Section 5.5a

Title: Draft 1 Emotional Health & Well-being

1. Overview

The World Health Organisation states ‘there is no health without mental health’. Our mental well-being can be seen as a resource for life, influencing how we think and feel about ourselves and others, how we interpret events and consequently how we behave and function in day to day life. The Mental Health Foundation cites that one in four adults and one in ten children are likely to have mental health issues in anyone year. This has a profound impact on the quality of peoples’ lives affecting ability to form/sustain relationships, ability to work in paid employment, and at worst the ability even to get through a day.

In the United Kingdom mental health issues are responsible for the largest burden of disease - 28% of the total burden, compared to 16% each for cancer and heart disease. Common mental health issues such as depression and anxiety are more prevalent among people experiencing greater economic disadvantage (Mental Health Foundation 2015).

Promoting well-being and preventing mental health problems is a crucial element of wider public health strategy, since a person’s mental health influences and is influenced by a broad range of social, economic, cultural, environmental and wider health factors.

There is compelling evidence to indicate that action to improve mental well-being and reduce mental illness across the population results in a wide range of health and non-health outcomes including: higher educational achievement, reduced unemployment and worklessness, reduced reliance on welfare and disability benefits, higher productivity in the workplace, reduced crime and anti-social behaviour, better social relationships and community involvement and reduced costs to health and social services (Joint Commissioning Panel for Mental Health, 2015).

In the same context, poor mental wellbeing, sense of poor self-image, social ostracism or bullying and real or perceived stigma, jeopardizes cohesion and *social sustainability.* As such, this theme is intrinsically linked to the Well-being Goals and many of the other population health priority themes.

2 The story behind the data

Nearly a quarter (23%) of the total burden of disease in the UK is attributable to mental disorder. This compares to 16% for cardiovascular disease and 16% for cancer (World Health Organisation, 2008).Over three quarters of mental health problems have emerged by the age of twenty, making childhood determinants primary in future mental well-being.

Data regarding Welsh population mental well-being and trends over time is limited and not comparable with other countries due to differences in data collection. The main data sources available are outlined below.

Mental well-being in children and young people

Information to describe mental well-being in children and young people is not routinely available at a local authority level. The Health Behaviour of School-aged Children (HBSC) Survey 2013-14 (Welsh Government, 2015) asks a number of relevant questions, the findings for Wales are outlined below:

- 18% of children said they had felt nervous more than once a week in the past 6 months.
- 18% of children said they had felt low more than once a week in the past 6 months.
- Among year 11 pupils (aged 15-16 years), 84% boys and 73% girls rated their life satisfaction as 6 or higher on a scale of 1-10.
- Over a third of pupils reported being bullied at school in the past two months.

Mental health problems in children and young people

Data is not collected on prevalence of mental health problems in children and young people. Numbers of children and young people with any mental health problem can be predicted by applying estimated UK prevalence to ABUHB population projections (data extracted from the Daffodil system). Estimations of prevalence are based on the report 'Mental Health of Children and Young People in Great Britain 2004, National Statistics, 2005' as follows:

- 10% of children and young people aged 5-15 had at least one clinically diagnosed mental disorder. The most prevalent disorders included:
    - Anxiety and depression: 4%

- Conduct disorder: 6%
- Hyperkinetic disorder: 2%
- Less common disorders (including autism, tics, eating disorders and mutism): 1%

This data reveals that prevalence of mental health problems appears to be greater in boys (11%) than girls (8%) and to increase with age.

The table below shows the predicted number of children in ABUHB aged 5-15 with any mental health problem (Daffodil system, July 2016).

Children aged 5-15 predicted to have any mental health problem, projected to 2020

Area	**2015**	**2020 (projected)**
Aneurin Bevan University Health Board	6,919	7,220
Blaenau Gwent	766	795
Caerphilly	2,208	2,274
Monmouthshire	1,045	1,018
Newport	1,842	1,985
Torfaen	1,058	1,148

Mental well-being in adults

The main source of data offering a perspective on mental health and illness in the area is the Welsh Health Survey.

Mental well-being is measured in the Welsh Health Survey using the SF-36 questionnaire, which produces a Mental Component Summary (MCS) score. Higher scores indicate better health. The table below shows the average MCS scores for each local authority area, compared with the ABUHB and Welsh average.

SF-36 Mental Component Summary scores

Wales	49.4
Aneurin Bevan University Health Board	48.9
Blaenau Gwent	47.0
Caerphilly	48.2
Monmouthshire	50.6
Newport	49.6
Torfaen	48.7

Welsh Health Survey, 2014 + 2015, age standardised, persons aged 16+

This indicates that on average adults in Blaenau Gwent have slightly worse mental health than for the Health Board or Wales as a whole.

Mental health problems in adults

The Welsh Health Survey reveals that 14% of people in the ABUHB area report being treated for a mental illness, the vast majority of which is anxiety and depression. These figures have remained relatively stable since 2013/14. The table below which shows the breakdown for each local authority area, and shows in Blaenau Gwent the percentage of those treated for mental illness is slightly higher than for the Health

Board or Wales as a whole. It illustrates a slightly higher rate than all for the Health Board or Wales as a whole.

Adults who reported currently being treated for a mental illness (%)

Wales	13
Aneurin Bevan University Health Board	14
Blaenau Gwent	17
Caerphilly	16
Monmouthshire	11
Newport	13
Torfaen	15

Welsh Health Survey, 2014 + 2015, age standardised, persons aged 16+

The Welsh Health Survey SF-36 scores have been transformed to give an indication of the number of cases of mental disorder. This indicates that there are a much greater proportion of people experiencing a common mental illness (anxiety and / or depression) than those seeking treatment (28% vs 14% in the ABUHB area), and this is consistent with findings of psychiatric morbidity surveys in England. There are many reasons for this including: stigma of mental health problems, lack of accessible / acceptable help, lack of awareness of the need to seek help.

Percentage of adults free from a common mental disorder (2013-14)

Wales	74
Aneurin Bevan University Health Board	72
Blaenau Gwent	66
Caerphilly	70
Monmouthshire	78
Newport	74
Torfaen	69

Public Health Wales, Our Healthy Future Indicators (2015) *http://howis.wales.nhs.uk/sitesplus/922/page/65519*

Overall in Wales, a greater percentage of females than males report being treated for a mental illness, and females also report poorer wellbeing than males (Public Health Wales, 2016).

There is also a strong link between deprivation and poor well-being / being treated for a mental illness, with 8% of the people in the least deprived quintile reporting a mental health condition, compared with 20% in the most deprived quintile (Public Health Wales, 2016). This report also found that 24% of those who are long term unemployed or have never worked, report a mental health condition compared to 9% of adults in managerial and professional groups in Wales.

Suicide and self-harm

Each year in Wales between 300 and 350 people die from suicide. This is about three times the number killed in road accidents. Although relatively rare, suicide has a devastating impact on all concerned. It is

estimated that for every person who dies through suicide at least six others are significantly and directly affected (Talk to Me 2: Suicide & Self-harm Prevention Strategy Wales 2015-2020).

Suicide is one of the three leading causes of death in the 15-44 age group; the other two being road traffic injuries and inter-personal violence. Notably it is the second leading cause of death among young people in the 15-19 years age group. Men are around three times more likely to die by suicide than women (Talk to Me 2: Suicide & Self-harm Prevention Strategy Wales 2015-2020).

In Wales suicide rates were highest in males in the 30 to 49 year old age groups during 2003 to 2012. There is a secondary but lower peak amongst elderly males of 80 years plus. For females, with the highest rate seen in 30 to 34 year olds and 45 to 54 year olds (Talk to Me 2: Suicide & Self-harm Prevention Strategy Wales 2015-2020).

Among both males and females there is an association between suicide and deprivation. Rates are higher in our more deprived communities and this gap appears to be widening in Wales. This is consistent with existing literature and highlights that suicide prevention should address inequalities that exist in society (Talk to Me 2: Suicide & Self-harm Prevention Strategy Wales 2015-2020).

It is important to note that suicide statistics and trends need to be interpreted with caution because the small numbers, delays in registration and inconsistencies in recording cause of death can produce unreliable rates. This is especially relevant to comparisons of annual fluctuations and small area / population group rates. Comparisons

across different countries are difficult to make because of differences in coding and cultural differences in the classification of intent.

The European age-standardised rate per 100,000, people aged 10 years and above, for suicide from 2010 to 2014, was 13. This was slightly higher than for other Local Authority areas in the Health Board area and Wales, but not statistically significantly higher (Public Health Wales Observatory 2016, Public Health Outcomes reporting framework).

Self harm is one of the top five reasons for medical admission in the United Kingdom and results in significant social and economic burden due to the utilisation of health services, particularly with respect to unscheduled hospital care, to treat the injury/ overdose. The UK has one of the highest rates of self-harm in Europe (Talk to Me 2: Suicide & Self-harm Prevention Strategy Wales 2015-2020).

In 2010 there were 4,450 individuals admitted to inpatient care in Wales following self harm. Some individuals are admitted more than once in any year. This does not take into account those assessed in A&E departments who do not require admission, or the many more who do not attend following an incident of self harm. The true scale of self harm is estimated to be 1 in every 130 people. The age and pattern of self harm shows that young women aged 15-19 have the highest prevalence with some evidence of an increase in males over 85 (Talk to Me 2: Suicide & Self-harm Prevention Strategy Wales 2015-2020).

Dementia

Data is not collected on dementia prevalence. The best available data we have is predicted numbers of people with dementia and early onset dementia, generated by applying estimated UK prevalence rates to population projections (data extracted from the Daffodil system, September 2015).

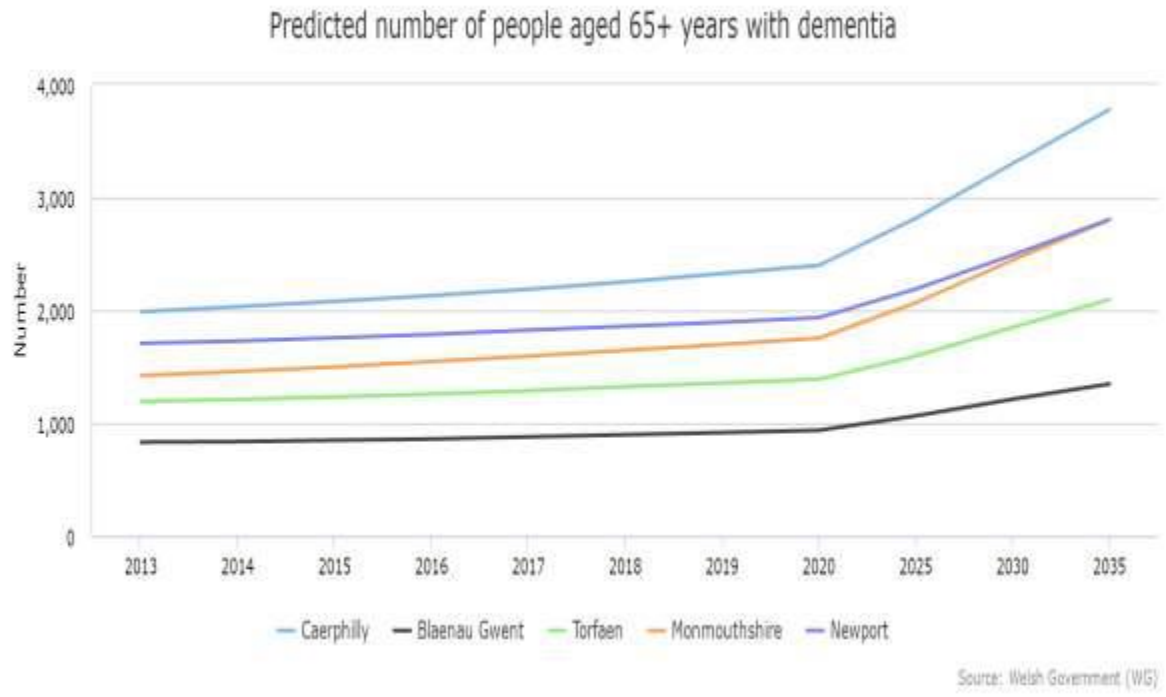
The prevalence of early onset dementia is relatively low (less than 1% in males and females). The data shows that in 2015, 152 people aged 30-64 in ABHB area are predicted to have early onset dementia (Daffodil system, September 2015). Predicted numbers to 2030 are relatively stable.

The prevalence of dementia in the 65 and over population increases steadily with age, from 1.5% (males)/1% (females) in the 65-69 age range, to 19.5% (males)/25% (females) in the 85+ age range. The total numbers of over 65s in ABHB predicted to have dementia increases from 7,414 in 2015 to 11,298 in 2030 (Daffodil system, September 2015). This rise is linked to increasing life expectancy leading to a higher proportion of older people in the population.

The predicted number of cases of people aged 65 years and over with dementia at Local Authority level is outlined in the figure below. Prevalence is predicted to increase sharply as life expectancy increases and more people live for longer.

There are currently just over 37,000 people living with dementia in Wales.. Dementia is more common as people age with one in 14 people over 65, one in 6 people over 80 and one in 3 people over 95 has a form

of dementia. In 2013 there were approximately 900 people age 65+ living with dementia in Blaenau Gwent. This is projected to rise to over 1300 people by 2035 (Welsh Government) as illustrated in the graph below. This rise is linked to increasing life expectancy leading to a higher proportion of older people in the population.



3. What we know from engagement

During Phase 1 of the Blaenau Gwent We Want Engagement programme numerous engagement activities and events were undertaken throughout the borough to gather people's views around the following key areas:

- Citizen values, aspirations and priorities;

- Citizen needs – insight into the needs they and their communities encounter within daily life and what the best solutions may be and
- Citizen assets –what people can and already contribute themselves such as self-care, citizen and community action and volunteering.

Views were captured via a questionnaire, which was also made readily available through a variety of channels including Public Services Boards partner representatives' websites and social media (for example, Blaenau Gwent We Want Facebook page) etc.

Furthermore, links to an online questionnaire were also distributed to the Blaenau Gwent Citizen Panel, a panel of Blaenau Gwent residents who voluntarily agree to get involved and take part in partnership engagement activities.

Questions put to residents included:-

Q1. What do you think is special about Blaenau Gwent?
Q2. What things are important to you to live well and enjoy life?
Q3. What would make Blaenau Gwent a better place?
Q4. What can you do to help make Blaenau Gwent a better place?

Approximately 1,000 residents were participated during Phase 1 of the Blaenau Gwent We Want Engagement Programme.

Mental health and wellbeing were mentioned explicitly in a number of responses; mostly in relation to the need for more widespread services for those with poor mental health. What is notable though is that the majority of factors most commonly identified in response to what is special about Blaenau Gwent, have a potential positive effect on wellbeing i.e.

- Environment, 186 (36%)
- Community, 84 (16%)
- Education & Skills, 35 (7%)
- Social Activities, 28 (5%)
- Landscape, 104 (20%)
- Parks, 67 (13%)
- Community Spirit, 54 (10%)
- Schools, 28 (5%)
- Quality of exercise facilities, 21 (4%)

However, other factors which are known to affect welling such as employment, income, safety, community cohesion and improved housing were mentioned as key factors that would make Blaenau Gwent better. Information from many voluntary organisations and services represented and Blaenau Gwent's Neighbourhood Care Networks supports the need for more low level mental health and resilience services are needed in Blaenau Gwent and mental health and wellbeing features on both Blaenau Gwent NCN plans.

4. What we know from existing research

The Faculty of Public Health (2016) describe some important principles underpinning population mental health action:

- Promoting mental well-being moves the focus away from illness and concentrates on an individual's resilience, social purpose, autonomy and ability to make life choices. Engaging with communities to frame issues and solutions and build on assets is central.

- The social, cultural, economic and environmental determinants of mental health need to be considered and addressed.
- In order to prevent widening health and social inequalities, interventions should be applied in a universally proportionate way, with a whole population well-being approach and additional support for groups at higher risk of mental health problems.
- Personal risk and protective factors are determined in early childhood, primarily in the context of family relationships, so a life-course approach is essential. In addition, we know that interventions at different life stages interact with each other and can have a cumulative effect.

There is evidence of many cost-effective interventions to promote wellbeing, these include:

- Promotion of parental mental and physical health,
- Support after birth,
- Breastfeeding support,
- Parenting support
- Pre-school and early education programmes (improved school readiness, academic achievement, positive effect on family outcomes)
- School-based mental health promotion programmes (reduced levels of mental disorder, improved academic performance, social and emotional skills).
- Improved housing and reduced fuel poverty

- Neighbourhood interventions including activities which facilitate cohesion and community empowerment
- Debt advice and enhanced financial capability
- Physical activity through active travel, walkable neighbourhoods and active leisure
- Integrating physical and mental well-being through universal healthy lifestyle programmes
- Interventions to enhance social interaction (capital) activities such as arts, music, creativity, learning, volunteering and timebanks
- Positive psychology and mindfulness interventions, interventions to increase mental health literacy and encourage early help-seeking for mental health problems *(i.e. in ABUHB, implementation of Foundation Tier work)*
- Spiritual awareness, practices and beliefs.
- Work-based mental health promotion
- Work-based stress management, including early recognition and intervention for mental health problems
- Support for unemployed people.
- Psychosocial interventions
- Prevention of social isolation
- Addressing hearing loss
- Interventions for ‘living well’ (see above).
- Reduce violence and abuse
- Tackle alcohol and substance misuse
- Target specific at-risk groups

(Public Health Wales, (2016), Joint Commissioning Panel for Mental Health (2015) and National Mental Health Development Unit (2010).

5. What this tells us about Well-being in Blaenau Gwent

There is significant cross-over between the effective approaches to improving mental well-being and the other population health priority themes in this document, as well as the 7 well-being goals.

An effective approach to population mental well-being includes a combination of evidence-based interventions that are applied systematically across the life course to:

- Promote well-being and develop resilience
- Prevent mental illness
- Identify and treat mental illness at the earliest possible opportunity

There is also a need to enhance protective factors and minimise risk factors for mental well-being.

Since over three quarters of mental health problems have emerged by the age of twenty, a focus on childhood determinants is key. Of these determinants, family relationships are of primary importance. In addition, addressing risk and protective factors later in life will influence rates of recovery, remission and relapse from physical health conditions as well as mental health problems (Faculty of Public Health, 2016).

In this assessment of need, it is clear that continued effort and focus are required to promote wellbeing and prevent mental ill-health in Blaenau Gwent. Mental wellbeing and resilience are fundamental to strong

relationships, to positive parenting, to preparedness for work, to educational achievement and personal fulfilment etc. it should therefore be given great consideration when considering our wellbeing goals.

References

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Welsh Government (2011) National Dementia Vision for Wales

Welsh Government 2016 Talk to Me 2: Suicide & Self-harm Prevention Strategy Wales 2015-2020

Welsh Health Survey (http://gov.wales/statistics-and-research/welsh-health-survey/?lang=en).