.5 - 4 times more likely to have a mental illness than the general population.** The most commonly reported debts among those with a mental illness were council tax, telephone, rent, gas, water, electricity, television and mail-order payments. There is considerable potential for protecting mental well-being in Croydon by tackling debt as a risk factor.

Average weekly earnings for a full-time employee were £575 for Croydon compared with £610 for London and £508 for England[46]; however housing costs are higher in London than for England as a whole.

[44] Skapinakis P, Weich, S et al (2006) Socio-economic position and common mental disorders. Longitudinal study in the general population in the UK. British Journal of Psychiatry 189:109–117.
[45] Jenkins R, Bhugra D, Bebbington P, Brugha T, et al (2008). Debt, income and mental disorder in the general population. Psychological Medicine 38, 1485-1494.
[46] NOMIS, ONS annual survey of hours and earnings - resident analysis, January-December 2011

For the majority of mental health conditions, there is a relationship with low income which is stronger for men than for women. For example, the prevalence of common mental disorders is 2.7 times higher for men in the lower 20% income bracket compared with the highest 20% income bracket, and 1.4 times higher for women[47].

Croydon Council and voluntary sector organisations currently provide a range of welfare rights services across Croydon. For more information about Croydon's approach to maximising income in vulnerable groups, including **welfare benefits information and credit unions**, see the JSNA Children in poverty chapter.

The current evidence suggests that debt advice interventions do alleviate financial debt, and hence reduce mental health problems resulting from debt. For the general population, contact with face to-face advice services is associated with a 56% likelihood of debt becoming manageable[48], while telephone services achieve 47%.[49] In comparison, around one-third of problem debt may be resolved without any intervention. Economic modelling does note that for the greatest cost-effectiveness, careful consideration needs to be given to the mix between face-to-face, telephone and web-based provision of debt advice.[50]

7.2 Expected impact of changes to welfare reform

Many Croydon residents are likely to be affected by the government's huge welfare reform agenda, which may lead to cuts in many entitlements and therefore reduced income. Croydon will be one of just four boroughs in the UK to have the government's new benefit cap introduced in April 2013. The overall amount of benefit a household can get will be capped at £500 a week for families and £350 for single households. It is estimated that approximately 800 families in Croydon will be affected by the benefit cap from April 2013.

Universal credit is the new single credit which is set to replace Child Tax Credits, Working Tax Credits, Housing Benefit, Income Support, income-based Jobseeker's Allowance and income-related Employment and Support Allowance and will be introduced across the UK in October 2013. There is a concern by some agencies that vulnerable groups, especially people with disabilities and people suffering from a mental health illness may have to go through a potentially stressful appeals process if their benefits are cut. There are a number of organisations providing welfare rights advice in Croydon and all of them have reported increases in the number of cases having to progress to appeal as applications are turned down in the first instance. Legal Aid

[47] Adult Psychiatric Survey 2007, Information Centre for Health and Social Care
[48] Williams K, Sansom A (2007) Twelve Months Later: Does Advice Help? The Impact of Debt Advice: Advice Agency Client Study. London: Ministry of Justice.
[49] Pleasence P, Balmer NJ (2007) Changing fortunes: results from a randomized trial of the offer of debt advice in England and Wales. Journal of Empirical Legal Studies 4:465–475.
[50] Knapp, Martin and McDaid, David and Parsonage, Michael (2011) Mental health promotion and mental illness prevention: the economic case

funding finishes in April 2013 and this means that there will be less advice available to support those who need it.

Recommendation 7

It is recommended that commissioners continue to fund debt advice and welfare rights service and consider the mix between face-to-face, telephone and web-based provision in Croydon.

Recommendation 8

It is recommended that signposting to welfare advice, particularly employment, benefit uptake, debt management, financial literacy information and self-help be improved, and targeted at specific groups who may be particularly vulnerable to financial debt and mental health problems, for example low-income communities.

7.3 Employment and working lives

The workplace is a key setting that can affect the mental health and well-being of working adults. Employment can be good for mental health and well-being.[51] Lack of work is detrimental to health and well-being.[52] [53]. Evidence shows that interventions to increase employment chances and to improve mental health at work are both effective and cost effective.[54]

The overall employment level in Croydon has been higher than the London average over the last several years. However in March 2012 at 68.6%, it was just 0.6% above the London average. Male employment has dropped to 73.1% - well below the London average of 75.1% - while female employment was at 64%, above the London average of 60.7%.

Mental well-being can be improved at work by addressing key influencing factors such as social support, enhanced job control, increased staff involvement, workload assessment, effort/reward balance, role clarity, and policies to tackle bullying and harassment.[55] However, one in six adults of working age in the UK experiences some symptom of mental distress (sleeplessness, irritability, worry) that does not meet the criteria for a diagnosis of mental ill health, but can affect their ability to work.

One in six of the working-age population experiences symptoms that meet the criteria for a clinical diagnosis of anxiety and/or depression.[56] This can lead to loss of productivity

[51] Department of Health and Department of work and pensions (2008) Working for a healthier tomorrow
[52] Royal College of Psychiatrists (2008). Mental Health and Work. London.
[53] Waddell G & Burton AK (2006). Is work good for your health and well-being? Norwich: The Stationery Office.
[54] Mills P, Kessler R, Cooper J, Sullivan S (2007) Impact of a health promotion program on employee health risks and work productivity. American Journal of Health Promotion 22:45–53.
[55] (Williams et al., 1998; Stansfeld et al., 1999; Ferrkoie, 2007).
[56] Department for Work and Pensions/Department of Health (2009). Working Our Way to Better Mental Health: A framework for action. London.

because of sickness absence, early retirement, and increased staff turnover, recruitment and training and therefore also has an economic impact.

Employers in both the public and private sectors should be encouraged to carry out an annual stress and well-being audit, and to act on its findings. Standardised auditing instruments of the Health and Safety Executive (HSE) or others should be used to identify if there is a problem, and if so, the source of the problem.

Recommendation 9

It is recommended that workplaces in Croydon should be targeted to ensure employers are maximising opportunities to improve the mental well-being of their employees and to raise the profile of the importance of mental health and well-being at work.

7.3.1 Unemployment

Unemployment is a risk factor for mental illness. The longer someone is unemployed, the more vulnerable they are to depression, anxiety and suicide.[57]

Nationally, people who are unemployed consult their GPs more often than the general population. **Depression and anxiety are four to ten times more prevalent among people who have been unemployed for more than 12 weeks.**

Figure 13 shows that in November 2011, 13.2% of working age people in Croydon were on out-of-work benefits, compared with 12.6% for London and 12.2% for England[58]. **The proportion of people on out-of-work benefits has been rising at a greater rate within Croydon than for London** and England as a whole in the last 10 years, particularly since the economic recession began in 2008.

7.3.2 Young people 16-18yrs Not in Education, Employment or Training (NEET's)

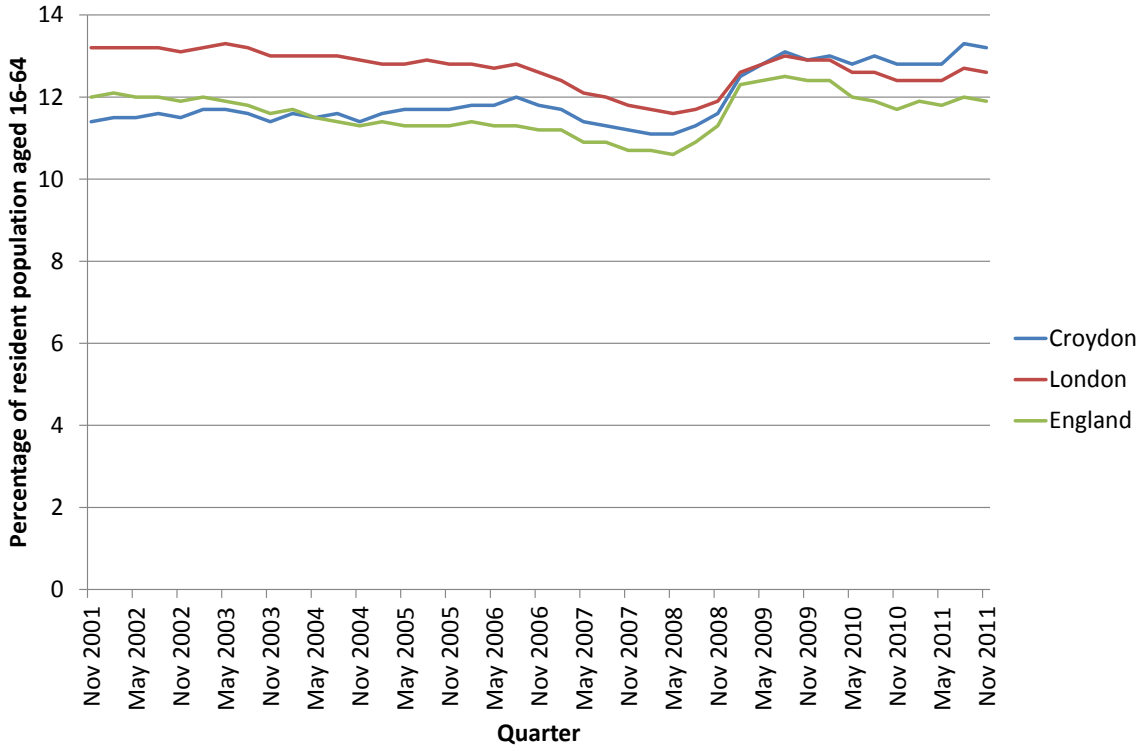
Young people not in education, employment or training are at risk of becoming depressed and disengaged from wider society. Being NEET at age 16-18 for more than six months is associated with negative outcomes later in life, including unemployment, reduced earnings, poor health and depression.

Research also shows that there is an association between the percentage of young people who are NEET and the performance of the wider labour market. Therefore, as noted if Croydon has more people claiming out of work benefits, the NEET population is also likely to be higher.

This population group and associated issues will be covered in more detail in the JSNA chapter Emotional Health and Well Being of Children 0-18.

[57] Department for Work and Pensions/Department of Health (2009). Working Our Way to Better Mental Health: A framework for action. London.
[58] NOMIS, DWP benefit claimants - working age client group, November 2011

Figure 13: Proportion of people on out-of-work benefits, 2001-2011



Source: NOMIS, DWP benefit claimants - working age client group

7.3.3 Employment of people with mental health conditions

Work can play a vital role in recovery for many people with mental health problems,[59] (see schizophrenia JSNA chapter). According to the Office for National Statistics' Annual Population Survey, nationally one third of people with depression, learning disabilities, mental health problems or nervous disorders are currently in employment[60]. Of those with more severe mental health problems, in 2011/12 4.9% of adults receiving secondary mental health services in Croydon were known to be in paid employment at the time of their most recent review, compared with 5.9% for London as a whole, and 8.0% for England as a whole[61].

There are 13,000 (2.1%) Croydon residents aged 16 and over who claim employment support allowance or incapacity benefit because of a mental health condition, compared with 1.9% for the London Suburbs cluster[62], and 2.1% for England as a whole[63]. There are 4,640 people who claim disability living allowance because of a mental health

[59] Borg, M. & Kristiansen, K. (2008) Working on the edge: the meaning of work for people recovering from severe mental distress in Norway. Disability & Society, **23** (5) 511-523.
[60] NOMIS, Annual Population Survey, April 2011-March 2012
[61] Social Care and Mental Health Indicators from the National Indicator set, 2010/11 (http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/social-care-and-mental-health-indicators-from-the-national-indicator-set--2010-11-final-release)
[62] Local authorities that have a similar population composition to Croydon.
[63] NOMIS, Benefit claimants, November 2011

condition – 1,900 for psychosis, 1,420 for a learning disability, 780 for a neurotic disorder, and 540 for other mental health conditions[64].

There is strong evidence that Individual Placement and Support (IPS) is the most effective method of helping people with severe mental health problems to achieve sustainable competitive employment.

Current employment support services, particularly those provided by the voluntary sector, are limited in their capacity and are unlikely to meet needs in the near future. The need for employment support services is likely to increase in the face of changes to the benefit system (outlined in 7.2)

Improving working lives	
What the evidence says works	**What we're doing in Croydon**
Support for the unemployed Improving the economic outcomes of young people and adults by increasing opportunities to be in education, employment or training.	Provision of a work club programme at Thornton Heath Library aimed at reducing unemployment delivered through a volunteering role Implementing a revised skills and employment strategy for the borough. Key strands of work in the future will be to identify who existing provision is targeted at, identify gaps and target 'disadvantaged' families and neighbourhoods to ensure that support is available to access and remain in employment
Creating healthy working environments	Well workforce – is a joint NHS and Local authority project that aims to embed the promotion of well-being to foster a flourishing workforce
Supported work for those recovering from mental illness.	Croydon employment support service is a service that supports people with disabilities, including mental health problems, to find appropriate paid employment Status employment work with people with disabilities or mental health problems to find work or move closer to work; this can be through education; training, paid work or volunteering. Mind in Croydon employment support is a

[64] NOMIS, Benefit claimants, November 2011

	service designed to assist people with mental health problems to find work
Additional Croydon Information: Croydon Employment Support Service (CESS) Mind in Croydon Employment Support Status employment NICE guidance Promoting mental well-being at work (PH22) NICE guidance Promoting physical activity in the workplace (PH13) May 2008 NICE guidance Workplace interventions to promote smoking cessation (PH5) Apr 2007	

7.4 Fear of Crime

Fear of crime can have a negative effect on well-being. People experience more stress from the fear of crime and safety issues than from any direct experience of crime[65]. In addition, local press coverage of criminal activity enhances the effect of crime on mental well-being.[66]

In Croydon there is a gap between actual crime rates and perceptions of crime. Fear of crime doesn't correspond with Croydon's crime rates, which are similar to those throughout the London boroughs. The Safer Croydon Partnership carries out a wide range of multi-agency actions to tackle crime and the anti-social behaviour. The partnership also engages regularly with local residents to help give a greater sense of community confidence.

7.5 Housing and physical security

"Even intuitively, poor housing conditions will have an effect on mental well-being; the home provides more than shelter, and the 'meaning of home', for example as a haven of security, is an accepted psychological and social construct"[67]

Mental health and housing are closely connected particularly because of the neighbourhoods, communities and social networks that our homes place us in. The specialist and supported accommodation that is provided for people with mental health problems also impacts on well-being. Mental illness often leads to homelessness and equally, becoming homeless, living in poor quality or insecure housing can lead to mental health issues.[68]

Croydon's housing strategy sets out local plans to meet housing need and to respond to the government's housing reform programme.[69]

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[65] The Effect of the Physical Environment on Mental Wellbeing (Foresight report)
[66] Cornaglia & Leigh, 2011
[67] Wilkinson, D. (1999) Poor housing and ill health: A summary of research evidence, DoH, Scotland.
[68] Mind. Housing and mental health factsheet. http://www.mind.org.uk/help/social_factors/housing_and_mental_health#mentalhealth
[69] Croydon's Housing Strategy 2011-2015

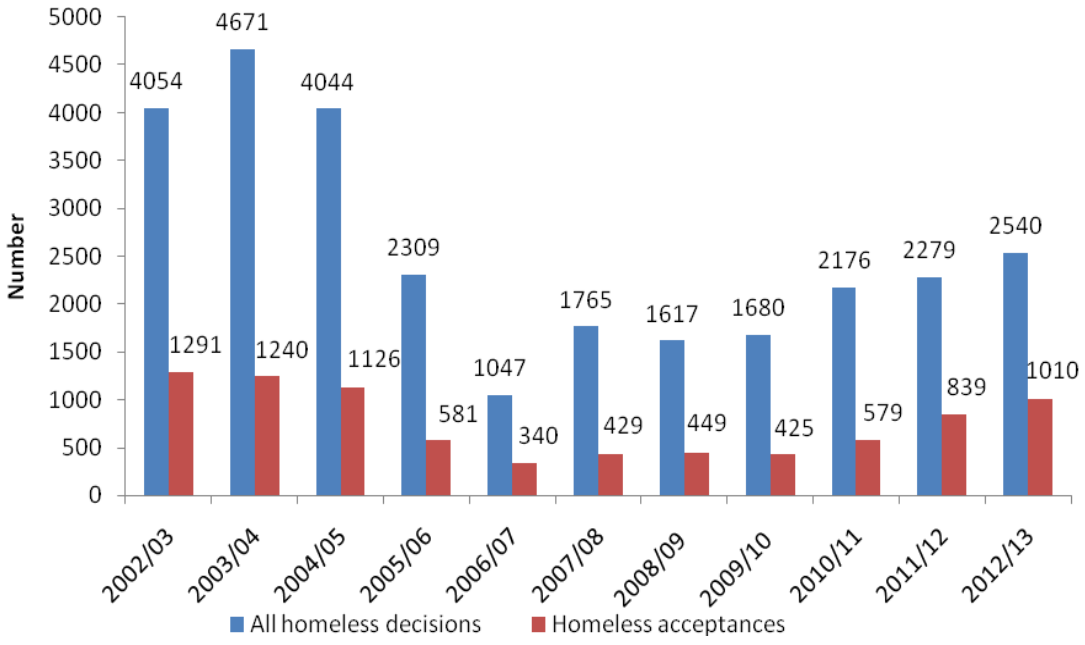
7.5.1 Homelessness

For people with mental health problems, being homeless can delay access to treatment, recovery and social inclusion. Accessing any services and gaining employment is often more difficult for people who do not have settled accommodation.

Mental ill health is common among people who experience homelessness or who are forced or choose to sleep rough; estimates range from one third up to 76% and these are therefore an important at risk group. An estimated 43% of clients in an average homelessness project in England are likely to have mental health needs and 59% may have multiple needs.[70] The highest rates of mental health conditions are found among rough sleepers and young people who are homeless. They are also least likely to access mainstream health and mental health services and more likely to experience significant barriers in accessing services.

In the last year Croydon has seen an increase of 45% in the number of households accepted as being homeless, with reasons including exclusion from a parent, rent arrears in private accommodation, ending of a short hold tenancy and violent relationship breakdown.

Figure 14: Decisions made on homelessness applications and acceptances, Croydon, 2002/03-2012/13



Source: Department of Communities and Local Government

There has also been an increase in the use of non-self-contained bed and breakfast emergency accommodation of 45% compared to previous year. The number of

[70] St Mungo's (2009). Down and Out? The final report of St Mungo's Call 4 Evidence: mental health and street homelessness. London.

households in all forms of emergency accommodation currently stands at over 460 (January 2013).

The current economic climate and recession have been the major factors impacting on homelessness, with families unable either to continue to accommodate children and other relatives, or to afford increasing rents on incomes decreasing in real terms. "Generation rent" as they are now being called, has greatly reduced prospects of getting on the housing ladder. The knock on effect is fierce competition for private rented accommodation and a dramatic reduction in private rented accommodation available to the council to meet the need of homeless households.

7.5.2 Housing for adults with mental health conditions

In 2011/12, 71.4% of adults receiving secondary mental health services in Croydon were known to be in settled accommodation at the time of their most recent review, compared with 73.8% for London as a whole, and 57.8% for England as a whole[71].

Lack of appropriate housing can be a significant contributor to delayed discharge from hospital. A lack of housing or support can also lead to increased readmission rates, over-use of residential care and, in some cases, the use of out of area or other high-cost services. Investment in housing and housing-related support can contribute significantly to reducing demand on acute and specialist services.

Housing-related support in Croydon is mainly delivered through the Supporting People Programme[72]. Supporting People funds a wide range of supported housing services, including sheltered housing, homeless hostels, floating support, women's refuges and supported lodgings. These services help lots of different kinds of people to live independently. Some of these services provide long term support to vulnerable people who will always need some kind of help to maintain a tenancy. Other services are short term services to help vulnerable homeless people to resettle or to prevent people from becoming homeless in the first place.

Recommendation 10

It is recommended that all people who work with individuals and families in their community, workplace or voluntary organisation should receive appropriate mental health training

Recommendation 11

Training for housing case workers should build awareness, enable professionals to spot signs early, and provide support around simple adjustments and flexibilities that can prevent housing breakdown. Improved joint working and sharing of knowledge across health, housing and related services and sectors is

[71] Social Care and Mental Health Indicators from the National Indicator set, 2010/11 (http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/social-care-and-mental-health-indicators-from-the-national-indicator-set--2010-11-final-release)

[72] Croydon's supporting people information

needed to make sure that people with mental health problems are supported appropriately in a timely manner.

7.6 Education and lifelong learning

Education also protects mental health across the life course and having access to educational opportunities throughout life is associated with improved mental health outcomes. Low educational attainment is a risk factor for common mental health problems. [73]

Achievement of 5 or more A* to C grades at GCSE or equivalent including English and Maths was at 61.6% in 2011-12, as compared to London's 61.3%.

The proportion of working age population with no qualifications in Croydon (8.9%) is lower than the London average (9.3%).

Lifelong learning is essential to protect mental capital. Successful achievement in education and training contributes to mental and physical well-being, both directly and by enabling individuals and groups better to achieve their goals. Croydon Adult Learning and Training (CALAT) provide vibrant, high-quality adult learning opportunities on behalf of the London Borough of Croydon.

In an ageing society, successful participation in adult learning plays a particularly critical role, not solely in enabling workers to adapt and adjust to the rapidly-changing requirements of their jobs, but also in helping adults lead an active and satisfying life.

[73] Kirkwood T, Bond J, May C et al (2008) Foresight Mental Capital and Well-being Project. Mental capital through life: Future challenges. The Government Office for Science, London

8. Enhancing mental health and well-being through stronger, resilient communities and the civil society

"People expressed attachment to the communities in which they lived and to their networks of families and friends, rather than to the physical places…
Social and family networks and feelings of safety were what helped to retain people in deprived areas." [74]

8.1 Social relationships and the core economy

As the model of well-being (Figure 3) highlights, social relationships and the core economy are important to mental health and well-being. Communities and social networks to which individuals belong over their lifetime have a significant impact on health and health inequalities. Communities have an essential role in **enhancing control, increasing resilience, facilitating participation and promoting inclusion**, which are the key protective factors for well-being.

Croydon's Stronger Communities Strategy focuses on three long-term priorities; encouraging greater community empowerment; changing the way people do things for themselves and promoting strong and active communities.[75] All of these priorities are key protective factors for well-being and the action plan for the strategy will contribute to improving mental well-being. Croydon's equalities strategy outlines how Croydon is fostering good community relations between all the diverse communities who live in the Borough. [76]

Box 6 - Religion or belief and mental health considerations

- How people define mental health and mental illness is influenced by culture, background, values, religious belief systems and spirituality.
- It is important to understand the beliefs of local residents in communities to ensure that services work in a way that is appropriate with their beliefs. People with beliefs, for example, that focus on fatalism may be less motivated to engage in activities to protect mental health, such as exercising or gaining employment.
- Spirituality can be a protective factor for mental health.
- Information on religion is not routinely collected in primary or secondary care, despite being a protected characteristic. It is important to capture this and use data to ensure that there is no discrimination in health services, so that services are able to meet the needs of all members of the community regardless of their religious belief.

[74] Joseph Rowntree Foundation (2008) People's attachment to place: The influence of neighbourhood deprivation
[75] Croydon's Stronger Communities Strategy
[76] Croydon's Equality Strategy 2012 – 2016

8.1.1 Increasing resilience, social participation and inclusion

Resilience reflects the extent to which communities are able to exercise informal social controls or come together to tackle common problems.[77] Levels of trust, reciprocity, participation and cohesion within a community influence well-being[78]. A culture of cooperation and tolerance, a sense of belonging and strong social relationships are all protective of mental health.[79]

Social inclusion is the ability to access opportunities that most people take for granted, for example; education, transport, jobs, leisure, credit or finance. For individuals, social participation and social support are associated with reduced risk of common mental health problems and better self-reported health. Participation is the extent to which people are involved and engaged in activities outside their immediate household, and includes cultural and leisure activities, as well as volunteering, membership of clubs and groups, as well as participation in local decision-making, collective action, voting and other forms of civic engagement.

Social isolation is an important risk factor for both deteriorating mental health and suicide. People who have mental health problems benefit from social participation which increases the likelihood of recovery, while low contact with friends and low social support decreases the likelihood of a recovery by up to 25%.[80] It is important to remember that certain groups of people may need additional support to participate and get involved in community activity, e.g. Mind in Croydon's buddying project shows that people with mental health problems benefit from having 'buddies' who give a bit of additional motivation and encouragement.

The evidence around social isolation supports the importance of **social prescribing** i.e. non-medical interventions to improve mental health and well-being. Croydon currently has limited social prescribing. Social prescribing fits well with national and local agendas to improve health and reduce inequalities because it is: patient centred; not just about what the NHS can do; it is a conduit for involving patients in their community and opening the channels between statutory and voluntary sectors.[81]

Psychosocial interventions have been shown to be effective in improving mental well-being. Interventions to increase social participation, physical activity, continued learning,

[77] Foresight Mental Capital and Well-being Project (2008). Final project report. London: The Government Office for Science.
[78] Whiteford et al, 2005; Barry and Friedli 2008
[79] Moodie and Jenkins, 2005
[80] Pevalin and Rose (2003)Social capital for health Investigating the links between social capital and health using the British Household Panel Survey. Health Development Agency (HDA)
[81] Friedli L, Watson S (2004) Social prescribing for mental health Leeds and York: Northern Centre for Mental Health

volunteering, and welfare benefit advice can prevent mild to moderate mental health problems, and have been effective when working with older people.[82]

Box 7 – Sexual orientation and gender reassignment and mental health considerations

- Anxiety, depression, self-harm and suicidal feelings are more common among lesbian, gay and bisexual people than among heterosexual people.[83] [84]
- There is a strong association between homophobic bullying and poor mental health, including low self-esteem, fear, stress and self-harm.[85]
- Trans people are those who have changed from one gender to another and may be at higher risk of mental health problems due to discrimination and social exclusion.
- These experiences place many trans people at risk of alcohol abuse, depression, suicide, self-harm, violence and substance abuse which all can affect well-being.
- The largest survey of trans people in the UK found that one in three people have attempted suicide.[86]

8.2 Croydon's civil society

Croydon's thriving voluntary sector delivers many services and projects that promote mental health and well-being, including debt advice, singing groups, counselling and much more.[87]

It also plays a vital role in connecting all communities by bridging gaps, providing information and advocacy for civil society organisations and networks. Voluntary organisations are using technology and other methods to encourage people in Croydon to be involved in local decision making, which can enhance control and facilitate participation.

There are many volunteering opportunities in Croydon which provide ways to participate, learn new skills, meet new people and improve self-confidence. There is a positive

[82] Cattan M, White M, Bond J et al (2005). Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions. Ageing & Society 25: 41–67.
[83] King M, McKeown E, Warner J et al (2003). Mental health and quality of life of gay men and lesbians in England and Wales. British Journal of Psychiatry 183: 552-558.
[84] King M, Semlyen J, See Tai S et al (2008). Mental disorders, suicide and deliberate self-harm in lesbian, gay and bisexual people: a systematic review. BMC Psychiatry 8: 70.
[85] Stonewall (2007). Education for all: research: facts and figures: mental health.www.stonewall.org.uk/education_for_all/research/1731.asp#Mental_health
[86] Whittle S, Turner L and Al-Alami M, The Equalities Review, Feb 2007
[87] Croydon's mental health directory

association between time spent volunteering and a range of indicators, such as a sense of belonging, satisfaction with the area, feeling safe, and being satisfied with the local council and services.[88]

Imagine Croydon run a volunteering service for people with mental health problems. They also run a befriending service to support mental health service users to access mainstream activities. Croydon Voluntary Action run a volunteer centre which provides a wide range of opportunities locally, the over 45 age group is more likely to volunteer than those under 45.

Croydon Council has been pioneering the **Asset-Based Community Development (ABCD) approach** with Croydon Voluntary Action. ABCD considers local assets as the primary building blocks of sustainable communities, and this approach is being developed in different wards including Thornton Heath, Selhurst and Broad Green. Identification of the assets - human, social, material, financial, entrepreneurial and other resources - in communities can contribute to building mental well-being through community empowerment and encouraging community action, cohesion and participation. ABCD moves away from the traditional assessment of communities in terms of needs, issues and deficits and instead focuses on talents, capacity, skills and opportunities.

Many of Croydon's voluntary organisations are delivering services that could be socially prescribed. **Age UK Croydon** is one example of an organisation offering a structured programme of activities through their Smart Health Hub project to local people including: physical activities, healthy eating initiatives, weight management sessions, community activities and volunteering opportunities. This is a three year project that is funded through the lottery.

Recommendation 12

It is recommended that Croydon commissioners explore access to social interventions in primary and community care pathways through social prescribing – specifically volunteering, including timebanks, exercise and physical activity, arts and creativity, learning and educational opportunities and environmental activity.

[88] The London Borough of Croydon Places Survey 2008

8.3 Croydon's green spaces and parks

Safe, green spaces may be as effective as prescription drugs in treating some forms of mental illnesses, without the costs of side-effects and ever-rising numbers of prescriptions.[89]

Croydon Council manages 127 public parks and countryside sites. Green space can be a protective factor for mental health and can impact on communities' resilience and well-being. Research shows that presence of green spaces contributed to an increased ability for the poorest, single-parent mothers to cope with major life issues, reductions in crime, and in aggression indicators.[90] [91]

Access to green space is more challenging in the North of the borough which is more deprived and as seen in Figure 18 has poorer levels of well-being.

Evidence demonstrates that one of the best ways for children to stay both physically and mentally healthy is through access to a variety of unstructured play experiences.[92] **Play streets are low cost,** yet offer a play opportunity for children by closing streets to traffic for a few hours each week to **play out and socialise in a safe place.** Play streets have also been shown to foster better neighbourhood relations and cohesion.[93]

Recommendation 13

It is recommended that Croydon Children, Families and Learners Partnership could work with the Planning department to explore the feasibility of developing 'play streets', particularly in the North of the Borough.

[89] http://www.fph.org.uk/uploads/r_great_outdoors.pdf

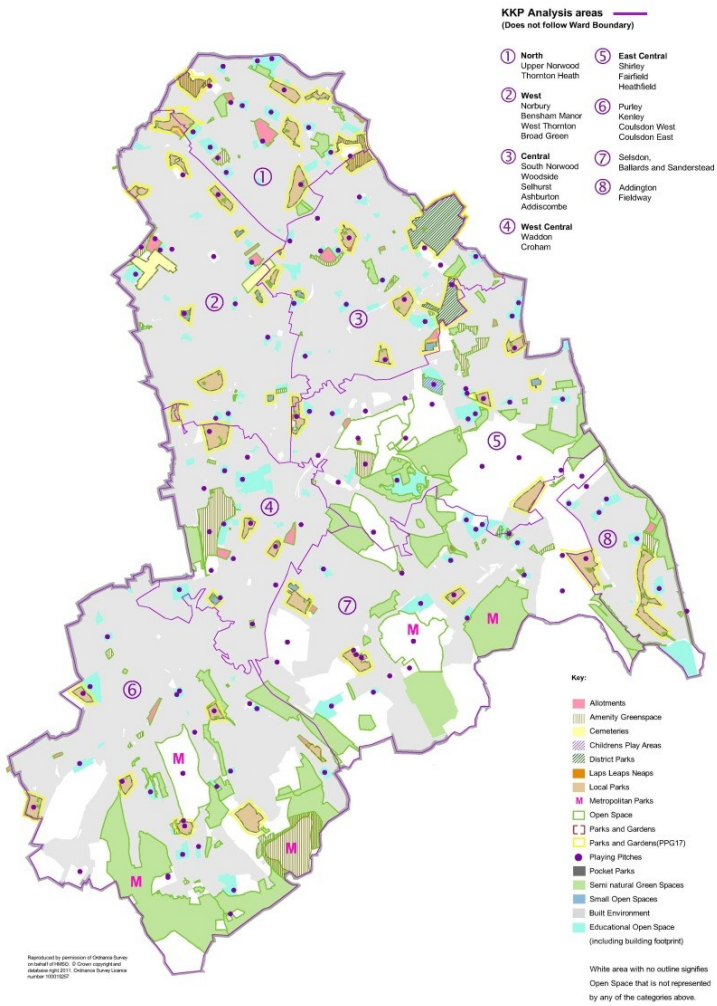
[90] Kuo F (2001) "Coping With Poverty: Impacts Of Environment And Attention In The Inner City" Environment and Behavior, Vol 33 No 1 January 2001

[91] Kuo FE, Sullivan WC (2001) "Aggression And Violence In The Inner City: Effects Of Environment Via Mental Fatigue". Environment And Behaviour 33 No4 July 2001 543-571

[92] Ginsburg K (2006) 'The Importance of Play in Promoting Healthy Child Development and Maintaining Strong Parent-Child Bonds,' PEDIATRICS Vol 119, No 1, January 2007 pp 181-191.

[93] London play http://www.londonplay.org.uk/document.php?document_id=1833

Figure 15: Green spaces and parks in Croydon



Source: Croydon Council

8.3.1 Community participation in Croydon's green spaces

Croydon's parks and green spaces offer many opportunities for individuals to get involved and participate which are core protective factors for good mental health. e.g. through the friends of parks and conservation volunteering. A range of free guided wildlife walks are offered through the Greenspaces team by experienced and knowledgeable wardens and volunteers. This again demonstrates the positive impact that non NHS services have on promoting well-being in Croydon.

Recommendation 14

It is recommended that Croydon Council publicise the work of the Greenspaces team more widely and raise awareness of the benefits of the environment on mental health and well-being.

Creating safe, resilient, connected communities	
What the evidence says works	**What we're doing in Croydon**
Improving quality of life through increasing opportunities for participation, personal development and problem-solving that enhance control and prevent isolation.	Croydon Council launched a volunteering and community action programme in March 2012 and Croydon Voluntary Action run the Volunteer Centre. Croydon's Youth Council encourages young people to be involved in decision making. Croydon Age UK offers the national telephone befriending project 'Call in Time' and has a range of inclusion projects for older people. Imagine offers a befriending service for mental health service users to build their confidence, reduce feelings of isolation and form social networks. Mind in Croydon's buddying service supports people with mental health problems to engage in community activities.
Community empowerment and interventions that encourage improvements in physical and social environments, and strengthen social networks.	Encouraging greater community empowerment by giving local people and communities more power to take decisions and shape their neighbourhoods is a key priority of the Stronger Communities Strategy. Mind in Croydon offers a social networking service for people with mental health problems to engage in activities in the community. Connected Croydon is a programme of coordinated public realm projects and transport improvements that will transform Croydon Metropolitan Centre (CMC) in to a more walkable and liveable place.
Additional Croydon Information: Croydon's stronger communities strategy 2011 - 2014 Croydon Community Strategy 2010 - 2015 Croydon's Equality Strategy 2012 – 2016 Croydon's Welfare Benefits information Connected Croydon Programme Mind in Croydon Talk2Croydon	

9. Enhancing mental health and well-being across life stages

Evidence shows that when considering how to protect mental well-being it is important to take a life course approach to ensure a positive start in life, into healthy adulthood and working life, through to older years.[94]

9.1 Evidence-based actions to improve individual well-being

It is important to remember that anyone in Croydon can be affected by a mental health problem.

Generally, people are aware of what they should be doing to improve their physical health. For example, most people know that stopping smoking is good for their health, and would know where to go if they broke their arm. However, people are less aware that there are simple ways to improve their own mental health, whatever the circumstances of their lives. The Five Ways to Well-being[95] are evidence based recommendations for protecting mental health
Box 8).

Box 8 – Five Ways to Well-Being

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

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

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

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

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

[94] Foresight (2009) *Foresight Mental Capital and Wellbeing Project Final Project report*. London: The Government Office for Science.
[95] http://www.neweconomics.org/sites/neweconomics.org/files/Five_Ways_to_Wellbeing.pdf

Recommendation 15

It is recommended that the local version of the Five Ways to Well-being be updated by Public Health Croydon to raise public awareness, and ensure people are well informed and motivated to look after their mental health.

Recommendation 16

It is recommended that work is carried out to ensure all frontline professionals in all organisations across Croydon promote the Five Ways to Well-being, particularly to clients with risk factors for poor mental health.

9.1.1 Children and young people

As the population information shows, the school age population of Croydon is expected to grow by a fifth between 2011 and 2021. Research shows that experiences and interventions at one stage of life can affect mental health and well-being for years and even affect other life stages. Therefore, the early years are vital for creating the conditions for good mental health across a person's life course. [96]

Croydon Children and Families Partnership identified children and young people's emotional health and well-being as a local priority and as a consequence it has been identified as one of the four main concerns for the Children and Families Partnership: Be Healthy Sub-group during 2012-13.

The 2012/13 JSNA deep dive chapter on Emotional Health and Well Being of Children 0-18 will explore the needs and gaps of this population group in more detail.

Evidence strongly indicates that the most cost-effective way to prevent the development of mental health problems and promote mental well-being and resilience is to focus on childhood and adolescence.[97] Half of all mental health problems begin in childhood, and three-quarters appear by the mid-20s.[98]

The influences of parenting are extremely strong and support from at least one caring adult is protective against a wide range of adverse issues. Highly cost-effective interventions exist to support positive parenting with children of all ages.[99] Effective parenting support also needs to include the development of effective referral routes and awareness-raising, for example with local GPs, schools, health visitors and other frontline professionals working with young families. Department of Health research shows that when the wider costs of crime are included, **total gross savings** over 25

[96] Foresight Mental Capital and Well-being Project (2008) London: The Government Office for Science.
[97] Zechmeister I, Kilian R, McDaid D (2008) Is it worth investing in mental health promotion and prevention of mental illness? A systematic review of the evidence from economic evaluations, BMC Public Health.
[98] Kim-Cohen J, Caspi A, Moffit T et al. Prior juvenile diagnosis in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. Archives of General Psychiatry 60. 709–717 (2003).
[99] No Health Without Mental Health - A guide for Local Authorities

years exceed the average cost of introducing a **parenting intervention** by a factor of around 8 to 1.[100]

Recommendation 17

It is recommended that Croydon's Children, Families and Learning partnership continue to prioritise the provision of parenting interventions in, and offer evidence-based parenting interventions to, families with children at risk of conduct disorder and those experiencing behavioural problems.

Children and young people who are emotionally resilient are more able to deal with difficulties in their lives and to cope with uncertainty. Self-esteem, self-efficacy (a belief in your abilities), readiness to learn and developing a positive social identity are protective assets for good mental health. These factors need to be promoted in childhood as they build resilience, and this can influence a number of health and social outcomes in later life.

What happens to children has a major impact on their mental health throughout life. In this respect experience of trauma including violence and sexual abuse is highly significant and a risk factor for poor mental health in adolescence and adulthood.[101]

Promoting good mental health and preventing mental illness begins in pregnancy, therefore it is important to note Croydon's increase in the under 5s population. Maternal smoking, use of alcohol and poor diet are associated with lower birth weight and poor mental health in children. Health visitors are well placed to identify mothers suffering from postnatal depression and to provide preventative screening and early interventions.

Box 9 - Pregnancy and maternity and mental health considerations

- One in ten new mothers experience postnatal depression (United Kingdom, Department of Health, 2011)
- Anxiety and postnatal depression affect 22% of mothers within one year of birth. Mothers suffering from postnatal depression or anxiety are less able to look after their baby well and research suggests that in practice a significant proportion of women with postnatal depression are missed in primary care.[102]

[100] Knapp, Martin and McDaid, David and Parsonage, Michael (2011) Mental health promotion and mental illness prevention: the economic case

[101] Centres for Disease Control and Prevention (2005) Adverse Childhood Experiences Study. Centre for Disease Control and Prevention.

[102] Kessler D, Bennewith O, Lewis G, Sharp D (2002) Detection of depression and anxiety in primary care: follow up study. British Medical Journal 325:1016.

Recommendation 18

It is recommended that the health of pregnant women continues to be prioritised in Croydon and that consideration be given to offering universal routine enquiry and targeted treatment for women at risk of depression, with a home visiting programme and health visitor training for postnatal depression, as part of a package of measures to improve perinatal mental health.[103] [104]

9.1.2 Parents with mental health problems

It is not possible to obtain accurate figures for the number of parents in Croydon with mental health problems; however, if we use the national prevalence figures quoted above, we can assume that many children in Croydon are living with at least one parent with a mental health problem. Some of these will be serious mental health problems. Poor parental mental health is associated with a four to five-fold increased risk of emotional/conduct disorder in children.[105] It is estimated that children who had conduct problems as a child commit 80% of the crime in the UK.[106]

Parents with mental health problems need support and recognition of their responsibilities as parents. Their mental health problems can have an impact on their parenting and on the child over time. Research shows that their children have an increased risk of developing mental health problems, indicating a strong link between adult and child mental health.[107]

Mind in Croydon deliver a parenting advocacy support service, funded by Comic Relief, where an advocate works on a one-to-one basis with parents' mental health needs. Experience within the Mind in Croydon team suggests that parents with mental health problems are sometimes reluctant to access mental health services, as they are concerned that their mental health needs may lead to their children being placed on the Child Protection Register or removed from their care. This highlights the particular sensitivity and need to work non-judgementally when supporting parents who have mental health needs.

9.1.3 Children in poverty

Children who live in poverty can be at greater risk of developing mental health problems. Children living in households with the lowest 20% of incomes have a three-fold

[103] Holden JM, Sagovsky JL, Cox JL (1989) Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. British Medical Journal 298:223–226.
[104] Morrell CJ, Warner R, Slade P et al (2009) Psychological interventions for postnatal depression: cluster randomised trial and economic evaluation: the PONDER trial. Health Technology Assessment 13(30).
[105] Meltzer H, Gatward R, Corbin T, et al (2003) Persistence, Onset, Risk Factors and Outcomes of Childhood Mental Disorders. Office for National Statistics & TSO (The Stationery Office).
[106] Sainsbury Centre for Mental Health (2009) The chance of a lifetime: Preventing early conduct problems and reducing crime
[107] Office of the Deputy Prime Minister (2004) Mental health and social exclusion, Social Exclusion Unit Report, London, ODPM.

increased risk of mental health problems than children from households with the highest 20% of incomes.[108] (See JSNA 2011/12 chapter on children in poverty)

9.1.4 Children and Adolescents

Using schools as settings to help children and young people to recognise and manage emotions and improve their well-being is effective. Evidence shows that participants in school-based Social and Emotional Learning (SEL) programmes demonstrate significantly improved social and emotional skills, attitudes, behaviour, and academic performance.

Croydon was a pilot in the TaMHS (Targeted Mental Health in Schools) government programme. TaMHS aimed to support the development of mental health support in schools for children and young people aged five to 13 at risk of, and/or experiencing, mental health problems and their families. The TaMHS Working Group are continuing to oversee the introduction of co-ordinated capacity building within early years and primary school clusters to develop staff competencies and frontline intervention skills.

Croydon's voluntary sector partners including Croydon Drop In and Off the Record also deliver a number of outreach services to improve child and adolescent mental health across the Borough and in schools.

Roots of Empathy will be run in primary schools in the borough by Croydon-based charity the WAVE (Worldwide Alternatives to Violence) Trust, with support from Croydon Voluntary Action. The programme is being funded by the Big Lottery and around 2,500 children are expected to take part over the next three years. Root of Empathy is an evidence based programme that has shown improvements in reducing levels of aggression amongst school children (aged 5-10) whilst raising social and emotional competence and increasing empathy.

[108] Green H, McGinnity A, Meltzer H, et al (2005) Mental Health of Children and Young People in Great Britain, 2004. Office for National Statistics.

The Early Years Effective interventions that reduce risk factors and enhance protective factors for good mental health in children and young people	
What the evidence says works[109] [110] Promote good parental mental and physical health to improve early child development and well-being. Promote maternal well-being and reduce adverse outcomes of pregnancy and infancy. Continue in later years with universal and targeted approaches.	**What we're doing in Croydon** Croydon's infant mortality strategy includes actions which aim to improve experiences for women and their families when accessing services specifically before and during pregnancy and up to their child's first birthday. Croydon's Adult Perinatal Community Mental Health Team works with mothers who have had a previous mental health problem or may be at risk and work closely with the maternity team and health visitors. Croydon children's centres and other early years settings provide a base from which to support parents and to work directly with young children to develop positive relationships and social skills and to build their self-esteem and confidence.
Promote good parenting skills – universal as well as targeted early intervention programmes for common parenting problems and more intensive interventions for high risk families to prevent conduct disorders.	Universal programmes like the Child Health programme. The Early Intervention and Family Support commissioned programme will provide support for 12,030 children and families a year and is commissioned until 2015. Croydon Family Power funded by the lottery is a unique combination of evidence-based approaches building child-empathy, enhancing parental capabilities and strengthening family resilience, alongside innovative

[109] Commissioning well-being for all

[110] NICE Guidance Social and emotional well-being - early years: guidance Oct 2012

NICE Guidance Antenatal and postnatal mental health(CG45) Feb 2007

NICE Guidance Pregnancy and complex social factors (CG110), Sep 2010

NICE Guidance Weight management before, during and after pregnancy (PH27) Jul 2010

NICE Guidance Quitting smoking in pregnancy and following childbirth (PH26) Jun 2010

	community development work utilising the natural assets in our communities. Mind in Croydon deliver the Independent Parenting Advocacy Service.
Build social and emotional resilience of children and young people through whole-school approaches including prevention of violence and bullying.[111]	An Emotional Health and Well-being Toolkit online local resource is currently being developed for staff working in educational settings to assist children and young people aged 0 - 18 years (or 25 yrs with SEN and/or disability) with their emotional health and well-being.
Croydon additional information: Croydon's children and young people's partnership Croydon's children and young people's need assessment 2012 Croydon's Emotional Health and Well-being Toolkit Croydon's Practitioner Space provides a web-based facility for practitioners working with children and young people. Mind in Croydon – Parenting Advocacy Project JSNA chapter Emotional health and well-being of children aged 0-18 (weblink) Croydon Voluntary Action Croydon Drop In Croydon Off the Record	

9.1.5 Working age population

The large numbers of people in the working age population offer substantial opportunities to introduce interventions that protect mental health through the work-place, as well as preventing poor mental health that can be triggered through workplace factors, such as stress.

Work can play an important role in promoting mental well-being and is an important determinant of self-esteem and identity. It can provide a sense of fulfilment and opportunities for social interaction. For most people, work also provides their main source of income.[112]

However, work can also cause stress and there are implications for the working age population who are unemployed, as this is a risk factor for poor mental health. Levels of economic inactivity vary across Croydon, with particularly high levels in areas of deprivation.

9.1.6 Older People

Croydon's over 55 population is estimated to **increase by over 15%** between 2011 - 2021. While the numbers of older people are increasing in Croydon, ideas of what old

[111] NICE guidance: Social and emotional well-being in primary education (PH12) Mar 2008
NICE Guidance Social and emotional well-being in secondary education (PH20) Sep 2009

[112] NICE guidance Promoting mental well-being at work (PH22) Nov 2009

age is will also change. Working life will be extended, and different types of retirement will evolve. (See JSNA 2010/11 Living well in later life JSNA)

Keeping well as we age, both physically and mentally, will become even more important. An increasing issue facing an ageing population will be the greater numbers of people with dementia. (See JSNA 2011-12 dementia chapter and dementia strategy p.143). Croydon Council and its partners are hosting a series of workshops to explore how to connect people, keep people in touch, and use the internet and social community sites. A number of workshops have also been delivered with the involvement of older people.

Recommendation 19

It is recommended that Croydon's commissioners consider developing their educational programmes for older adults, particularly around information technology. This could increase social connectedness and play an important role in helping people to overcome the memory effects of dementias.

Many factors in older age (such as retirement, increasing ill health, bereavement or a drop in income) can lead older people to become socially isolated, which is a risk factor for mental health problems. However, a decline in mental well-being should not be viewed as a natural and inevitable part of ageing. Older people in Croydon should be empowered to maintain the best possible mental capital, and so keep their independence and well-being. Croydon's POP service aims to bring together a number of specialist advisors to various venues in the Borough to support over 50s.

Current indications are that 25% of older people in the community have symptoms of depression that may require intervention; 11% will have minor depression and 2% major depression.[113] (Living well in Later Life JSNA 2010/11, JSNA depression 2012/13)

Social activities, social networks, keeping busy and 'getting out and about', good physical health and family contact are among the factors most frequently mentioned by older people as important to their mental well-being.[114]

Croydon Council funds around 50 third sector prevention services for older people including day opportunity and lunch club groups, support groups, advocacy, benefits, online social network, travel support, low level support and reablement when returning home from hospital and carers respite. The prevention services have shown to reduce the uptake of statutory services and reduce social isolation.

Recommendation 20

It is recommended that Croydon Council and the voluntary sector co-ordinate and raise awareness of healthy ageing programmes for older people, particularly amongst GPs, and take action to measure improvements in well-being.

[113] Godfrey M, Townsend J, Surr C, et al (2005) Prevention and Service Provision: Mental Health Problems in Later Life. Institute of Health Sciences and Public Health Research, Leeds University & Division of Dementia Studies, Bradford University.

[114] Promoting Mental Health and Well-being in Later Life

Evidence supports the effectiveness of befriending initiatives, which are often delivered by volunteers. Befriending can potentially be of value both to the person being befriended and the 'befriender'. For those receiving the intervention, particularly older people, it promotes social inclusion and reduces loneliness, while for the befriender, there is the personal satisfaction of contributing to the local community by offering support and skills. Specific potential benefits include the improved mental well-being of the person receiving the intervention, a reduced risk of depression, and associated savings in health care costs.[115] Age UK Croydon offers the national "Call in Time" telephone befriending service, recognising that a friendly chat on the phone can make all the difference to someone who is isolated or lonely.

Recommendation 21

It is recommended that Croydon's Older People's Partnership consider the feasibility of a co-ordinated befriending project in Croydon offering different opportunities for older people, in addition to phone befriending.

Later life Effective interventions that reduce risk factors and enhance protective factors for good mental health in older people	
What the evidence says works [116]	**What we're doing in Croydon**
Improve the quality of older people's lives through psychosocial interventions and enhanced physical activity. Encourage physical activity and offer exercise on prescription.	Age UK Croydon run a Smart Health project for older people offering opportunities for physical activity, arts and craft and other activities. Active lifestyles deliver Croydon's exercise on referral service. Croydon's POP service offers a range of healthy ageing services.
Falls prevention through social support and education[117]	Croydon's integrated falls is a multi-disciplinary falls team that aim to restore independence and reduce future injuries. Age UK Croydon offer support to identify and help reduce risks and hazards in the home.

[115] Mead N, Lester H, Chew-Graham C, Gask L, Bower P (2010) Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis. British Journal of Psychiatry 196:96–101.
[116] NICE Guidance Four commonly used methods to increase physical activity (PH2) Mar 2006
NICE Guidance Mental well-being and older people (PH26), Oct 2008
NICE Guidance Depression with a chronic physical health problem (CG91), Oct 2009
[117] NICE Guidance The assessment and prevention of falls in older people (CG21), Nov 2004

Encourage volunteering and offer opportunities for life-long learning	Croydon Voluntary Action acts as a broker for volunteers in Croydon, referring them on to over 600 local voluntary sector groups.
Croydon additional information: Croydon's older peoples strategy Age UK Croydon – Smart Health project Croydon Voluntary Action – Volunteer information Croydon Active Lifestyles Croydon POP Services Croydon Dementia JSNA Croydon Living Well in Later Life JSNA NICE guidance Mental well-being and older people (PH16)	

10. Enhancing mental health and well-being by considering the relationship with physical health

Increased smoking is responsible for most of the excess mortality of people with severe mental health problems. Adults with mental health problems, including those who misuse alcohol or drugs, smoke 42% of all the tobacco used in England.[118]

The relationship between physical and mental health is complicated and connected. As physical and mental illnesses are often related with common risk factors, it is difficult to separate the relationship between the two. For example, behaviours associated with depression (such as smoking, excessive alcohol consumption and sedentary lifestyle) are also risk factors for chronic physical illness. Chronic physical illnesses can result in reduced ability to exercise, increased isolation, poorer quality of life, job loss, financial insecurity, increased stress and relationship strain; all risk factors for poor mental health.

Poor mental health is associated with **poor self-management of illness**, which results in worse outcomes for people and is costly.

Recommendation 22

It is recommended that mental health promotion is built into mainstream public health priorities by the adoption of a holistic approach to physical and mental well-being and by addressing the mental health dimensions of 'traditional' public health issues such as obesity, smoking, alcohol and sexual health.

10.1 People with diagnosed mental illness

People with mental illness can often lead unhealthy lifestyles because of their social circumstances. Many people with schizophrenia smoke, are obese (sometimes a side effect of medication) and take little exercise. People who use mental health services are less likely than the general population to be offered routine health checks like blood pressure, cholesterol, weight checks, or to receive opportunistic advice on smoking cessation, alcohol, exercise or diet, which is an equalities issue.[119]

Consequently, people with mental illnesses are far more likely than the general population to die from coronary heart disease and respiratory disease and suffer from chronic illnesses, such as diabetes. People with mental health problems need good access to services aimed at improving health, for example, stop smoking services. (2012/13 JSNA Chapters on Depression and Schizophrenia)

[118] No health without mental health: a cross-government mental health outcomes strategy (2011)
[119] NHS information centre

10.2 Smoking and mental health

Reducing the prevalence of smoking is a key priority for Croydon. People with a mental health disorder smoke almost half of all tobacco consumed and account for almost half of all smoking-related deaths.

Smokers are four times more likely to stop smoking for good with the support of a local stop smoking service who can advise on right products to use and offer regular support and information. Croydon has a comprehensive stop smoking service, however to date commissioned services do not specifically target people with mental health problems.

Rates of smoking at in-patient mental health units are 70%, compared to 21% in the general population.[120] South London and Maudsley NHS Foundation Trust (SLaM) is making all mental health units smoke-free by the beginning of 2013-14. SLaM is also to start recording smoking status of patients with mental health problems and support them to quit where this is the patient's wish.

10.3 Obesity and mental health

Reducing the number of adults who are overweight or obese is a Croydon priority. Regular physical activity is associated with a greater sense of well-being and lower depression and anxiety for all the population and across all age groups.[121] However, we know that a large number of Croydon's population is sedentary and either overweight or obese, and therefore not gaining from the benefits physical activity has on mental health.[122]

There is limited national evidence on how to design physical activity interventions that benefit everyone, particularly people with mental health problems. However Mind in Croydon has been carrying out innovative work into this area, and has a number of projects under its Active Minds service that have been evaluated positively by the University of East London, including their Boxercise project. These projects reduce weight and BMI and increase activity as well as increasing social inclusion. [123]

Mind in Croydon also offer volunteer 'buddies' who support people with mental health problems to take part in physical activity and who are referred to Croydon's exercise on referral scheme, as well as taking part in other physical activities.[124].

[120] http://www.rcpsych.ac.uk/PDF/Final%20PS4%20briefing_for%20website%20A4.pdf
[121] Foresight (2008) The Effect of Physical Activity on Mental Capital and Well-being
[122] Healthy Weight, Healthy Lives JSNA.
[123] Hefferon, K., Mallery, R., Gay, C., & Elliott, S. (2012): 'Leave all the troubles of the outside world': a qualitative study on the binary benefits of 'Boxercise' for individuals with mental health difficulties. Qualitative Research in Sport, Exercise and Health /2159676X.2012.712995
[124] Mind in Croydon buddying report

These innovative projects are currently funded via charitable grants that are due to end in March 2013. Consideration needs to be taken about how to continue these services.

Recommendation 23

It is recommended that voluntary sector organisations are supported to find alternative funding when charitable grants are coming to an end or that statutory funding be considered for projects demonstrating positive outcomes.

10.4 Substance abuse, alcohol problems and mental health

There is a close relationship between alcohol problems and mental health. People with mental health problems are at higher risk of alcohol problems and vice versa.

Evidence shows that training frontline practitioners in alcohol identification and brief advice (IBA) can be effective by equipping frontline staff with the skills to identify individuals whose drinking might be impacting on their health. Frontline practitioners who might regularly come into contact with people who may be drinking too much e.g. housing officers, A&E staff or paramedics are given training to be able to deliver simple, structured advice on how to reduce consumption.

10.5 People with long term conditions

People with long-term conditions such as diabetes or cardiovascular disease are two to three times more likely to experience depression, anxiety and other mental health problems. (JSNA Depression chapter)

Nationally, the number of people with long term conditions is increasing because of the ageing population. More effective treatments are also becoming available for certain long term conditions, for example, HIV, that enable people to live longer with the condition. In Croydon, the main driver for the increase in long term conditions is the growth in the total population.

Box 10 – Disability and mental health considerations

- Social inclusion and life chances such as employment, education, housing and opportunities to be independent influence the mental health of people with disabilities or long term conditions.
- Estimates of prevalence of mental health problems in people with learning disabilities vary from 25-40%, depending on the population sampled and the definitions used.[125]
- People with learning disabilities are more vulnerable to more of the risk factors associated with mental ill health, such as adverse life events and lack of social support, and are much less likely than the general population to be able easily to access psychiatric services.[126]

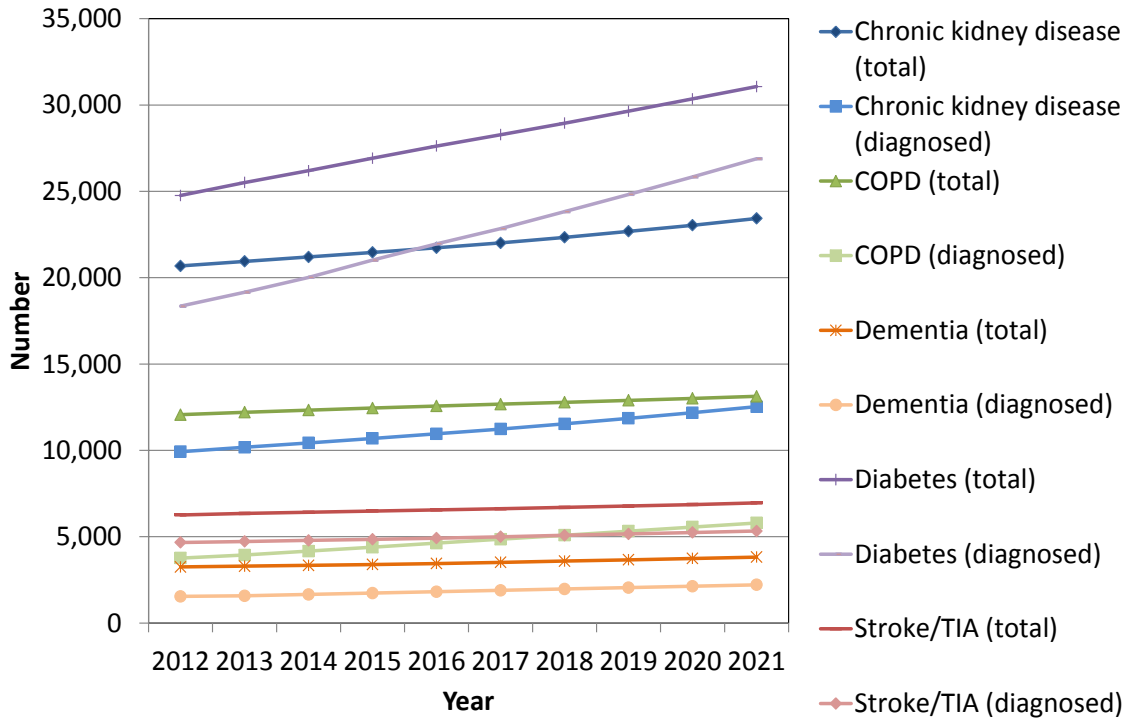
[125] Department of Health (1993). Services for people with learning disabilities, challenging behaviour or mental health needs. Project group report. London: Department of Health.
[126] Bouras N, Holt G, Gravestock S (1995). Community care for people with learning disabilities: deficits and future plans. Psychiatric Bulletin 19: 134−137.

The presence of mental health problems in people who have long term physical conditions is associated with increased healthcare use and cost. For example, for people with diabetes the total health expenditure is 4.5 times higher for those who also have depression than for those without depression[127]. This is significant as can be seen from **Figure 16** diabetes is set to increase. In chronic heart disease (CHD), depressed patients have higher rates of complications.[128] People with chronic obstructive pulmonary disease (COPD) are more likely to have to stay longer in hospital if they also have a mental health problem.[129]

People with a mental health condition are more likely to also have a long term health condition than people who do not have a mental health condition, as shown in Figure 17.

People with a mental health condition are much more likely to have asthma, COPD, epilepsy, Parkinson's disease or stroke/TIA.

Figure 16: Projected number of long term conditions in Croydon's population, 2012-2021



Source: Projections based on data from Croydon general practices

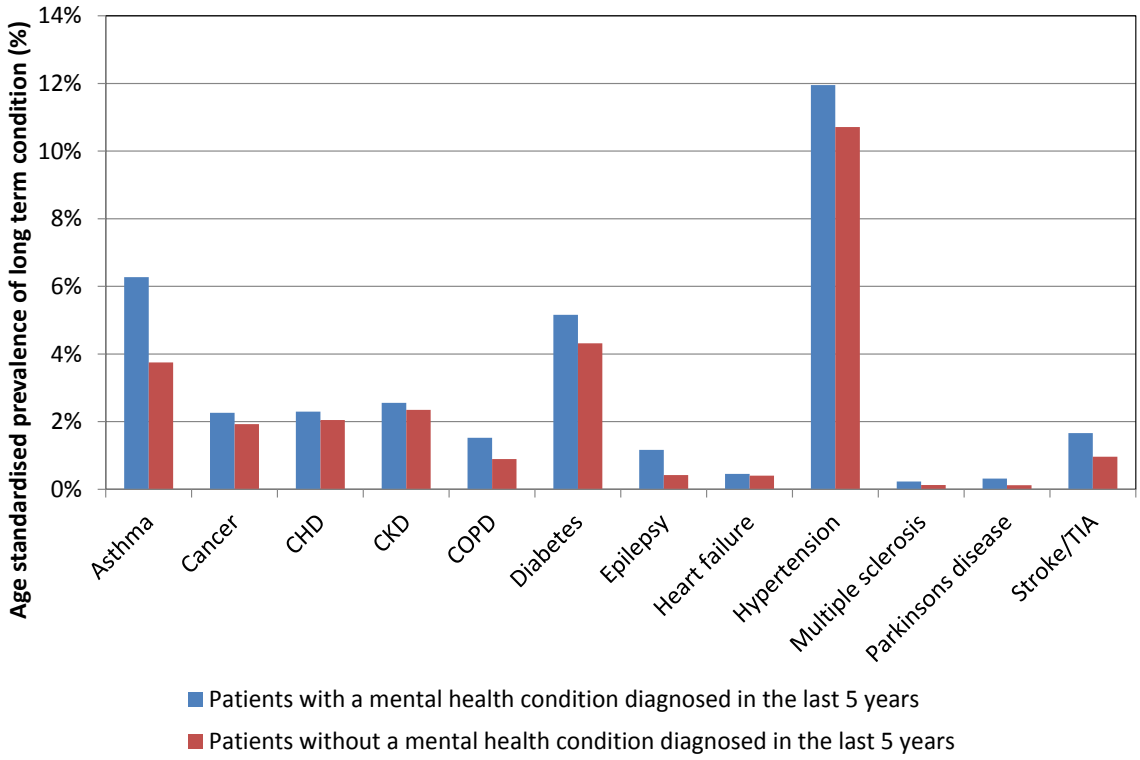
[127] Egede et al. Comorbid depression is associated with increased health care use and expenditures in individuals with diabetes. Diabetes Care 2002; 25(3): 464-70.
[128] Lauzon et al. Depression and prognosis following hospital admission because of acute myocardial infarction. Can Med Assoc J 2003; 168(5): 570-571.
[129] Ng T, Niti M, Tan W, Cao Z, Ong, K, Eng P. Depressive symptoms and chronic obstructive pulmonary disease: effect on mortality, hospital readmission, symptom burden, functional status, and quality of life. Arch Intern Med. 2007;167(1):60-67.

Recommendation 24

It is recommended that all frontline staff (statutory and voluntary sector) in contact with people with physical health conditions and long term conditions should be given mental health awareness training to be able to respond appropriately to the mental health needs of these groups.

The Croydon Public Health Intelligence Team (C-PHIT) has also carried out analysis to project future prevalence of long term conditions given the changing population and this is available from the team upon request.

Figure 17: Prevalence of long term conditions in patients with a diagnosed mental health condition compared with patients without a diagnosed mental health condition



Source: Data from Croydon general practices

Note: CHD = Coronary heart disease; CKD = Chronic kidney disease; COPD = Chronic obstructive pulmonary disease

Integrating mental health and physical health	
What the evidence says works	**What we're doing in Croydon**
Integrating physical and mental well-being through universal lifestyle programmes to reduce smoking and obesity and to encourage exercise.	Active Lifestyles runs universal physical activity programmes and an exercise on referral project. Active Lifestyles run an exercise referral scheme where people are referred by their GP or other health professional. Mind in Croydon delivers a variety of projects through Active Minds which focus on reducing social isolation by enabling people to take part in leisure, sports and social activities. Their Buddying Service has improved the uptake of many Active Lifestyles programmes by people with mental health problems who would not have participated without additional support. Croydon health promotion resources aim to provide quality information about health improvement activity across the borough of Croydon. The website has various campaigns and a monthly health calendar. Croydon's Healthy Living Hub is another opportunity for people to receive support and information around healthy lifestyles and is based in the central library.
Tackling alcohol and substance abuse, including direct measures with those abusing alcohol and screening programmes.	Croydon Drug and Alcohol Action Team (DAAT) will be providing a range of IBA training, which will be targeted at key frontline professionals across the borough in 2013/14
Additional Croydon Information Croydon Active Lifestyles information including exercise on referral. Croydon Active Minds Project NICE (2009) Depression in Adults with Chronic Physical Health Problems: Treatment and management. Clinical Guideline 91. Croydon health promotion resources Croydon's healthy living hub	

11. Measuring mental well-being and data limitations

Understanding how people in Croydon feel about their own mental well-being and the quality of their lives is important, and we also need to be able to measure whether or not interventions are making a positive difference.

In recent years there has been a growing interest in measuring well-being at government level. There is currently no consensus on the best way to do this. For the most part, well-being indicators tend to be subjective in that they are based upon judgements made by the individual about how they think and feel.

The Office for National Statistics (ONS) has a Measuring National Well-being Programme, which aims to go beyond subjective well-being to incorporate the social context in which a person lives their life. It includes:

- quality of life measures, looking at different areas of national well-being such as health, relationships, job satisfaction, economic security, education environmental conditions,
- measures of 'subjective well-being' – i.e. individuals' assessment of their own well-being.

In measuring subjective well-being in 2011, ONS found London to have the lowest life satisfaction and highest level of anxiety of any region in the UK.[130]

The Greater London Authority has attempted to consider well-being at a local level and the differences shown within boroughs and between wards is useful when thinking about targeting resources. The well-being scores are based on 12 different indicators including; health, economic security, safety, education and the environment. [131]

Croydon has three wards (Coulsdon East, Sanderstead, Selsdon & Ballards) among the 25% of London wards with the highest and five wards (Broad Green, Fieldway, New Addington, Selhurst, South Norwood, Thornton Heath) among the 25% of London wards with the lowest well-being scores. When compared with all wards across London, Selsdon & Ballards is among the 5% wards rated best for well-being, and Fieldway and New Addington are among the ten wards in London rated poorest for well-being. Fieldway has the third lowest well-being score in London. As Figure 18 shows there is a clear link between the most deprived wards in Croydon and levels of well-being.

The Croydon key dataset is a series of indicators relating to health and well-being which allows an 'at a glance' view of Croydon in comparison to the rest of the country and this includes some of the GLA indicators.

[130] First ONS Annual Experimental Subjective Well-being Results, Office for National Statistics, July 2012
[131] http://data.london.gov.uk/datastore/package/london-ward-well-being-scores

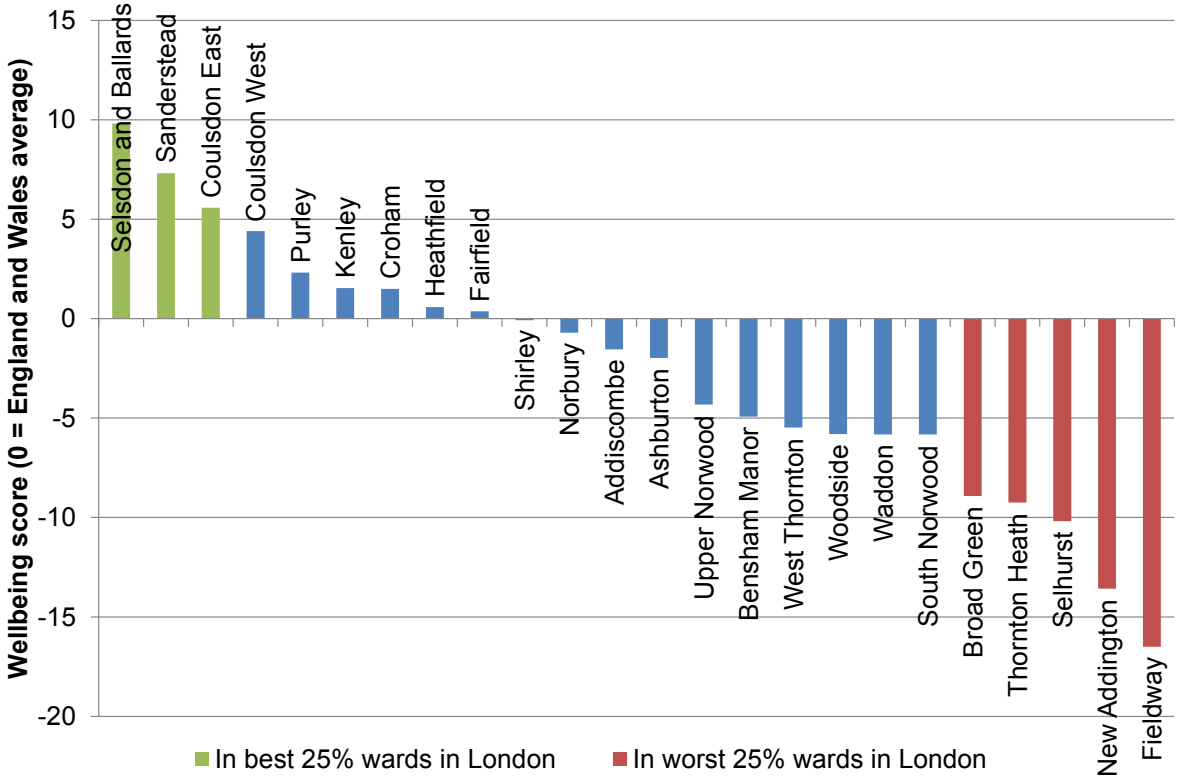
11.1.1 Warwick Edinburgh Mental well-being scale (WEMWBS)

One tool that can be used to measure well-being is WEMWBS, which is a validated, easy to use scale for assessing a population's mental well-being. It measures the mental well-being impact at baseline, during and on completion of an intervention or programme.[132]

Recommendation 25

It is recommended that WEMWBS or a similar tool be routinely used to measure differences of well-being at baseline and after intervention in services/ interventions/projects that have an impact on mental health in Croydon.

Figure 18: Well-being scores for Croydon electoral wards, 2010



Source: London Ward Well-Being Scores (2012 edition), Greater London Authority

11.1.2 Mental well-being impact assessment (MWIA)

MWIA is an innovative and effective process for ensuring that policies, strategies, initiatives and commissioning proposals improve people's mental well-being as much as possible. The process enables evidence based recommendations to be identified to strengthen the positive and mitigate against any potential negative impacts. A helpful checklist can support this process: Mental Well-being Checklist [133] MWIA also includes a process to develop indicators to measure improvement. It focuses on population groups

[132] Warick Edinburgh Mental well being scale

[133] National Mental Health Development Unit Mental Wellbeing Checklist

who may experience health inequalities and social injustice with a particular emphasis on those most at risk of poorer mental well-being.

Recommendation 26

It is recommended that the use of Mental Well-being Impact Assessment tools be encouraged to assess how all strategies, commissioning decisions and directly provided services can support and improve mental health and well-being.

Recommendation 27

It is recommended that Croydon considers the indicators that it can use to best measure well-being in conjunction with emerging national work, to understand and monitor Croydon's mental health and well-being across time.

12. Conclusion and key messages

The overview chapter has assessed the risk and protective factors to positive mental health and well-being in Croydon. Good mental health is essential to physical health, relationships, education, training, work and being resilient.

Mental health is everyone's business: Individuals, families, employers, schools, colleges and communities all need to play their part in promoting mental well-being in Croydon. Improving mental health and well-being in Croydon will potentially bring wider social and economic benefits by building individual and community resilience.

Address inequalities: Deprivation and inequalities are increasing in Croydon and it is unclear what impact the recession will have on the prevalence and burden of mental illness. However, evidence would suggest that promoting mental health and well-being should be key priorities and strategies should include interventions and policies which address wider determinants.

Focus on prevention of mental illness and promotion of mental well-being: As the majority of mental health problems start in childhood and last a lifetime and prevention and early intervention can reduce these long-term adverse effects, the early years should be prioritised as a focus for mental health promotion.

Take a life course perspective: Recognise that while the foundations for positive mental health are made in the early years, there is evidence that we can protect and promote well-being and resilience in adulthood, particularly through meaningful activity and employment and then on into a healthy old age.

Integrate physical and mental health Physical health and mental health are inextricably linked. The promotion of mental health should not be seen as less important than physical health. There is a need to increase understanding of the links between physical health and mental health, particularly in areas such as tobacco, alcohol, obesity and physical activity.

Measure levels of mental well-being in Croydon

There is a need to collect data on how Croydon residents feel about their own mental well-being. Any intervention or policy should be able to be measured to assess whether or not they are making a positive difference.

13. Appendices

Appendix 1:
Methods used for the projections of mental health conditions in Croydon to 2021

Appendix 2:
Mental health needs of specific groups in Croydon

Appendix 1: Methods used for the projections of mental health conditions in Croydon to 2021

This appendix describes the methods used for the projections of mental health conditions in Croydon to 2021 shown in the overview chapter in Table 1.

1.1 Projections for mental health conditions

Future numbers of people in Croydon with mental health conditions were estimated by first creating population projections for Croydon based on the latest available data from the 2011 Census, and applying national and local prevalence rates to these using several methods of estimation. Where possible, an adjustment was made for changes in deprivation, using the Index of Multiple Deprivation.

The population projections used are shown in section 1.2.1 of this appendix, and the methods of estimation are shown in Box 1.

Where alternative methods were available for a condition, a judgement was made about which method was most likely to be accurate for the projection to be included in the chapter. In general, underlying prevalence rates were assumed to remain stable, but method C was used where recent trends showed a much greater increase than if the underlying prevalence rates had remained the same.

Box 11 Methods used in calculation of projections

A. **National** prevalence data from surveys of diagnosed and undiagnosed cases has been applied to population projections by **age and sex,** not including an adjustment for deprivation.

B. **Local** prevalence data from GP diagnosed cases has been applied to population projections by **age and sex**, including an adjustment based on recent trends in **deprivation**[134].

C. Projecting forward as a **linear trend** the number of GP diagnosed cases of the condition[135].

[134] The adjustment assumes that changes in deprivation in Croydon will continue at the same rate as between 2001 and 2008.

[135] This method was used for conditions where prevalence rates appeared to be increasing over time rather than remaining stable.

It is important to note that each method has been based on the assumptions that growth in Croydon's population will continue at the same rate as between the 2001 and 2011 Censuses, which may or may not be the case.

Table 1: Estimated numbers of adults with mental health conditions in Croydon, projected to 2021

Projection	Method used	Detailed methodology
1) Dementia (diagnosed+undiagnosed)	A	Estimated diagnosed and undiagnosed prevalence of dementia in the population. Using national prevalence rates from Dementia UK report. Assumes prevalence rate is same as national and remains the same.
2) Dementia (diagnosed)	C	Diagnosed dementia. Trend from QOF data continued as linear trend. Assumes trend in number on QOF register continues.
3) Mild alcohol dependence (diagnosed+undiagnosed)	A	Estimated diagnosed and undiagnosed prevalence of mild alcohol dependence in the last 6 months. Prevalence rates from the Adult Psychiatric Morbidity Survey 2007, Information Centre for Health and Social Care. Assumes prevalence rate is same as national and remains the same.
4) Moderate or severe alcohol dependence (diagnosed+undiagnosed)	A	Estimated diagnosed and undiagnosed prevalence of moderate or severe alcohol dependence in the last 6 months. Prevalence rates from the Adult Psychiatric Morbidity Survey 2007, Information Centre for Health and Social Care. Assumes prevalence rate is same as national and remains the same.
5) Drug dependence including cannabis (diagnosed+undiagnosed)	A	Estimated diagnosed and undiagnosed prevalence of drug dependence including cannabis in the past year. Prevalence rates from the Adult Psychiatric Morbidity Survey 2007, Information Centre for Health and Social Care. Assumes prevalence rate is same as national and remains the same.
6) Drug dependence excluding cannabis (diagnosed+undiagnosed)	A	Estimated diagnosed and undiagnosed prevalence of drug dependence excluding cannabis in the past year. Prevalence rates from the Adult Psychiatric Morbidity Survey 2007, Information Centre for Health and Social Care. Assumes prevalence rate is same as national and remains the same.
7) Problem gambling (diagnosed+undiagnosed)	A	Estimated diagnosed and undiagnosed prevalence of problem gambling. Prevalence rates from the Adult Psychiatric Morbidity Survey 2007, Information Centre for Health and Social Care. Assumes prevalence rate is same as national and remains the same.
8) Serious mental illness (diagnosed)	C	Diagnosed serious mental illness (including schizophrenia, bipolar disorder and other psychoses). Trend from QOF data continued as linear trend. Assumes trend in number on QOF register continues.
9) Schizophrenia (diagnosed)	B/C	Diagnosed schizophrenia. Current Croydon prevalence rates by age and sex applied to population projections and constrained to the overall serious mental illness projection. Assumes trend in number on QOF register continues.
10) Bipolar disorder (diagnosed)	B/C	Diagnosed bipolar disorder. Current Croydon prevalence rates by age and sex applied to population projections and constrained to the overall serious mental illness projection. Assumes trend in number on QOF register continues.
11) Other psychoses (diagnosed)	B/C	Diagnosed other psychotic disorder. Current Croydon prevalence rates by age and sex applied to population projections and constrained to the overall serious mental illness projection. Assumes trend in number on QOF register continues.
12) Depression at a point in time (diagnosed+undiagnosed)	A	Estimated diagnosed and undiagnosed prevalence of depression at any point in time for adults aged 16 and over. Prevalence rates from the Adult Psychiatric Morbidity Survey 2007, Information Centre for Health and Social Care. Assumes prevalence rate is same as national and remains the same.

Projection	Method used	Detailed methodology
13) Depression in last 5 years **(diagnosed)**	B	Depression diagnosed in the last 5 years. Current Croydon prevalence rates by age and sex applied to population projections and adjusted for deprivation. Assumes prevalence rate remains the same and deprivation continues to increase at the same rate.
14) Mixed anxiety and depressive disorder **(diagnosed+undiagnosed)**	A	Estimated diagnosed and undiagnosed prevalence of mixed anxiety and depressive disorder for adults aged 16 and over. Prevalence rates from the Adult Psychiatric Morbidity Survey 2007, Information Centre for Health and Social Care. Assumes prevalence rate is same as national and remains the same.
15) Generalised anxiety disorder **(diagnosed+undiagnosed)**	A	Estimated diagnosed and undiagnosed prevalence of generalised anxiety disorder for adults aged 16 and over. Prevalence rates from the Adult Psychiatric Morbidity Survey 2007, Information Centre for Health and Social Care. Assumes prevalence rate is same as national and remains the same.
16) Phobias **(diagnosed+undiagnosed)**	A	Estimated diagnosed and undiagnosed prevalence of phobia for adults aged 16 and over. Prevalence rates from the Adult Psychiatric Morbidity Survey 2007, Information Centre for Health and Social Care. Assumes prevalence rate is same as national and remains the same.
17) Obsessive compulsive disorder **(diagnosed+undiagnosed)**	A	Estimated diagnosed and undiagnosed prevalence of obsessive compulsive disorder for adults aged 16 and over. Prevalence rates from the Adult Psychiatric Morbidity Survey 2007, Information Centre for Health and Social Care. Assumes prevalence rate is same as national and remains the same.
18) Panic disorder **(diagnosed+undiagnosed)**	A	Estimated diagnosed and undiagnosed prevalence of panic disorder for adults aged 16 and over. Prevalence rates from the Adult Psychiatric Morbidity Survey 2007, Information Centre for Health and Social Care. Assumes prevalence rate is same as national and remains the same.
19) Any common mental disorder **(diagnosed+undiagnosed)**	A	Estimated diagnosed and undiagnosed prevalence of 1 or more common mental disorders for adults aged 16 and over. Common mental disorders include depression, mixed anxiety and depression, generalised anxiety disorder, phobias, obsessive compulsive disorder and panic disorder. Prevalence rates from the Adult Psychiatric Morbidity Survey 2007, Information Centre for Health and Social Care. Assumes prevalence rate is same as national and remains the same.
20) Postnatal depression **(incidence,** **diagnosed+undiagnosed)**	A	Estimated incidence of diagnosed and undiagnosed postnatal depression. Incidence estimated based on 10%-15% of women having a baby (http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/postnatalmentalhealth/postnataldepression.aspx). Assumes 12.5% incidence and that birth rate continues to increase at same rate as 2007-2011.
21) Post-traumatic stress disorder **(diagnosed+undiagnosed)**	A	Estimated diagnosed and undiagnosed prevalence of post-traumatic stress disorder. Prevalence rates from the Adult Psychiatric Morbidity Survey 2007, Information Centre for Health and Social Care. Assumes prevalence rate is same as national and remains the same.
22) Eating disorder **(diagnosed+undiagnosed)**	A	Estimated diagnosed and undiagnosed prevalence of eating disorder. Prevalence rates from the Adult Psychiatric Morbidity Survey 2007, Information Centre for Health and Social Care. Assumes prevalence rate is same as national and remains the same.
23) Personality disorder **(diagnosed+undiagnosed)**	A	Estimated diagnosed and undiagnosed prevalence of antisocial or borderline personality disorders. Prevalence rates from the Adult Psychiatric Morbidity Survey 2007, Information Centre for Health and Social Care. Assumes prevalence rate is same as national and remains the same.
24) Autism **(diagnosed+undiagnosed)**	A	Estimated diagnosed and undiagnosed prevalence of autistic spectrum disorder among adults. Prevalence rates from the Adult Psychiatric Morbidity Survey 2007, Information Centre for Health and Social Care. Assumes prevalence rate is same as national and remains the same.

Projection	Method used	Detailed methodology
25) Autism (diagnosed)	C	Diagnosed autistic spectrum disorder. Linear trend from prevalence numbers 2009-2012. Assumes trend in prevalence among adults continues.
26) Learning disability (diagnosed+undiagnosed)	A	Estimated diagnosed and undiagnosed prevalence of learning disability including people with mild learning disabilities who are less likely to be known to services. Prevalence rates from 'Estimating the Current Need/Demand for Supports for People with Learning Disabilities in England', Eric Emerson & Chris Hatton, Institute for Health Research, Lancaster University, 2004. Assumes prevalence rate is same as national and remains the same.
27) Learning disability (diagnosed)	C	Diagnosed learning disability. Linear trend from prevalence numbers 2009-2012. Assumes trend in prevalence among adults continues.

1.2 Projected change in underlying population demographics

1.2.1 Population by age and sex

For the most recent available population projections, see the Office for National Statistics (http://www.ons.gov.uk/ons/) and Greater London Authority (http://data.london.gov.uk/) websites.

The population projections used in this report were defined for the purpose of the JSNA, based on the best data available at the time, including the first release of published data from the 2011 Census.

They are based on the assumption that Croydon's population will continue to grow between 2011 and 2021 at a similar rate to the population growth between the 2001 Census and 2011 Census.

Table 2: Usual resident population by age and sex for Croydon, projected to 2021

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
All ages	363,500	367,000	370,600	374,100	377,600	381,000	383,900	386,700	389,600	392,400
M 0-4	14,500	14,700	15,100	15,200	15,300	15,400	15,400	15,400	15,300	15,300
M 5-14	23,800	24,200	24,600	25,100	25,800	26,500	27,100	27,700	28,200	28,700
M 15-24	23,600	23,500	23,500	23,400	23,200	23,000	22,900	23,000	23,100	23,200
M 25-34	27,700	28,200	28,600	28,900	29,300	29,600	29,700	29,800	29,700	29,700
M 35-44	25,900	25,700	25,600	25,600	25,700	25,600	25,700	25,900	26,200	26,500
M 45-54	25,500	25,800	25,900	26,000	26,100	26,200	26,200	26,000	25,800	25,600
M 55-64	17,200	17,200	17,400	17,700	18,000	18,300	18,600	19,000	19,400	19,700

M 65-74	11,100	11,400	11,500	11,700	11,900	12,000	12,000	12,100	12,200	12,200
M 75-84	6,800	6,800	6,900	6,900	6,900	7,000	7,200	7,300	7,400	7,600
M 85+	2,000	2,100	2,100	2,200	2,300	2,400	2,400	2,500	2,600	2,800
F 0-4	14,100	14,200	14,500	14,700	14,900	15,000	15,000	15,000	14,900	14,900
F 5-14	23,100	23,600	24,000	24,400	24,900	25,400	26,000	26,500	27,000	27,500
F 15-24	23,800	23,800	23,800	23,800	23,600	23,500	23,400	23,500	23,600	23,700
F 25-34	29,600	30,100	30,500	30,800	31,100	31,400	31,600	31,600	31,600	31,600
F 35-44	27,500	27,300	27,300	27,500	27,700	27,700	27,900	28,200	28,500	28,900
F 45-54	26,800	27,100	27,300	27,400	27,400	27,300	27,000	26,700	26,400	26,100
F 55-64	18,500	18,600	18,800	19,200	19,600	20,100	20,700	21,200	21,700	22,200
F 65-74	13,000	13,300	13,600	13,800	14,100	14,200	14,300	14,400	14,500	14,700
F 75-84	8,800	8,900	8,900	9,000	9,000	9,000	9,200	9,300	9,500	9,700
F 85+	3,900	4,000	4,000	4,100	4,200	4,300	4,400	4,500	4,600	4,800

Source: Croydon Public Health Intelligence Team (C-PHIT), based on data from the 2001 Census, 2011 Census and Greater London Authority

1.2.2 Deprivation adjustment

The Index of Multiple Deprivation published by the Department for Communities and Local Government (http://www.communities.gov.uk/) shows that deprivation was increasing in Croydon relative to other areas in England between 2001 and 2008[136].

Projections to 2021 were created from this data, using a linear trend, and were used where possible to apply a deprivation adjustment to data (see Method B in Box 1). They are based on the assumption that Croydon is going to continue to grow more deprived at the same rate.

[136] The Index of Multiple Deprivation 2010 was based on 2008 data, and for 2004 was based on 2001 data.

Appendix 2: Mental health needs of specific groups in Croydon

The overview chapter specifically highlights the associated risks for mental health for groups of people who have protected characteristics as defined in the Equality Act.

However, there are also a number of other groups of people who can be at higher risk of mental health problems and the needs of these groups should be considered in any services or programmes of work. It is particularly important to promote the well-being of these groups.

Carers

There are an estimated 6.4 million people in the UK providing unpaid care and support to ill, frail and disabled friends and family members. Large numbers of children and young people act as carers to their family members and a disproportionately high numbers of carers (10%) are from the BAME communities (Carers UK, 2010).

Croydon has about 30,000 carers, 5,000 of those providing more than 50 hours of care each week. Recent research shows that between 75% and 85% of carers report mental health problems, predominantly depression, anxiety and stress. (Carers UK, 2011)

Offenders and ex-offenders

Over 90% of prisoners had one or more mental health problem from the range of psychosis, neurosis, personality disorder, hazardous drinking, drug dependence. Dual diagnosis, that is a prisoner with a mental health problem AND a drug or alcohol dependency, is common; approximately 1 in 10 are affected by a severe mental illness. Prisoners on remand show higher rates of mental disorder than convicted prisoners. Women show higher rates of neurotic disorder than men. (Lord Bradley, 2011)

Nearly one-third of prisoners have no accommodation on their release and a considerable proportion of people in the homeless population also have offending histories. In 2010 48% of St Mungo's clients nationally were ex-offenders (Centre for Mental Health, 2011).

Veterans

Every year, approximately 1 person in every 1,000 regular service personnel is discharged for reasons related to mental well-being[137]. Veteran's mental health has

[137] Veterans: mental health
http://www.nhs.uk/Livewell/Militarymedicine/Pages/Veteransmentalhealth.aspx

become more recognized in recent years and as a result much more is known about the subject. Contribution to a reduction of stigma associated with poor mental health.

Recent research indicates that mental health problems are most likely to be experienced by a specific group of young single men who leave the services early. These young men may have poor social skills, limited basic education, dyslexia or dyscalculia and difficulty in adjusting to change. Because they have left the services early, they are entitled to receive considerably less support on discharge.

Veterans are reported to comprise approximately 3.5% of the total prison population (Centre for Mental Health, 2010)

The most common diagnosis is for Post Traumatic Stress Disorder or PTSD. The veterans' mental health charity Combat Stress has reported that between 2005 and 2009, 75% of their clients (a total of 608 people) had a diagnosis of PTSD, often in association with other mental health needs[138].

In December 2011, Croydon launched its Armed Forces Community Covenant. This pledge seeks to ensure that the armed forces are brought closer to their civilian counterparts in the borough, and that their needs are properly recognised and dealt with. This is the case with regards to veterans' mental health.

Due to data protection reasons it is not possible to know the exact numbers of regular personnel or veterans in the borough. However, the number of reservists at 1st November 2012 is just over 1100, of whom around one fifth are also Croydon residents.

The regiments where these reservists serve, as well as armed forces charities such as the Royal British Legion and SSAFA Forces Help sit on the Covenant's Working Group. This group has sought advice from veteran's mental health charities, and has promoted a campaign to encourage people to volunteer as mentors to support veterans with mental wellbeing issues.

The Covenant Working Group will continue to liaise with local mental health care providers to ensure that the needs of service personnel are met. It is also planning to investigate further the impact on the mental well-being of service families following the publication of *Unsung Heroes: Developing a better understanding of the emotional support needs of Service families* earlier this year[139].

[138] Across the wire: Veterans, mental heralth and vulnerability http://www.mod.uk/NR/rdonlyres/6F674D12-FBBA-40A8-B53F-74F7B4570408/0/Across_the_wire.pdf

[139] Unsung Heroes: Developing a better understanding of the emotional support needs of Service families http://www.centreformentalhealth.org.uk/pdfs/unsung_heroes.pdf

People who experience domestic violence and abuse

Evidence of the prevalence of domestic violence shows that one in four women will be affected by domestic violence in their lifetime; domestic violence accounts for 16% of all violent crime, rising to 24% in certain local authority areas.

The recent report from Croydon Safer Partnership on Domestic Violence in Croydon shows the all-pervasive and continuing problem. During the 12 month period from July 2011 to June 2012, there were 5,955 allegations. Of these 30% were of serious types of violence. The most dangerous age is from 20 through to early thirties with females most at risk, in particular they account for 83% of victims where there was serious violence. With police stating a 20% increase in 'reported' domestic abuse and sexual violence in the last 12 months, the demands on the limited services available are of concern.

Domestic violence is the major cause of injury to women under 60 years of age and a major risk factor for psychiatric disorders, chronic physical conditions and substance abuse. Women experiencing domestic violence are at greater risk of depression, post-traumatic stress disorder (PTSD), substance abuse, anxiety, insomnia, suicidality and social dysfunction as well as experiencing greater physical ill health.

At least 750,000 children a year witness domestic violence. Children observing domestic violence can experience a range of long term effects, including physical damage, behavioural problems, mental health problems, exposure to multiple adversities, violence, mental health, substance abuse, developmental delay, academic problems leading to diminished educational attainment, and lower take up of healthcare, such as risk of under immunisation.

There is a strong link between child physical abuse and domestic violence with estimates ranging between 30% and 66% of households where domestic violence occurs. (United Kingdom, Department of Health, 2010)

Trafficked people

Adult victims of trafficking are trafficked all over the world for little or no money – including to and within the UK. They can be forced to work in the sex trade, domestic service, forced labour, criminal activity or have their organs removed to be sold.

A recent report on trafficked women in support settings found that the overwhelming majority experienced physical violence and/or sexual abuse while trafficked; they reported very high levels of symptoms indicative of post-traumatic stress disorder (PTSD), of suicidal thoughts and of depression (United Kingdom, Department of Health, 2010b)

Forced marriage, within and outside the UK, can be considered to be a form of trafficking

Gypsies and travellers

The risk of depression and anxiety is nearly three times higher than average and the risk of depression is twice as great, Women in gypsy and traveller communities are twice as likely to suffer mental health problems. (United Kingdom, Department of Health, 2011d)

People with addictions

Problem gambling

Problem gambling – that is, gambling to the extent that it impacts on the person's health and family and social relationships, can be particularly common in people who have depression, an anxiety disorder or bipolar disorder. (Royal College of Psychiatrists, 2011)

Substance abuse

Research shows that substance misuse may cause or increase symptoms of mental illness. On the other hand, mental illness may lead someone to abuse substances.

Depression, anxiety and schizophrenia are more likely to be linked to substance misuse. The drug use can stop people making a full recovery. It is also more likely to lead to them becoming unwell again or to have to be re-admitted to hospital. (Royal College of Psychiatrists, 2012)

Adult survivors of childhood abuse

Exposure to severe adversity in childhood and adolescence have been shown to have an impact on attainment, aspirations and emotional and mental wellbeing in adulthood. (Harvard University. Centre on the Developing Child, 2012)

In 2012 an estimated 25,748 adults in Croydon aged 18-64 years were predicted to be survivors of childhood sexual abuse. This figure is estimated to increase by 10% to 28,399 by 2030. (PANSI, 2012-2030)

Lone parents

Research published in 2006 showed that there is a higher rate of mental disorder of all types among lone parents than for adults living as a couple with children. Lone parents are almost three times more likely than couples with children to have more serious functional psychoses (this includes disorders such as schizophrenia and bipolar affective disorder) or drug dependence, and are nearly twice as likely as couples with children to have a neurotic disorder. (Gould, 2006)

Croydon has an estimated 58,000 people living in lone parent families, roughly 26,000 of whom are children. (Office for National Statistics, 2010)

Living alone

People living on their own are more likely to have worse mental health. This group is 1.6 times as likely to experience a depressive episode and is much more likely to have other kinds of mental health problems, including obsessive compulsive disorder and panic disorders. Some evidence shows that it is the transition to solo living that has the closest association with poor mental health. This is partly because relationship breakdown often leads to solo living.

Many older people living alone experience poor mental health as the result of loneliness and lack of contact with the community. People living alone over the age of 65 are twice as likely as other groups to spend more than 21 hours a day alone. (Bennett & Dixon, 2006).

In 2010, Croydon had an estimated 43,000 people living alone and approximately 17,510 were aged 65 years and over. (POPPI, 2012 - 2030)

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