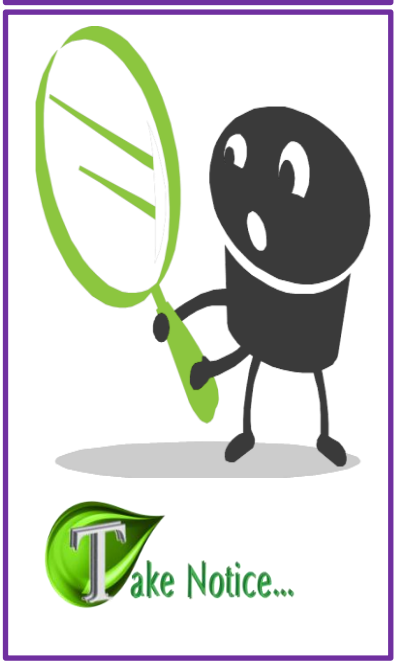
# Swindon Joint Strategic Needs Assessment

## Adult Mental Health and Wellbeing

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Improving health and wellbeing in Swindon

**2014**

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## Table of contents

Table of contents ..... 3
List of figures ..... 7
List of tables ..... 10
1. Executive summary ..... 12
2. Introduction ..... 17
2.2 Scope and purpose ..... 17
2.3 Local context ..... 18
2.4 What is mental wellbeing and mental Illness? ..... 19
2.4.1 Mental well-being ..... 19
2.4.2 Mental illness ..... 20
3. Background and national policy ..... 21
3.1 Mental health and well-being in the last 20 years ..... 21
3.2 The impact of economic downturn and changes to benefits on mental health and wellbeing ..... 23
4. Swindon Population Profile ..... 25
4.1 Swindon's current population ..... 25
4.2 Swindon current population by broad age band and ward ..... 25
4.3 Swindon Ethnic Mix ..... 25
4.4 Swindon's population change between 2001 and 2011 Census ..... 26
4.5 Swindon's population projections ..... 26
4.6 Population summary with regard to mental health ..... 27
5. Determinants of Mental Health and Wellbeing ..... 28
5.1 Genes and mental health ..... 38
5.2 Family circumstances ..... 38
5.3 Carers ..... 39
5.3.1 Young Carers ..... 40
5.4 Life events ..... 41
5.5 Maternal Health ..... 41
5.6 Socio-economic environment ..... 43
5.6.1 Deprivation in Swindon ..... 43
5.6.2 Education ..... 45
5.6.3 Employment and Income ..... 47
5.6.4 Unemployment ..... 48

Draft

5.6.5 Debt and mental health ..... 51
5.6.6 Housing ..... 52
5.6.7 Homelessness ..... 53
5.7 Social Cohesion ..... 54
5.7.1 Neighbourhoods, environment and crime ..... 54
5.7.2 Domestic Violence ..... 56
5.7.3 Counter Terrorism ..... 58
5.7.4 Social Networks and Social Support ..... 58
5.7.5 Minority groups ..... 59
6. Mental Well-being in Swindon ..... 68
6.1 National annual population survey on subjective well-being ..... 68
6.2 Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) ..... 71
6.3 Mental Wellbeing for those who experience mental health problems ..... 74
7. Mental Illness in Swindon ..... 75
7.1 Prevalence of common mental disorders ..... 76
7.1.1 Depression ..... 76
7.1.2 Eating disorders ..... 86
7.1.3 Attention Deficit Hyperactivity Disorder ADHD ..... 88
7.1.4 Autistic Spectrum Disorder ..... 89
7.1.5 Post Traumatic Stress Disorder (PTSD) ..... 90
7.2 Prevalence of severe and enduring mental health conditions ..... 92
7.3. What does the future look like? ..... 96
7.4 Associated behaviours ..... 97
7.4.1 Self-harm ..... 97
7.4.2 Suicide ..... 106
8. Inequalities, Stigma and Discrimination ..... 110
8.1 Stigma and discrimination surrounding mental health: ..... 111
8.2 Life expectancy and disability free life expectancy ..... 112
8.2.1 Smoking ..... 113
8.2.2 Alcohol and substance misuse ..... 114
8.2.3 Physical activity adults ..... 116
8.2.4 Healthy weight and diet ..... 117
8.3 Long Term Conditions and Disabilities ..... 118
8.3.1 People with disabilities and/or chronic long-term physical health problems ..... 118

Draft

8.3.2 Hearing impairment and sightloss ..... 121
8.3.3 Learning disability ..... 121
9. Mental Health and Wellbeing Services ..... 122
9.1 What services are offered in Swindon? ..... 124
9.1.1 Locality Teams ..... 124
9.1.2 Advice, Information & Advocacy Hub Project ..... 126
9.1.3 Wellbeing Co-ordination Project ..... 126
9.1.4 LIFT (Least Intervention First Time) Psychology Service ..... 129
9.1.5 Commissioned Voluntary and 3rd Sector Organisations delivering Mental Health Provision in Swindon ..... 130
9.1.6 Non Commissioned Third Sector and associated provision ..... 131
9.1.7 Supported Housing Provision ..... 132
9.1.8 Secondary Care Services in Swindon ..... 134
9.2 Commissioning System for Mental Health Services ..... 138
9.3 Safeguarding ..... 152
9.3.1 See the Adult See the Child ..... 153
9.4 Economic Review ..... 158
9.4.1 Spending on Mental Health Services in Swindon ..... 159
9.5 Evidence of effectiveness and cost effectiveness ..... 164
9.5.1 Treatment, NICE and Recovery ..... 164
9.5.2 Economic Evaluation of Prevention Interventions ..... 169
10. Gaps in service provision ..... 172
10.1 Dual Diagnosis ..... 173
10.2 Transition between Child and Adolescent mental health services (CAMHS) and adult mental health services. ..... 173
10.3 ADHD ..... 174
10.4 Access to advice, information and advocacy ..... 174
10.5 Acute Emotional Distress ..... 175
10.6 Eating Disorder Service ..... 176
10.7 Military Veterans ..... 176
11. What local people think? ..... 176
11.1 Mental health needs assessment focus group ..... 178
11.1.1 Mental Health Service User Survey ..... 181
12. Conclusion and recommendations ..... 187
12.2 Recommendations ..... 189
12.2 Priority for action ..... 194

Draft

## Appendices

Appendix 1 Abbreviations ..... 195
Appendix 2 Definitions ..... 197
Appendix 3 Demographic profile of Swindon ..... 199
Appendix 4 Prevalence of maternal mental health problems ..... 202
Appendix 5 Educational Attainment by Ward 2011 ..... 203
Appendix 6 Warwick Edinburgh Mental Wellbeing Scale seven questions ..... 204
Appendix 7 Five Ways to Wellbeing (NEF) ..... 205
Appendix 8 Mental Health Service Care Cluster Descriptions ..... 206
Appendix 9 Quality statements from NICE guidelines of service users experience in adult mental health in the NHS in England. ..... 213

Draft

## List of figures

Figure 1 Population change 2001 to 2031 by 5 year age groups (in numbers) ..... 27

Figure 2 A diagram to show the impact of factors on mental health and wellbeing .. 29

Figure 3 Swindon Lower Super Output Areas by local quintile group of deprivation (IMD 2010). (This map covers Swindon CCG area which includes Shrivenham.) .... 44

Figure 4 Percentage of people aged 16-64 years claiming Jobseekers Allowance in Swindon LA area, South West and England. ..... 50

Figure 5 Swindon - Police calls to domestic violence incidents, children present in households during incidents and DV offences: Rolling 12 month information (April 10-December 12) ..... 58

Figure 6 Broad ethnic groups resident in Swindon LA area and comparator groups, Census 2011. Blue arrows indicate percentage change for Swindon LA area since Census 2001. ..... 62

Figure 7 Percentage of broad non-white ethnic groups by Swindon wards (2010 ward boundaries), Census 2011. ..... 62

Figure 8 A chart to show the country of birth of Swindon Residents born outside England ..... 63

Figure 9 A Chart to the show the year of arrival in UK for Swindon residents not born in the UK. ..... 64

Figure 10 Distribution of the Warwick-Edinburgh Mental Wellbeing Scale scores (n = 3,389) from the residential survey in Swindon, 2012. ..... 72

Figure 11 Warwick-Edinburgh Mental Wellbeing Scale individual question responses.* ..... 73

Figure 12 Warwick-Edinburgh Mental Wellbeing Scale scores by Swindon wards, 2012. ..... 74

Figure 13 Percentage of adults (aged 18+) on GP register diagnosed with depression. ..... 77

Figure 14 Percentage of adults (aged 18+) on GP register diagnosed with depression, South West PCT's, 2011/12. ..... 78

Figure 15 A graph comparing GP practice referrals to LIFT Psychology Service compared to their prescribing rates for antidepressants. ..... 81

Figure 16 The chart below shows the national prevalence of some common mental health disorders by gender. ..... 82

Figure 17 Percentage of persons on GP register diagnosed with a severe mental health condition*. ..... 92

Figure 18 Percentage of persons on GP register diagnosed with serious mental health condition, South West PCT's, 2011/12. ..... 93

Figure 19 Number of people aged 18-64 forecast to have a common mental disorder in Swindon. ..... 96

Draft

Figure 20 Number of people aged 65+ forecast to have depression or severe depression in Swindon. ..... 97

Figure 21 A chart to show directly standardised rates of emergency hospital admissions for self harm 2011/12. (The small arrow shows Swindon, bold colours reflect local authorites in the South West). ..... 98

Figure 22 A graph to show admissions to GWH for self-harm by year 2009/10 – 2012/13* by gender. ..... 99

Figure 23 A graph to show the prevalence rates of individuals admitted to GWH for self harm from 2009/10 to 2012/13 (provisional rates). ..... 100

Figure 24 A graph to show the difference between the number of admissions and the number of individuals admitted by year and gender. ..... 101

Figure 25 Directly age standardised rate of hospital admissions for intentional self-harm, Swindon wards, 2010/11 - 2012/13 (three year average) ..... 102

Figure 26 A Graph to show the Direct Standardised Rate of hospital admissions for individuals who have self-harmed (three year average 2010/11 – 12/13) by deprivation quintile. ..... 103

Figure 27 A graph to show the crude rate of hospital admissions for self-harm by age (three year average 10/11 – 12/13) ..... 104

Figure 28 A graph to show the crude rate of individuals admitted to GWH for self-harm by age (three year average 010/11 – 12-13) ..... 104

Figure 29 A graph to show attendance and admissions at GWH ED between April 2011 and August 2013. ..... 105

Figure 30 A graph to show the variation in hour of arrival at ED by day of the week. ..... 105

Figure 31 A graph to show the average length of stay (in days) for admissions for self-harm via ED from April 11 – August 13. ..... 106

Figure 32 Mortality from Suicide & Injury Undetermined 2001-02 to 2008-10 (directly standardised rate, all ages, 3-year average) ..... 107

Figure 33 Mortality from suicide and injury undetermined (directly standardised rate, all ages, annual trend) ..... 107

Figure 34: Swindon Mortality from Suicide & Injury Undetermined by Sex 1993 – 2010, (directly standardised rate, all ages, annual) ..... 108

Figure 35 Rate of Opiate and Crack Users in Swindon by 100,000 population (2010/11) ..... 115

Figure 36 Rate of injection users by 100,000 population for Swindon 2010/11 ..... 116

Figure 37 Source of referrals to Swindon community mental health services for adults of working age, 2011/12. ..... 142

Figure 38 Proportion of Swindon AOWA community mental health services caseloads by broad age group, March 2012[145]. ..... 144

Figure 39 Caseload of Swindon AOWA community mental health services by gender and the proportion from black and minority ethnic groups, March 2012. ..... 145

Draft

Figure 40 shows a comparison of the proportion of ethnic groups in Swindon in comparison with the active mental health caseload. ..... 146

Figure 41 AWP active caseload by ward of residence. ..... 147

Figure 42 Activity carried out by the Swindon AOWA community mental health services during 2011/12. ..... 148

Figure 43 Summary of Swindon admissions to adult acute mental health services by age group, gender and ethnicity, 2011/12. ..... 149

Figure 44 Directly standardised rate from hospital admission for mental health 2009/10 to 2011/12 by ranked by Local Authority (the small arrow indicates Swindon UA) ..... 150

Figure 45 Re-admissions of Swindon patients to adult acute mental health wards by the time elapsed since their previous admissions, 2011/12. ..... 151

Figure 46: Forecast Expenditure for Commissioned Mental Health Services 2012/13 (S75 Financial Monitoring Returns) ..... 160

Figure 47: Mental health commissioned services excluding AWP (S75 Financial Monitoring Returns) ..... 160

Figure 48: Adults investment per head on mental health (Department of Health Financial mapping Returns) ..... 161

Figure 49: Spend on Adult Mental Health Services for Accommodation and Secure and High Dependency Placements (Department of Health Financial Mapping Returns) ..... 162

Figure 50: Proportion of Spend on Residential Care (Department of Health Financial Mapping Returns) ..... 162

Figure 51 Amount spent by mental health team by year. ..... 163

Figure 52 A comparison of levels of stress outside the work place reported in the mental health service user survey compared to the findings of residents survey... 182

Figure 53 comparison of sources of support reported in the mental health service user survey compared to the findings of residents survey..... 183

Figure 54 A comparison of how safe respondents to the mental health survey and residents survey felt in the areas where they lived both during the day and after dark. ..... 184

Figure 55 A comparison of how satisfied with key domains of life respondents to the mental health survey and residents felt. ..... 185

Figure 56 A comparison of how satisfied respondents to the mental health survey and residents were with a range of services. ..... 186

Figure 57 Swindon LA area population pyramid, Census day 2011. ..... 200

Draft

## List of tables

Table 1 Ethnic Groups of the population of Swindon (Source: 2011 Census data) ..... 26

Table 2 Factors affecting mental health ..... 31

Table 2 Factors affecting mental health ..... 33

Table 3 A table to show the key determinants of mental health in relation to the demographics of Swindon. ..... 34

Table 4 Percentage of pupils achieving 5+ A* - C grades at GCSE 2009 -2013 ..... 46

Table 5 Highest level of qualification gained of working age population (16+ years), Census 2011. ..... 46

Table 6 Employment by occupational group, Census 2011. ..... 47

Table 7 Median gross annual pay in £, Census 2011. ..... 48

Table 8 Number and percentage of people aged 16-64 years claiming Job Seekers Allowance January 2013 by Swindon ward. ..... 50

Table 9 People claiming disability living allowance with the disabling condition being psychosis, psychoneurosis or personality disorder, May 2012. ..... 51

Table 10 People claiming disability living allowance with the disabling condition being psychosis, psychoneurosis, personality disorder, dementia, behavioural disorders, alcohol & drug abuse and hyperkinetic syndromes (attention-deficit), May 2012. ..... 51

Table 11 Density (per hectare) of past housing completions ..... 53

Table 12 Number and percentages of ethnic groups in Swindon LA area and comparator groups, Census 2011. ..... 61

Table 13 Subjective wellbeing questions from the UK Annual Population Survey together with the scoring measures ..... 69

Table 14 Experimental Subjective Wellbeing Data from the Annual Population Survey, April to September 2011, and April to September 2012. ..... 70

Table 15 Percentage and number of adults (aged 18+) on GP register diagnosed with depression in Swindon. ..... 77

Table 16 National prevalence rates (%) of common mental health disorders in the past week by gender ..... 83

Table 17 Estimated number of people with CMD in Swindon CCG area by age and sex ..... 84

Table 18 National prevalence rates of Common Mental Health Conditions by socio-economic quintile ..... 86

Table 19 Prevalence of eating disorder by age and sex estimated national prevalence rate ..... 87

Table 20 Applied national prevalence rates of eating disorder to Swindon CCG population ..... 87

Table 21 Applied national prevalence rates of ADHD in the past 6 months to Swindon CCG Population (numbers) ..... 89

Table 22 National prevalence (%) of Autistic Spectrum Disorder in the past year ..... 90

Table 23 Estimated number of individuals in Swindon CCG area with Autistic Spectrum Disorder by age and sex (numbers) ..... 90

Draft

Table 24: National prevalence (%) of Post-Traumatic Stress Disorder in the past week by age and sex ..... 91

Table 25: Estimated number of individuals in Swindon CCG area with PTSD in the past week by age and sex (Numbers) ..... 91

Table 26 Numbers attending LIFT Psychology clinical sessions by common conditions and referrals to step 3. ..... 92

Table 27 Percentage and number of persons on GP register diagnosed with mental health condition* in Swindon. ..... 93

Table 28 National prevalence (%) of Psychotic disorder in the past year by age and sex ..... 94

Table 29 Estimated number of individuals in Swindon CCG area with psychotic disorder by age and sex (numbers). ..... 94

Table 30 National prevalence (%) of Anti-social personality disorder in the past year by age and sex ..... 95

Table 31 Estimated number of individuals in Swindon CCG area with Anti-social personality disorder by age and sex (Numbers) ..... 95

Table 32 National prevalence (%) of Borderline personality disorder in the past year by age and sex ..... 95

Table 33 Estimated number of individuals in Swindon CCG area with Borderline personality disorder by age and sex (Numbers) ..... 96

Table 34 The actual number of Swindon Admissions to GWH for Self Harm by year and Gender ..... 99

Table 35 A Table to show the number of individual patients admitted to GWH for self-harm by year. ..... 100

Table 36 Long term health problems or disability ..... 120

Table 37 Long term health problems or disability 65+ 0nly ..... 120

Table 38 Supported housing for people with mental health problems, 2012/13 ..... 133

Table 39 Percentage Adults in contact with Mental Health Services in stable accommodation (2012/13) ..... 134

Table 40 Swindon community mental health referrals, adults of working age 2010/11 and 2011/12. ..... 141

Table 41 Arrests and Section 136 detentions in Swindon LA area. ..... 154

Table 42 Number of admissions to the 136 suite at Sandalwood Court by age and gender ..... 156

Table 43 The table shows the amount spent in Swindon in 2010/11 by service and the proportion of the total. ..... 163

Table 44 Stepped Care Model – assessing demand for services in Swindon ..... 166

Table 45 Swindon LA population by age and sex, Census day 2011. ..... 199

Table 46 Swindon's ward population by broad age band, Census 2011 ..... 200

Draft

# 1. Executive summary

## Introduction and Context

Mental health and wellbeing are fundamental to our ability to flourish as individuals and as a community. Mental and physical health are intertwined and for many 'there is no health without mental health'[1]. Mental wellbeing can be defined as "a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (World Health Organization (WHO)). Mental illness can be defined as the existence of a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions (WHO).

## Mental Wellbeing

Mental wellbeing in Swindon is broadly in line with the national level. Using the National Wellbeing Survey, Swindon residents are slightly less satisfied than the national population but they felt more worthwhile, happier and less anxious than the national population. However, whereas mental wellbeing in the national population improved during 2012/13 in Swindon it slightly deteriorated. The Swindon 2012 resident's survey included measures to assess the mental wellbeing of the Swindon population. There was no difference in wellbeing between genders but those over 65 years of age had better wellbeing than those aged 16-24 years and those in most deprived parts of Swindon had significantly worse wellbeing scores than those in the least deprived areas. Those with mental health disorders face specific challenges in maintaining wellbeing and should be given particular attention in order to promote resilience and self-reliance. Those with mental health disorders can still improve their mental wellbeing.

The Five Ways to Wellbeing are evidence based ways to improve mental wellbeing. The Five Ways are: Connect with others; Be Active; Give or do something for others; Take Notice of what is happening around you; Keep Learning something new.

## Mental Health Disorders

Whether or not a person develops a mental health disorder depends on their individual vulnerability, influenced by the presence of predisposing factors, their exposure to particular circumstance and on the operation of their protective factors. It is important to recognise the highly individual interplay of the vulnerability and resilience of an individual, as well as the wider societal factors affecting everyone's lives, when considering mental health and wellbeing.

[1] No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages' DOH 2011.

### Factors affecting mental health include:

| | | |
|---|---|---|
| Family circumstances | Life events | Socio-economic environment |
| Education | Employment | Social networks |
| Social support | Social isolation and transport | Military experience |
| Migration & Ethnicity | Sexual orientation | Age & Gender |
| Caring responsibilities | Maternal mental health | Disability/physical ill-health |
| Debt | Housing and homelessness | Social cohesion |
| Neighbourhoods/Environment | Crime | Domestic violence |

Where possible this JSNA assesses these factors in Swindon compared to the national and regional situation and indicates the impact this may have on mental health of the Swindon population.

In Swindon it is estimated that between 22,600 and 29,000 individuals have a common mental health disorder such as anxiety, depression, phobias, panic and Post Traumatic Stress Disorder. Estimates indicate that the number of people in Swindon with depression is slightly higher than the national and regional average but the numbers with severe and enduring mental health conditions is slightly lower than national and regional averages. Swindon also has the third highest rate of prescribing of anti-depressants in the South West. The number of people with mental health disorders is predicted to rise over the next twenty years due mainly to demographic changes.

### Self-Harm and Suicide

Hospital admission rates for self-harm are high in Swindon compared to elsewhere. In fact Swindon has the 15th highest admission rates for self-harm out of 150 local authorities. Admissions from Central Ward and Parks and Walcot areas have statistically higher admissions than other areas of the town.

Suicide rates in Swindon, having been statistically lower than the national and South West regional average are now no longer significantly different. The rate has increased from a low in 205-2007 to 6.72 per 100,000 to 10.77 per 100,000 in 2010-12. On average in Swindon there are 16 suicides per year.

### Inequalities, Stigma and Discrimination

Nationally, according to the annual Time for Change report, there has been an improvement in attitudes to mental illness. However, stigma and discrimination is all pervasive, with nearly 9 out of 10 mental health service users (87%) report its negative impact on their lives.

Those with severe mental illness die on average 20 years earlier than the general population.

Those with mental health disorders are more likely to smoke, less likely to take physical exercise, have issues concerning dual diagnosis (mental health and substance misuse) and less likely to be a healthy weight.

On average those with mental health problems have fewer qualifications, find it harder to find and retain work, have lower incomes, are more likely to be homeless and are more likely to live in areas of deprivation than the general population.

Those with long-term physical conditions or disabilities are more likely to experience mental health problems.

## Current Services and Service Developments

There are a range of mental health and wellbeing services in Swindon ranging from locality and Health Ambassador teams, housing, social care, employment and other voluntary sector commissioned and non-commissioned services, primary care GP and psychology services through to secondary and specialist mental health services. These are to be enhanced with the planned Advice, Advocacy and Information hub and the Wellbeing Co-ordination Project. In additional there is the Mindful Employer Initiative promoting mental health with employers and Mental Health First Aid and ASIST suicide prevention training.

However, important key factors are that secondary care mental health services have recently undergone a re-organisation and third sector commissioned services (including housing, employment and social support) are all under review. Concerns raised during this needs assessment with regard to the secondary care re-structure include:

- the discharge of many service users from secondary care
- fast tracking those who become unwell back into secondary care
- the impact the re-structuring has had on primary care LIFT and Improving Access to Psychological Therapies (IAPT) services.

There are a large number of individuals on out of area placements which accounts for a disproportionate spend. There are plans to resettle these individuals into Swindon where appropriate.

## What do Local People Think?

During the needs assessment the view of local service users and carers were sought through focus groups, consultation exercises and a service user survey. The general findings showed Swindon mental health service users were more likely to report stress outside the workplace that they were unable to cope with than Swindon residents generally and they were more likely to turn to services for support. In general, service users felt considerably less safe in the areas where they live and in the town centre than other Swindon residents. They thought supporting people back into work (meaningful paid activity) was a priority and were concerned about the impact of benefit changes. They also highlighted the particular difficulties they had with maintaining a healthy lifestyle.

With regard to mental health services, mental health service users had concerns that changes to the services would reduce capacity and choice. They thought that services should focus on early intervention rather than leaving problems to get worse before being able to access services. Service users, carers and support staff all expressed concerns about re-accessing services in a timely manner when they are required. Service users would prefer to access support in their communities rather than through a central location.

Carers thought that social isolation was a particular concern for service users and many felt that service users would be entirely socially excluded without their carers support. They also expressed concern that their voice, as a carer, was not heard, particularly in GP and Social Care services.

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## Recommendations

This JSNA has highlighted how broad mental health and wellbeing is and how many different factors can impact on an individual's mental health and wellbeing. The following recommendations should inform the development of a local mental health strategy and remind readers that almost all statutory services commissioned and provided will impact on the mental wellbeing of the people in the area served. Recommendations may require a review of funding.

The following recommendations are for action across organisations:

1) Ensure a more co-ordinated approach to the commissioning services by all statutory and voluntary sectors, which impact directly on mental health and wellbeing in order to prevent duplication or gaps in service. This should include primary and secondary care adult and children mental health services, substance misuse, public health, social care and housing.

2) Develop initiatives to improve mental wellbeing that focus on communities with lower levels of wellbeing taking into account ethnicity, age and deprivation.

3) Develop an innovative approach to promoting and implementing the Five Ways to Wellbeing and build it into work delivered by all staff in all organisations in Swindon. www.fivewaystowellbeing.org

4) Develop Initiatives to address social isolation targeting those at risk. Ensure that older people are actively engaged in society. Continue and enhance initiatives to encourage social integration such as work carried out by the Health Ambassadors and Locality Teams targeting socially isolated groups. Social isolation of vulnerable individuals can lead to extreme social, political or religious ideals and radicalisation and Mental Health Service providers should be aware of radicalisation and the Channel Process in order prevent vulnerable patients being targeted for radicalisation.

5) Ensure Mental Health Services are accessible to all equality and marginalised groups including: ethnicity and disability sight and hearing loss and learning disabilities; those living in areas of deprivation and those who are homeless.

6) Ensure those working with individuals in relation to benefits, be those employment, disability, housing or other benefits, are aware of the needs of this client group and make reasonable adjustments to ensure that individuals receive benefits they are entitled to. Health and social care providers, mental health services and financial sectors should be aware of the impact of debt on mental health and should ensure they are linked to debt advice services as required.

7) Ensure that the needs of the whole family of the mental health service user are considered and the voices of young carers are heard. "See the Adult See the Child" protocols should be followed http://www.swindonlscb.org.uk/procedures/Pages/Home.aspx. Carer's assessments should be embedded in standard practice to ensure their physical, social and psychology needs are met.

8) Review the physical health needs of those with mental health disorders. All service, and particularly mental health service, providers should promote effective health improvement initiatives.

9) Establish and support a local Time For Change group to raise awareness of mental health issues and tackle the stigma associated with it.

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10) Ensure that the mental health needs of those aged 16 – 25 years are met and that the transition between CAMHS and Adult services is facilitated.

11) Review the implementation of section 136 of the Mental Health Act should be undertaken to ensure that services meet the quality standards outlined by National Institute for Health and Clinical Excellence. This has implications for both mental health services (place of safety for adults and young people) and the police who may require additional training.

12) Develop a self-harm register at Great Western Hospital to gain further insight into the high hospital admission rates for self harm in Swindon. This would provide understanding regarding links to deprivation, ethnicity and domestic violence and lead to targeted work to prevent admissions.

13) Collaborative work with Multi Agency Public Protection Arrangements (MAPPA) should be undertaken to support the repatriation of those being treated in specialist services out of area back to Swindon and ensure measures are in place to reduce any risks. This will address the disproportionate spend on out of area placements and improve the services delivered to individuals.

14) Undertake further analysis of anti-depressant prescribing in Swindon to understand the high rates of prescribing and develop strategies to reduce the prescribing rates where appropriate alternatives exist or can be developed.

15) Ensure the Dual Diagnosis (mental health and substance misuse) pathways are implemented and evaluated to ensure that the needs of this vulnerable group (including those on probation) are met. This pathway should include those with Korsakoff's syndrome, which is an alcohol related dementia.

16) Evaluate the effectiveness of the restructuring of Avon Wiltshire Partnership services to include appropriateness of discharges and responsiveness of the "fast track" pathways back into services. The evaluation should include the impact the reorganisation has had on different elements of the service including LIFT psychology. Commissioners should ensure that funding follows the patient.

17) Ensure mental health services are based on the stepped care approach and early intervention models which focus on prevention, early intervention and promoting mental health and wellbeing in Swindon. Primary care psychology services should maintain an open access and public mental health approach of least intervention first time.

18) Ensure support for people with long-term physical health conditions remains available in order to address mental health issues they may experience. Current Department of Health funding ceases in April 2014 so a review of current funding will be required. Mental health needs should also be considered with end of life care.

19) Review and implement existing integrated Eating Disorder pathways. Consideration should be given to commissioning a community eating disorder service or ensuring the present service is fit for purpose, visible and accessible.

20) Review the provision of Attention Deficit Hyperactivity Disorder (ADHD) treatment to ensure it meets the needs of adults with ADHD. A broader piece of work to support carers of people with enduring mental health needs and complex learning disabilities and/or ADHD needs to be undertaken.

21) Address the gap in service for those who are acutely emotionally distressed but not necessarily mentally ill. This could have a positive impact in reducing suicide and admissions

for self-harm. This should be considered in the context of existing crisis support services and link to the Hospital Based Psychiatric Liaison Service.

# 2. Introduction

## 2.1 How to read this document

The scope of this needs assessment is very broad and comprehensive which has made it a long document. The table of contents on page 2 gives as much detail as possible about what is contained in each chapter. Much thought and debate has been given to the order of the chapters and there are some very important issues, such as stigma, discrimination, inequalities, self-harm and suicide, covered towards the end of the document. It is understood that many people will not have time to read the needs assessment from beginning to end but the authors would urge readers to use the table of contents to navigate their way to areas of particular interest.

## 2.2 Scope and purpose

This adult mental health and wellbeing needs assessment focuses on five key areas**:**

- To understand and describe the population of Swindon[2], particularly with relevance to risk factors impacting on mental health and mental wellbeing.
- To describe the protective factors for mental health and mental wellbeing and assess how these relate to Swindon.
- To understand and describe the inequalities experienced by those with mental health problems and assess how these may be addressed.
- To understand current prevalence of mental illness in Swindon, to describe current services and assess if they are appropriate and meet the need in Swindon.
- To undertake an economic review of current spend on mental health treatment in Swindon.

It will build on and complement recent needs assessments undertaken in Swindon including:

**Drugs and Alcohol –** the drugs needs assessment is produced annually and the alcohol needs assessment has been undertaken relatively recently and will not be included. However, dual diagnosis will be considered**.**

**Dementia –** A dementia needs assessment has been undertaken separately. This needs assessment will exclude dementia but the other mental health needs affecting older people will be considered.

**Probation –** NHS Wiltshire are currently leading on mental health needs assessment within probation for Swindon and Wiltshire.

**Maternal and Infant Health Mental Health –** A needs assessment was undertaken in 2010 and is in draft form. This will be picked up in the Children and Young People Mental Health Needs Assessment due to be undertaken later this year. Maternal mental health is of particular significance with regard to infant and childhood mental health and is an important factor with regard to prevention. A service review was also undertaken for Swindon and Wiltshire

[2] The population of Swindon refers to the Unitary Authority resident population unless otherwise specified. Swindon Clinical Commissioning Group population is used in the sections relating to primary and secondary care services.

The purpose of the needs assessment is to understand the mental health needs of the population of Swindon in order to inform the commissioning and provision of services. It will inform the allocation of resources to tackle the problems caused my mental health problems, improve mental health and wellbeing and reduce inequalities. It should be used to shape strategies and policies which impact on mental health and wellbeing. It will highlight gaps in data or service provision. Key recommendations for commissioning will be a product of the assessment.

Throughout this document the Foresight Mental Capital and Wellbeing Project[3] is referenced widely. The Foresight Report was commissioned by the government in 2008 to review all the scientific and other evidence available to develop a vision for:

a) The opportunities and challenges facing the UK over the next 20 years and beyond, and the implications for everyone's "mental capital" and "mental wellbeing".
b) What we all need to do to meet the challenges ahead, so that everyone can realise their potential and flourish in the future.

The Foresight Report States that:

"if we are to prosper and thrive in our changing society and in an increasingly interconnected and competitive world, both our mental and material resources will be vital. Encouraging and enabling everyone to realise their potential throughout their lives will be crucial for our future prosperity and wellbeing." (P9)[3]

### 2.3 Local context

Swindon Borough Council, like every other local authority has been facing significant challenges which include:

- Demand for service and complexity of care is increasing as more people live longer with long-term medical conditions
- Demographic changes – both increases in risk of poor health associated with ageing and increased diversity contributes to demand
- A major reduction in the council's financial resources.
- The impact of the recession and increasing diversity of the local population

The Council's response to these challenges has been to work together with local statutory, voluntary, community and private partners to secure the most cost effective services for people in Swindon and at the same time focus on developing health and resilient communities and shape Swindon's economic future which will reduce vulnerability and promote independence.

The five strategic priorities identified by full Council in Autumn 2012 pledge to:

- Work with residents to create well cared for neighbourhoods
- Ensure the right skills, right jobs, in the right places
- Together, find new ways to reduce vulnerability and improve health for all
- Work with people and families to help them fulfil their potential
- Make best use of Swindon's resources inside and outside the Council

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There are six change programmes to support the delivery of these priorities include:

- Managing Adult Demand
- Strengthening Families
- Reshaping Streetsmart
- Leisure, Libraries and Culture
- Growing Economy
- Delivering Witchelstowe

The above statement from the Foresight Report applies equally well to Swindon as it does to the whole of the UK. The majority of the work of the Council will impact on or contribute to the mental health and wellbeing of the population. Mentally healthy and resilient individuals, families and communities will be more capable and independent which will reduce demand for services, reduce crime and antisocial behaviour, provide an engaged and motivated workforce, and encourage a vibrant and diverse leisure and cultural arena.

The mental health needs assessment will contribute to and inform all six change programmes to some extent.

Swindon Clinical Commissioning Group came into existence in April 2013 and has a vision to:

"ensure everyone in Swindon lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities"

Their mission is to optimise the health of the people of Swindon.

Mental health and wellbeing have been identified as a priority for the CCG and the Health and Wellbeing Board.

This needs assessment will contribute to the vision, mission and priorities of the CCG and Health and Wellbeing Board.

## 2.4 What is mental wellbeing and mental Illness?

### 2.4.1 Mental well-being

The World Health Organisation define Mental health as "*a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community".*

The Foresight Report defines mental wellbeing as "*a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society.*" [3] p10

[3] Foresight Mental Capital and Wellbeing Project 2008. Final Project Report Executive Summary. The Government Office for Science, London

The Foresight Report links mental well-being to mental capital, which it defines as "encompassing a person's cognitive and emotional resources. *It includes their cognitive ability, how flexible and efficient they are at learning and their "emotional intelligence", such as their social skills and resilience in the face of stress. It, therefore conditions how well an individual is able to contribute effectively to society and also to experience a high personal quality of life*" p10.

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### 2.4.2 Mental illness

There is no agreed definition for mental health disorders or illness but the one definition provided by the World Health Organisation[4], which it acknowledges is problematic is .. "the existence of a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions." The ICD-10 codes[4] developed by WHO are widely used to classify different mental health conditions using a combination of symptoms.

Mental Illnesses can be grouped into those deemed to be common and those that are severe and enduring. For some, mental illness can be seen on a continuum with mental wellbeing, as we all experience a level of mental distress and periods of better or worse mental health. For others mental illness and mental wellbeing should be viewed separately as you can suffer from mental illness but have good levels of mental wellbeing.

**Common mental disorder (CMD)** problems include:

Conditions such as depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder, may affect 15% of the population at any one time[5]. Common mental health problems can also include eating disorders although these are not included in the NICE guidance above.

**Severe and enduring mental health** problems include:

Over a lifetime, Schizophrenia and bipolar disorder may affect about 1% of the population[6].

Using population size estimates from the 2011 census data this would equate to between 25,203 and 29,422 individuals with common mental disorder in Swindon and a further 1500 -1600 with a severe and enduring mental health condition.

It should be pointed out that it is possible to suffer from a mental health problem but have good mental well-being.

Further definitions of specific mental health conditions can be found in Appendix 2 and further information on prevalence can be found in chapter seven below.

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[4] World Health Organisation, ICD-10 Classification of Mental and Behavioral Disorders: Clinical Descriptions and Diagnostic Guidelines, World Health Organisation, Geneva, 1992,
[5] NICE 2011. CG123 Common Mental Health Disorders.
[6] NICE Clinical Guidelines GC38 (2006) and 82 (2009)

# 3. Background and national policy

## 3.1 Mental health and well-being in the last 20 years

In 2005, The Sainsbury Centre for Mental Health produced a book detailing the developments in mental health care during the previous 20 years. In the forward Matt Muijen wrote that there had been a "tremendous transformation that has taken place over that time"[7]. He also predicted that in the future "*mental health care will take on a much broader remit, incorporating well-being, prevention, treatment and recovery. The challenge will be to create a dynamic balance between improving the mental well-being of the population, preventing mental health problems in groups at risk and treating and integrating people with mental health problems into society*"[8].

Since 2005, further progress in mental health services and public mental health has seen this prediction come to fruition and it is in this context that this Mental Health Needs Assessment has been written. Our challenge will be to outline how we can continue to improve mental health care alongside improving the mental well-being of the population, preventing mental illness in at risk groups and integrating people with mental health problems into society with the recovery agenda.

In 2011, Department of Health published 'No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages'. This strategy recognises that mental health and well-being is fundamental "to our quality of life, central to our economic success and interdependent to our success in improving education, training and employment outcomes and tackling some of the persistent problems that scar our society, from homelessness, violence and abuse to drug use and crime".

No Health without Mental Health outlined 6 key objectives:

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

The reason for the change of focus to include prevention as well as treatment comes from significant evidence about the economic and personal cost of mental health problems.

Mental ill health represent up to 23% of the total budget of all ill health in the UK and nearly 11% of England's annual secondary care budget is spent on mental health[9]. Estimates have suggested that the cost of treating mental health problems could double over the next 20 years[10]. In 2003, the cost of mental health problems in England was estimated at £77 billion, including the cost of loss of productivity and wider impact on well-being. More recent estimates put this now at £105 billion. (Ibid p10).

[7] The Sainsbury's Centre for Mental Health 2005. Beyond the Water Towers. The Unfinished Revolution in Mental Health Services 1985 - 2005. Ed. Bell A. & Lindley P.
[8] Ibid P6
[9] Ibid p10
[10] Ibid p10

**No Health Without Mental Health**

The No Health without Mental Health: implementation framework outlines what many agencies and partners can contribute to ensure delivery of the 6 objectives outlined above. It outlines 10 points to translate the vision into reality and delivery tangible changes to people's lives.

1. Mental health has 'parity of esteem' with physical health within the health and care system
2. People with mental health problems, and their families and cares, are involved in all aspects of service design and delivery
3. Public services improve equality and tackle inequality
4. More people have access to evidence based treatments – IAPT (Improving Access to Psychological Therapies)
5. The new public health system includes mental health from day one
6. Public service intervene early
7. Public service work together around people's needs and aspirations
8. Health services tackle smoking, obesity and co-morbidity for people with mental health problems
9. People with mental health problems have a better experience of employment
10. We tackle the stigma and discrimination faced by people with mental health problems

These objectives are consistent with indication from the three outcomes frameworks (for the NHS, Public Health and Adult Social Care). Progress will be measured using a national mental health dashboard which is to be developed. Additional progress reports regarding these commitments will be produced by the DH.

The implementation guidance goes on to outline what local organisations can do to implement the strategy including: CCGs, providers of mental health services, providers of acute and community health services, primary care providers, local authorities, health and wellbeing boards, social services, commissioners and providers of public health services, local scrutiny – Health Overview and Scrutiny Committees (OSCs), local Healthwatch, community groups, schools and colleges, employment support, employers, criminal justice and housing organisations.

The National Suicide Prevention Strategy[11] was produced in September 2012 by the Department of Health recognised that suicide is a major issue for society and a leading cause of years of life lost. The strategy outlines two main objectives: to reduce the suicide rate in the general population in England; to provide better support for those bereaved or affected by suicide. The six key areas that are highlighted for action in the National Strategy are:

1. To reduce the risk of suicide in key high-risk groups including young and middle aged men, people in the care of mental health services, people with a history of self-harm; people in contact with the criminal justice system and some specific occupational groups including: doctors, nurses, veterinary workers, farmers and agricultural workers.
2. To tailor approaches to improve mental health in specific groups including: children and young people; survivors of abuse or violence; veterans; people living with long-term physical health conditions; people with untreated depression; people who are especially vulnerable due to

[11] Preventing Suicide in England. A cross-governmental outcomes strategy to save lives. Department of Health 2012

social economic circumstances; people who misuse drugs or alcohol; lesbian, gay, bisexual and transgendered people; and Black, Asian and minority ethnic groups and asylum seekers.

3. To reduce access to the means of suicide the national guidance suggests tackling: hanging and strangulation in psychiatric inpatient and criminal justice settings; self-poisoning; those in high-risk locations; and those on the rail and underground networks.
4. To provide better information and support to those bereaved or affected by suicide it is important to: provide effective and timely support of the families bereaved or affected by suicide; have a place effective local response to the aftermath of a suicide and provided information and support for families friends and colleagues who are concerned about someone who may be at risk of suicide.
5. To support the media in delivering sensitive approaches to suicide and suicidal behaviour government wants to promote the responsible report of suicide in the press and to support the internet industry to remove content that encourage suicide and provide ready access to suicide prevention services.
6. To support research, data collection and monitoring. The government will continue to support high-quality research on suicide, suicide prevention and self-harm through the National Institute of health Research and the policy Research Programme. Work will also continue regarding data monitoring and National Framework Public Health indictors.

### 3.2 The impact of economic downturn and changes to benefits on mental health and wellbeing

The combination of the impact of the economic downturn, recession and a prolonged period of low growth, combined with changes to benefit entitlement is likely to have a negative impact on mental health and wellbeing.

The Royal College of Psychiatrist report[12] sum this up in relation to the demand for mental health services:

"We recognise that the challenge posed by the downturn is twofold:

1. demand for mental health services is likely to increase as a result of unemployment, personal debt, home repossession
2. and other fallout from the recession the UK government and the devolved administrations are under pressure to reduce levels of spending on public services." P7

The recommendations the report makes for government include: supporting employers to retain people with mental health problems in work; challenge stigma and discrimination; ensure the right support is available to people with mental health problems to return to work; promote better wellbeing for all; cost saving initiatives from different sectors e.g. mental health diversion schemes; and prioritising research.

The same report highlights for following priorities for commissioners:

- Keep a long-term perspective – avoid short term gains for long term pain
- Continue investment in early intervention
- Invest in models delivering savings elsewhere in the health system and beyond
- Enable clinicians to lead on redesigning care pathways

[12] Mental Health and the Economic Downturn: National Priorities and NHS Solutions. 2009. Royal College of Psychiatrists, Mental Health Network, NHS Confederation & London School of Economics and Political Science Royal College of Psychiatrists reference: OP70

It highlights five main areas where efficiencies can be found (see box below):

operational efficiencies; care pathways and service redesign; staffing efficiencies; wider system efficiencies – including primary care, physical health care, psychological therapies and joined up working; and allocative decisions including disinvestment.

**Priorities for finding efficiencies**

Operational efficiencies – these will typically involve merging back-office functions. This will need careful planning to ensure changes bring about efficiencies and patient benefits, rather than unintended consequences.

Care pathway efficiencies – service redesign is key. Clinical leaders and managers need to be prepared to take this work forward together.

Staffing efficiencies – staff are the greatest resource of the NHS. However, staff also account for the vast majority of costs in the NHS. It is therefore inevitable that workforce efficiencies will be made.

Wider system efficiencies – new offers to primary care, addressing physical healthcare costs through mental health intervention, psychological therapies and joined-up working may lead to savings.

Allocative efficiencies – we need to acknowledge where disinvestment is needed, consider where we might bring patients back into local services and provide greater support for commissioners. P16

From : Mental Health and the Economic Downturn: National Priorities and NHS Solutions. 2009. Royal College of Psychiatrists,

## 4. Swindon Population Profile

Below is a very brief profile of the population of Swindon. There is some additional information in **Appendix 3**. For a more in depth population profile please refer to the Swindon Joint Strategic Needs Assessment.

**Key points in this section are:**

- There are more males than females aged under 45.
- There are twice as many females as males aged 85+
- Age is not distributed evenly across the town
- Swindon population increased by 16% between 2001 – 2011. This was the largest increase in the South West and the 12th largest in the UK.
- Predicted changes in population profile for Swindon indicate larger numbers of those under twenty five and over 40 years of age combined with a decrease in those aged between 25 and 40.
- 84.6% of the population are White British. 5.2% White Other; 6.4% Asian/Asian British

These key points have implication for social isolation, carers responsibilities, suicide prevention.

### 4.1 Swindon's current population

The total population for Swindon UA residents was 209,156 at the 2011 Census. Overall, there are an equal number of males and females residing in Swindon. However, there are gender differences across age bands. There are more males aged under 45 (2,252 more males than females) and more older women aged 70+ in Swindon (2,571 more females than males). The largest disparity is seen in the 85+ age group where there are twice as many women than men; the difference being largely attributable to the gender gap in life expectancy. (See **Appendix 3** for a more detailed breakdown of population profile in Swindon).

Compared to England, there is a higher percentage of people, aged 25 to 50 and children aged under 5 years in Swindon and relatively lower percentage of people aged 15 - 24 and 60+.

### 4.2 Swindon current population by broad age band and ward

The percentage of young people (0-19) residing in Swindon wards varies from around 20% in Eastcott to 30% in Penhill. The percentage of working age people (20-64) varies from 55% in Wroughton & Chiseldon to 71% in Eastcott. The percentage of older people (65+) range from 3.4% in Abbey Meads to 22% Wroughton & Chiseldon. (See **Appendix 3** for more details)

### 4.3 Swindon Ethnic Mix

Table 1 below shows the ethnic make-up of Swindon from the 2011 Census data. It can be seen that in Swindon the largest group is White British followed by Asian/Asian British and then White Other which includes, Gipsy and travellers, white Irish and all other white. Swindon has a higher ethnic mix than the South West but lower than the national average. Looking in more detail at the Asian

population Swindon has a higher percentage of Asian Indian population than the national average. Full details in **Appendix 3**

Table 1 Ethnic Groups of the population of Swindon (Source: 2011 Census data)

| Broad ethnic group | Census 2011 | | | | | |
|---|---|---|---|---|---|---|
| | Numbers | | | Percentage | | |
| | Swindon UA | South West | England | Swindon UA | South West | England |
| **White: English/Welsh/Scottish/Northern Irish/British** | **177,028** | 4,855,676 | 42,279,236 | **84.6** | 91.8 | 79.8 |
| **White Other** | **10,870** | 190,753 | 3,001,906 | **5.2** | 3.6 | 5.7 |
| **Asian/Asian British** | **13,365** | 105,537 | 4,143,403 | **6.4** | 2.0 | 7.8 |
| **Mixed/multiple ethnic group** | **4,226** | 71,884 | 1,192,879 | **2.0** | 1.4 | 2.3 |
| **Black/Black British** | **2,861** | 49,476 | 1,846,614 | **1.4** | 0.9 | 3.5 |
| **Other ethnic group** | **806** | 15,609 | 548,418 | **0.4** | 0.3 | 1.0 |
| **Total population** | **209,156** | **5,288,935** | **53,012,456** | **100** | **100** | **100** |

## 4.4 Swindon's population change between 2001 and 2011 Census

The total Swindon population increased 16% over ten years from 180,100 in 2001 to 209,156 in 2011 (ONS mid-year estimates). This population increase was the largest in the South West and the 12th largest of all local authorities in England. The shape of the population, in terms of age-groups did not change greatly during this period. For example, people aged 0 to 14 years inclusive made up 19.7% of the population in 2001, and constituted 18.5% in 2011. People aged 65+ years made up 13.8% of the population both in 2001 and in 2011.

## 4.5 Swindon's population projections

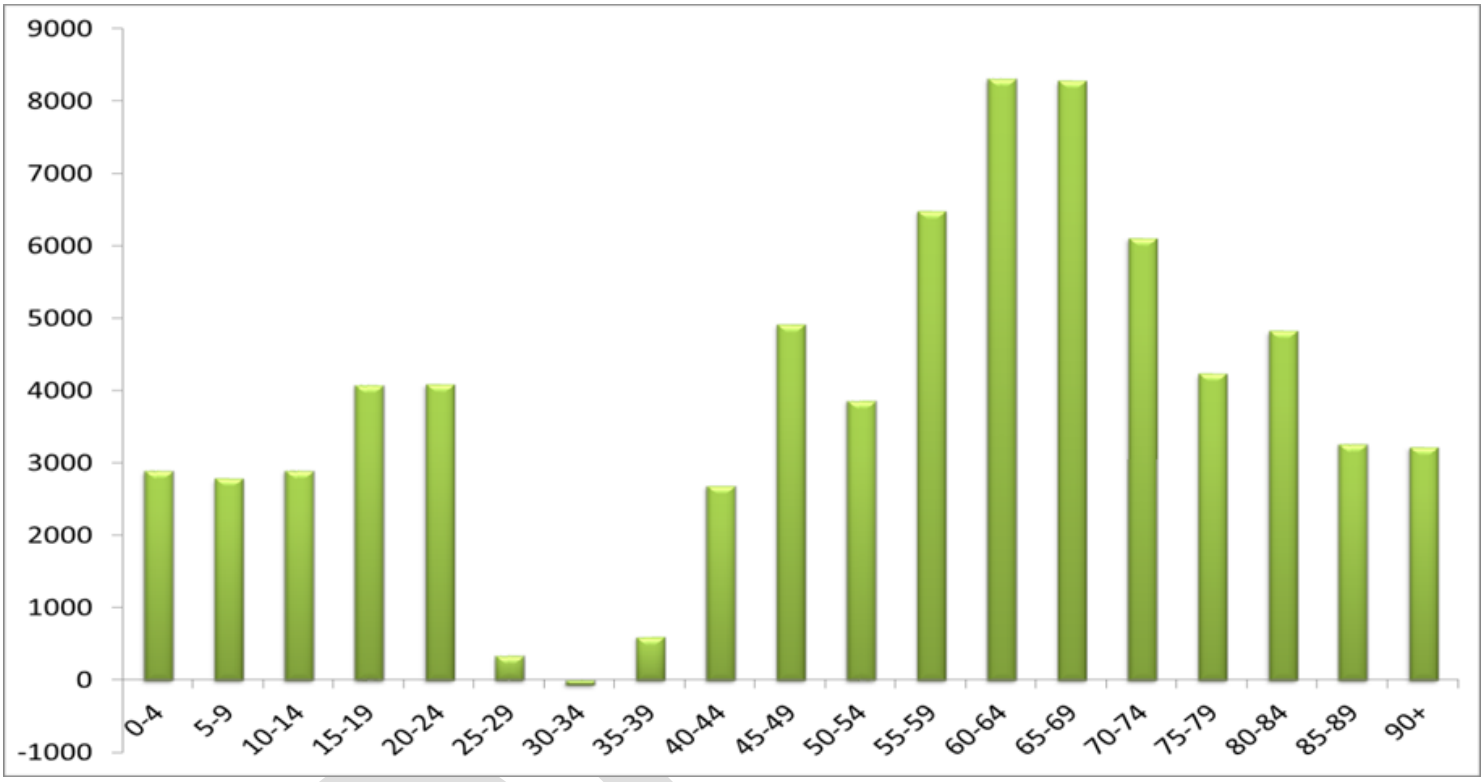
Interim 2011-based LA population projections from ONS provide us with a forecast of how the population might change in the future. These figures are based on an extrapolation of past trends and fluctuations in the building of new housing in Swindon could weaken the reliability of such forecasts.

Swindon's population is predicted to increase from 209,156 in 2011 to 225,300 people by 2016 (7.4%) and to 239,500 by 2021 (14.2%)[13]. For children aged 0 to 14 years inclusive, ONS projects increases from 38,800 in 2011 to 42,800 by 2016 (10.3%) and 46,700 by 2021 (20.2%). For people aged 65+ years the predicted increases are from 29,100 in 2011 to 34,200 (17.7%) by 2016 and 39,200 by 2021 (34.9%).

[13] Estimates are given rounded to the nearest 100 here, while the percentage changes are derived from the exact figures

Provisional predicted change in population size from 2001 – 2031 are shown in the graph below.

Figure 1 Population change 2001 to 2031 by 5 year age groups (in numbers)




## 4.6 Population summary with regard to mental health

- From the data above we can see that Swindon has grown faster than most towns in England and may therefore have individuals and families who have no family connections or social networks. This should be taken into account when developing new housing and services.

- The larger proportion of males under the age of 45 may be significant with regard to suicide rates. We know that single, males under the age of 45 are at highest risk. Males tend not access mental health services as readily as females.

- The growth rate in Swindon is expected to continue with a proportionately larger growth in those under 14 and particularly those over 65 years. This may have implications for relatively small number of middle aged individuals possibly having to care for older relatives and children. It may also have implications for the social isolation of older people.

Further profile of the Swindon population can be found under determinants of mental health in section 5 below.

## 5. Determinants of Mental Health and Wellbeing

There are a number of factors that are thought to be associated with Mental Health and Wellbeing. Whether or not a person develops a mental health problem will depend on their individual vulnerability, influenced by the presence of predisposing factors, their exposure to particular circumstances and on the operation of their protective factors. It is important to recognise the highly individual interplay of the vulnerability and resilience of an individual, as well as the wider societal factors affecting everyone's lives, when discussing mental health matters.

This chapter begins with a diagram from the Foresight report Figure 2 which encapsulates the main factors that impact on mental health and wellbeing. It shows protective and detrimental factors. Most of these factors are explored in more detail in the sections below to see how they affect individuals in Swindon.

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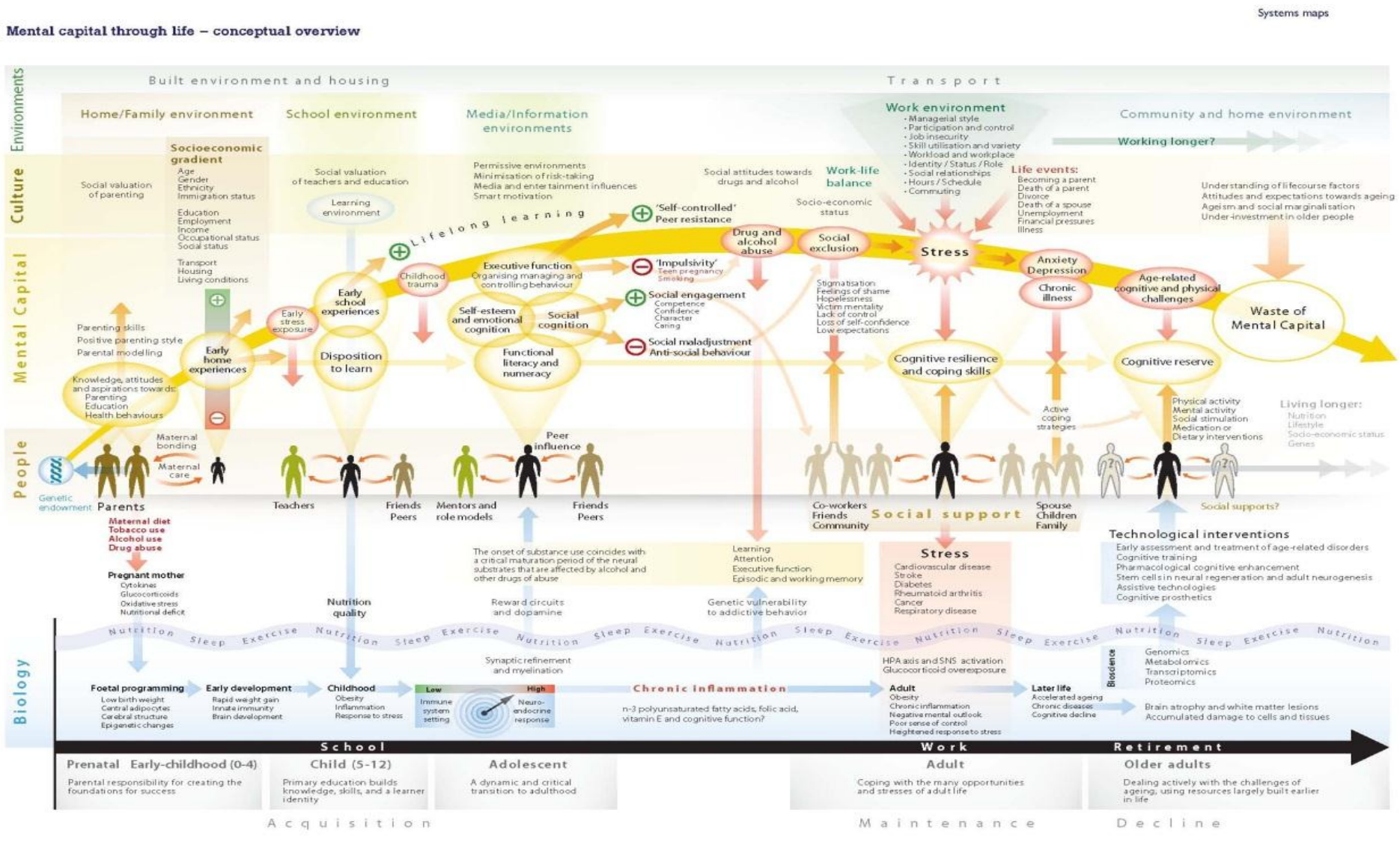
Figure 2 A diagram to show the impact of factors on mental health and wellbeing




Source: Taken from Mental Capital and well-being: Making the most of ourselves in the 21st Century (2008) Foresight

The tables below highlight some of the key determinants of mental health (Table 2) and where possible assesses Swindon demographics in relation to these.

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Table 4 below summarises the key findings of this section but further detail for each indicator can be found further on in the section.

Table 2 Factors affecting mental health

| **Factors affecting mental health include:** | |
|---|---|
| • Family circumstances<br>• Life events<br>• Socio-economic environment<br>• Education<br>• Employment<br>• Social Networks<br>• Social Support<br>• Social Isolation / transport<br>• Ethnicity<br>• Migration<br>• Sexual Orientation<br>• Military experience | • Caring responsibilities<br>• Maternal mental health<br>• Disability/physical ill-health<br>• Debt<br>• Housing<br>• Homelessness<br>• Social cohesion<br>• Neighbourhoods, Environment<br>• Crime<br>• Domestic Violence<br>• Age<br>• Genetics |

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Table 4 A table to show the key determinants of mental health in relation to the demographics of Swindon.

(It should be noted that whilst Swindon may rate better than the national average for key determinant this notes not mean that the determinant is not an issue.)

| **Determinant of mental health** | **Swindon measure (national average in brackets where available)** | **RAG (higher, average or lower risk than national average (Red, Amber or Green) Blue for areas where there is no comparator measure but the issue is still of concern)** |
|---|---|---|
| **Family circumstances** | | |
| Children in Care | 53 / 10,000 (60/10,000) | |
| Percentage married or same sex civil partnership (CP) | 48.9% (46.8%) | |
| Percentage – divorced or separated | 12.7% (11.7%) | |
| Percentage of those with dependent children who were married, Civil Partners or co-habiting who had only one family | 70.9% (66.2%) | |
| Lone parents | 21.5% (24.5%) | |
| Lone parents or living alone | 29.6% (30.2%) | |
| One person households over the age of 65 years (although this is likely to change) | 10.2% (12.4%) | |
| **Carers** | | |
| Percentage of population who are carers | 9.5% (10.3%) | |

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| | | |
|---|---|---|
| Increase in number of carers since 2001 | 24% (3%) | |
| Increase in numbers providing 20-29 hours of care (2001 – 2011) | 69% | |
| Swindon Young Carers (percentage of those registered with Swindon Young Carers caring for someone with a mental health problem.) | 31.5% | |
| **Socio-economic environment** | | |
| Deprivation – percentage living in the most or second least deprived areas. (However, it should be noted that there are pockets of deprivation within the town 14.3% live in the most deprived areas) | 60% (40%) | |
| **Education and Employment** | | |
| Percentage achieving 5 or more GCSEs A* - C | 55% (60%) | |
| Percentage with level four qualifications and above (Degree level or equivalent) | 23% (27%) | |
| 69% of the population aged 16-74 economically active | 69% (62%) | |
| Not in Education, employment or Training (16 -18 year olds) | 6% (9.9%) | |
| Number of people with mental health problems in employment (2009/10) | 6.4% (7.9%) | |
| Mean gross annual pay | £21,237 (£21,794)<br>Particularly low for women<br>(£15,046 (£16,725)) | |
| Unemployment rate (April to March 13) | 8.3 (8%)<br>This is unusual for Swindon where the unemployment rate has traditionally been slightly lower than the national average) | |

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| | | |
|---|---|---|
| Unemployment rate (June 12 – June 13) | 7.5 (7.8)<br>Males 8.8 (8.2)<br>Females 7.0 (7.3) | |
| Job Seekers Allowance and Disability Living Allowance claims (2013)<br>JSA (2013)<br>DLA (2012) | 3.2% (3.4%)<br>4.3% (5.1%) | |
| JSA for 16 – 24 year olds | (October 13)<br>6% (5.5%) | |
| **Debt** (average unsecured debt) | £14,278 (£13,705)<br>(Sept 2013) | |
| **Crime** | | |
| All Crime (per 1000 population) (Nov 12 – Oct 13) | 62.17 (61.66) | |
| Crimes against the person (1000) (Nov 12 – Oct 13) | 13.88 (12.63) | |
| **Housing** | | |
| Percentage of council homes not meeting the Government's Decent Homes Standards | 1.7% (22%) | |
| Homelessness | 1.1 per 100,000 (2.0 per 100,000) | |
| | 94% of homeless people in Swindon and Wiltshire under the age of 35 had a mental health need | |
| **Social Isolation** | | |
| Percentage of social care clients who feel they have as much support as they would like<br>Percentage who feel socially isolated | 39.5 % (43.2%)<br>9.2% (5.8%) | |
| Ethnicity | Although Swindon is not as ethnically diverse as the UK average there is considerably | |

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| | | |
|---|---|---|
| | higher non-white population than in the rest of the South West. Particularly in relation to non-white British and Asian Populations. | |
| Migration | Migration into Swindon has risen exponentially since 2001<br><br>Between 2001 – 2009 14,025 people in Swindon were born outside the UK | |

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## 5.1 Genes and mental health

The strongest indicator of risk for most psychiatric disorders is having a close relative with the disorder, however genes rarely cause mental illness directly[14]. Whilst the genetic vulnerability can be an undercurrent in many psychiatric disorders, it is particularly significant for psychosis where it is the single most important factor. In common mental disorders individuals genetic makeup may open up a vulnerability to the effects of adverse life-events.[12,15] Yet, while the twin and adoption literature leaves little doubt that genes are a factor in determining our vulnerability or resilience to mental ill health, they also point to the importance of the interplay of genes, environment and social factors thought our life course, from in-utero environment, childhood experiences to life-events at any age.

## 5.2 Family circumstances

Individual emotional wellbeing is profoundly influenced by the early social and family environment. Positive emotions in infancy are associated with positive cognitive and social behaviour that may provide the basis for resilience throughout life[16]. Looked after children have particularly high rates of mental health problems. It is estimated that 60% of those in care have emotional or mental health problems[17]. Although mental health can improve with a stable placement for many the impact on mental wellbeing will be long term.

The figures below show the rate of children in care per 10,000 under 18 population. This shows that in Swindon we have a lower proportion of children in care compared to the national average. It equates to about 250 children in care in Swindon.

| | **2009** | **2010** | **2011** | **2012** | **2013** |
|---|---|---|---|---|---|
| **England** | 54 | 57 | 58 | 59 | 60 |
| **Swindon** | 53 | 54 | 51 | 55 | 53 |

Source DFE Annual Report

Being married is generally associated with positive mental health, probably because amicable marriage provides social support, including emotional, financial, and instrumental support[18]. This would indicate that it is the stability and duration

[14] Jenkins, R., Meltzer, H., Jones, P., Brugha, T., Bebbington, P., Farrell, M., Crepaz-Keay, D., Knapp, M. 2008. Mental health: Future Challenges. Foresight, 104-08-Fo/on. The Government Office for Science, London, UK.
[15] Uher, R and McGuffin, P. 2008. State-of-Science Review: SR-B1 Genetics of Mental Ill-Health in Children and Adults and Interaction of Genes with Social Factors
[16] Huppert, F. 2008. Mental Capital and Wellbeing: Making the most of Ourselves in the 21st Century. State-of-Science Review: SR-X2 Psychological Wellbeing: Evidence Regarding Its Causes and Consequences
[17] NICE 2010 (modified 2013) PH28 Looked after children and young people.
[18] Robin, S. 2012. The Relationship between Marriage and Mental Health. Psychiatry Weekly, Vol 7, Issue 14

of the relationship which provides the protective effect on mental health, rather than the legal relationship status[19].

According to the Census, 48.9% of Swindon residents compared to 46.8% in England were either married or in a registered same-sex civil partnership (excluding separated) in 2011. 12.7% in Swindon were either separated (but still legally married or in a same-sex civil partnership) or divorced compared to 11.7% in England.

Of the 27,039 households with dependent children in Swindon 70.9% had only one family and were either married, civil partnership or co-habiting couples compared to a national figure of 66.2%. 21.5% were lone parent families compared to a national figure of 24.5%. Statistically this is positive for the mental health and wellbeing of those in Swindon. However, more than a third of those households in Swindon the lone parent was not in employment.

Common mental health disorders are associated, among other factors, with living alone or as a lone parent, whereas psychosis is associated with living alone, separated or divorced[14].

According to the 2011 Census, the percentage of one person households in Swindon was similar to the national average (29.6% in Swindon (26,143 households) compared to 30.2% in England). However, there were less one person households over the age of 65 years than the national average (10.2% or 9,039 households of those in one person households in Swindon compared to 12.4% in England. This may change with the demographic projections outlined in para 4.4 above).

### 5.3 Carers

People who look after a sick, disabled or elderly people in a non-professional capacity may also be vulnerable to ill mental and physical health themselves. A survey of 1000 carers found that 21% of female and 12% of male carers had symptoms of neurosis[20]. This is, however, mediated by a number of factors such as the relationship between the carer and the cared for, whether they live together or not, the type of problem or difficulty which the person being cared for is experiencing and the duration of the caring relationship. Those supporting people with mental health, personality disorder or substance misuse problems can be wary of seeking help outside of the family because of the stigma and discrimination still often associated with these conditions[21]. The value of carers as being fundamental to strong families and stable communities has been recognised and there is a national commitment to enhance the available support for them to enable carers to maintain a balance between their caring responsibilities and a life outside caring[19].

[19] Gibb, S., Fergusson, D., Horwood, J. 2011. Relationship Duration and Mental Health Outcomes: Findings from a 30-year Longitudinal Study. The British Journal of Psychiatry, 198: 24-30
[20] Singleton, N., Aye-Maung, N., Cowie, A., Sparks, J., Bumpstead, R., Meltzer, H. 2002. Mental Health of Carers. National Statistics. London, The Stationery Office. Social Exclusion Unit. Mental Health and Social Exclusion.
[21] DOH 2010. Recognised, Valued and Supported: Next steps for the Carers Strategy.

There is also some evidence that giving support to others, in a caring role or in the form of volunteering may be associated with higher levels of wellbeing[22] Volunteering in particular, can help to build self-esteem and promote a sense of purpose and self-worth in children and young people, working-age adults and retired people. It contributes to forming social networks and to community cohesion[23]. It should be noted that there is a difference between voluntary and enforced caring responsibilities.

In Swindon we had 19,480 unpaid carers at the 2011 Census, which is likely to increase with the aging population. The majority (64%) provided between 1 and 19 hours care per week. However, there were around 4,370 carers who provide 50 or more hours care per week. Although the percentage of carers in Swindon is lower than the national average (9.5% compared to 10.3%) the increase in Swindon since 2001 is substantial (24% increase in Swindon compared to 3% nationally). The largest increase was for those providing 20 – 49 hours of care which went up between the two censuses by 69%). The role that carers play will be of increasing significance in relation to the demands on services.

### 5.3.1 Young Carers

The Royal College of Psychiatrists state that 68% of women and 57% of men with a mental illness are parents. There are currently 467 young carers registered with Swindon Young Carers Centre, 54% are under 13 and 47% between the ages of 13 and 17 years. 147 of these young carers support a family member who has a mental health issue. It is important that these children and young people get access to services and support that they require, as national research has shown that they are more likely to be children in need, are more likely to experience health problems or developmental delay and may even require alternative care at times. 30% of children who have parents with a mental health problem will experience mental health problems themselves during adolescence.

Young carers[24] from the Carers Centre, who had parents with mental health problems pointed out that those who provide adult mental health service may not meet the child caring for their patient, especially if they visit during school hours. The practitioner may feel that the child is so young they don't know what is going on and they may not think it is appropriate to talk to them about the care they think their parent needs. However, the young person is aware of what is going on and do understand the care needs of their parents are often the one who is left to try and find alternative help when a service is not meeting the needs of their parent. They felt that lack of communication between services and follow up with the patient to see how they were progressing made it hard to ensure that their parents got the help they needed. Changes to the benefits system had exacerbated the problem.

[22] Huppert, F. 2008. Mental Capital and Wellbeing: Making the Most of Ourselves in the 21st Century. State-of-Science Review: SR-X2 Psychological Wellbeing: Evidence Regarding its Causes and Consequences

[23] DOH 2011. No Health without Mental Health. A Cross-Government Mental Health Outcomes Strategy for People of All Ages.

[24] With thanks to Seren and Lauren, Young Carers Centre

The Young Carers Centre pointed out that Team Around the Child meetings were mainly attended by Children's Services and adult services were often not clear about the purpose of the meeting. They felt that lack of services for parents made it difficult to meet the needs of the family.

### 5.4 Life events

There can be any number of life events both positive and adverse that can affect the mental health and wellbeing of an individual. Life events may be intertwined with other wellbeing factors such as socioeconomic and family circumstances. Nevertheless, adverse life events are important risk factors particularly for common mental health disorders (CMD), self-harming and eating disorders[25,26,27]. The strongest associations between life events and CMD were for recent threats to health, recent interpersonal problems and lifetime stressors including sexual abuse and expulsion from school[28]. Similarly, people with psychosis are found to have experienced much higher rates of exposure to stressful life events than the general population, including relationship problems, illness, bereavement and victimisation[25].

Whilst there is strong evidence for the continuity of a mental illness from childhood to adulthood, the cause of some disorders appears to vary with age. Age sensitive life-events and environmental factors can affect the typically adolescent onset of anxiety and eating disorders. Similarly, higher prevalence of physical illness and social stressors, such as bereavement and possible consequent isolation, may trigger depressive symptoms in older age. Depression and dementia are significant public mental health issues for older people and later life depression is also a predictor of dementia[29]

However, when considering the role of life events for mental health, it is important to remember that events may not have a causal impact on the development of symptoms, rather they may act as a trigger among people who are biologically or psychologically predisposed to a disorder[22]. The debate regarding the impact of life events versus genetic / biological influences is still raging and at this point the evidence base is not fully conclusive.

### 5.5 Maternal Health

One in seven women will experience mental health problems during pregnancy or in the postnatal period and one in 10 new mothers is likely to experience postnatal

[25] NICE 2011. CG123 Common Mental Health Disorders.
[26] NICE 2004. CG9 Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa, and Related Eating Disorders.
[27] NICE 2004. CG16 Self-Harm - The Short-Term Physical and Psychological Management and Secondary Prevention of Self-Harm in Primary and Secondary Care.
[28] Jenkins, R., Meltzer, H., Jones, P., Brugha, T., Bebbington, P., Farrell, M., Crepaz-Keay, D., Knapp, M. 2008. Mental health: Future Challenges. Foresight, 104-08-Fo/on. The Government Office for Science, London, UK.
[29] Stewart, R. and Prince, M. 2008. State-of-Science Review: SR-B2. The Influence of Demographic, Social and Physical Factors on Ageing and the Mental Health of Older People.

depression; small but significant numbers of new mothers (approximately two per thousand) will be admitted to hospital for specialist treatment for post-partum psychosis[30]. The underlying course of most pre-existing mental health disorders or their prognosis is not significantly altered during pregnancy (with the exception of bipolar disorder, which shows an increased rate of relapse and first presentation). However, mental ill health occurring during pregnancy and the postnatal period may have greater adverse consequences for all concerned, than they do at other times in life[31]. For the women, there may be an additional concern about her ability to care for herself, her family and for her infant. For the infant and the possible siblings, maternal mental health disorder can affect their social and cognitive development and may have long-term consequences on their future mental health and wellbeing[32].

Social factors, again, play an important role in both the cause and maintenance of mental disorders during pre and postnatal time[29]. Significant numbers of women bring children up alone, in poverty or in suboptimal accommodation, which serves to emphasise the vulnerability of some women and their children. Pregnancy is also a time when domestic abuse may start or escalate[29]. Women who experience domestic violence are not only at increased risk of injury and death, but also physical, emotional and social problems. Adversity may play an important role in the maintenance of mental disorder in adults and increase psychological vulnerability of children whose parents have a mental disorder[29].

There were 2,946 live births in Swindon in 2011 with a maternity rate[33] of 67.5 (per 100,000 women aged 16-44 years) compared to 61.7 in the South West and 63.5 in England. Based on the figures above this would equate to approximately 420 mothers with a mental health condition ante or post natal. We would expect to see about 300 women with post-natal depression. (See table in

[30] DOH 2009. New Horizons: Towards a Shared Vision for Mental Health: Consultation.
[31] NICE 2007. Antenatal and Postnatal Mental Health.
[32] NICE 2007. Antenatal and Postnatal Mental Health.
[33] Maternities per 1,000 women aged 15-44. A maternity is a pregnancy resulting in the birth of one or more children, including stillbirths. ONS 2012

Appendix 4)

## 5.6 Socio-economic environment

Mental ill-health is strongly associated with a number of social determinants such as low level of education, unemployment, low income or material standard of living. Having mental health problems can also lead to this status, i.e. people with mental health problems tend to have fewer qualifications, find it harder to get work, have lower incomes, may be homeless and are more likely to live in areas of high socio-economic deprivation[34,35,36]

In general, there is a social gradient whereby higher levels of income and socio-economic status are associated with higher levels of wellbeing and lower rates of disorder[32]. Income inequality - relative poverty - and poor mental well-being and health are strongly associated. Recent analyses have indicated that out-of-control debts are the crucial mediating variable between low income and mental ill-health, and it may be that financial control is also a critical factor in mental wellbeing[31,32].

### 5.6.1 Deprivation in Swindon

Swindon residents are overall better off compared to the England average. According to the Indices of Deprivation 2010, almost 60% of Swindon's population or around 123,350 people live in the least and second least deprived areas compared to 40% in England[37]. Similarly, the average IMD deprivation score in Swindon was 14.3 which is statistically significantly better than the England average of 19.8.

However, there are pockets of deprivation in Swindon and 18 areas are deemed to be among the 20% most deprived in England. These 18 areas are home to about 30,000 people which equates to about 14.3% of Swindon residents. (See figure 3).

Eight of Swindon's 22 wards contain at least one of these areas. Nine of these 18 areas are also within the most deprived 10% nationally. These areas are split among 4 wards (Penhill, Gorse Hill & Pinehurst, Walcot, and Parks) and represent about 14,000 people which equates to 7% of the Swindon population.

Draft

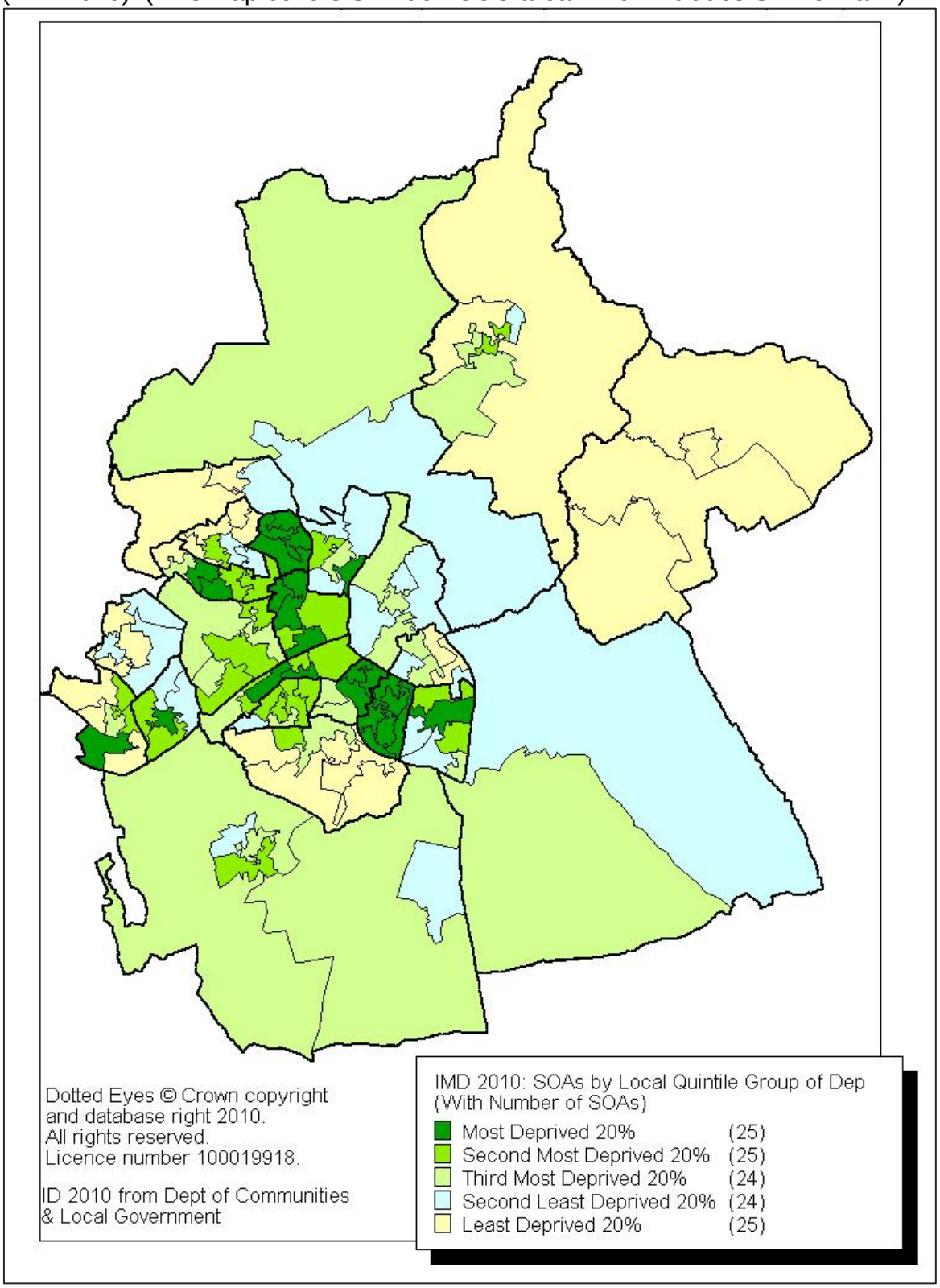
[34] Barry, M. and Friedli, L. 2008. State-of-Science Review: SR-B3 The Influence of Social, Demographic and Physical Factors on Positive Mental Health in Children, Adults and Older People

[35] DOH 2011. No health without mental health. A cross-government mental health outcomes strategy for people of all ages.

[36] Huppert, F. 2008. Mental Capital and Wellbeing: Making the most of ourselves in the 21st century State-of-Science Review: SR-X2 Psychological Wellbeing: Evidence Regarding Its Causes and Consequences

[37] The Indices of Deprivation 2010 (IMD 2010) use a group of statistical indicators to rank the 32,482 Lower Layer Super Output Areas (LSOAs) in England in terms of aspects of their deprivation. The deprivation score among all LSOA's in England ranged from 0.53 to 87.8 where lower values indicate less deprivation.

Figure 3 Swindon Lower Super Output Areas by local quintile group of deprivation (IMD 2010). (This map covers Swindon CCG area which includes Shrivenham.)



### 5.6.2 Education

It is recognised that education and learning play a significant role in offering a range of lasting benefits both for individuals and for the society. Apart from the effects on employability and earnings, education and learning also increases the likelihood that people are active in their wider community, thus, promoting social inclusion and cohesion within society[38]. Conversely, those with poor education and low levels of literacy and numeracy are much more likely to experience unemployment, find themselves in poorly paid jobs and have more limited and smaller social networks[39]. Evidence also shows that both formal and informal learning can have a direct impact on wellbeing, offering protection against conditions such as depression and cognitive decline in old age and helps to confer resilience to stress and adverse life events[34]. Education may also directly affect health outcomes by making individuals more able to process information and therefore makes them more likely to seek diagnosis and follow given treatment more diligently[40].

Whilst most studies find higher educational qualifications protective against poor mental health, a reverse effect has also been proposed as a consequence of job-related stress in occupations requiring a high level of education, as well as a consequence of raising expectations that may not have been fulfilled[36].

- Education in Swindon

Educational attainment in Swindon is lower than the national average. According to the Department for Education, 52.7% of pupils in Swindon, achieved 5 or more A*- C (or equivalent) grades at GCSE in 2011/12 which was statistically significantly lower than the England (59.4%) and the South West (57.5%) average.

We now have provisional figures for 2012/13 which shows that GCSE attainment has improved in the last year. This is in line with improvements in the South West and Nationally (see Table 5 Percentage of pupils achieving 5+ A* - C grades at GCSE 2009 -2013

Provisional results indicate that 1,254 pupils achieved 5+ A*-C grades including English and Maths GCSEs in 2012/13 (which is the expected attainment level at the end of Key Stage 4), out of 2,269 pupils. This equates to 55%.

[38] Foresight Mental Capital and Wellbeing Project 2008. Mental Capital and Wellbeing: Making the most of Ourselves in the 21st Century.
[39] Friedli, L. 2009. Mental Health, Resilience and Inequalities. Mental Health Foundation and World Health Organization (WHO) Europe.
[40] Chevalier A. and Feinstein L. 2006. Sheepskin or Prozac: The Causal Effect of Education on Mental Health. Institute for the Study of Labour (IZA). Discussion Paper No. 2231.

Table 5 Percentage of pupils achieving 5+ A* - C grades at GCSE 2009 -2013

| 5+A*-C including English and Maths GCSEs | | | | | |
|---|---|---|---|---|---|
| | 2009 | 2010 | 2011 | 2012 | 2013 |
| Swindon LA | 46% | 50% | 52% | 53% | 55% |
| National | 51% | 55% | 58% | 59% | 60% |
| South West | 52% | 55% | 58% | 58% | 59% |
| Stat Neighbours | 52% | 55% | 58% | 60% | 61% |

*2012/13 results are provisional*

Data from the Census 2011 show that Swindon was similar to the South West and England with 21% (34,424) of people aged 16+ with no qualifications (Table 6). Swindon had a higher percentage of working age population (16+ years) with level 1 or 2 qualifications (35%) compare to the South West (30%) and England (29%) and lower percentage of level 3 and above qualifications (34%) compared to the South West (41%) and England (40%).

Table 6 Highest level of qualification gained of working age population (16+ years), Census 2011.

| | Percentage | | |
|---|---|---|---|
| | **Swindon LA** | **South West** | **England** |
| No qualifications | 21% | 21% | 22% |
| Level 1 (1-4 GCSEs or equivalent qualifications) | 17% | 14% | 13% |
| Level 2 (5 GCSEs or equivalent qualifications) | 17% | 16% | 15% |
| Apprenticeship | 5% | 4% | 4% |
| Level 3 (2 or more A-levels or equivalent qualifications) | 12% | 13% | 12% |
| Level 4 and above (Bachelor's degree or equivalent, and higher qualifications) | 23% | 27% | 27% |
| Other qualifications (including foreign qualifications) | 6% | 4% | 6% |
| **All categories** | **100%** | **100%** | **100%** |

Source: ONS

Across Swindon wards the percentage of people aged 16+ with no qualifications ranged from 38.7% in Penhill to 7.3% in Abbey Meads. There is a positive relationship ($R^2 = 0.70$) between the percentage of people aged 16+ with no qualifications and average deprivation level in Swindon wards. (see

**Appendix 5** for further details).

### 5.6.3 Employment and Income

Work is generally understood to have an important role in promoting mental wellbeing. It is an important determinant of self-esteem and identity as well as providing a sense of fulfilment and opportunities for social interaction[41].

Nevertheless, whilst being employed can promote mental wellbeing, a poor work environment, characterised by features such as high demand/low control, and effort-reward imbalance, can have negative effects on mental health and contribute to feelings of stress[37,42].

- Employment in Swindon

Swindon's major employers are based in manufacturing and engineering dominated by Honda's car manufacturing plant and BMW/Mini. Other large private sector employers include insurance, banking and building societies, pharmaceuticals and food distribution. Swindon is also the location for all but one of the National Research Councils and has the registered Head Office of the National Trust. According to the Census 2011, 69% of the population aged 16-74 in Swindon were economically active and in employment. This was statistically significantly higher than England (62%) and the South West (64%). However, Swindon LA had also a slightly higher percentage of NEET (16-18 year olds not in education, employment or training) (6%) than the South West (5.7%) but was significantly lower than England (9.9%) at the end of 2011 (Department for Education).

Table 7 Employment by occupational group, Census 2011.

| | Males | | | Females | | |
|---|---|---|---|---|---|---|
| % | Swindon | South West | England | Swindon | South West | England |
| Managers, directors & senior officials | 11.6 | 13.3 | 13.3 | 7.1 | 8.5 | 8.1 |
| Professional occupations | 15.9 | 15.6 | 16.5 | 15.1 | 17.6 | 18.6 |
| Associate professional & technical occupations | 13.2 | 13.6 | 14.0 | 11.8 | 10.5 | 11.5 |
| Administrative & secretarial occupations | 4.9 | 4.3 | 4.8 | 20.2 | 18.5 | 19.0 |
| Skilled trades occupations | 17.9 | 22.5 | 19.1 | 2.3 | 3.3 | 2.6 |
| Caring, leisure & other service occupations | 2.3 | 3.1 | 3.2 | 14.9 | 17.2 | 16.2 |
| Sales and customer service occupations | 5.6 | 5.4 | 5.7 | 14.2 | 11.8 | 11.5 |
| Process plant & machine operatives | 14.4 | 11.0 | 11.9 | 2.3 | 1.8 | 1.8 |
| Elementary occupations | 14.2 | 11.2 | 11.5 | 12.0 | 10.8 | 10.7 |
| **All categories:** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** |

Source: ONS

The percentage of adults receiving secondary mental health services known to be in employment at the time of their most recent assessment, formal review or multi-disciplinary care planning meeting (NI150) in 2009 - 2010 was 6.4% in Swindon

[41] NICE 2009. PH22 Promoting Mental Wellbeing at Work.
[42] Barry, M. and Friedli, L. 2008. State-of-Science Review: SR-B3 The Influence of Social, Demographic and Physical Factors on Positive Mental Health in Children, Adults and Older People.

which was similar to England (7.9%) but statistically significantly lower than the South West (9.3%) (The Information Centre for Health and Social Care). In 2012/13 the health and social care outcomes framework indicated that 10.9% of adults in contact with mental health services Swindon were in employment. This was better than the England averages of 7.7%, and comparator areas 7.3%.

Table 8 Median gross annual pay in £, Census 2011.

| | Swindon | South West | England |
|---|---|---|---|
| Male | 27,813 | 25,229 | 27,024 |
| Female | 15,046 | 15,206 | 16,725 |
| Person | 21,237 | 20,079 | 21,794 |

Source: ONS

### 5.6.4 Unemployment

Unemployment has been associated with the presence of mental health problems and lower levels of life satisfaction[43]. The negative impact of unemployment on wellbeing can depend on context. In areas of high unemployment the impact on individuals appears to be less than in areas of low unemployment although the social impact may be very serious[40]. However, it may be that unemployment is more strongly associated with the absence of positive wellbeing than with the presence of symptoms of psychological distress i.e. unemployed people do not on average show evidence of mental health problems such as depression or anxiety, rather, they fail to flourish[40]. There is strong evidence that re-employment leads to improved self-esteem, improved general and mental health, and reduced psychological distress and minor psychiatric morbidity. The magnitude of this improvement is more or less comparable to the adverse effects of job loss[44]

Involuntary joblessness may affect and contribute to a person's decline in physical, mental and emotional wellbeing[45,46]. However, starting work, staying in work or returning to work may also prove to be more difficult for people with a mental health condition. It is therefore difficult to ascertain if being jobless leads to a poorer mental health state or if a person's poorer mental health state is the reason behind a person's joblessness. For example, a recent survey by the Department for Work and Pensions showed that people at the beginning of claiming Jobseekers allowance (JSA) had nearly twice the rate of severe neurotic symptoms (14.7%) than the general population (8.5%) and more than a fifth (22.6%) of the cohort had a common mental disorder (CMD) like anxiety or depression. JSA claimants with a CMD held more negative views about work with lower self-confidence in their work search abilities and lower optimism about the

[43] Huppert, F. 2008. State-of-Science Review: SR-X2 Psychological Wellbeing: Evidence Regarding Its Causes and Consequences.
[44] Waddell, G. and Burton, A. 2006. Is Work Good for Your Wellbeing? London. The Stationery Office.
[45] Paul K I & Moser K 2009. Unemployment impairs mental health: Meta-analyses. Journal of Vocational Behavior.74(3): 264-282.
[46] Ford, E., Clark, C., McManus, S., Harris, J., Jenkins, R., Bebbington, P., Brugha, T., Meltzer, H. and Stansfeld S. 2010. Common mental disorder, unemployment and welfare benefits in England. Public Health. 124(12): 675-81.

future compared to claimants without CMD. They were also more likely to have been dismissed from their last job, to give a personal and health related reason for leaving their last employment and less likely to enter jobs during the study period than JSA claimants without CMD. Two-thirds of the JSA claimants believed that working leads to a better health[47].

- Unemployment in Swindon

Overall, Swindon had an estimated 7,900 unemployed people (aged 16-64) between October 2011 and September 2012. The number is model-based derived from the Annual Population Survey and Jobseeker claimant counts. Swindon's unemployment rate was lower (7.3%) than the average of England (7.9%) but higher than the South West average (6.0%).

The unemployment rate in Swindon has fluctuated over the last three years between 7.0% in the period April 10 – March 11; 6.8% between April 11- March 12 and 8.3% in the period between April 12 – March 13. The England equivalent rates are 7.7%, 8.2% and 8.0%. These figures are derived from the Annual Population Survey (NOMIS accessed 060813). The unemployment rate has since fallen to 7.5% against a national rate of 7.8% but the rate for males, 8.8% is higher than the national rate of 8.2%. This has implications for mental health problems and suicide risk. NOMIS rates for June 13 accessed 111213)

#### 5.6.4.1 Jobseeker allowance

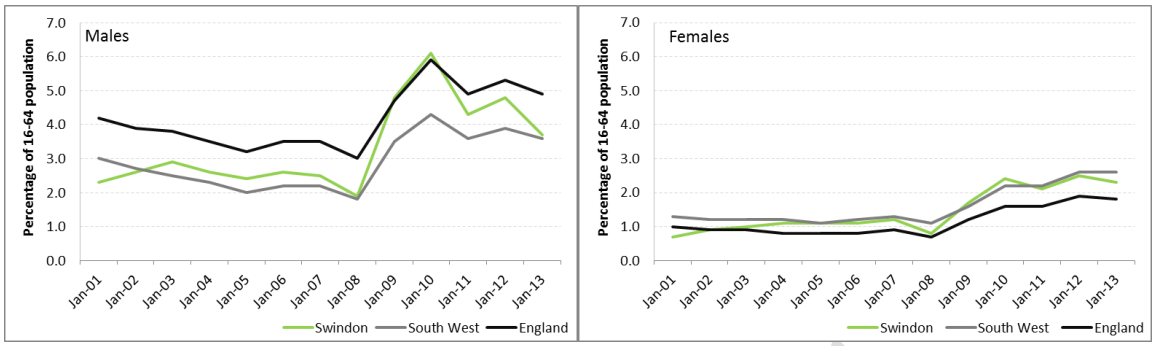
In the last three years the numbers claiming job seekers allowance has remained consistent in Swindon. In June 2011 the rate was 3.1% (England rate 3.6%); in June 2012 the rate was 3.3 (England rate 3.7) and in June 2013 in Swindon the rate was 3.2 (England rate 3.4).

There is some variation between men and women claiming job seekers allowance. The graphs shown in Figure 4 below show that from 2008 – 2010 there was a sharp increase in both male and female claimants. While for men this has fallen back the increase plateaued for women and has remained at the increased level. Fewer females than males in Swindon are on Jobseekers allowance.

Younger Swindon residents, aged 16-24, had a higher percentage of people on Jobseekers allowance (5.1%) than people aged 25-49 (2.9%) and 50-64 (2.1%). The pattern was similar for males and females. However, among the younger age group the majority (70%) had only been on Jobseekers allowance a relative short period (up to 6 month) in January 2013; only 18% had been on Jobseekers allowance over a year. Both older age groups, 25-49 and 50-64, had higher percentages of people having received job seekers allowance for more than a year (24% and 26%, respectively).

[47] McManus S., Mowlam A., Dorsett R., Stansfeld S., Clark C., Brown V., Wollny I., Rahim N., Morrell G., Graham J., Whalley R., Lee L. & Meltzer H. 2012. Mental Health in Context: The National Study of Work-Search and Wellbeing. Department for Work and Pensions. Research Report No 810.

Figure 4 Percentage of people aged 16-64 years claiming Jobseekers Allowance in Swindon LA area, South West and England.




Source: NOMIS

Among Swindon wards the percentage of people on Jobseeker allowance ranged from 7.6% in Penhill to 0.6% in Ridgeway (Table 9)

Table 9 Number and percentage of people aged 16-64 years claiming Job Seekers Allowance January 2013 by Swindon ward.

| Ward (2010) | Number | % |
|---|---|---|
| Penhill | 294 | 7.6 |
| Parks | 385 | 6.0 |
| Gorse Hill & Pinehurst | 341 | 5.3 |
| Walcot | 252 | 5.2 |
| Central | 423 | 5.1 |
| Toothill & Westlea | 197 | 3.8 |
| Moredon | 234 | 3.7 |
| Eastcott | 293 | 3.6 |
| Dorcan | 193 | 3.4 |
| Western | 221 | 2.8 |
| Freshbrook & Grange Park | 198 | 2.8 |
| St Philip | 127 | 2.2 |
| St Margaret | 138 | 2.1 |
| Old Town & Lawn | 160 | 2.0 |
| Shaw & Nine Elms | 130 | 1.9 |
| Wroughton & Chiseldon | 111 | 1.8 |
| Covingham & Nythe | 96 | 1.7 |
| Abbey Meads | 223 | 1.6 |
| Highworth | 72 | 1.4 |
| Haydon Wick | 89 | 1.3 |
| Blunsdon | 26 | 1.2 |
| Ridgeway | 12 | 0.6 |
| **Swindon** | **4,215** | **3.0** |

Source: NOMIS

### 5.6.4.2 Disability living allowance (DLA)

In May 2012 9,040 (4.3%) of Swindon's population (all ages) claimed disability living allowance (DLA); lower than the South West (4.7%) and England (5.1%). 67% had been claiming DLA for 5 years and over.

Draft

580 (13.0%) males and 650 (14.2%) females claimed DLA due to mental health conditions such as psychosis, psychoneurosis or personality disorder (Table 10). That figure increased to 880 (19.7%) males and 730 females (16.0%) when conditions such as dementia, behavioural disorders, alcohol & drug abuse and hyperkinetic syndromes (attention-deficit) were included (Table 11).

Table 10 People claiming disability living allowance with the disabling condition being psychosis, psychoneurosis or personality disorder, May 2012.

| | Number | | Percentage | |
|---|---|---|---|---|
| | Males | Females | Males | Females |
| **Swindon LA** | 580 | 650 | 13.0 | 14.2 |
| **South West** | 17,196 | 18,570 | 13.8 | 14.7 |
| **England** | 186,620 | 195,550 | 13.6 | 14.9 |

Source: NOMIS

Table 11 People claiming disability living allowance with the disabling condition being psychosis, psychoneurosis, personality disorder, dementia, behavioural disorders, alcohol & drug abuse and hyperkinetic syndromes (attention-deficit), May 2012.

| | Number | | Percentage | |
|---|---|---|---|---|
| | Males | Females | Males | Females |
| **Swindon LA** | 880 | 730 | 19.7 | 16.0 |
| **South West** | 25,630 | 21,440 | 20.1 | 16.9 |
| **England** | 272,190 | 224,190 | 20.2 | 17.2 |

Source: NOMIS

#### 5.6.4.3 Incapacity benefit (IB) & severe disablement allowance (SDA)

In May 2012, 3670 individuals claimed incapacity benefit (IB) or Severe disablement allowance (SDA) in Swindon. Mental and behavioural disorders accounted for 44% (1610) of these claims. (NOMIS)

### 5.6.5 Debt and mental health

There is some evidence of an association between debt or repayment difficulties and mental health problems and thoughts of suicide but not with suicide attempts[48]. There is plausible evidence that indebtedness is often subsequently followed by mental health problems and that the greater number of debts a person has, the higher their risk of also having a mental disorder.

Debt can significantly change how people live their lives and cause uncertainty about the future as well as engender feelings of stigma and shame. An individual's worry or concern about their debt can have an equal or larger negative impact on mental health than the actual size or amount of that debt. In a large economic recession more people will be affected by debt. Many of these people will have little previous experience of coping with hardship and these people maybe at greater risk of mental health problems than others.

[48] Royal College of Psychiatrists 2010. Debt and Mental Health what do we know? What should we do? Fitch et Al

People with debt and mental health problems often do not seek help for financial difficulties. Customers with debt often do not disclose they have mental health problems to creditors due to fear of information being used against them or feelings of embarrassment.

Health, money advice and creditor sectors should be aware of the impact of debt on mental health[48]. There should be direct links between these different sectors to ensure that the needs of those experiencing financial hardship are met.

- Debt in Swindon

The local CAB report indicates that in quarter 3 of 2012/13 debt was the second most frequent issue that clients presented with: 1,067 contacts in total. Links were established between the local branches of MIND and CAB and a MIND worker was trained and supported by CAB. New ventures with the CAB include links to GP practices in more deprived areas of the town.

Statistics collected by Step Change[49] show that in September 2013 the average unsecured debt in Swindon was £14,278 against a national average of £13,705.

### 5.6.6 Housing

Home is the place where people spend the greatest amount of their time, thus, it is an important determinant of health and wellbeing overall. Affordability, quality, size/design, symbolic value, choice, autonomy, privacy, location relative to services, amenities and transportation are all important issues[50.] Social and psychological dimensions of housing are related to sense of being able to exercise control in one's life and the home is a crucial site for establishing and maintaining social relationships[50]. Poor housing quality such as structural problems and dampness can lead to poorer mental health and enhance feelings of depression and excessive worrying. However, housing repairs can diminish this distress[51] .

In April 2011, the Building Research Establishment (BRE) prepared an assessment of condition of private housing stock in Swindon. The results indicate that the Swindon private sector housing stock is better than the national average. 25% of private homes were deemed as non-decent compared to a national average of 34%. 15% of household were deemed as vulnerable and of these 4% were housed in non-decent housing compared to a national figure of 7%. Vulnerable households in this context means a household at risk of homelessness because they have issues (may be lifestyle or health related) that make it difficult for them to manage their home e.g. paying rent, complying with tenancy conditions etc.)

[49] http://www.stepchange.org/Debtview/Debtview/atlas.html accessed 02/12/13

[50] Dunn J Housing as a Determinant of Mental Captital. State of Science Review: SR-E27 2008 Foresight mental capital and wellbeing: Making the most of ourselves in the 21st century. Government Office for Science, London.

[51] Cooper, R., Boyko, C. and Codinhoto, R. (2008). 'State of science review: the effect of the physical environment on mental wellbeing'. Foresight mental capital and wellbeing: Making the most of ourselves in the 21st century. Government Office for Science, London.

In terms of the condition of Council homes, latest figures suggest 1.7% of the Council's homes in Swindon do not meeting the Government's Decent Homes standards. This compares to the South West regional average of 17.6% and the England average of 22%.

Swindon's Strategic Housing Market Assessment 2011 highlighted that nationally *'The density of new housing developments has increased by 84 per cent since 2001, according to new government research. New developments last year were built to an average density of 46 dwellings per hectare, compared with the 2001 average of 25 dwellings per hectare.'*[52]

The Swindon Assessment[53] highlights that evidence from SBC Planning records indicate that between 2006 and 2010 an average of 41 per cent of new housing was in the form of flats, with only 12.5 per cent in the form of four bedroom houses. In terms of densities, Swindon has set densities on a site-by-site basis ranging from 16 to 463 dwellings per hectare, with most within the range of 25 to 50. The overall average for the sites specified in the Local Plan is 59.8 dwellings per hectare. Table 12 indicates the densities achieved on the three major development sites in Swindon since 2006.

Table 12 Density (per hectare) of past housing completions

| | 2006/7 | 2007/8 | 2008/9 | 2009/10 | 2010/11 |
|---|---|---|---|---|---|
| Northern Development Area | 45.15 | 44.23 | 44.17 | 33.85 | 26.02 |
| Wichelstowe | 0 | 0 | 63.14 | 58.79 | 50.90 |
| Swindon remainder | 88.30 | 82.18 | 68.48 | 62.35 | 49.54 |

Source: SBC Planning records

### 5.6.7 Homelessness

There is growing concern over the relationship between homelessness and mental ill-health. Research has found that despite the difficulties of accurately measuring psychiatric morbidity rates among homeless adults it is apparent the majority of this population have severe mental health problems[54]. This figure is based on the statutory homeless population. The estimated prevalence of metal ill health may be 40–50 times higher than in the general population[23]. The type of mental ill health can vary according to the type of homelessness (sleeping rough, using a night shelter, staying in special hostels or using temporary, leased accommodation) but the most prominent disorders experienced by homeless people appear to be depression, affective disorders, psychosis including

[52] Inside Housing; 1st June 2009
[53] Swindon's Strategic Housing Market Assessment 2011
[54] Meltzer H 2008 The Mental Ill-Health of Homeless People Foresight mental capital and wellbeing: Making the most of ourselves in the 21st century. Government Office for Science, London

schizophrenia and personality disorders. All epidemiological studies point to a high level of co-occurrence of these conditions54.

The causal link between homelessness and mental ill-health is the subject of an on-going debate. Some argue that the psychiatric problems of many of the homeless may result directly from their poverty and associated lack of accommodation. Others contend that the majority first experienced their symptoms of mental disorder before becoming homeless.

According to the Department for Communities and Local Government there were 6 people (estimated) sleeping rough on Swindon streets in autumn 2012. Number of statutory homeless households expressed as a crude rate per 1,000 households give an estimated of 1.1 homeless households per 1,000 households in 10/11 in Swindon LA area. This is statistically significantly better than the South West (1.5 per 1,000 households) and the England average (2.0 per 1,000 households).

In 2013 a Gaps Needs Analysis for Wiltshire and Swindon homelessness support services[55] was undertaken. The Draft report shows that support for mental health issues for all age groups was a commonly identified need and the most identified need in those under 35. The draft report concludes that the findings "suggest that support for the mental health issues (and likely deteriorating mental health) across all ages is the most prominent reason for presentation to homelessness services and especially for the under 35s". Almost all (94%) of those under 35 presented with a mental health need.

## 5.7 Social Cohesion

### 5.7.1 Neighbourhoods, environment and crime

The physical environment around us, as well as the social structure associated with our environment, can have a profound influence on our wellbeing. Both the quality of the individual dwelling and the neighbourhood are important. Feeling of safety when at home and in the neighbourhood is associated with positive mental health and sense of social connectedness to the community[51]. Conversely, fear of crime can curtail both social and physical activities and lead to poorer mental and physical health[56].

Enhancements to one's neighbourhood can bring about positive change in mental wellbeing (e.g. level of depression). Residents living on a housing estate substantially improved their mental health after physical changes were made to the area, in consultation with the local authority. The physical improvements, for example, replacing old leaky wooden porches and front doors with new PVC fittings, closing alleyways, fencing in ambiguous semi-private spaces and resurfacing of roads, helped to sustain residents' lowered anxiety levels at three years after the improvements occurred[51].

Living in an urban area is associated independently with an increased risk of psychoses[14]. It is suggested that poorer urban neighbourhoods, in terms of both material deprivation and available social support, may fail to buffer against the

[55] Smarter Working in Tougher Times Draft Report (2013) A Gap Analysis for Wiltshire and Swindon homelessness support services Roanne Wootten Julian Housing

[56] Stafford, M., Chandola, T., and Marmot, M. (2007), 'Association Between Fear of Crime and Mental Health and Physical Functioning', *American Journal of Public Health*, 97: 2076-2081.

stresses of city living. Both perceived and actual ambient properties such as crowding, the presence of graffiti, vandalism, street litter, maintenance of buildings, traffic, parking, places to stop and chat, personal safety, lack of recreation facilities, green spaces and noise are seen as significant predictors of wellbeing, distress and chronic depressive symptoms in neighbourhoods[51] .

Exposure and access to views of nature can improve individuals' health and wellbeing by providing restoration from stress and mental fatigue. Residents living in urban social housing with nearby vegetation (e.g. trees) were significantly more effective in managing their major life issues, felt a greater sense of connectedness to the community, and experienced fewer incidents of violence than residents living in more barren environments[51].

Swindon's Green Infrastructure Strategy 2010 – 2026 acknowledges the importance of green spaces and infrastructure to the health and wellbeing of the population of Swindon and its importance in the future expansion plans of the town. It also acknowledges that many of the open green spaces lie outside the boundaries of the Borough Council. The recommendations from the strategy include:

- Improve access to, and quality of, parks, open spaces and links to the wider countryside
- Increase the level and diversity of community participation in the planning, development and enjoyment of Swindon's green infrastructure.
- Strengthen the network of bio-diverse habitats across Swindon.
- Ensure GI plays a central role in Swindon's sustainable and economic growth.
- Improve the integration of GI into Swindon's local transport priorities
- Improve the integration of GI into Swindon's strategic priorities

### Swindon Neighbourhoods

In 2012 Swindon Borough Council undertook a resident's survey, randomly selecting 14,885 households who were sent the survey. The survey found that 77% of people who responded were either very or fairly satisfied with where they lived (i.e. the area within a 15-20 minute walk of their home). This was a slight reduction on the 2010 figures of 81%. 8% were very of fairly dissatisfied. Those who live in the Town Centre and North Central areas were significantly less satisfied that those from the South and West of the town.

The survey gave list of 20 important factors that make a place good to live in and asked the respondents to select the 5 most important ones. The issues highlighted in the survey as being most important factors influencing how they felt about their area was fear of crime and clean streets followed by parks and open spaces and health services. When asked which factors needed improving in their area they sited road repairs, activities for teenagers and clean streets as the top three factors. Fear of crime was cited as 6$^{th}$ most important, improvements to parks and open spaces, 11$^{th}$ and improvement to health services 16$^{th}$ most important. This may indicate that residents are relatively satisfied with the factors that they consider most important to making the area they live in a pleasant place to live. Also to be noted is that access to nature which was considered the 9$^{th}$ most important factor in making somewhere a good place to live was only cited at the

17th in the most important factor that needed improving in the place where individuals live. This may indicate that in general people appreciated the importance of access to nature and felt that it was accessible.

Levels of crime in Swindon have fallen over the past few years. One example of this is the number of new cases of antisocial behaviour recorded by SBC. In 2010/11 SBC recorded 400 new antisocial behaviour cases, in 2011/12 this rose to 467 but in 2012/13 this fell to 279. The number of Acceptable behaviour contract also decreased from 47 in 2010/11 to 11 in 2012/13. The number of Anti-social behaviour Orders increased from 9 in 2010/11 to 36 in 2011/12 before decreasing to 23 in 2012/13. Swindon's crime rate is about average for England. Rates from iQuanta show that in the last year (Nov 12 – Oct 13) there were 62.17 crimes per 1000 population against a national average of 61.66. For crimes against the person there were 13.88 per 1000 in Swindon against a national rate of 13.88 per 1000 population.

### 5.7.2 Domestic Violence

The Crime Survey for England and Wales 2011/12[57] found the national lifetime prevalence (age 16-59 years) of any domestic abuse to be 18% in males (the equivalent of 11,800 men in Swindon) and 31% in females (equivalent to approximately 20,000 women in Swindon). In the last year it is estimated that 5000 women and over 3000 men living in Swindon have experienced domestic violence.

Female victims were more likely to suffer from non-physical abuse, threats and sexual assault. 14% had received treatment for mental health services[58].Female victims are more likely to experience repeated assaults and they are more likely to report emotional distress or fear as a result of the violence. Domestic violence is associated with psychiatric illness, including depressive disorder, suicidality, anxiety, alcohol and drug misuse and post-traumatic stress disorder (PTSD)[59]. Women's Aid state that:

- Abused women are at least three times more likely to experience depression or anxiety disorders than other women.
- One-third of all female suicide attempts and half of those by Black and ethnic minority women can be attributed to past or current experiences of domestic violence.
- Women who use mental health services are much more likely to have experienced domestic violence than women in the general population.
- 70% of women psychiatric in-patients and 80% of those in secure settings have histories of physical or sexual abuse[60].

[57] Crime Survey for England and Wales. 2011/12.
[58] Smith et al. Home Office Statistical Bulletin. 2012. Homicides, Firearms offences and Intimate Violence 2010/11: Supplementary Volume 2 to Crime in England and Wales 2010/11.
[59] Royal College of Psychiatrists 2002 Council Report Domestic Violence
[60] http://www.womensaid.org.uk/domestic-violence-survivors-handbook.asp?section=00010001000800010036000 2 accessed 2 October 2013

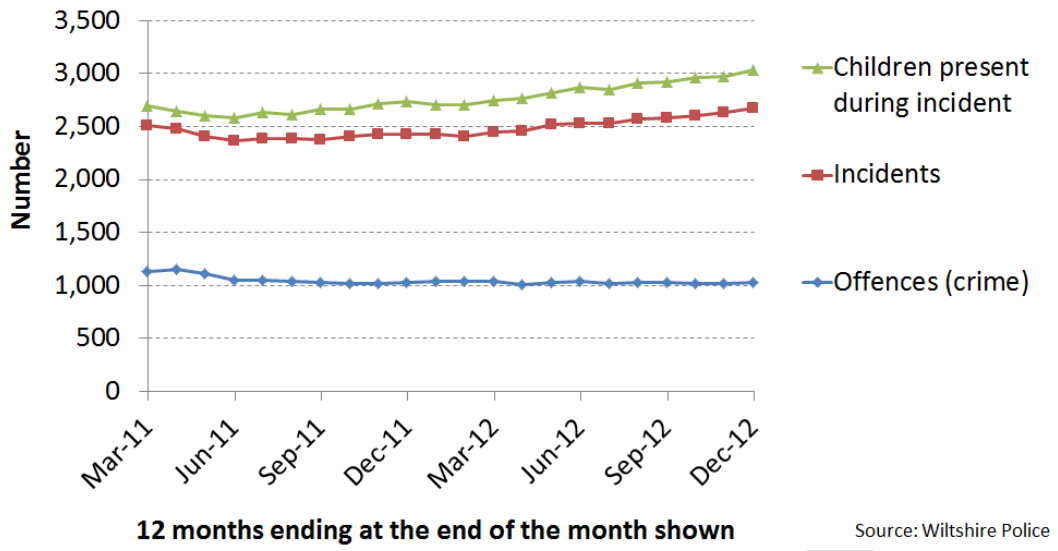
The Royal College of Psychiatrists Council Report[59] highlights that although psychiatric disorders in victims of domestic violence are generally the consequence of trauma, it is also possible that individuals with depression, anxiety or phobia may be drawn to, or attract, dominant or aggressive partners. The report goes on to explore perpetrators and states that in general, domestic violence does not arise as a consequence of mental illness. However, it does highlight that "Men who batter their partners are characterised as extremely hostile towards, although highly dependent on them. They have low self-esteem, they lack assertiveness, are emotionally inexpressive and tend to be socially and sexually inadequate. They use violence often accompanied by psychological and sexual abuse as a way of controlling their partners". The report highlights the need for Psychiatrists to receive training on the aetiology, effects and range of interventions for victims and perpetrators of domestic violence. This should include the association with child abuse and alcohol/drug misuse.

The draft Swindon Domestic Violence Needs Assessment (2013) has more detail on domestic violence in Swindon with particular reference to the impact on children. However, in this document they cite a cohort study comparing rates of self-harm among victims of domestic assault presenting to an Emergency Department (ED) with those rates among other ED patients. They found that patients experiencing domestic violence were more likely to present with self-harm, had more ED contacts and there was a moderate correlation between the number of episodes of self-harm and the number of assaults. Nearly 25% of domestic assault victims had self-harmed during the 8 year study period. They concluded that at least 5% of self-harm patients will have suffered domestic violence in the year before presentation.[61] This may be of particular significant considering our high rates of admission for self-harm

The incidents of domestic violence in Swindon increased between 2010 and 2013 (see Figure 5 below) However, the number of incidents recorded as an offence after an initial decrease has actually remained stable during the same period In 2010/11 and 2011/12 14% of incidents were repeat incidence. This increased in 2012/13 to 22%.

[61] Boyle et al. 2006. The association between domestic violence and self-harm in emergency medicine patients. Emergency Medicine Journal, 23, 604-607

Figure 5 Swindon - Police calls to domestic violence incidents, children present in households during incidents and DV offences: Rolling 12 month information (April 10-December 12)




Taken from the Swindon Domestic Violence Needs Assessment 2013.

### 5.7.3 Counter Terrorism

Acts of terrorism are carried out by people who have had their views excessively radicalised. This can be on political or religious grounds and can either occur through influence of others or by self-radicalisation, usually through the internet. People tend to be vulnerable to radicalisation for a number of reasons that include, rejection, isolation, persecution, sense of identity, substance misuse and a whole host of other influencers. Those who have poorer mental health or wellbeing may be more vulnerable to radicalisation. There is no simple tick-list that identifies people who could be radicalised. To assist people who are at risk of radicalisation, there is a process called Channel, which targets support to people who have been identified as being at risk of radicalisation, seeking to divert them before they participate in anything illegal. In Swindon 2011/12 there were 83 "racially/religiously aggravated offences", in 2012-13 there were 113 and for the first 5 months of 2013 -14, 41 offences. Services should be aware of the potential of radicalisation and the Channel Process.

### 5.7.4 Social Networks and Social Support

It is well established that social support is strongly related to mental health. Some studies have shown that social isolation is as great a risk factor for premature death as smoking[50]. Social support not only increase emotional well-being but also buffers the negative emotional effects of stressors that people experience during the life course. The key components of social support are:

- **emotional support** (having warm and caring personal relationships, friends or family that can convey positive self-esteem and security),

- **practical or tangible support** (help available with concrete needs such as financial support or transport, including the perception of available help should it be required)
- **informational support** (which refers to good information and advice available, underlying the ability to make positive choices and increase personal sense of control[62].

The wider protective social factors for positive mental health include; a culture of cooperation and tolerance between individuals, institutions and diverse groups in society; a sense of belonging to family, school, workplace and community; and a good network of supportive relationships. In contrast, social exclusion damages both physical and mental health. Populations at most risk from social exclusion include:

- those with limited opportunities for employment (particularly, women, racial and ethnic minority groups, refugees, sex workers)
- people living with disabilities, addictions or chronic illnesses
- homeless people
- long-term unemployed
- school leavers
- older people living on reduced income[14].

#### 5.7.4.1 Social Isolation in Swindon.

It is difficult to measure social isolation in the broader population. However, as part of the public health outcome framework there is a measure for the percentage adult social care users who have as much social contact as they would like according to the Adult Social Care Users Survey. In Swindon 39.5% of those included in the survey reported they had as much social contact as they would like. This was lower than the South West (44.8%) and England (43.2%). 9.2% surveyed in Swindon said they felt socially isolated compared to 5.8% in England and 5.9% in the South West. Related to social isolation is the issue of transport. Affordable accessible transport is essential with regard to keeping friends and family in touch and enabling individuals to access health, education and social activities which keep them mentally well.

### 5.7.5 Minority groups

There are a number of factors that can increase the risk of individuals from any minority group of developing mental health problems, including discrimination, socioeconomic deprivation, poor community cohesion and greater social isolation.

#### 5.7.5.1 Ethnicity

Different ethnic groups have different rates and experiences of mental health problems, reflecting their diverse cultural and socio-economic contexts and access to culturally appropriate treatments. Importantly, culture is known to exert an

[62] McCourt C (2003) Social Support in C Squire (ed) The Social Context of Childbirth Oxford Radcliffe Medical Press.

influence on the presentation and subjective experience of illness. Research suggests that Asian people, including Indian, Bangladeshi and Pakistani people, are more likely to present to their GP with physical manifestations of depression, and do so more frequently than their white counterparts[63].

Whilst acknowledging the potential shortfalls in accurate recording of mental health prevalence amongst different ethnic groups, the Mental Health Foundation offers the following national picture[64].

- African Caribbean people are three to five times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia.
- African Caribbean people are also more likely to enter the mental health services via the courts or the police, rather than from primary care, which is the main route to treatment for most people. They are also more likely to be treated under a section of the Mental Health Act, are more likely to receive medication, rather than be offered talking treatments such as psychotherapy, and are over-represented in high and medium secure units and prisons.
- Asian people have better rates of recovery from schizophrenia, which may be linked to the level of family support.
- Suicide is low among Asian men and older people, but high in young Asian women compared with other ethnic groups. Indian men have a high rate of alcohol related problems.

The National Wellbeing Survey provided additional evidence regarding the wellbeing of those from BME communities. The survey concluded that "Black, Arab, Bangladeshi, Pakistani, and Indian people experience significantly lower well-being than White people in the UK. The differences apply across multiple measures of well-being, and persist even after taking into account a number of factors known to affect wellbeing such as relationship status, labour market status, and home ownership[65].

Gypsies and Travellers are socially excluded diverse ethnic groups, which, on the basis of existing small scale and anecdotal evidence, have specific health needs that have not been systematically assessed[66]. Yet, it is understood that the scale of health inequality between the traveller population and the UK general population is large, endemic and pervasive, with reported health problems ranging from chronic health issues to reports of high incidence of anxiety and depression[67]. Despite greater health need, Gypsies and Travellers use

[63] Depression: The NICE Guideline on the Treatment and Management of Depression in Adults (Updated edition) The Royal College of Psychiatrists 2010 National Collaborating Centre for Mental Health

[64] Mental Health Foundation (accessed 30th April 2013) http://www.mentalhealth.org.uk/help-information/mental-health-a-z/B/BME-communities/

[65] Well-being patterns uncovered: An analysis of UK data NEF Saamah Abdallah and Sagar Shah Nov 2012

[66] Parry, G., Van Cleemput, P., Peters, J., Walters, S., Thomas, K. and Cooper, C. (2004) *The Health Status of Gypsies and Travellers in England*, Sheffield, University of Sheffield.

[67] Cemlyn S et al (2009) Inequalities experienced by Gypsy and Traveller Communities: a review (PDF 1.19MB), (Research report 12). London: Equality and Human Rights Commission

mainstream health services less than general population. Some of the reasons for not accessing mental health services and other health services involve practical difficulties, such as isolation, complex procedures for registering with GPs to access services. A small-scale research project by Bristol MIND found that attitudes and approaches in coping with mental health issues in Gypsy and Traveller communities, as well as the language used to describe their issues were culturally specific[68].

- Ethnicity in Swindon

At the last Census (2011) around 21,260 people in Swindon belonged to a non-white ethnic group making up 10.2% of the total population (Table 13). This is higher than the South West average (4.6%) but lower than the England average (14.6%). Since the last Census (2001) the percentage of non-white ethnic groups in Swindon has doubled. This is mainly due to an increase in the Asian/Asian British ethnic group which in 2001 made up 1.1% (2,045) of the Swindon population and now make up 6.4% (13,365). The Black/Black British ethnic group saw a 0.7% increase since 2001 making up 1.4% (2,861) of Swindon's population. The mixed/multiple ethnic group saw a slight decrease of 0.5% between 2001 and 2011, making up 2.0% (4,226) of Swindon's population (Table 13 and Figure 6).

The white non-British ethnic group has also increased from 3.7% (6,702) in 2001 to 5.2% (10,870) in 2011. Polish are the largest group in the white non-British 25% followed by the Irish (17%) and Western European (11%). The percentage of Irish has decreased since 2001 where they made up 34% of the white non-British ethnic group in Swindon. Around 180 Gypsy and Irish travellers were resident in Swindon in 2011.

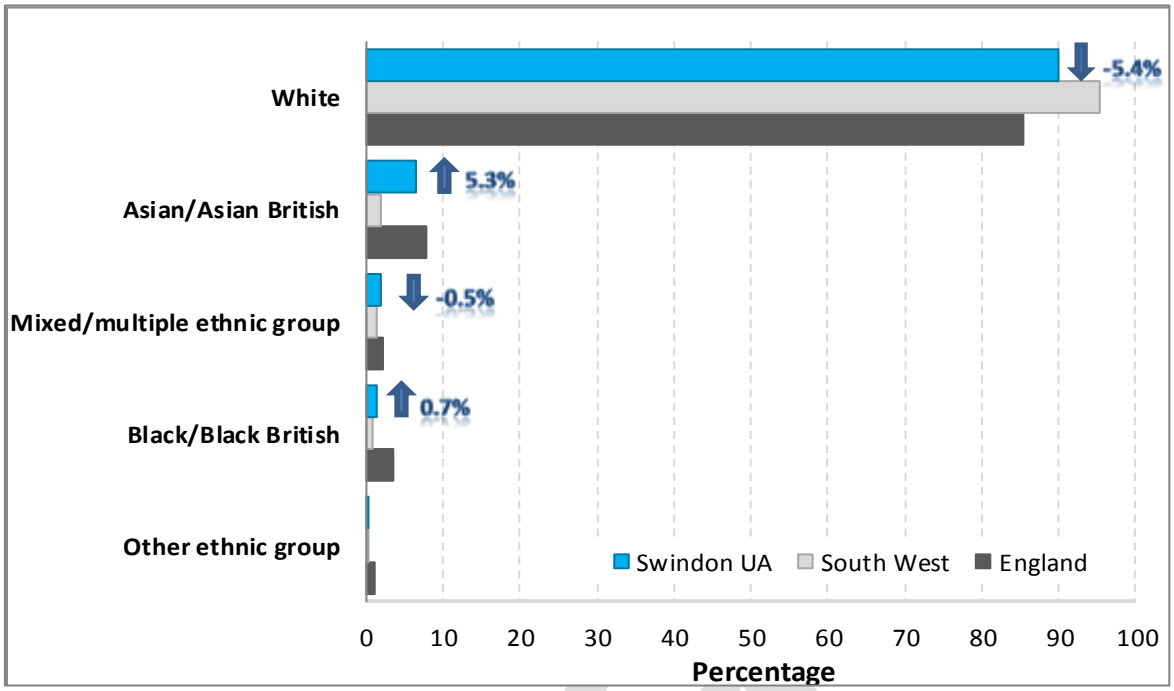
Table 13 Number and percentages of ethnic groups in Swindon LA area and comparator groups, Census 2011.

| Broad ethnic group | Census 2011 | | | | | |
|---|---|---|---|---|---|---|
| | Numbers | | | Percentage | | |
| | Swindon | South West | England | Swindon | South West | England |
| White British | 187,898 | 5,046,429 | 45,281,142 | 89.8 | 95.4 | 85.4 |
| White Non-British | 10,870 | 190,753 | 3,001,906 | 5.2 | 3.6 | 5.7 |
| Asian/Asian British | 13,365 | 105,537 | 4,143,403 | 6.4 | 2.0 | 7.8 |
| Mixed/multiple ethnic group | 4,226 | 71,884 | 1,192,879 | 2.0 | 1.4 | 2.3 |
| Black/Black British | 2,861 | 49,476 | 1,846,614 | 1.4 | 0.9 | 3.5 |
| Other ethnic group | 806 | 15,609 | 548,418 | 0.4 | 0.3 | 1.0 |
| **Total population** | **209,156** | **5,288,935** | **53,012,456** | **100.0** | **100.0** | **100.0** |

Source: ONS, Census 2011

[68] Cemlyn S et al (2009) Inequalities experienced by Gypsy and Traveller Communities: a review (PDF 1.19MB), (Research report 12). London: Equality and Human Rights Commission

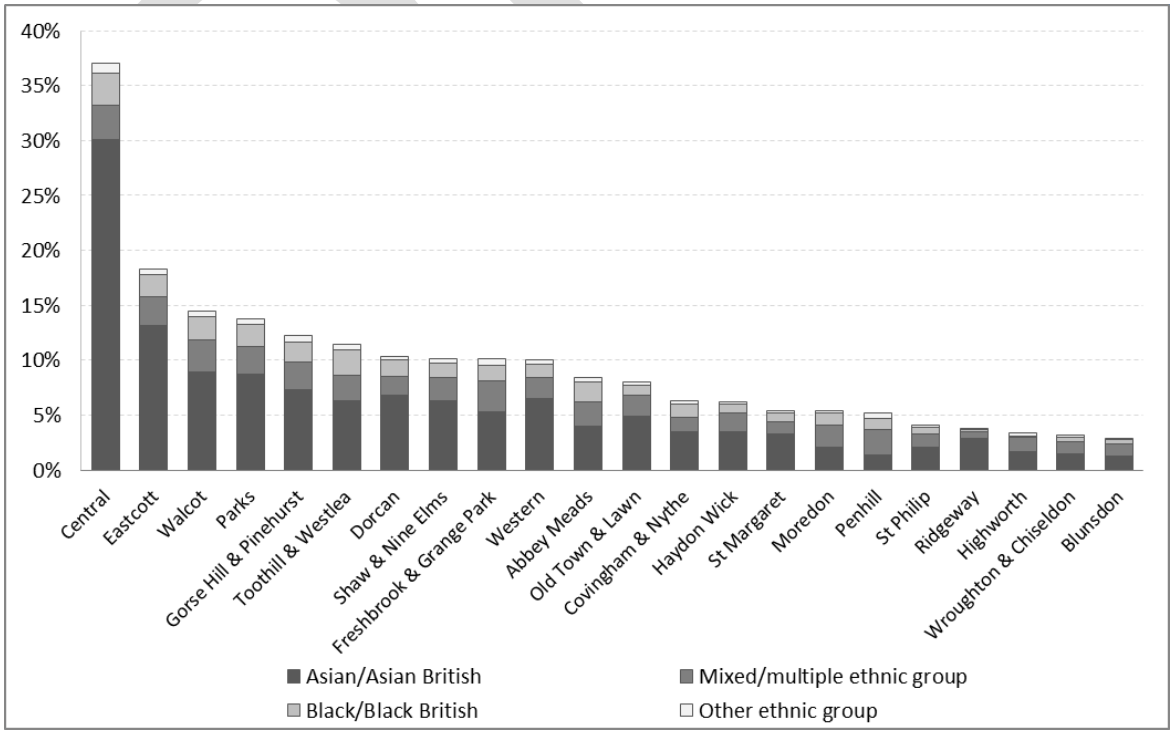
Figure 6 Broad ethnic groups resident in Swindon LA area and comparator groups, Census 2011. Blue arrows indicate percentage change for Swindon LA area since Census 2001.




Source: ONS, Census 2011

The percentage of non-white ethnic groups in Swindon wards ranged from 37% in the Central ward to 3% in Blunsdon. Asian/Asian British were the largest non-white ethnic group in most wards in Swindon (Table 13).

Figure 7 Percentage of broad non-white ethnic groups by Swindon wards (2010 ward boundaries), Census 2011.




Source: ONS, Census 2011

### 5.7.5.2 Migration

Migration and post-migratory experiences can be major stressors, leading to increased risk of metal health problems. According to the Foresight report[14], the incidence of mental illness for long-term migrants in the UK are higher than for the indigenous population, and higher than those of their home country. Of all substantial immigrant groups that have been studied, highest incidence rates of psychoses are consistently observed for Black Caribbean and Black African groups in the UK. The report also draws attention to the Non-British white immigrants who may be approximately at double the risk of psychoses than the White British groups.

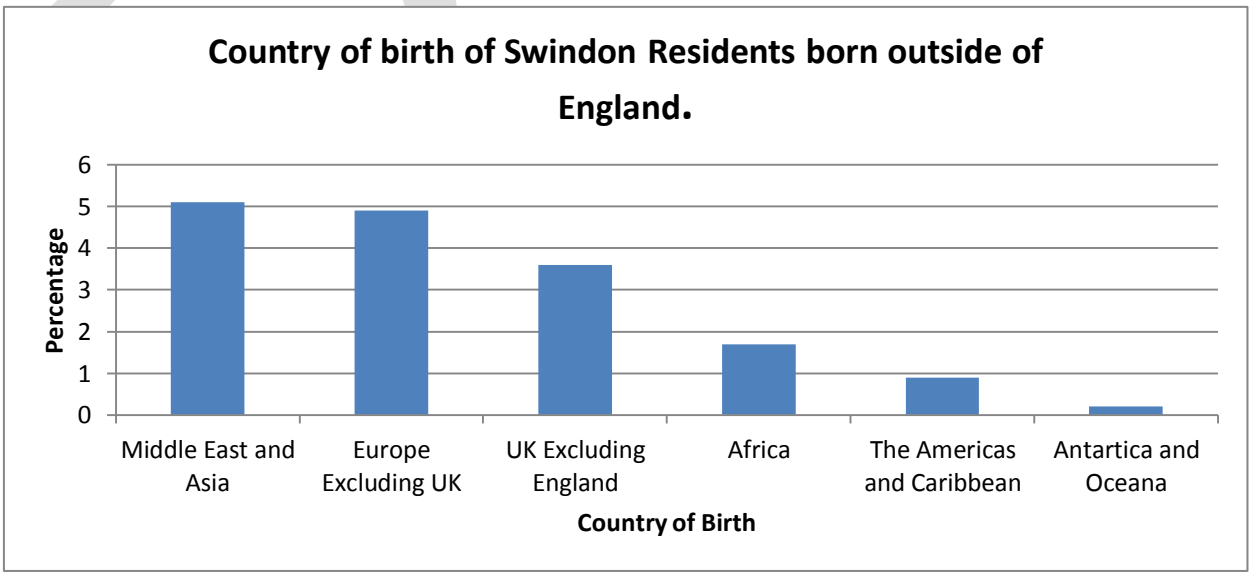
The report[14] notes that the elevated rates of psychoses in immigrants are not restricted to first generation immigrants but are also present in their UK-born, 'second and third generation' descendants. This suggests that it is not the migration alone that causes psychoses; post-migratory factors are also likely to be important.

Vulnerable migrants such as refugees and asylum seekers have significantly higher rates of post-traumatic stress disorder (PTSD)[14].

In Swindon, the CAB report that immigration is the third most common issue that people consult CAB about. 13% of clients came from an Asian or Asian British background, 3% came from Black or Black British background, 10% were recorded as white other and 63% had a white ethnicity.

In Swindon according to the 2011 census 87.1% of residents were born in the UK and of these 83.5% were born in England. The chart below shows that the majority of those not born in the UK were born in the Middle East and Asia followed by the rest of Europe.

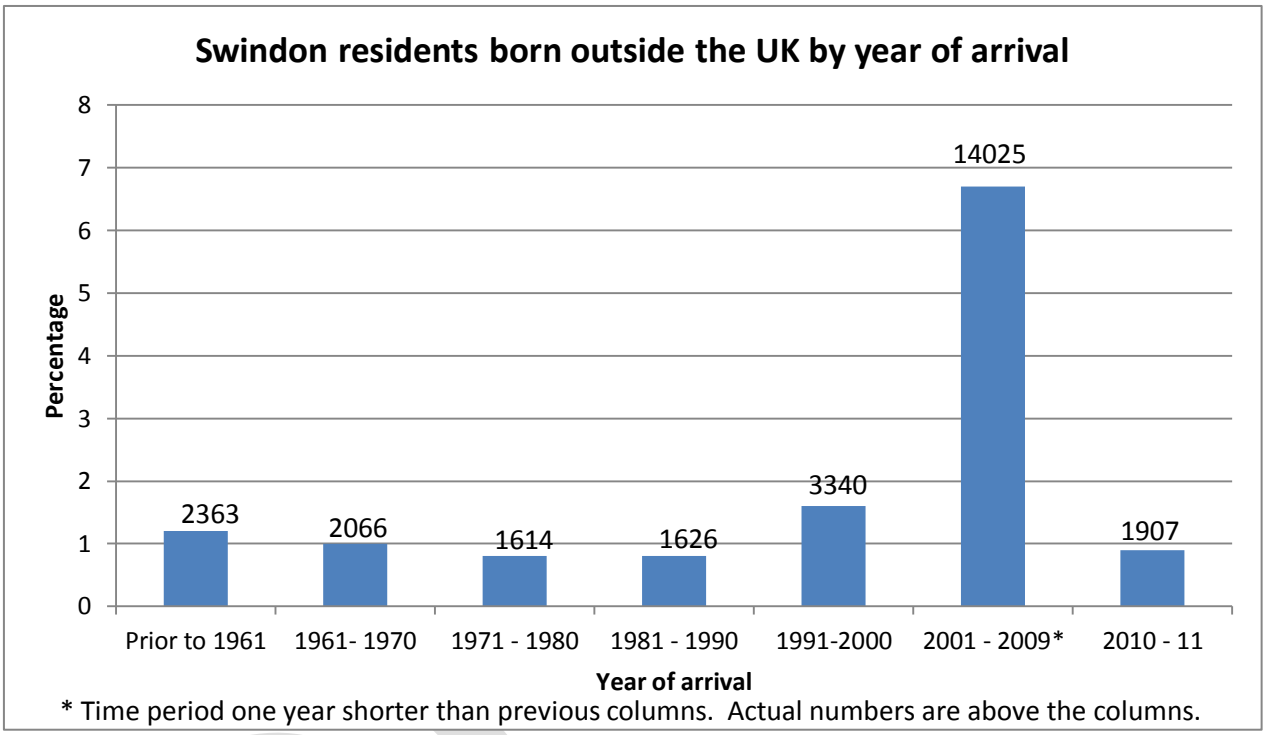
Figure 8 A chart to show the country of birth of Swindon Residents born outside England




Source: ONS Census 2011

There has been a steep increase in migrants arriving in Swindon over the past decade. The chart below shows that prior to 1991 migration was stable or slightly falling, this increased during 1991-2000 but has risen exponentially since 2001.

Figure 9 A Chart to the show the year of arrival in UK for Swindon residents not born in the UK.




Source: ONS census data 2011.

### 5.7.5.3 Sexual orientation

A systematic review[69] undertaken in 2008 concluded that lesbian, gay and bisexual men and women (LGB) are at higher risk of suicidal behaviour, mental disorder and substance misuse and dependence than heterosexual people. The results of their review demonstrate a two-fold excess in risk of suicide attempts in the preceding year in men and women, and a four-fold excess in risk in gay and bisexual men over a lifetime. Similarly, depression, anxiety, alcohol and substance misuse were at least 1.5 times more common in LGB people. Findings were similar in men and women but LB women were at particular risk of substance dependence, while lifetime risk of suicide attempts was especially high in LGB men[69] .

This review was limited to documenting the incidence of mental health problems in LGB people, nevertheless the authors do cautiously propose, that it is likely that the social hostility, stigma and discrimination that most LGB people experience is

[69] King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., et al. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. BMC Psychiatry, 8, 17.

at least part of the reason for the higher rates of psychological morbidity observed[69].

There are no local estimates of the numbers of people in Swindon's population who belong to the lesbian, gay, bisexual and transgender (LGB&T) groups. However, Swindon Joint Strategic Needs Assessment 2012 estimates that the figure could be in the region of 12,000.

#### 5.7.5.4 Military veterans

With the UK's long-standing and continuing role in military campaigns, there has been an increasing public concerns about the long term health of military personnel and their families, especially those who have left the Armed Forces. Whilst the prevalence of mental health disorders in serving personnel and veterans is broadly similar to that of the general population[70,71], many veterans may not seek help for their problems, partly because of the stigma attached to mental illness, or because they lack confidence that civilian health professionals will understand the military context.

However, there are two distinct groups of veterans that may be more vulnerable.

- The risk of suicide in men aged 24 and younger who had left the armed forces early was approximately two to three times higher than the risk for the same age group in the general and serving populations.
- Reservists post-deployment can also be vulnerable to common mental health disorder (26% compared to 16%) and twice as likely to have PTSD (6% compared to 3%) than non-deployed reservists.

Most veterans do not develop mental health problems as a result of serving in the military, but some are more likely to run into difficulties and social exclusion than others, with pre-service problems an important predictive factor, and the culture of heavy alcohol use within the services a significant problem (Mental Health Foundation, 2010,).

We do not have definitive figures on the number of military veterans who are resident in Swindon. However, the 2011 census data shows that there were 739 military veterans none of whom lived in communal residences. The Army Reservists (formally Territorial Army) report 110 individuals in Swindon. Figures obtained from LIFT Psychology showed that in 2012/13, 61 military veterans were seen by the service which accounted for 100 hours of clinical time. An additional 20 individuals were either current service personnel or dependents of current serving armed service personnel.

#### 5.7.5.5 Offenders

Offenders are a vulnerable group who are known to be disproportionately affected by mental health conditions. Research suggests that up to 90% of prisoners have

[70] King's Centre for Military Health Research: *A fifteen year report* September 2010 What has been achieved by fifteen years of research into the health of the UK Armed Forces? University of London King's Centre For Military Health Research

[71] Samele Chiara 2013 the Mental health of services and Ex-service personnel. A review of the evidence and perspectives of key stakeholders. Mental Health Foundation on behalf of Forces in Mind Trust.

a diagnosable mental illness (diagnosis included substance misuse) and 39% of offenders supervised by probation services have a current mental health condition[72,73]. Mental health needs in this population are often associated with issues of alcohol and/or drug misuse and social exclusion[74].

There is no prison in Swindon, however around 750 offenders serve a community sentence supervised by Wiltshire Probation Trust in Swindon every year.

Nationally, there is evidence to suggest that mental ill health in the probation caseload is often unrecognised and untreated[75]. In Spring 2013 a mental health needs assessment of Probation Service users in Swindon and Wiltshire was conducted in partnership with Wiltshire Council Public Health and Wiltshire Probation Trust.

The aim of this needs assessment was to determine the level of mental health needs of service users and to investigate the extent to which the services provided by the Probation Service and wider health and social care providers are accessible to and meet the needs of this group. A JSNA Bulletin presenting the complete findings of this health needs assessment is available from the Swindon JSNA website. Key points are presented below.

- Prevalence of mental health problems was found to be higher in Probation Service users than in the general population, with evidence that over a third (35% self-reported in survey, 38% recorded in Offender Assessment System (OASys)) experience depression whilst on Probation.
- There was a clear link between mental health and emotional wellbeing and service users' motivation for offending and risk of reoffending.
- 14% of the caseload was identified as at risk of deliberate self-harm.
- Housing, money problems, and alcohol use were found to be significantly associated with the mental health of service users.
- Mental health was recognised by Probation Service staff as a significant issue for their clients, but conditions were often undiagnosed.
- Service users encountered a number of barriers in accessing mental health services. These were often associated with their "chaotic lifestyles".
- Dual diagnosis (a mental health condition co-occurring with substance misuse) featured as a common concern and was seen by service users and staff as a main barrier to accessing mental health services.
- A need for tools and training to enable Offender Managers to identify clients with mental health problems and signpost them to appropriate health services

[72] Brooker C. et al, Mental health services and prisoners: A review, London: Department of Health, (2003)

[73] Brooker, C., Sirdifield, C., Blizard, R., Maxwell-Harrison, D., Tetley, D., Moran, P., Pluck, G., Chafer, A., Denney, D. & Turner, M. (2011) An Investigation into the Prevalence of Mental Health Disorder and Patterns of Health Service Access in a Probation Population. Lincoln: University of Lincoln.

[74] Warner G, Ingleson L, Chatters S, Atkin J, Crick J. 2012. JSNA Topic Summaries. Offenders. NHS North Yorkshire and York [Online] Available at: www.northyorks.gov.uk/CHttpHandler.ashx?id=18919&p=0

[75] Brooker C, Glyn J. 2012. Briefing 45: Probation services and mental health. Centre for Mental Health [Online}. Available at: http://www.centreformentalhealth.org.uk/publications/probation_2012.aspx?ID=667

Improving the mental health of offenders would lead to better outcomes for the individuals affected, the Criminal Justice System and society as a whole. The Probation Mental Health JSNA Bulletin identifies a number of recommendations to achieve this. These include:

- Introduction of mental health screening tools to support Offender Managers to routinely assess their clients and identify individual need.
- Developing the Offender Manager role in prevention and early identification and intervention, including promoting self-help.
- Improving signposting and referral pathways from the Probation Service in to Mental Health Services including those with dual diagnosis (substance misuse and drugs) e.g. through reviewing the Health Trainer role, mapping services and staff awareness, mentoring, improving access to self-help and revising practice standards.
- Mapping services and reviewing pathways for those with a dual diagnosis of mental health and substance misuse problems.

#### 5.7.5.6 Older peoples mental health

A review[76] of demographic, social and physical factors on ageing and the mental health of older people as part of the Foresight Project. The review looked at both dementia and depression. As dementia is not part of the scope for this needs assessment only the findings for depression will be reported here. The review found that "social isolation and physical ill-health (particularly when associated with disability) are important and preventable risk factors for late-life depression" P2. Contact with and social support from friends are particularly important for bolstering mood and morale in older people[76]. On top of spouses and relatives older people value friends for companionship and emotional support.

Society changes in social fragmentation, disruption and family structures, are likely to have a substantial impact of prevalence of depression which is associated with loneliness and social isolation in older people[76].

The report[76] recommends:

- Population-level interventions designed to promote full and active participation of older people in society
- Individual-level interventions in clinical setting to treat impairment, limit disability and maximise function.
- Evaluate and promote as appropriate, effective models of social network building both within the older age group (e.g. University of the Third Age) and trans-generationally (e.g. school/ youth engagement programmes).
- Ensure that older people are not selectively excluded from evidence-based interventions for depression e.g. cognitive behaviour therapy (CBT), interpersonal therapy (IPT) and antidepressants. (P8)

[76] Foresight report Mental Capital and Wellbeing: making the most of ourselves in the 21st Century. State-of-science Review: SR-B2. The Influence of Demographic, Social and Physical Factors on Ageing and the Mental Health of Older People. 2008 The Government Office for Science (Stewart R and Prince M – Institute of Psychiatry

# 6. Mental Well-being in Swindon

**Chapter summary**:

- Mental wellbeing is important from an environmental, societal and economic perspective
- Mental wellbeing in Swindon is broadly in line with the national level. Using the National Wellbeing Survey Swindon resident are slightly less satisfied that the national population, but they felt more worthwhile, happier and less anxious than the national population
- According to the National Wellbeing Survey 2012/13 Swindon residents have slightly lower level of wellbeing than they had the previous year while the national population and those in the South West had improved mental wellbeing.
- The Warwick Edinburgh Wellbeing Survey, included as part of the residents Survey 2012 showed there was no difference in wellbeing between the genders but those over 65 years had better mental wellbeing than those age 16 -24 years; those in the most deprived areas of Swindon had worse wellbeing than those in least deprived areas. Those in Central, Parks, Penhill wards had the lowest wellbeing scores.
- The mental wellbeing of those with mental health problems face specific challenges but should be given particular attention in order to promote resilience and self-reliance. Those with mental health problems can improve their mental wellbeing.

The government recognised in 2010 that Gross Domestic Product alone was not a good measure of the state of the nation and that other environmental, societal and economic factors need to be taken into account. Work on measuring national wellbeing is still in development but the Mental Health Foundation point out that there is considerable evidence to show that positive wellbeing influences a wide range of outcomes for individuals and communities, including better physical and mental health, higher educational attainment and more social cohesion[77].

## 6.1 National annual population survey on subjective well-being

In April 2011 four questions on subjective well-being were included in the national (UK) Annual Population Survey (Table 14). All questions were answered on a scale of 0 to 10 where 0 is 'not at all' and 10 is 'completely'. The average of responses from 0-10 was calculated and in addition, to give a better picture of the distribution of the data, the first three questions are presented as the proportions of answers that fall between 0-6 (very low/ low) and 7-10 (medium/high). The last question, 'Overall, how anxious did you feel yesterday', is presented as the proportion of answers that fall between 0-3 (low/ medium) and 4-10 (high/ very high).

[77] Measuring Wellbeing: an introductory briefing 2011 Mental Health Foundation.

Table 14 Subjective wellbeing questions from the UK Annual Population Survey together with the scoring measures

| **Question** | **Over all scoring measure** | **Distribution Score** | |
|---|---|---|---|
| | | Lower Measure | Higher Measure |
| **Overall, how satisfied are your life nowadays?** | 0-10<br>(0 being not at all and 10 being completely) | 0-6 (very low or low) | 7 -10<br>(medium /high) |
| **Overall, to what extent do you feel the things you do in your lie are worthwhile?** | 0-10<br>(0 being not at all and 10 being completely) | 0-6 (very low or low) | 7 -10<br>(medium /high) |
| **Overall, how happy did you feel yesterday?** | 0-10<br>(0 being not at all and 10 being completely) | 0-6 (very low or low) | 7 -10<br>(medium /high) |
| **Overall, how anxious did you feel yesterday?** | 0-10<br>(0 being not at all and 10 being completely) | 0-3<br>(low/ medium) | 4-10 (high./very high) |

Abdallah and Shah[78] analysed the data and found that on a national level lower levels of wellbeing were experienced by:

- those with a disability
- those with Black, Arabic, Bangladeshi, Pakistani and Indian ethnicities
- those who experience long-term unemployment (more than six months)
- those with temporary employment contracts
- those who work very long house (over 55 hours per week)
- those living in urban areas
- those from more deprived areas
- those who are single or widowed

Higher levels of wellbeing were experienced by:

[78] Well-being patterns uncovered: An analysis of UK data NEF Saamah Abdallah and Sagar Shah Nov 2012



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- those who are retired
- those who work part-time out of choice,
- those who live in rural areas

The report also states "Together, overall deprivation and income predicted more than half of the variation in well-being inequality between local areas in England, highlighting that tackling deprivation would serve to both increase average well-being and reduce well-being inequality." [78] P37

The national wellbeing survey was repeated for 2012-13 and the figures for Swindon, the South West and England can be seen in Table 15 below. On a local authority level the sample size was relatively small and outcomes need to be interpreted with some caution. However with this caveat in mind:

- Swindon residents felt less satisfied in 2012/13 than they did the previous year whilst those in the South West and England felt more satisfied.
- Swindon residents felt more worthwhile than those in the South West and England.
- There was no change in the level of happiness between 2011/12 and 2012/13 in Swindon, with residents feeling slightly happier than the rest of England but slightly less happy than those in the South West.
- There was a slight drop in those feeling anxious in Swindon and levels of anxiety appear slightly lower in Swindon than in the South West and England. Table 15

Table 15 Experimental Subjective Wellbeing Data from the Annual Population Survey, April to September 2011, and April to September 2012.

All questions were answered on a scale of 0 to 10 where 0 is 'not at all' and 10 is 'completely'.*

**Q. Overall how satisfied are you with your life nowadays?**

| | **2011/12** | **2012/13** | **Difference between years** |
|---|---|---|---|
| **Swindon** | 7.50 | 7.41 | -0.09 |
| **South West** | 7.52 | 7.54 | +0.02 |
| **England** | 7.40 | 7.44 | +0.04 |

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**Q. Overall, to what extent do you feel the things you do in life are worthwhile?**

| | 2011/12 | 2012/13 | Difference between years |
|---|---|---|---|
| **Swindon** | 7.77 | 7.80 | +0.03 |
| **South West** | 7.76 | 7.76 | 0 |
| **England** | 7.66 | 7.68 | +0.02 |

**Q. Overall how happy did you feel yesterday?**

| | 2011/12 | 2012/13 | Difference between years |
|---|---|---|---|
| **Swindon** | 7.30 | 7.30 | 0 |
| **South West** | 7.38 | 7.34 | -0.04 |
| **England** | 7.28 | 7.28 | 0 |

**Q. Overall, how anxious did you feel yesterday?**

| | 2011/12 | 2012/13 | Difference |
|---|---|---|---|
| **Swindon** | 2.96 | 2.92 | -0.04 |
| **South West** | 2.99 | 3.0 | +0.01 |
| **England** | 3.15 | 3.05 | -0.1 |

Source: ONS

*Note: last question has different score ranges for the very low/low and medium/high category with low scores indicating a better outcome compared to the first three questions where high scores indicate a better outcome.

### 6.2 Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)

WEMWBS has been recommended for use by central government and has been referenced in both the evidence review accompanying the recent public health white paper[79] and the new mental health strategy[80] and was specifically developed to measure positive mental health. The questions cover aspects of positive

[79] Department of Health 2010. Our Health and Wellbeing Today. London: Crown Copyright
[80] Department of Health 2011. No health without mental health: A cross-government mental health outcomes strategy for people of all ages London: Crown Copyright.



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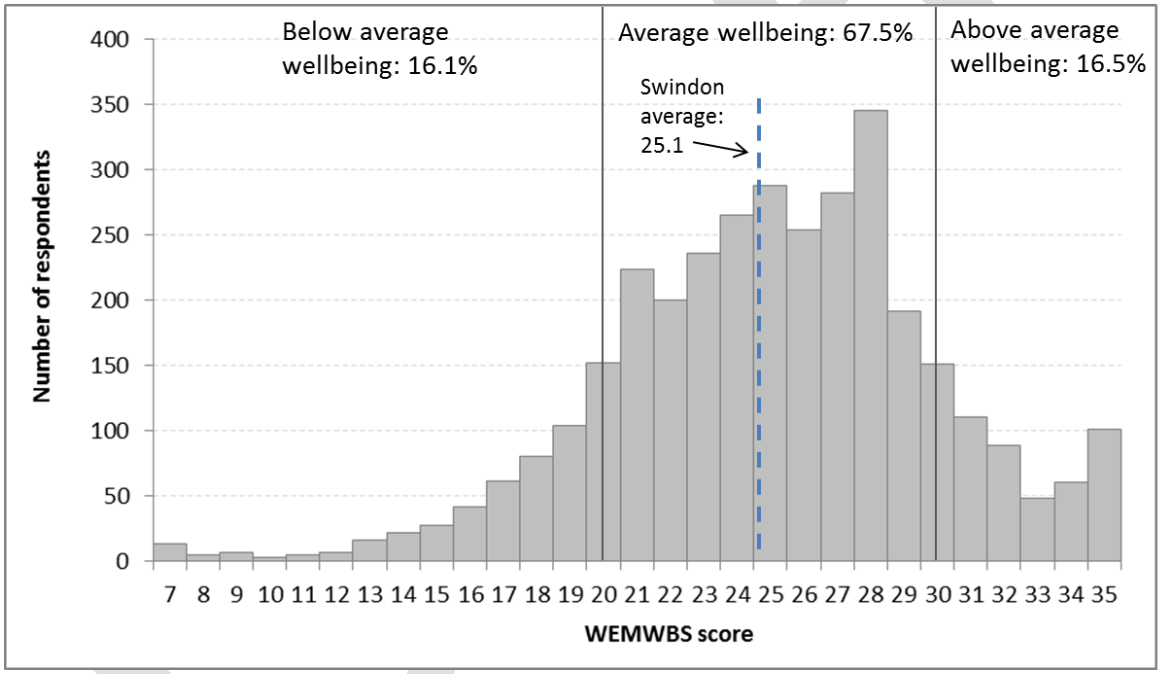
feelings of optimism, usefulness, relaxation, satisfying interpersonal relationships and positive functioning.

In order to assess the mental well-being of Swindon's population, the short version (seven instead of fourteen questions) of the Warwick-Edinburgh Mental Wellbeing Scale[81] was included in the local Swindon resident survey in 2012 (see Appendix 6).

The WEMWBS data from the Swindon resident survey presented in Figure 10 were based on 3,389 people (1,575 males, 1,769 females and 46 persons with no gender information) who had answered all seven questions[82]. Most of the respondents in Swindon were categorised as having average wellbeing (67.5%), whereas a relatively small proportion of respondents were categorised as having below average and above average wellbeing (16.1% and 16.5%, respectively)

Figure 10 Distribution of the Warwick-Edinburgh Mental Wellbeing Scale scores (n = 3,389) from the residential survey in Swindon, 2012.



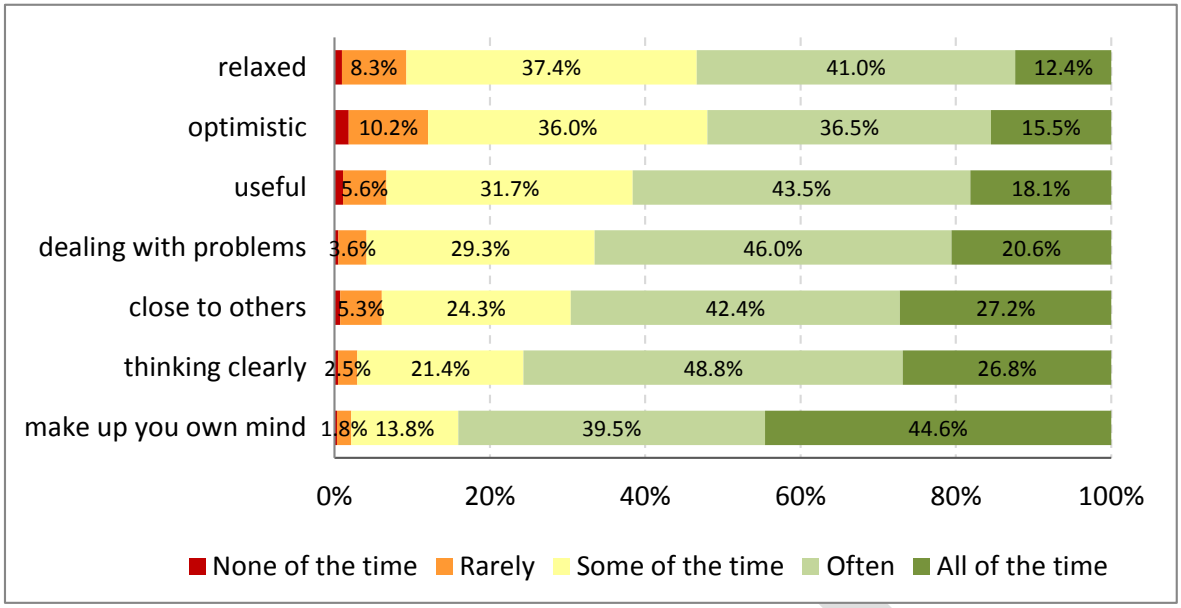

Source: Swindon residential survey, 2012

The breakdown in responses to the seven questions can be seen in Figure 11 below. We can see that at the time of the survey Swindon residents did not feel particularly relaxed, optimistic or useful but they were able to make up their own mind, think clearly, deal with problems and felt close to others.

[81] Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS © NHS Health Scotland, University of Warwick and University of Edinburgh, 2006, all rights reserved)

[82] Younger people, in particular younger males, were under-represented and older (aged 45+ years) individuals were over-represented. Slightly more females than males responded to the survey. Survey data here are presented unweighted i.e. no adjustments were made to account for over- and under-representation of respondents. Respondents were categorised as having below average (2SD below: score range 7 - 20), average (score range 21 - 29) and above average (2SD above: score range 30 - 35) wellbeing.

Figure 11 Warwick-Edinburgh Mental Wellbeing Scale individual question responses.*




Source: Swindon residential survey, 2012

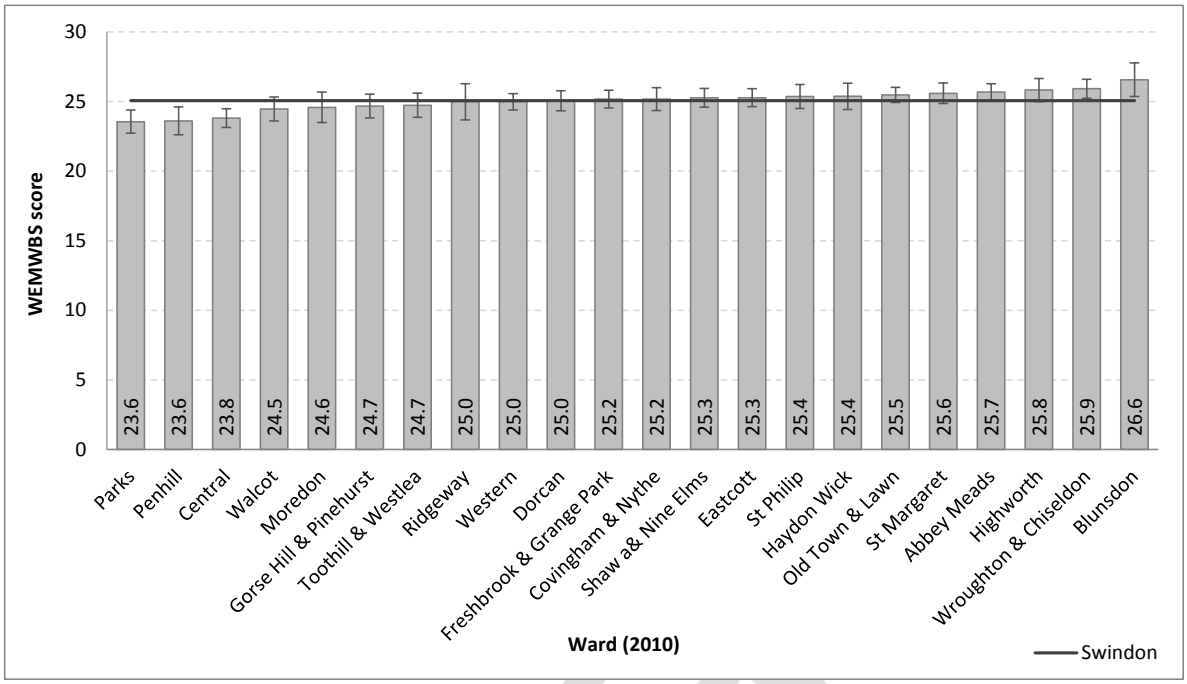
*Full questions in Appendix 6

Swindon's average wellbeing score was 25.1 (range: 7 - 35) in 2012 which was slightly lower than the England average of 25.5 in 2010 (Health Survey England 2010: 14-item questionnaire: 51/2 = 25.5)[83]. Findings from the Swindon survey showed:

- There was no difference in the average wellbeing score between males and females.
- There were some variation in wellbeing scores among age groups, deprivation level and Swindon wards.
- Those aged 65+ had, on average, a statistically significantly higher wellbeing score (25.9) than those aged 16 - 24 (23.5)
- Those in the most well-off quintile had a statistically significantly higher wellbeing score (25.7) than those in the two most deprived quintiles (DQ 4: 24.9 and DQ 5: 23.6). Survey respondents living in Blunsdon had, on average, a statistically significantly higher wellbeing score and Parks, Penhill, Central residents had statistically significantly lower wellbeing scores than the Swindon average (Figure 12)

[83] Health Survey England, 2010. https://catalogue.ic.nhs.uk/publications/public-health/surveys/heal-surv-resp-heal-eng-2010/heal-surv-eng-2010-resp-heal-ch7-well.pdf

Figure 12 Warwick-Edinburgh Mental Wellbeing Scale scores by Swindon wards, 2012.




Source: Swindon residential survey, 2012

## 6.3 Mental Wellbeing for those who experience mental health problems

We saw from the definitions in section 2.3.1 that everyone, with or without a mental illness can experience better or worse mental wellbeing. Ensuring that optimum levels of wellbeing are achieved for the Swindon population is essential if we are to reduce demand for services.

We do not have specific data on the wellbeing scores of those with mental illness in comparison to the wider population in Swindon but the focus group (see chapter 11 discussed mental wellbeing from their perspective and the specific challenges they face to achieving it.

It has been recognised that for some individuals additional support is required to build resilience and self-reliance. Further on in this document in section 9.1.8 changes to the mental health services provided by AWP have been outlined. The recovery approach has influenced many of these changes as mental health services change to try and encourage service users to become more independent and less reliant of specialist mental illness services. However, for some discharged from mental health services the transition is difficult particularly if individuals have been supported by the service for a long time. This has highlighted the need for a wellbeing co-ordination approach and a wellbeing coordination project is being developed which links into the Managing Adult Demand Programme (see section 2.3.) and builds on the Advice, Information and Guidance project (see section 9.1.3).

## 7. Mental Illness in Swindon

### Key findings

- Swindon GP registers indicate that Swindon population has slightly higher rates of depression than the national and regional average
- Prescribing of anti-depressants has increased over the last 3 years – Swindon has the 3rd highest rate of anti-depressant prescribing in the South West
- It is unclear is there is a strong correlation between practices referral to LIFT psychology and prescribing levels. It is would appear that 12% of the variation in prescribing anti-depressants in GP practices can be linked to referrals to LIFT psychology.
- Local prevalence data by condition is not available. However, crude estimates based on the Adult Psychiatric Morbidity Survey has been applied to the Swindon population
- Swindon GP registers for those with severe mental health illness indicate lower levels of severe mental illness than in the rest of the South West and England.
- The number of people with mental health conditions looks set to rise over the next couple of decades. Much of this is to do with demographic changes rather than a particular expected increase in prevalence. However, services and commissioners should be aware of this expected increase when planning services.
- Admission rates for self-harm in Swindon for adults and young people are higher than the national and regional average.
- Suicide rate in Swindon having been statistically significantly lower than the national and south west average are now no longer significantly different. The rate has increased from a low in 2005 – 2007 of 5.75 per 100,000 to 7.26/100,000 in 2008/10.

This section describes the prevalence of some key mental health conditions in Swindon. Much of the data is displayed by Clinical Commissioning Group (CCG) area (previously PCT area) rather than Unitary Authority area. This is because mental health services are commissioned by the CCG and data reported from Avon and Wiltshire Mental Health Partnership is reported for the commissioned

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area. In order to maintain consistency we have applied national prevalence rates to the Swindon CCG population.

As highlighted on page 20 above there is no agreed definition of mental health disorders. Earlier this year the fifth edition of the Diagnostic and Statistical Manual of Mental disorders was released prompting fresh debate about the value of psychiatric diagnosis. The British Psychological Society division of Psychology produced a Position Statement[84] in which they argue that "there is a need to move away from psychiatric diagnoses such as schizophrenia, Attention Deficit Hyperactivity Disorder, personality disorder and conduct disorder, which have significant conceptual and empirical limitations, and develop alternative approaches which recognise the centrality of the complex range of life experiences in the emergence of mental distress and the personal impact of social and relational circumstances including trauma". The statement recognises that until an alternative construct is developed there is a need to retain psychiatric diagnosis in order to determine access to services, eligibility for benefits etc.

This needs assessment uses psychiatric diagnosis to estimate prevalence but there is acknowledgement that some conditions such as ADHD and Autism do not necessarily strictly fit these criteria. This debate should also be taken into account when reading section 9.2 regarding the concept of Payment by Results which uses a mental health clustering tool rather than diagnosis to organise commissioned services.

## 7.1 Prevalence of common mental disorders

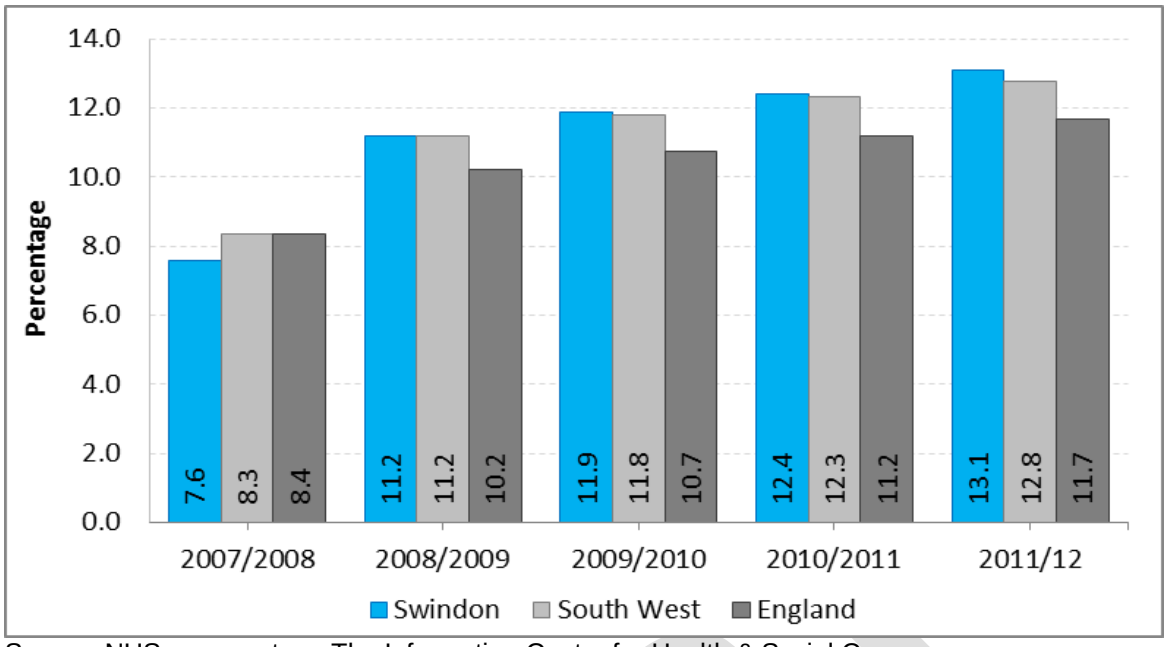
### 7.1.1 Depression

The graph Figure 13 below shows that the number of individuals diagnosed with depression in Swindon has increased from 7.6% in 2007/08 to 13.1% in 2011/12. Increases can also been seen for the South West and England but the rise for Swindon has been more marked. In 2007/08 Swindon had a slightly lower rate of diagnosis with depression than England and the South West but by 2011/12 Swindon had a significantly higher rate than the South West and England.[85]

It is difficult to say if this is a recording issue or if the increase reflects a true increase. The IAPT service started in Swindon in 2008 which increased throughput but also increased recording of diagnosis. However, It could be that some of the socio-demographic issues discussed in Chapter Five for example increases in migration, economy, etc. could be reflected in the graph below.

[84] Division of Clinical Psychology Position Statement on Classification Time for a Paradigm Shift in Psychiatric Diagnosis. May 2013
[85] Community mental health profile 2013 (PHO)

Figure 13 Percentage of adults (aged 18+) on GP register diagnosed with depression.




Source: NHS comparators, The Information Centre for Health & Social Care

The table below gives more detail of the numbers behind Figure 13. It shows that in 2007/08 there were 12,335 adults diagnosed by GPs with depression. This had increased to 22,641 in 2011/12.

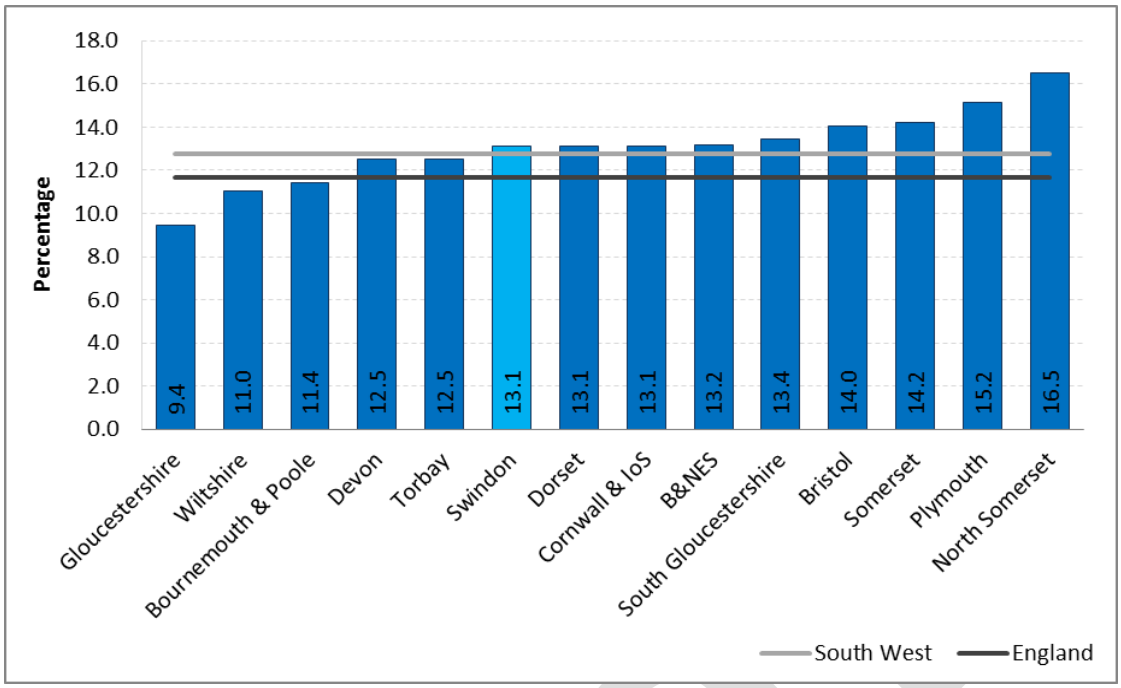
Table 16 Percentage and number of adults (aged 18+) on GP register diagnosed with depression in Swindon.

| Year | 2007/2008 | 2008/2009 | 2009/2010 | 2010/2011 | 2011/2012 |
|---|---|---|---|---|---|
| % | 7.6 | 11.2 | 11.9 | 12.4 | 13.1 |
| Number | 12,335 | 18,550 | 19,988 | 21,104 | 22,641 |
| GP register population | 162,640 | 165,707 | 168,310 | 170,321 | 172,698 |

Source: NHS comparators, The Information Centre for Health & Social Care

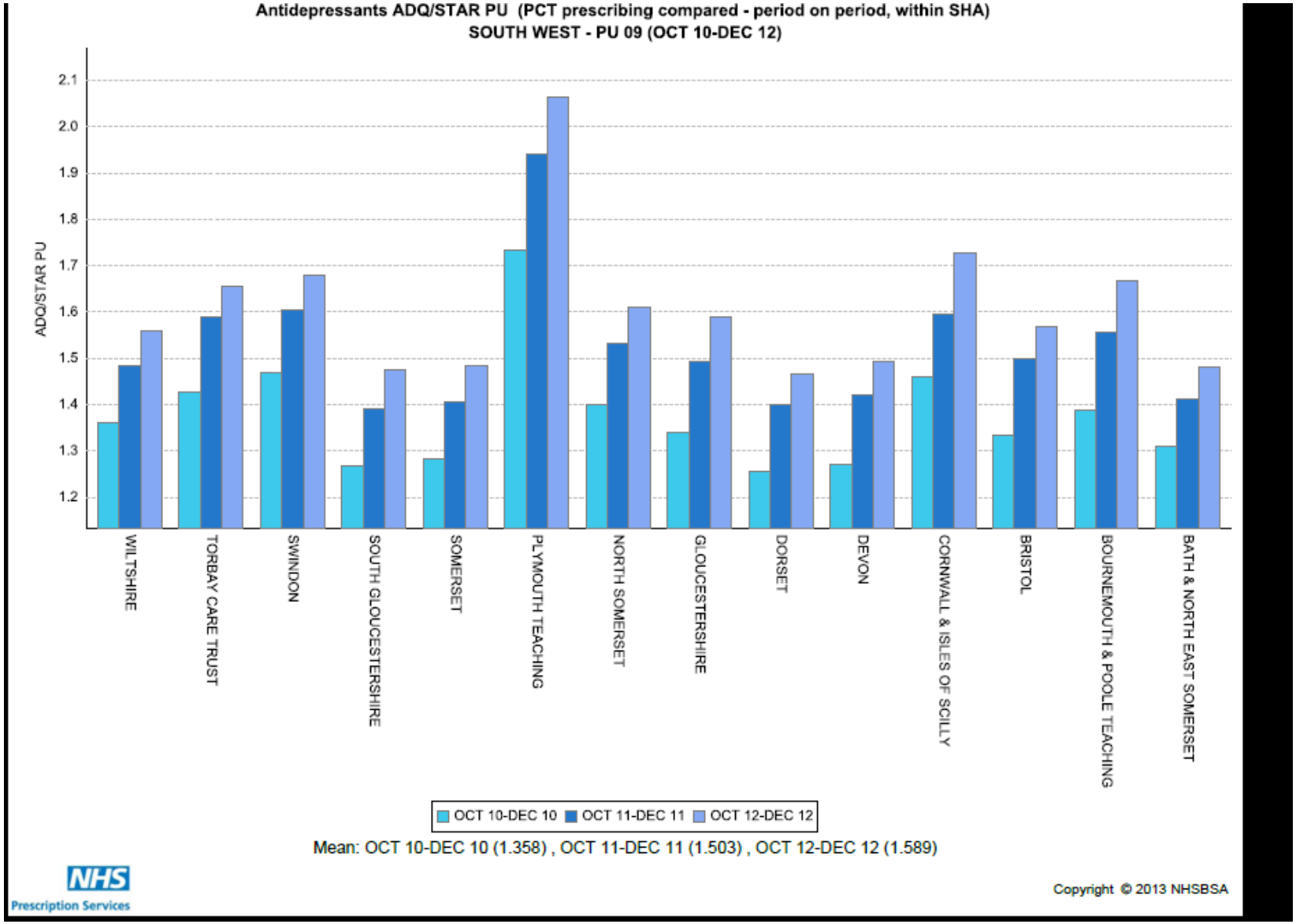
Further details of the diagnosis rates, for 2011/12, throughout the South West can been seen in the graph below (Figure 14). We can see from the figures above that Swindon would appear to have a slightly higher rate of depression than the national average. However, this may be due to the LIFT Psychology model which bases counsellors in each GP practice which may raise awareness among GPs to screen for depression more frequently.

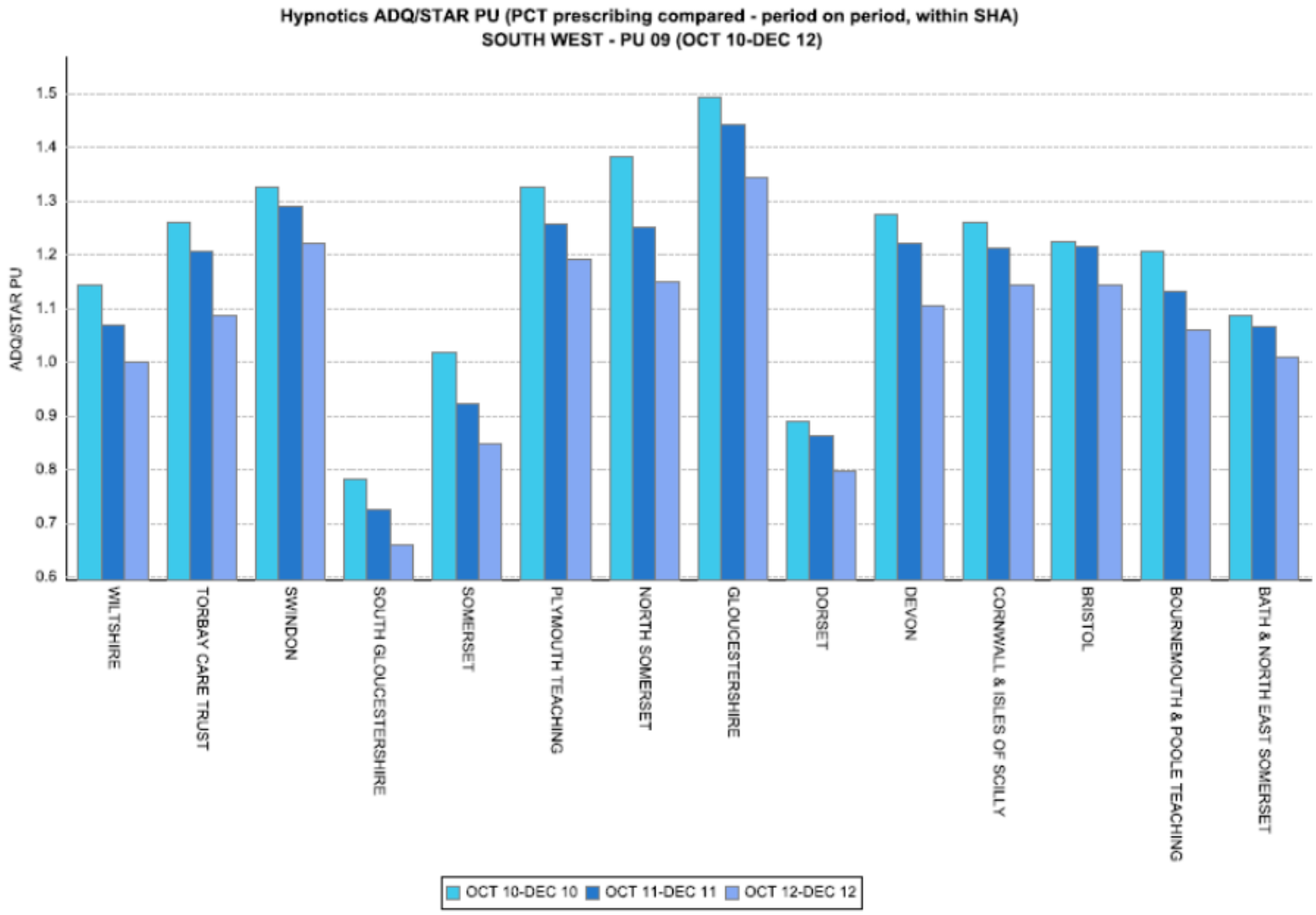
Figure 14 Percentage of adults (aged 18+) on GP register diagnosed with depression, South West PCT's, 2011/12.




Source: NHS comparators, The Information Centre for Health & Social Care

Prescribing of antidepressants has increased in Swindon as elsewhere over the last three years. The charts below shows that Swindon has the third highest prescribing rate for antidepressants in the South West and the second highest prescriber of hypnotics (sleeping tablets). The charts have been weighted for population size and demographics.


Antidepressants ADQ/STAR PU (PCT prescribing compared - period on period, within SHA)
SOUTH WEST - PU 09 (OCT 10-DEC 12)
ADQ/STAR PU
2.1
2.0
1.9
1.8
1.7
1.6
1.5
1.4
1.3
1.2
WILTSHIRE
TORBAY CARE TRUST
SWINDON
SOUTH GLOUCESTERSHIRE
SOMERSET
PLYMOUTH TEACHING
NORTH SOMERSET
GLOUCESTERSHIRE
DORSET
DEVON
CORNWALL & ISLES OF SCILLY
BRISTOL
BOURNEMOUTH & POOLE TEACHING
BATH & NORTH EAST SOMERSET
OCT 10-DEC 10
OCT 11-DEC 11
OCT 12-DEC 12
Mean: OCT 10-DEC 10 (1.358) , OCT 11-DEC 11 (1.503) , OCT 12-DEC 12 (1.589)
NHS
Prescription Services
Copyright © 2013 NHSBSA




Mean: OCT 10-DEC 10 (1.199) , OCT 11-DEC 11 (1.141) , OCT 12-DEC 12 (1.059)

NHS
Prescription Services

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Further analysis of GP prescribing data was undertaken to see if there was a correlation between the levels of prescribing of antidepressants in GP practices and their referral rates to LIFT Psychology which provides the Swindon IAPT (Improving Access to Psychology Therapies) service.

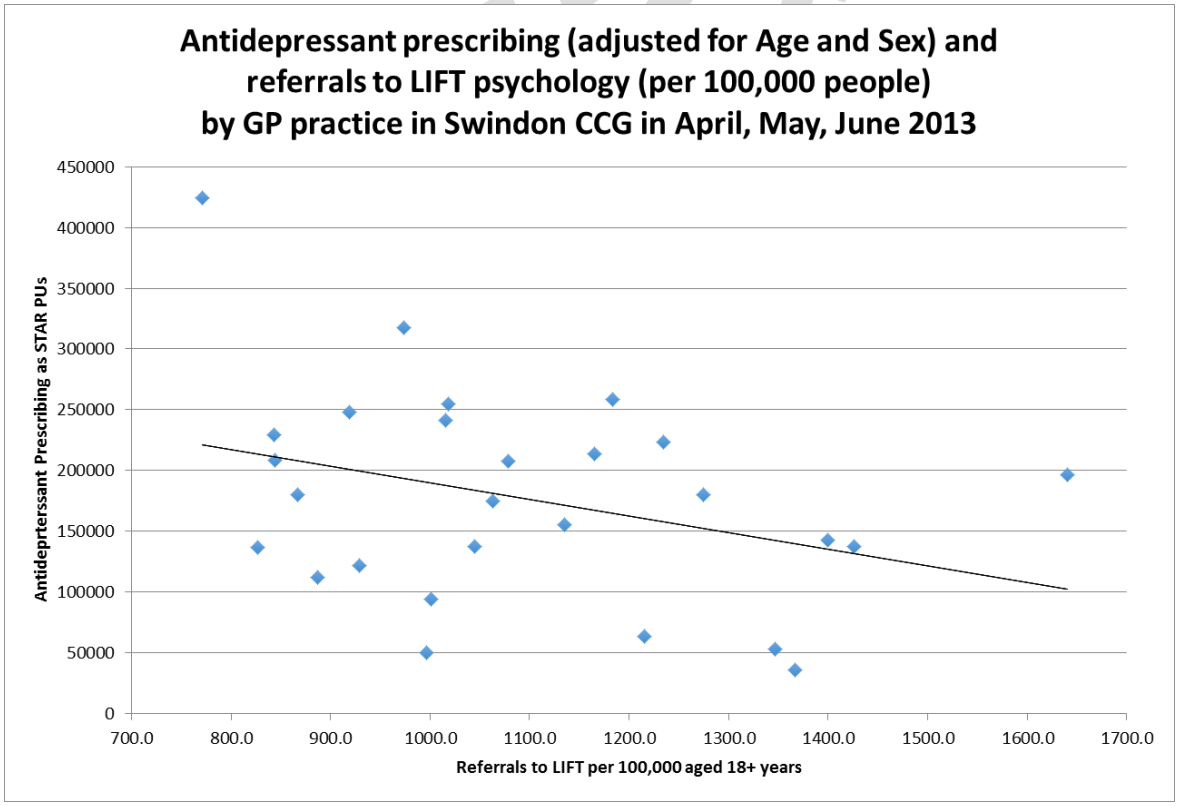
The graph (Figure 15) plots, by GP practice, referrals to the LIFT psychology service per 100,000 adults on the x axis and antidepressant prescribing, standardised for age and sex, on the y axis.

The scatter of points indicates a modest linear relationship, in which higher levels of referral to LIFT are associated with lower levels of antidepressant prescribing.

It cannot be shown from the graph if the use of LIFT reduced the need for antidepressants, or if GPs who do not favour antidepressants were more likely to refer to LIFT.

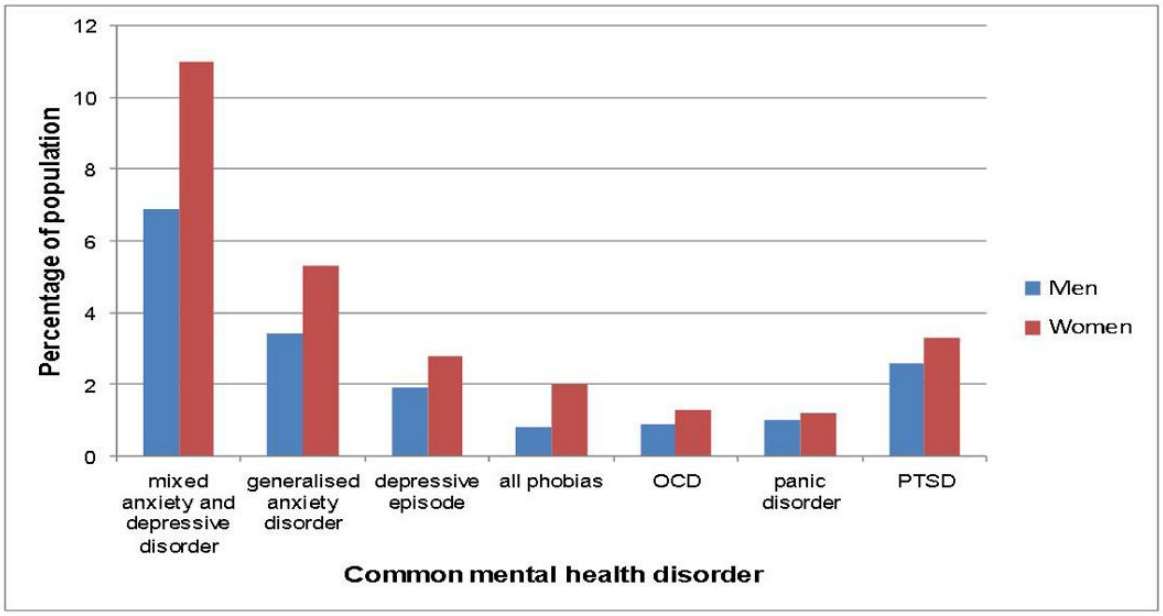
The R squared value for the linear relationship is 0.12, suggesting that levels of referral to LIFT "explain" 12% of the variation in antidepressant prescribing. This is equivalent to a correlation coefficient of about 0.30.

Figure 15 A graph comparing GP practice referrals to LIFT Psychology Service compared to their prescribing rates for antidepressants.



Nice Guidance[86] also provides national prevalence rates for some common mental health conditions. Figure 16 is based on prevalence rates outlined in this guidance. The chart shows the disparity in rates between males and females with far more females being diagnosed with these common mental health conditions.

Figure 16 The chart below shows the national prevalence of some common mental health disorders by gender.




**Adult Psychiatric Morbidity Data - Caveat**

An alternative way of estimating the prevalence of common mental health conditions is to use the Adult Psychiatric Morbidity Survey 2007. In the tables below the APMS data has been used to estimate prevalence of the conditions in Swindon. This is a very crude way to apply the data and has considerable limitations. It does not take in to account the determinants of mental health wellbeing outlined fully in chapter 5. The analysis below does not take into account educational attainment, migration, employment rates etc. it is just a crude application of the national prevalence rates. However, as the demographic profile of Swindon is usually very similar to the national profile the tables have been included with this caveat. The numbers in the tables 14 – 30 below give an indication of estimated prevalence rather than an exact rate. This is particularly pertinent with the breakdown in age bands where the numbers appear small. In addition, it should not be assumed that all of those identified in the tables will require treatment. Many may have been in treatment at some point and may now be managing their condition. Some will manage their condition without input from services.

[86] Commissioning Stepped Care for People with Mental Health Disorders – NICE Published November 2011

The table below show national prevalence rates of some key mental health conditions using the adult psychiatric morbidity survey data.

Table 17 below shows the national prevalence of common mental health conditions. Table 18 shows the estimated number of individuals in Swindon CCG area based on the national prevalence rates. This shows that in Swindon there could be up to 29,422 individuals with a common mental health condition although there may be double counting and individuals may have had more than one condition. Of these 29,422 there were 18,042 females and 11,380 males. This would equate to 61% female and 39% male.

20,727 of the 29,422 individuals identified in the APMS were identified as having mixed anxiety and depression or a depressive episode. This is slightly lower than the figure on the GP depression register see above. This would be expected as the APMS records people who have had the condition in last week only but people can be on the depression register for a longer time.

Table 17 National prevalence rates (%) of common mental health disorders in the past week by gender[87]

* The following tables must be viewed with caution as there give a very crude indication using nationally applied estimates to the Swindon population.

| **Common Mental Disorders (1 week)** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Males** | **Ages** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| **Mixed Anxiety & Depression** | | 8.2 | 7.4 | 7.4 | 8.1 | 6.8 | 3.9 | 3.8 | 6.9 |
| **Generalised Anxiety Disorder** | | 1.9 | 4.1 | 4.7 | 4.1 | 2.7 | 2.9 | 2.2 | 3.4 |
| **Depressive Episode** | | 1.5 | 2.7 | 2.6 | 2.6 | 1.5 | 0.4 | 0.5 | 1.9 |
| **Phobias** | | 0.3 | 1.5 | 1.5 | 0.7 | 0.6 | 0.3 | 0.0 | 0.8 |
| **Obsessive-Compulsive Disorder** | | 1.6 | 1.5 | 1.2 | 0.7 | 0.4 | 0.2 | 0.3 | 0.9 |
| **Panic Disorder** | | 1.4 | 0.9 | 1.3 | 0.8 | 0.6 | 1.0 | 0.3 | 1.0 |
| **Any CMD** | | 13.0 | 14.6 | 15.0 | 14.5 | 10.6 | 7.5 | 6.3 | 12.5 |

[87] *CMD: People could have more than one CMD, but MADD was an exclusive category.

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| Females | Ages | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | All |
|---|---|---|---|---|---|---|---|---|---|
| **Mixed Anxiety & Depression** | | 12.3 | 14.1 | 9.7 | 14.3 | 9.0 | 8.6 | 7.2 | 11.0 |
| **Generalised Anxiety Disorder** | | 5.3 | 4.3 | 5.9 | 8.0 | 5.5 | 3.6 | 2.9 | 5.3 |
| **Depressive Episode** | | 2.9 | 1.7 | 3.2 | 4.9 | 2.2 | 1.6 | 2.1 | 2.8 |
| **Phobias** | | 2.7 | 2.4 | 2.7 | 2.2 | 2.2 | 0.4 | 0.2 | 2.0 |
| **Obsessive-Compulsive Disorder** | | 3.0 | 1.5 | 1.0 | 1.6 | 0.7 | 0.4 | 0.5 | 1.3 |
| **Panic Disorder** | | 0.8 | 2.3 | 1.4 | 1.1 | 1.4 | 0.1 | 0.6 | 1.2 |
| **Any CMD** | | 22.2 | 23.0 | 19.5 | 25.2 | 17.6 | 13.4 | 12.2 | 19.7 |

Source: APMS 2007

Table 18 Estimated number of people with CMD in Swindon CCG[88] area by age and sex

| **Common Mental Disorders (1 week)** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Males** | **Ages** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| **Mixed Anxiety & Depression** | | 976 | 1167 | 1283 | 1443 | 832 | 339 | 239 | 6280 |
| **Generalised Anxiety Disorder** | | 226 | 647 | 815 | 730 | 330 | 252 | 138 | 3139 |
| **Depressive Episode** | | 179 | 426 | 451 | 463 | 184 | 35 | 31 | 1768 |
| **Phobias** | | 36 | 237 | 260 | 125 | 73 | 26 | 0 | 757 |

[88] Prevalence rates for geographic areas are produced by CCG rather than Unitary Authority as this the area from which services are commissioned.



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| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Obsessive-Compulsive Disorder** | | 191 | 237 | 208 | 125 | 49 | 17 | 19 | 845 |
| **Panic Disorder** | | 167 | 142 | 225 | 142 | 73 | 87 | 19 | 856 |
| **Any of these CMDs** | | 1548 | 2303 | 2601 | 2582 | 1297 | 653 | 396 | 11380 |

| **Females** | **Ages** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
|---|---|---|---|---|---|---|---|---|---|
| **Mixed Anxiety & Depression** | | 1423 | 2343 | 1594 | 2325 | 1059 | 784 | 624 | 10152 |
| **Generalised Anxiety Disorder** | | 613 | 715 | 969 | 1300 | 647 | 328 | 251 | 4825 |
| **Depressive Episode** | | 336 | 283 | 526 | 797 | 259 | 146 | 182 | 2527 |
| **Phobias** | | 312 | 399 | 444 | 358 | 259 | 36 | 17 | 1825 |
| **Obsessive-Compulsive Disorder** | | 347 | 249 | 164 | 260 | 82 | 36 | 43 | 1183 |
| **Panic Disorder** | | 93 | 382 | 230 | 179 | 165 | 9 | 52 | 1110 |
| **Any of these CMDs** | | 2569 | 3822 | 3203 | 4097 | 2072 | 1221 | 1058 | 18042 |

Source: applied estimates based on APMS 2007

In section 5.6.1 above the evidence showed that there is a strong correlation between deprivation and mental health. The APMS shows prevalence rates by income and sex and Table 19 shows the prevalence rates of common mental health problem by socio-economic quintile. This shows that in fact the second highest socio-economic quintile experiences less mental health problems than those in the highest quartile, particularly for women. However, those who experience the most mental health problems are those in the lowest followed by the second lowest quintiles.

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Table 19 National prevalence rates of Common Mental Health Conditions by socio-economic quintile

| **CMD in past week by Equivalised Household** | | | | | |
|---|---|---|---|---|---|
| **Income and Sex** | | | | | |
| **Adults** | **Highest** | **2nd Highest** | **3rd Highest** | **4th Highest** | **Lowest** |
| **Males** | 8.8% | 8.6% | 10.1% | 16.2% | 23.5% |
| **Females** | 18.1% | 13.1% | 20.1% | 24.0% | 25.1% |

### 7.1.2 Eating disorders

Eating disorders are characterised by an abnormal attitude towards food that causes someone to change their eating habits and behaviour. As with all mental health problems, eating disorders (anorexia nervosa, bulimia nervosa and related eating disorders) have a profound impact on the individual, their families and the society. The physical heath of the individual is significantly compromised by starvation and purging behaviours and comorbidity with anxiety, OCD and affective disorder impairs psychological health. The estimated incidence of anorexia nervosa in the general population is 19 per 100,000 per year in females and 2 per 100,000 per year in males. The highest rates have been observed in teenage girls aged 13 to 19 years where there were 51 cases per 100,000 per year[91]. The incidence of bulimia nervosa has been estimated at 18 new cases per 100, 000 a year in general population[89].

The 2007 Adult Psychiatric Morbidity Survey included a screen to identify prevalence of eating disorder. It found that 6.4% of the population had an eating disorder (Table 20). Eating disorders were more prevalent among women at 9.2% than men at 3.5%. Applying the national prevalence figures to the population of Swindon CCG indicates that there may be up to 11600 individuals in Swindon with an eating disorder 8451 of whom are female (Table 21).

[89] http://www.disordered-eating.co.uk/eating-disorders-statistics/bulimia-nervosa-statistics-uk.html

Table 20 Prevalence of eating disorder by age and sex estimated national prevalence rate

| **Eating Disorder (1 year) (Screen Positives)** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Ages** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| Males | | 6.1 | 5.1 | 3.3 | 3.7 | 2.0 | 1.5 | 0.5 | 3.5 |
| Females | | 20.3 | 12.6 | 10.0 | 9.9 | 3.9 | 2.4 | 0.9 | 9.2 |
| Persons | | 13.1 | 8.9 | 6.6 | 6.8 | 3.0 | 1.9 | 0.8 | 6.4 |

Source: APMS 2007

Table 21 Applied national prevalence rates of eating disorder to Swindon CCG population

| **Eating Disorder (1 year) (Screen Positives)** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Ages** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| **Males** | | 726 | 804 | 572 | 659 | 245 | 131 | 31 | 3169 |
| **Females** | | 2349 | 2094 | 1643 | 1609 | 459 | 219 | 78 | 8451 |
| **Persons** | | 3076 | 2898 | 2215 | 2268 | 704 | 349 | 109 | 11620 |

Further investigation was undertaken by the APMS (2007) which identified the proportion of those who screened positive for an eating disorder who reported that this had a significant impact on their life. This reduced the overall rate to 1.6% (2.5% for females and 0.6% for males). Applying this prevalence rate to the Swindon CCG population this would equate to 2853 individuals (2307 of whom are females and 546 of whom are male. Currently there are 32 individuals in Swindon being treated by AWP for eating disorders. (Please note that specialist eating disorder service is provided by a different organisation and LIFT Psychology also see patients with eating disorders).

These illnesses are often associated with depression, anxiety disorders, alcohol abuse and other disorders. Anxiety and obsessive compulsive disorders are present throughout the life course of anorexia nervosa, whereas the developmental trajectory for the binge eating group of disorders is preceded by depressive symptoms and followed by addictive problems[90].

[90] Janet Treasure (2008) **State-of-Science Review: SR-D16 Eating Disorders Mental Capital and Wellbeing: Making the most of ourselves in the 21st century**

The cause of eating disorders in common with most other psychiatric disorders is generally considered to be multifactorial, no single factor in isolation can account for the development of the disorder in an individual, nor can it be seen to account for the variation among individuals. Among the factors considered to contribute to the development of eating disorders are genetic factors, perfectionism, impulsivity, physical factors, such as obesity and socio cultural pressures about female weight and shape. Up to 70 per cent of cases implicate severe life stresses in the cause of both anorexia nervosa and bulimia nervosa[91]

### 7.1.3 Attention Deficit Hyperactivity Disorder ADHD

ADHD highlighted in this section and Autistic Spectrum Disorder described below are not necessarily a mental health disorder but they have been included here as it has been highlighted that individuals with these conditions fall between the Learning Disability Service and Mental Health Services and do not get access to appropriate support.

Attention deficit hyperactivity disorder (ADHD) is a common neurodevelopmental disorder that commences in early childhood and frequently persists into late adolescence or adult life. ADHD is a heterogeneous behavioural syndrome characterised by the core symptoms of hyperactivity, impulsivity and inattention. While these symptoms tend to cluster together, some people are predominantly hyperactive and impulsive, while others are principally inattentive. Psychiatric comorbidity is a key concern for ADHD with anxiety, oppositional defiant and conduct disorders being the most important.

Comorbidities can lead to diagnostic imprecision either by reducing the likelihood of detecting the underlying ADHD (when a disruptive disorder is also present) or by not being identified themselves, as in the case of comorbid anxiety.

The prevalence for strictly applied operational definitions of ADHD decline with age.

Applying the prevalence range commonly seen in children of 4-8%, one would expect to find 0.6-1.2% of adults retaining the full diagnosis by age 25 years and a larger percentage (2-4%) with ADHD in partial remission. This is consistent with population surveys in adult populations that estimate prevalence of ADHD in adults to be between 3 and 4% [92] Applying a rate of 4% would indicate that there are approximately 7200 individuals in Swindon aged 16 years or over with ADHD.

However, estimates applied to Swindon CCG population using ADHD screen positive[93] rates from the APMS 2007 are shown below in Table 22. These are considerably higher and equate to a prevalence rate of 8.2%. This may be due to

[91] **Eating Disorders** Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders **National Collaborating Centre for Mental Health 2004 National Clinical Practice Guideline Number CG9 Commissioned by NICE**

[92] NICE 2008 (reviewed March 2013) Attention deficit hyperactivity disorder Diagnosis and management of ADHD in children, young people and adults

[93] *ADHD: Prevalence of possible attention deficit hyperactivity disorder (ADHD) in the adult general population is covered. Screening was with the Adult Self- Report Scale-v1.1 (ASRS) for ADHD characteristics, score of 4 or more was positive screen.

the screen positive rather than full diagnosis, it may also indicate that there is an undiagnosed cohort of adults with ADHD.

Table 22 Applied national prevalence rates of ADHD in the past 6 months to Swindon CCG Population (numbers)

| **ADHD (6 Months)** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Ages** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| **Males** | | 1631 | 1530 | 1977 | 1407 | 587 | 400 | 314 | 7847 |
| **Females** | | 1609 | 1263 | 1314 | 1577 | 589 | 374 | 321 | 7046 |
| **Persons** | | 3240 | 2793 | 3291 | 2984 | 1176 | 774 | 635 | 14893 |

(Source: APMS 2007)

In Swindon, children with ADHD are only treated by CAMHS if there is an associated mental health condition.

At present there is a reported gap in service provision in Swindon for adults with ADHD.

From the CAMHS Caseload as of August 2013 there were 16, 16 year olds and 15**,** 17 year olds with a diagnosis of a mental health condition and ADHD.

### 7.1.4 Autistic Spectrum Disorder

"Autism is a *spectrum* condition, meaning that it is manifested to varying degrees of severity. At one extreme, a person may have no social skills, no language, and major learning difficulties. At the other extreme, the individual may have average or even above average IQ, precocious vocabulary (though a lack of interest in small-talk or chatting), and odd social skills (being one-sided or extremely self-centred). The former would receive a diagnosis of *classic autism.* The latter would receive a diagnosis of *Asperger Syndrome* (AS). Both of these are subgroups on the autistic spectrum. Both also share a strong preference for routines and repetition, and 'obsessional' interest in highly specific topics"[94].

Autism is a set of neurodevelopmental conditions affecting social and communication development and a narrow focus of attention. It affects boys far more often than girls. Its ultimate cause is likely to be genetic. Intervention is educational and psychological, rather than medical. Teenagers and adults with AS often suffer from additional mental health problems, the most common being depression. Many also feel suicidal; tragically some are so desperate as to attempt suicide, a proportion of whom actually die. The high levels of depression

[94] Simon Baron-Cohen (2008) **State-of-Science Review: SR-D10 Autism Spectrum Conditions**

are not surprising if people with AS feel that they do not fi t into society and feel rejected by the majority.[94]

According to the APMS the national prevalence for Autistic Spectrum Disorder is 1.0 % (Table 23) and is much more common in males than females. This national prevalence rate when applied to Swindon would equate to 1802 individuals 1621 of whom are male **(**Table 24**).**

Table 23 National prevalence (%) of Autistic Spectrum Disorder in the past year

| **Autistic Spectrum Disorder (1 year) (%)** | | |
|---|---|---|
| | **Ages** | **All (16+)** |
| **Males** | | **1.8** |
| **Females** | | **0.2** |
| **Persons** | | **1.0** |

Table 24 Estimated number of individuals in Swindon CCG area with Autistic Spectrum Disorder by age and sex (numbers)

| **Autistic Spectrum Disorder (1 year)** | | |
|---|---|---|
| | **Ages** | **All (16+)** |
| **Males** | | **1621** |
| **Females** | | **181** |
| **Persons** | | **1802** |

**Source: APMS 2007**

### 7.1.5 Post Traumatic Stress Disorder (PTSD)

According to the Adult Psychiatric Morbidity in England 2007 survey 3.0% of adults screened positive for *Post-Traumatic Stress Disorder*[95] in the past week. While men were more likely than women to have experienced a trauma, there was no significant difference by sex in rates of screening positive for current PTSD (2.6% of men, 3.3% of women). Table 25 below shows the population prevalence of screening positive for current PTSD. Applying these rates to the mid-2011 population estimates for Swindon implies that there are likely to be approximately 5,388 screening positive for PTSD in Swindon, of whom 2,340 are men and 3,048

[95] *PTSD figure is "screened positive", so actual number of cases could be lower

women Table 26. These figures are for those who screened positive for PTSD they did not receive a confirmed diagnosis so the actual number of cases may be lower.

Table 25: National prevalence (%) of Post-Traumatic Stress Disorder in the past week by age and sex

| **Post-Traumatic Stress Disorder (1 week) (Screen Positives) (%)** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Ages** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| **Males** | | **5.1** | **3.6** | **3.0** | **1.9** | **1.9** | **0.7** | **0.2** | **2.6** |
| **Females** | | **4.2** | **3.7** | **3.5** | **5.8** | **1.9** | **1.5** | **0.8** | **3.3** |
| **Persons** | | **4.7** | **3.7** | **3.2** | **3.9** | **1.9** | **1.1** | **0.6** | **3.0** |

Source: APMB 2007

Table 26: Estimated number of individuals in Swindon CCG area with PTSD in the past week by age and sex (Numbers)

| **Post-Traumatic Stress Disorder (1 week) (Screen Positives)** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Ages** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| **Males** | | 607 | 568 | 520 | 338 | 232 | 61 | 13 | 2340 |
| **Females** | | 486 | 615 | 575 | 943 | 224 | 137 | 69 | 3048 |
| **Persons** | | 1093 | 1183 | 1095 | 1281 | 456 | 198 | 82 | 5388 |

**Source:** Source: McManus et al, 2009

PTSD is often treated in primary care. Currently there are 49 individuals being treated by AWP secondary care for reaction to severe stress, and adjustment disorders. A further 56 have been treated by LIFT psychology.

LIFT Psychology Service provides Swindon IAPT service. Table 27 below shows the number of individuals attending clinical sessions for some common conditions. These do not include individuals attending courses or other therapeutic interventions.

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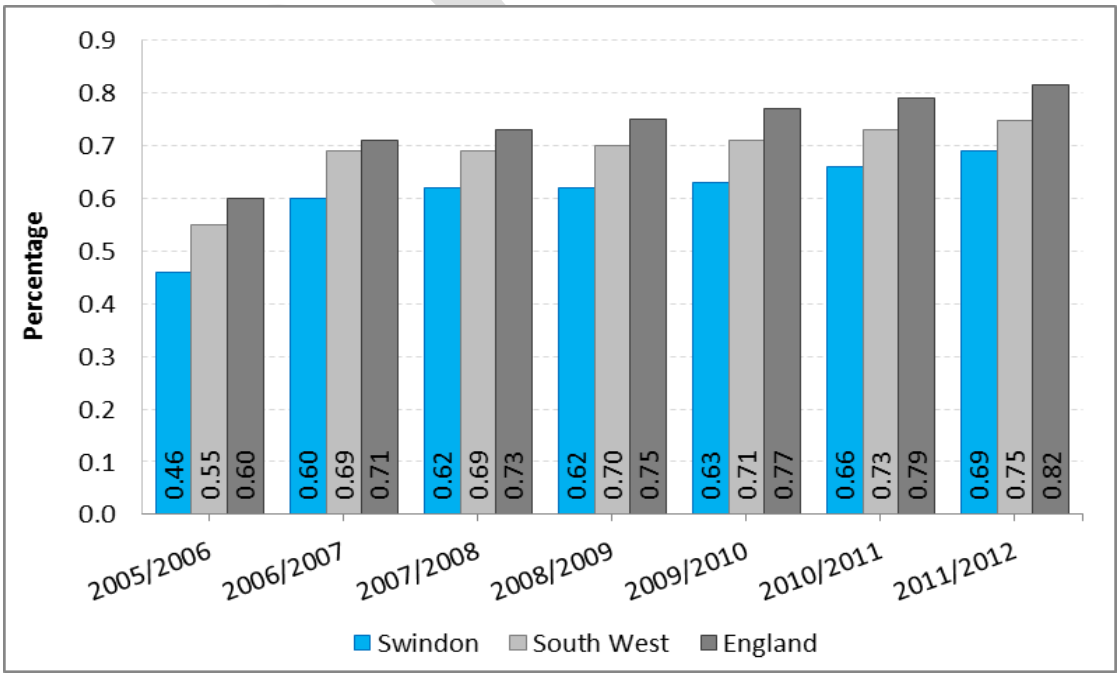
Table 27 Numbers attending LIFT Psychology clinical sessions by common conditions and referrals to step 3.

| Condition | Number of individuals attending clinical sessions | Number referred up to step 3 |
|---|---|---|
| Post Traumatic Stress Disorder | **56** | **8** |
| Depressive Episode or recurrent depressive episodes | **121** | **17** |
| Generalised Anxiety Disorder | **48** | **9** |
| Mixed Anxiety and Depression | **124** | **34** |
| Obsessive Compulsive Disorder | **57** | **5** |

## 7.2 Prevalence of severe and enduring mental health conditions

Figure 17 Percentage of persons on GP register diagnosed with a severe mental health condition*.




*People with schizophrenia, bipolar disorder and other psychoses
Source: NHS comparators, The Information Centre for Health & Social Care

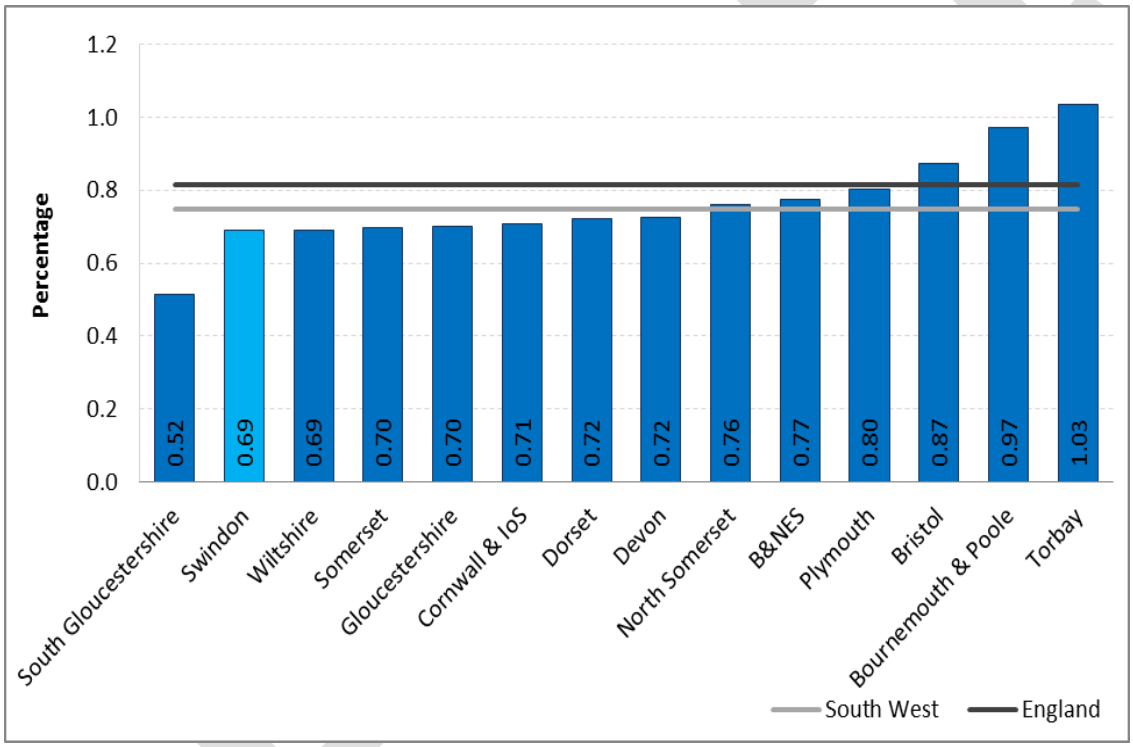
Table 28 Percentage and number of persons on GP register diagnosed with mental health condition* in Swindon.

| Year | 2005/2006 | 2006/2007 | 2007/2008 | 2008/2009 | 2009/2010 | 2010/2011 | 2011/2012 |
|---|---|---|---|---|---|---|---|
| % | 0.46 | 0.60 | 0.62 | 0.62 | 0.63 | 0.66 | 0.69 |
| Number | 937 | 1,226 | 1,299 | 1,313 | 1,362 | 1,441 | 1,526 |
| GP practice population | 201,806 | 203,850 | 208,675 | 212,561 | 215,788 | 218,182 | 221,360 |

*People with schizophrenia, bipolar disorder and other psychoses
Source: NHS comparators, The Information Centre for Health & Social Care

Interestingly, although the number on GP register diagnosed with mental health conditions is only 1.526 the active caseload for AWP in Swindon is 1638.It should be noted that this is not covering the same time period but could give an indication that the GP registers are not complete.

Figure 18 Percentage of persons on GP register diagnosed with serious mental health condition, South West PCT's, 2011/12.




*People with schizophrenia, bipolar disorder and other psychoses
Source: NHS comparators, The Information Centre for Health & Social Care

We can see from the figures above that in Swindon there are fewer people than on their GP mental health register than nationally or regionally.

The Adult Psychiatric Morbidity Survey (2007) estimates that the prevalence rate for psychotic disorder is around 0.4% (Table 29). This would equate to 695 individuals in Swindon with a psychotic disorder (Table 30). Currently in Swindon there are approximately 310 individuals with psychotic conditions on AWP current caseload.

Table 29 National prevalence (%) of Psychotic disorder in the past year by age and sex

| **Psychotic Disorder (1 year) (%)** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Ages** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| **Males** | 0 | 0.6 | 0.7 | 0.1 | 0 | 0 | 0 | 0.3 |
| **Females** | 0.4 | 0.2 | 1.1 | 0.8 | 0.6 | 0 | 0 | 0.5 |
| **Persons** | 0.2 | 0.4 | 0.9 | 0.5 | 0.3 | 0 | 0 | 0.4 |

Source: APMS 2007

Table 30 Estimated number of individuals in Swindon CCG area with psychotic disorder by age and sex (numbers).

| **Psychotic Disorder (1 year)** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Ages** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| **Males** | 0 | 95 | 121 | 18 | 0 | 0 | 0 | 234 |
| **Females** | 46 | 33 | 181 | 130 | 71 | 0 | 0 | 461 |
| **Persons** | 46 | 128 | 302 | 148 | 71 | 0 | 0 | 695 |

Source: APMS2007

**Personality Disorders**

Table 31 to Table 34 below show the national prevalence rates and local estimated numbers of individuals with Anti-social personality disorder (ASPD) and Borderline personality disorders (BPD) than ASPD. This shows that in total there may be about 1392 individuals in Swindon with personality disorder. Slightly more (795) have BPD than ASPD (597). Prevalence rates for ADPD are skewed towards younger age groups and males and BPD is higher in females and less associated with a particularly age range. In Swindon there are currently in the region of 87 individuals on the caseload of secondary mental health services with specific personality disorders.

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Table 31 National prevalence (%) of Anti-social personality disorder in the past year by age and sex

| **Anti-Social Personality Disorder (1 year) (%)** | | | | | |
|---|---|---|---|---|---|
| **Ages** | **18-34** | **35-54** | **55-74** | **75+** | **All** |
| **Males** | 1.7 | 0.2 | 0 | 0 | 0.6 |
| **Females** | 0.4 | 0 | 0 | 0 | 0.1 |
| **Persons** | 1.1 | 0.1 | 0 | 0 | 0.3 |

Source: APMS 2007

Table 32 Estimated number of individuals in Swindon CCG area with Anti-social personality disorder by age and sex (Numbers)

| **Anti-Social Personality Disorder (1 year)** | | | | | |
|---|---|---|---|---|---|
| **Ages** | **18-34** | **35-54** | **55-74** | **75+** | **All** |
| **Males** | 424 | 70 | 0 | 0 | 494 |
| **Females** | 102 | 0 | 0 | 0 | 102 |
| **Persons** | 527 | 70 | 0 | 0 | 597 |

Source: APMS2007

Table 33 National prevalence (%) of Borderline personality disorder in the past year by age and sex

| **Borderline Personality Disorder (1 year) (%)** | | | | | |
|---|---|---|---|---|---|
| **Ages** | **16-34** | **35-54** | **55-74** | **75+** | **All** |
| **Males** | 0.3 | 0.2 | 0.4 | 0 | 0.3 |
| **Females** | 1.4 | 0.5 | 0 | 0 | 0.6 |
| **Persons** | 0.8 | 0.4 | 0.2 | 0 | 0.4 |

Source: APMS2007

Draft

Table 34 Estimated number of individuals in Swindon CCG area with Borderline personality disorder by age and sex (Numbers)

| **Borderline Personality Disorder (1 year)** | | | | | |
|---|---|---|---|---|---|
| **Ages** | **16-34** | **35-54** | **55-74** | **75+** | **All** |
| **Males** | 83 | 70 | 84 | 0 | 237 |
| **Females** | 395 | 163 | 0 | 0 | 558 |
| **Persons** | 478 | 234 | 84 | 0 | 795 |

Source: APMS2007

**Bipolar Disorder**

*Bipolar disorder* is a relatively common condition with around 1 in 100 adults being diagnosed with the condition. Although it can occur at any age, it commonly starts between the ages of 18-24 with men and women and people from all backgrounds being affected equally (NHS Choices, 2009; RCPSYCH, 2009). Bipolar disorder is more frequent in people with higher socio-economic status.

Applying the estimated national prevalence rate of 1% to the Swindon population using 2011 census data for those over 18, we would expect to see in the region of 1605 individuals with a diagnosis of bipolar disorder. There are currently in the region of 120 individuals being treated by secondary mental health services for Bipolar Disorder.

## 7.3. What does the future look like?

The number of people with mental health conditions looks set to rise over the next couple of decades. Much of this is to do with demographic changes rather than a particular expected increase in prevalence. However, services and commissioners should be aware of this expected increase when planning services.

Figure 19 Number of people aged 18-64 forecast to have a common mental disorder in Swindon.

| | 2012 | 2015 | 2020 | 2025 | 2030 |
|---|---|---|---|---|---|
| **Common mental disorder** | 20,863 | 21,373 | 22,114 | 22,636 | 22,976 |
| **Borderline personality disorder** | 582 | 596 | 617 | 632 | 641 |
| **Antisocial personality disorder** | 461 | 471 | 487 | 498 | 507 |
| **Psychotic disorder** | 518 | 531 | 549 | 562 | 571 |
| **Two or more psychiatric disorders** | 9,360 | 9,584 | 9,916 | 10,147 | 10,304 |

Source: PANSI

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Particularly pertinent is the expected increase in the numbers of those over 65 years expected to develop depression. Planning for later life and initiatives to ensure that older people protect themselves from depression should be developed.

Figure 20 Number of people aged 65+ forecast to have depression or severe depression in Swindon.

| | 2012 | 2015 | 2020 | 2025 | 2030 |
|---|---|---|---|---|---|
| Depression | 2,641 | 2,878 | 3,245 | 3,705 | 4,347 |
| Severe Depression | 838 | 912 | 1,030 | 1,208 | 1,406 |

Source: POPPI

## 7.4 Associated behaviours

Although self-harm or suicide are not necessary an indication of mental illness they are often used in public health as an indicator of the prevalence of underlying mental ill-health. These have been referred to here as associated behaviour and included in the prevalence of mental illness section however it is important to note that those who self-harm or attempt suicide may not have any underlying mental illness.

### 7.4.1 Self-harm

Admission rates for self-harm are particularly high in Swindon and this section therefore goes into considerable detail in order to understand the factors behind this.

Self-harm can manifest as an individual episode of self-harm, which might be an attempt to end life, yet, many acts of self-harm are not directly connected to suicidal intent. They may be an attempt to communicate with others, to influence or to secure help or care from others or a way of obtaining relief from a difficult and otherwise overwhelming situation or emotion. Individuals who self-harm have high rates of mental health problems, alcohol and substance misuse and have an increased risk of death by suicide.

Since many acts of self-harm do not come to the attention of healthcare services the hospital attendance rates do not reflect the true scale of the problem. A national interview survey suggested that in UK between 4.6% and 6.6% of people have self-harmed. Most of those who attend an emergency department following an act of self-harm will meet criteria for one or more psychiatric diagnoses at the time they are assessed. More than two-thirds would be diagnosed as having depression although within 12–16 months two-thirds of these will no longer fulfil this diagnostic criteria. On the other hand, people diagnosed as having certain types of mental disorder (phobias and psychotic disorder) are more likely to self-harm. Whist self-harm can occur at any age, it is most common in adolescence and young adulthood. Overall, women are more likely to self-harm than men. This is most pronounced in adolescence, where girls may be three times more likely to self-harm than boys.

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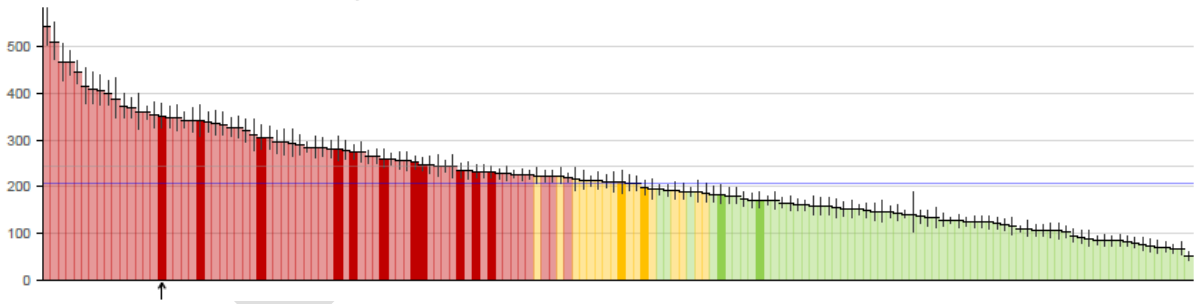
Life events are strongly associated with self-harm in two ways. First, there is a strong relationship between the likelihood of self-harm and the number and type of adverse events that a person reports having experienced during the course of his/her life. These include having suffered victimisation and, in particular, sexual abuse. Second, life events, particularly relationship problems, can precipitate an act of self-harm. Many people who self-harm have a physical illness at the time and a substantial proportion of these report this as a factor that precipitated the act. Self-harm is also much more common among prisoners than among the general population (NICE, 2004a).

Based on national prevalence rates above we would expect that approximately 10,000-13,000 individuals in Swindon have self-harmed. However, Social Norms work carried out in schools in Swindon over the last two years has shown that there may be higher levels of self-harm among young people in years eight and nine.

In Swindon the admissions rate for self-harm is high in comparison to other areas. From Figure 21 below it can be seen that out of 150 local authority areas Swindon had the 15th highest rate for directly standardised emergency hospital admissions for self-harm 2011/12. This equated to 362 admissions per 100,000 against a rate for England of 207 per 100,000. In 2010/11 the rate was 336 admissions per 100,000 for Swindon against a rate for England of 211 per 100,000. (Source: Community Mental Health Profiles)

Figure 21 A chart to show directly standardised rates of emergency hospital admissions for self harm 2011/12. (The small arrow shows Swindon, bold colours reflect local authorites in the South West).



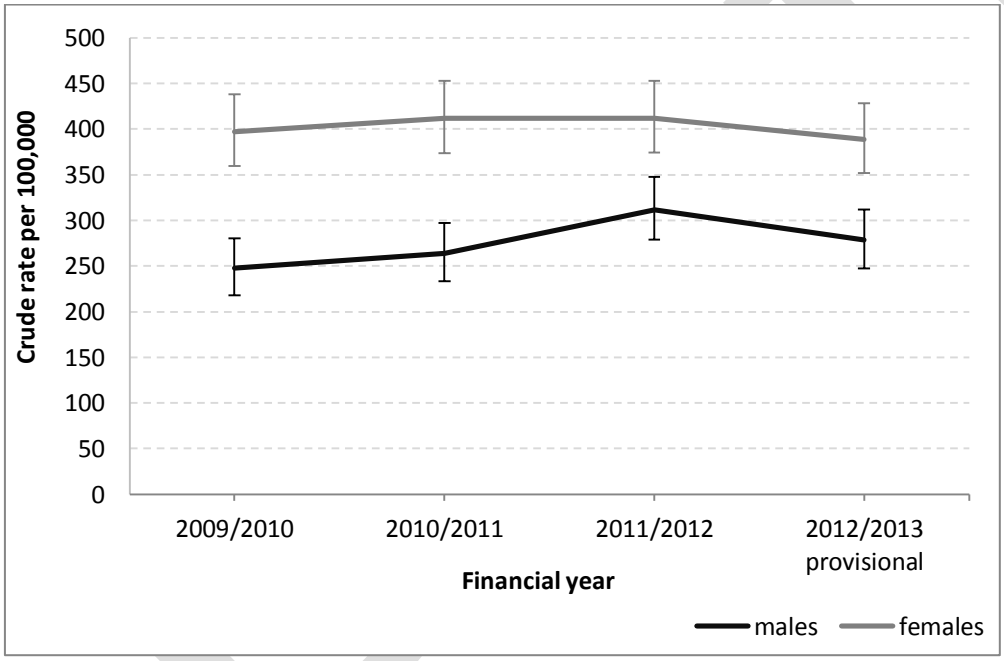

The admissions policies within hospitals vary with regard to self-harm and referral of psychiatric assessment. In Swindon individuals are often more likely to be admitted for psychiatric assessment rather than referred to out-patients. However, more work needs to be undertaken to understand more about why Swindon appears to have such high admissions rates.

Local analysis of admissions for Self Harm at GWH is shown below. This includes all admissions (not just emergency admissions which explains the slight variance to the figures above).

Data below shows an analysis of self-harm admissions data at GWH from the years 2009/10 to 2012/13 (provisional). The data is for all ages.

Figure 22 shows that for both males and females there has been a slight drop in the number of admissions but that in 2011/12 the gap between male and female admissions narrowed. This was due mainly to an increase in male admissions. Although over all we see a slight decrease this year this must be viewed with caution as the figures have not been confirmed for 2012 -13. It can be seen from the graph below that the differences are not statistically different. These are the number of admissions and some patients may have been admitted more than once.

Figure 22 A graph to show admissions to GWH for self-harm by year 2009/10 – 2012/13* by gender.




* 2012/13 figures are provisional

Table 35 The actual number of Swindon Admissions to GWH for Self Harm by year and Gender

| Admissions | 2009/2010 | 2010/2011 | 2011/2012 | 2012/2013 provisional |
|---|---|---|---|---|
| males | 253 | 273 | 327 | 295 |
| females | 406 | 426 | 432 | 412 |
| person | 659 | 699 | 759 | 707 |

During the four year period between 2009/10 and 2012/13 there were 2824 hospital admissions to GWH for self-harm for all ages.

These 2824 hospital admissions related to 1667 individuals. 75.4% of these individuals attended only once in this period but 12.7% attended twice, 7.4% attend three times and 4.5% attend 5 times or more.

The graph (Figure 23) below looks at the prevalence rate of patients who have been admitted for self-harm rather than the total number of admissions. This shows that the number of individuals appears to have risen slightly, which indicates that there are fewer repeat admissions but more individuals who have self-harmed over the past year. Again the variation is not statistically significant. The actual numbers are show in Table 36 below.

Figure 23 A graph to show the prevalence rates of individuals admitted to GWH for self harm from 2009/10 to 2012/13 (provisional rates).

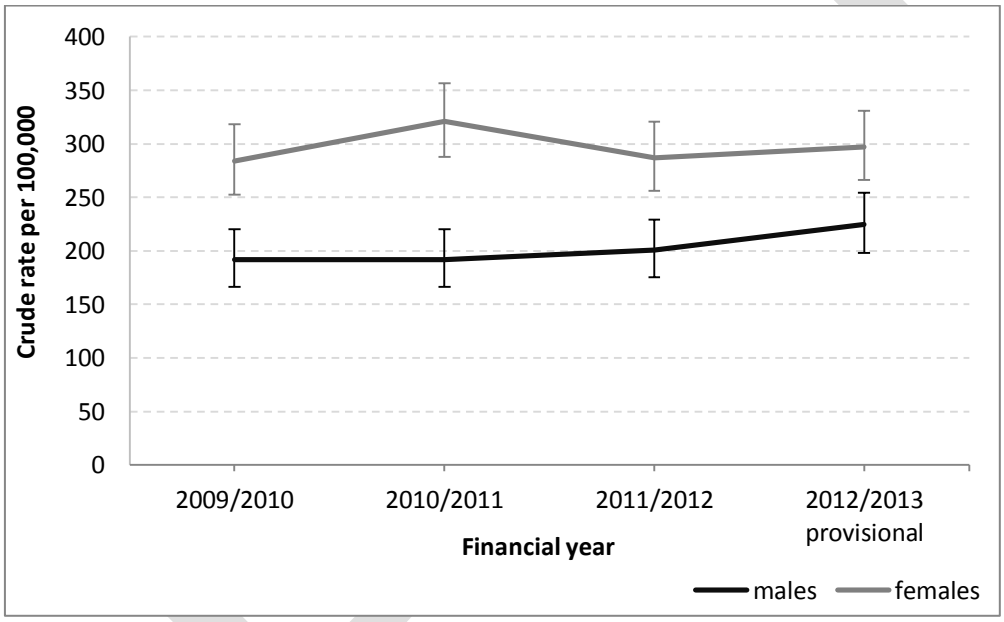


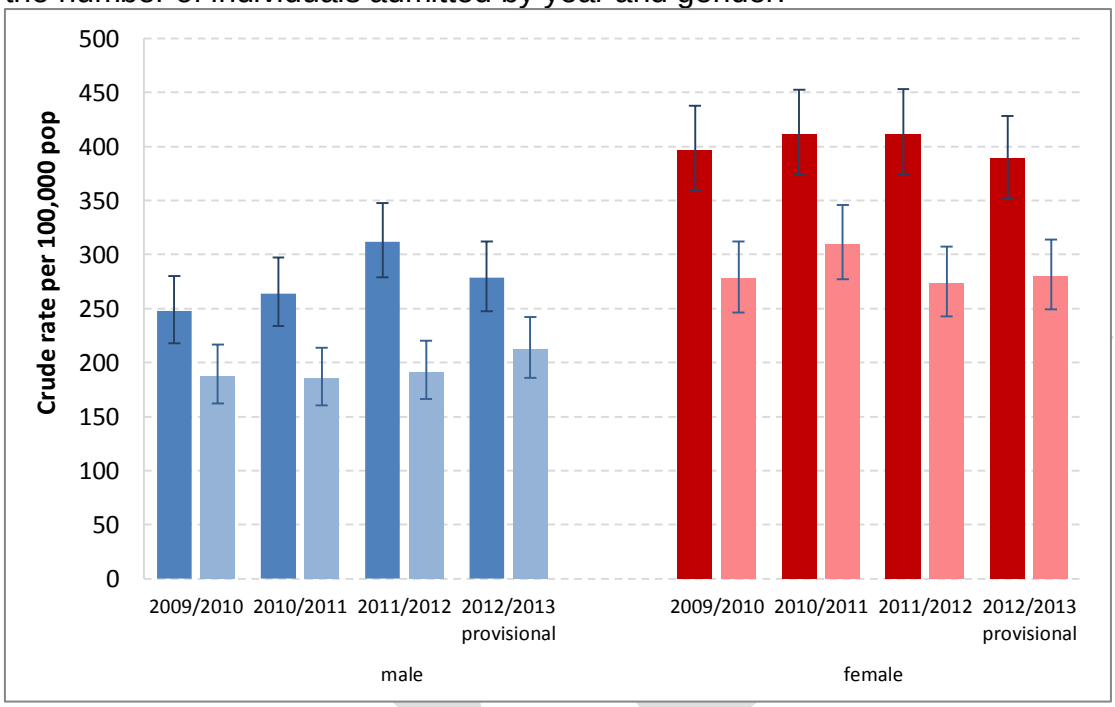

Table 36 A Table to show the number of individual patients admitted to GWH for self-harm by year.

| Individual patients | 2009/2010 | 2010/2011 | 2011/2012 | 2012/2013 provisional |
|---|---|---|---|---|
| males | 192 | 192 | 201 | 225 |
| females | 284 | 321 | 287 | 297 |
| person | 476 | 513 | 488 | 522 |

The graph below (Figure 24) shows clearly the difference between the rates of admissions for self-harm to the number of individuals admitted. The lighter colour denotes the number of individuals and bolder colour denotes the total number of

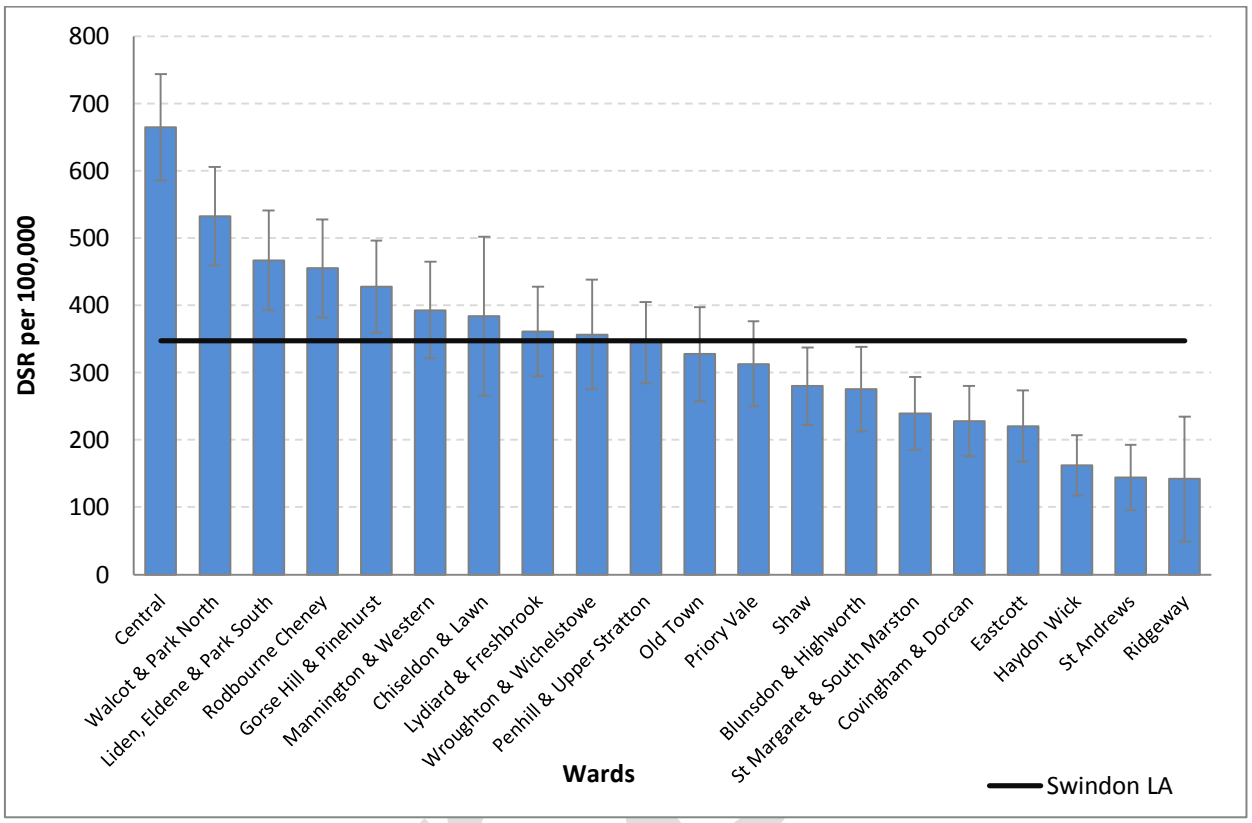
admissions. We can see that for both males and females there are a significant number of individuals who are repeatedly admitted for self-harm. The graph highlights the slight reduction in admissions despite a fairly consistent number of attendances.

Figure 24 A graph to show the difference between the number of admissions and the number of individuals admitted by year and gender.



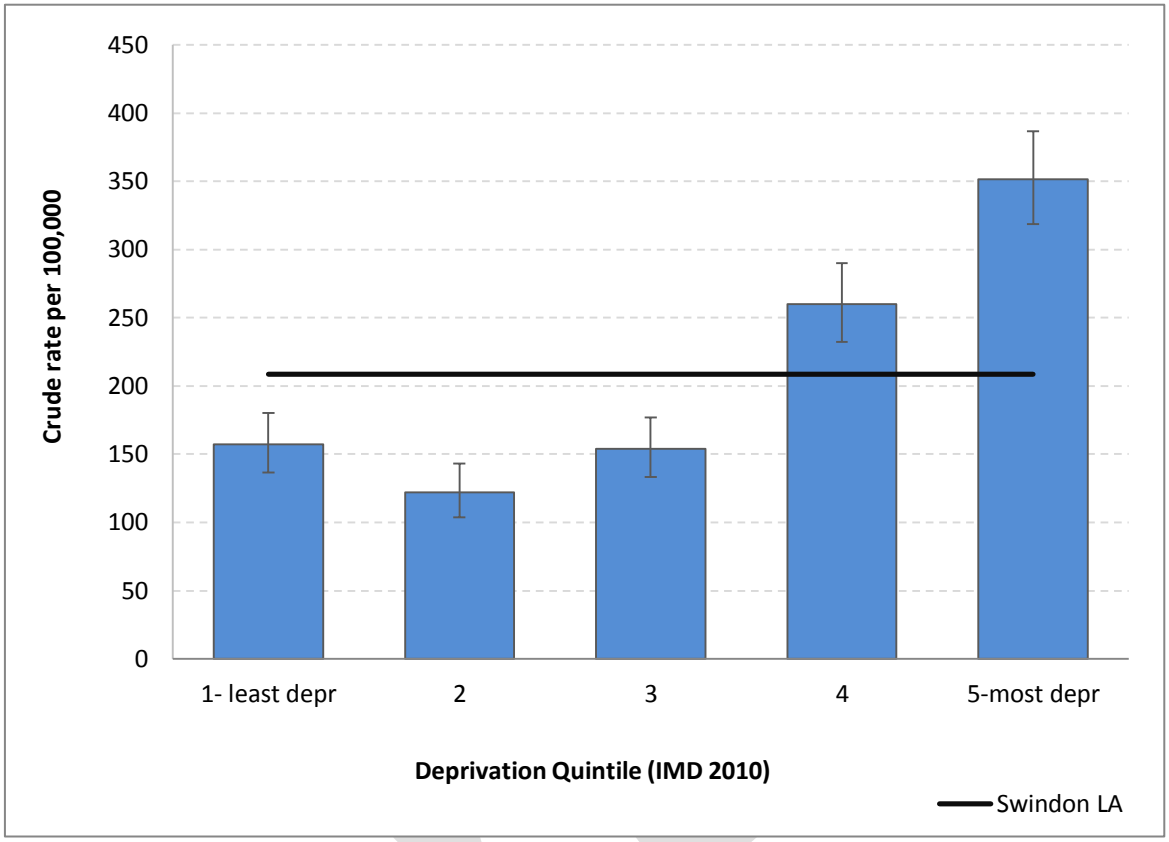

The graph below (Figure 25) shows the analyses of hospital admissions for self-harm by ward. We can see that there is significant variation in admissions with those in Central ward having the highest admission rates, followed by Walcot and Park North and Liden, Eldene and Park South. Those with the lowest admission rates are Ridgeway, St Andrews and Haydon Wick. As we know that there are particularly high numbers of the BME population leaving in Central ward further investigation into the ethnicity of those attending should be sort and analysed.

Figure 25 Directly age standardised rate of hospital admissions for intentional self-harm, Swindon wards, 2010/11 - 2012/13 (three year average)




An analysis of self-harm admissions and deprivation was undertaken on the Swindon admissions data. From the graph below we can see that there is a close association between admissions for self-harm and deprivation. Those in the two most deprived quintiles are significantly more at risk of hospital admissions for self-harm. This reflects the graph above.

Figure 26 A Graph to show the Direct Standardised Rate of hospital admissions for individuals who have self-harmed (three year average 2010/11 – 12/13) by deprivation quintile.




The graphs (Figure 27 & Figure 28) below show the crude rates of hospital admissions by age for both the rate of admissions and the rate of individuals admitted by age group. We can see that for the 20 – 29 year old age group the admission rates for males and females are very similar and there is no statistically significant difference in admissions for this group or for those aged 30 – 44 years or those over 60 years of age. For those under the age of 20 years and for those aged 45 – 49 years there are significantly more admissions for females.

Figure 27 A graph to show the crude rate of hospital admissions for self-harm by age (three year average 10/11 – 12/13)

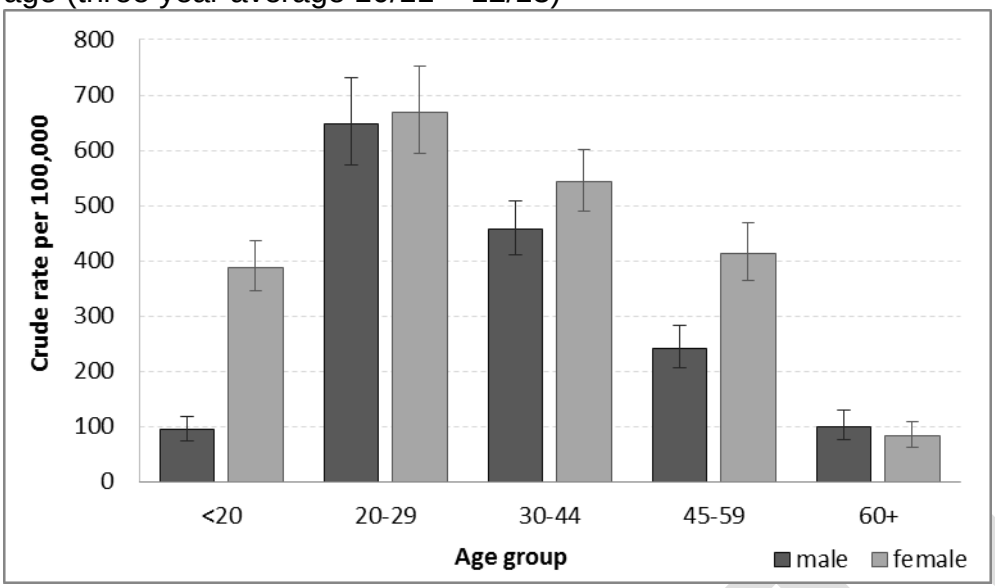
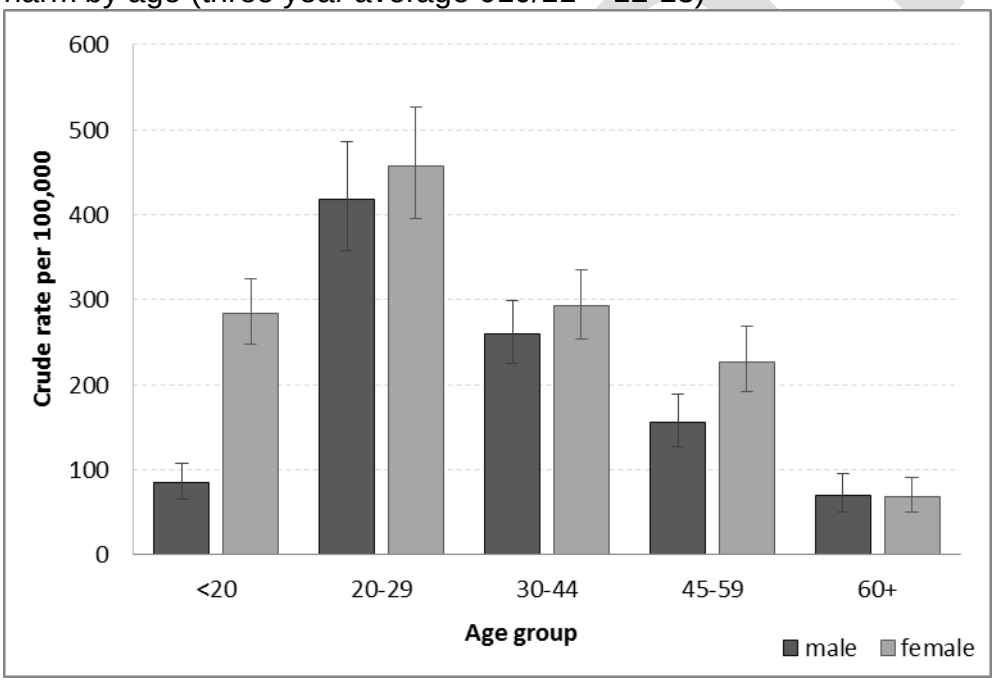
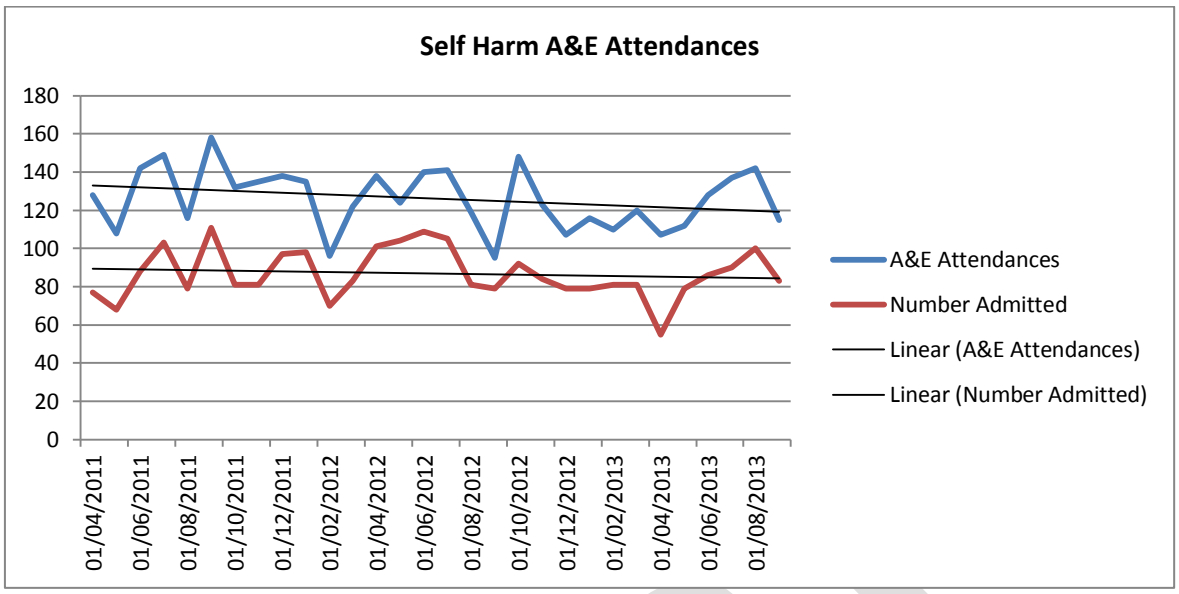



Figure 28 A graph to show the crude rate of individuals admitted to GWH for self-harm by age (three year average 010/11 – 12-13)




GWH have analysed their ED attendance and admissions data and as reflected in Figure 22 above the figures show a slight decrease in both admissions an attendances. However, the first quarter of 2013/14 did see another spike in both admissions and attendances. (Figure 29)

Figure 29 A graph to show attendance and admissions at GWH ED between April 2011 and August 2013.




Great Western Hospital have analysed the attendance at ED by day of the week and time. The graph below Figure 30 shows that there is only slight variation by day of attendance. There are slightly more attendances on Saturday and Sunday but otherwise the variation is minimal.

Figure 30 shows that there is considerable variation in the time of arrival. The peak times are between 18.00 and 01.00. There are relatively few arrivals in the early morning but arrivals increase from lunchtime on wards.

Figure 30 A graph to show the variation in hour of arrival at ED by day of the week.

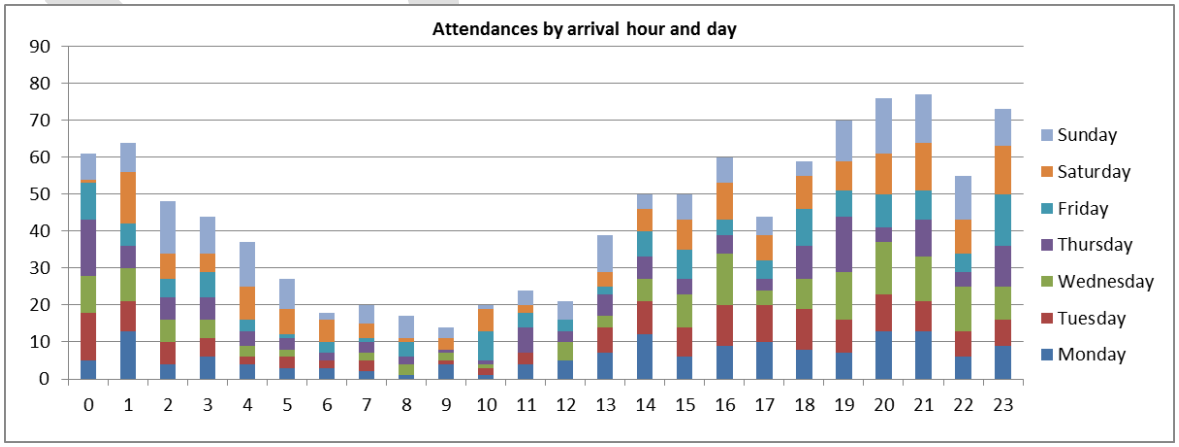
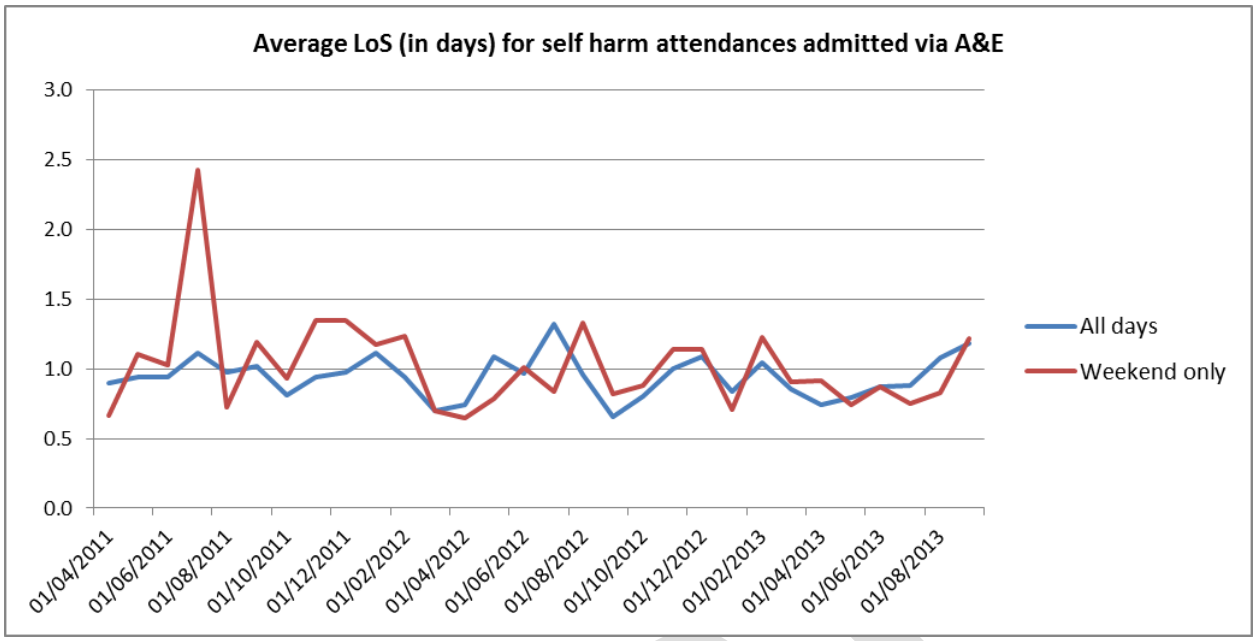



Figure 31 shows that the average length of stay is only 1 day and often not a full day. The length of stay in 2011 at the weekend was higher than the length of stay during week days but this variation is not apparent since April 2012. This may be due to the introduction of the Hospital psychiatric liaison service at the weekends.

Figure 31 A graph to show the average length of stay (in days) for admissions for self-harm via ED from April 11 – August 13.

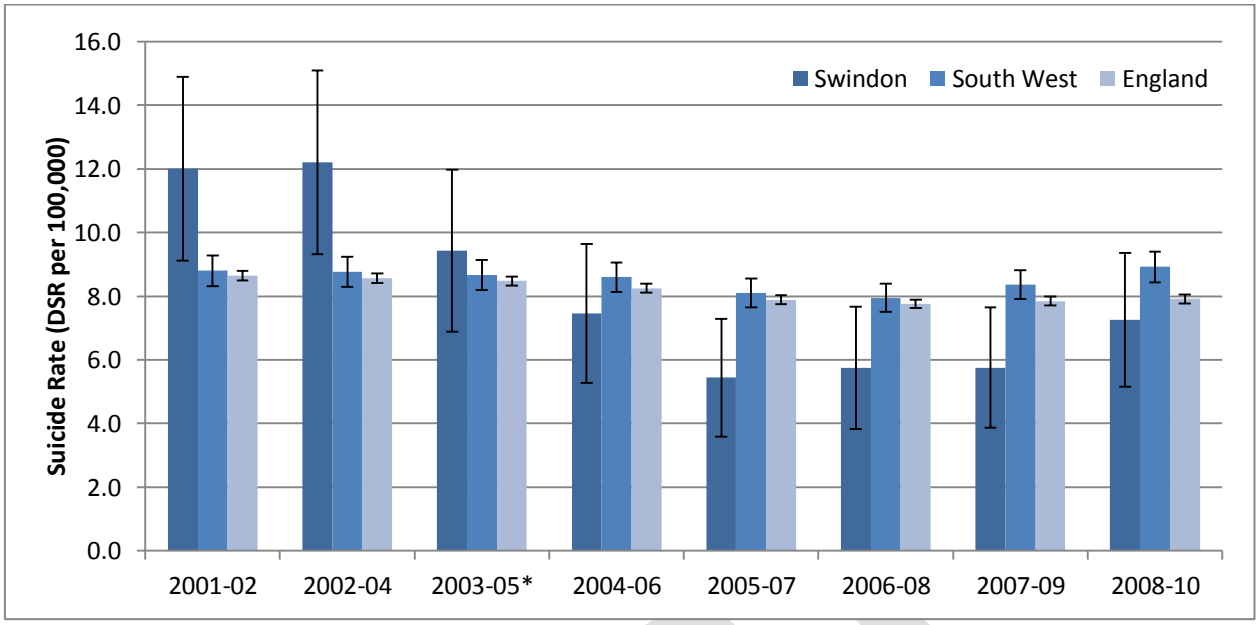



The Hospital Based Psychiatric Liaison team highlighted a gap in service for those not mentally ill but emotionally stressed to crisis point. These individuals are often reacting to stressful life events – bereavement, job loss, relationship breakup etc. They are at risk from suicide and self-harm but are not suitable for LIFT Psychology service as emergency intensive assessment is required. At present it is perceived that these individuals do not have access to any service as they would not fit the criteria of the intensive team however, they are acutely suicidal or at risk of self-harm and undergoing a stress reaction.

### 7.4.2 Suicide

Suicide rates in Swindon have historically been lower than national rates. However, in the last few years the rate has increased. The number of suicides in Swindon is relatively small which makes variation appear greater in Swindon that nationally or regionally. National figures for 2011 have not been published and will be published later this year with the 2012 figures. Figure 32 below shows the mortality from suicide and injury undetermined for Swindon, South West England and England between 2001 – 2010.

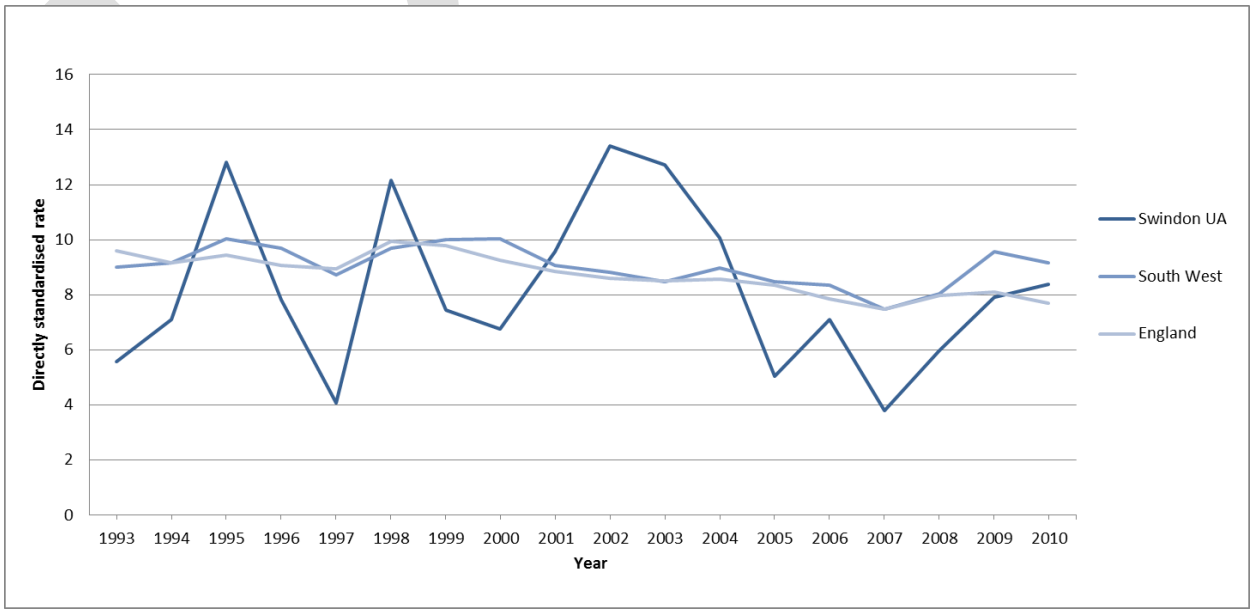
Figure 32 Mortality from Suicide & Injury Undetermined 2001-02 to 2008-10 (directly standardised rate, all ages, 3-year average)




Source: Health and Social Care Information Centre Indicator Portal 2013

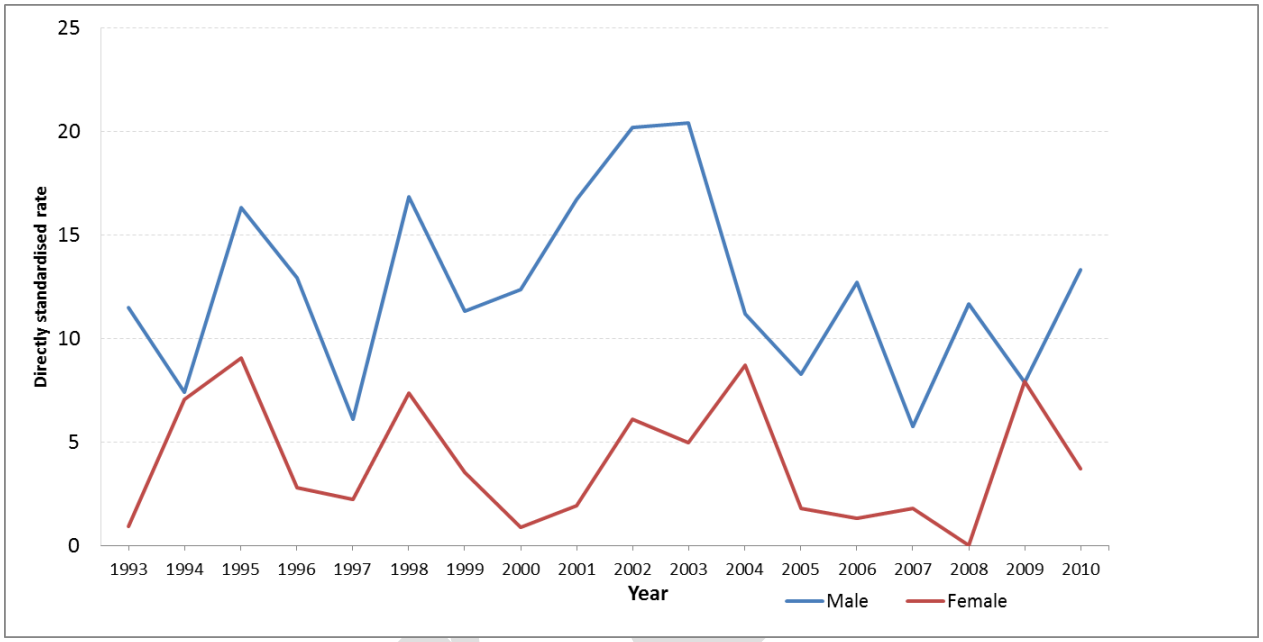
We can see from the trend line below that the overall the rates of suicide in Swindon, as elsewhere, are down. Because the numbers in Swindon are relatively small in comparison to the South West and England the variation is much larger. The rate in Swindon in 2007 was so low that the increase closer to national and regional levels appears very marked (Figure 33).

Figure 33 Mortality from suicide and injury undetermined (directly standardised rate, all ages, annual trend)



The rate for females is lower than the rates for males. This reflects the national picture (Figure 34).

Figure 34: Swindon Mortality from Suicide & Injury Undetermined by Sex 1993 – 2010, (directly standardised rate, all ages, annual)




Source: Health and Social Care Information Centre Indicator Portal

In Swindon we undertake an analysis of our local suicide data including information from GPs, Mental Health, Substance Misuse Services and Great Western Hospital. We undertake a regular local suicide audit which informs the suicide strategy. The 2013 Swindon Suicide audit and strategy shows:

- 69% of cases were male
- The mean age of death was 42 years
- 88% were White British
- 25% were in employment
- 94% were heterosexual
- 80% were single, separated, widowed or divorced.
- 45% lived alone
- 30.1% had a GP diagnosis of any mental illness made in 12 months prior to suicide.
- 18% had some contact with secondary mental health care services recorded

- 19% had a recorded attendance at the Great Western Hospital Emergency Department for self-harm. 11 of whom (69%) had been seen at least once in the year previous to death.
- 21% of cases had taken alcohol at the time of death.
- 12% of cases were thought to have taken non-prescribed drugs at the time of death.
- A very small number (<5%) had taken both drugs and alcohol at the time of death.

The audit has some key recommendations including:

- Ensure training on suicide prevention is available to those working with high risk groups.
- Focusing mental health promotion activity at men aged 35-49.
- Focus mental health promotion activity at those who are unemployed e.g. through the job centre
- Continue work with GWH regarding monitoring of attendance for self-harm, communication with primary care and mental health services and pathways between services
- Ensure that the mental health needs of those with physical long term conditions are met.
- Invest in a support campaigns to reduce social isolation and loneliness.
- Work with local planners and developers to include suicide risk in health and safety considerations when designing multi-storey car parks, bridges and high-rise buildings that may offer suicide opportunities.

Further details can be found in the Swindon Suicide Prevention Audit and Strategy 2013.

Draft

## 8. Inequalities, Stigma and Discrimination

### Key findings

- Those with severe mental illness die on average 20 years earlier than the general population.
- On average those with mental health problems have fewer qualification, find it harder to find and retain work, have lower incomes, are more likely to be homeless and are more likely to live in areas of deprivation than the general population.
- Stigma and discrimination is all pervasive, with close to 9 out of 10 service users (87%) reporting its negative impact on their lives
- According to the annual Time for Change report there has been an improvement in attitudes to mental illness. However, those with mental health problems are still more likely to smoke, less likely to take physical exercise, have issues concerning dual diagnosis (mental health and substance misuse), and less likely to be a healthy weight.
- Those with long term conditions or disabilities are more likely to experience mental health problems and experience dual discrimination. Those with hearing and sight loss and those with learning disabilities experience particular mental health problems. Those with long term conditions or disabilities are more likely to experience mental health problems and experience dual discrimination.
- Currently a Department of Health funded project to address the needs of those with long term conditions, through LIFT Psychology Service but funding ceases at the end of March 2014.

Draft

At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time[96]. Those with mental health problems often have fewer qualifications, find it harder to both obtain and retain work, have lower incomes, are more likely to be homeless and are more likely to live in areas of high social deprivation. Those with severe mental illness die on average 20 years earlier than the general population[97,98].

[96] Ibid p8
[97] Brown S, Kim M, Mitchell C and Inskip H 2010. Twenty-five Year Mortality of a Community Cohort with Schizophrenia. British Journal of Psychiatry 196: 116-121

Outlined above are the links between poor mental health and deprivation. The Marmot Review, Fair Society, Healthy Lives (2010) highlights the impact of social inequality on health. The report states that "Creating a fairer society is fundamental to improving the health of the whole population and ensuring a fairer distribution of good health." It highlights the importance of the life course in tacking inequalities and the importance of control. It suggests 6 key policy objectives to reduce health inequalities:

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop health and sustainable places and communities
- Strengthen the role and impact of ill health prevention

These key objectives have been picked up in the DH mental health strategy in which it highlights the need to tackle the inequalities that lead to poor mental health; tackle the inequalities that result from poor mental health and tackle the inequalities in service provision.

Those with mental health problems experience many inequalities, stigma and discrimination, This section will detail some of the health and social inequalities experienced by those with mental health problems and look at the stigma and discrimination they experience. It will look at the impact this has and outline

### 8.1 Stigma and discrimination surrounding mental health:

- Prevents people seeking help
- Delays treatment
- Impair recovery
- Isolates people
- Excludes people from day to day activities
- Stops people getting jobs

Time to Change[99,100] undertook a consultation with service users and carers to understand people's experience of stigma and discrimination. The report found that stigma and discrimination is all pervasive, with close to 9 out of 10 service users (87%) reporting its negative impact on their lives. The report found that the proportion of individuals who experienced stigma and discrimination were higher

[98] Parks J., Svendsen D., Singer P., Foti, M.E. 2006. Morbidity and Mortality in People with Serious Mental Illness, 13th Technical report, Alexandria, Virginia; National Association of State Mental health Program Directors. In ibid 2011

[99] Time to Change

[100] Time to Change is a charity, set up in 2009, led by Mind and Rethink Mental Illness to challenge Stigma and discrimination experienced by those with mental health problems.

for women, people living with severe mental illness, people who are gay, lesbian or bi-sexual those with additional disabilities and those who were middle aged indicating that multiple layers of discrimination was a problem[101]

The report also found that the top three things that service users stop or fear doing because of stigma and discrimination were firstly disclosure followed by activities, and employment. It was acknowledged that it was not always stigma and discrimination that stopped individuals doing things but "rather the illness itself or consequences of living with a mental health problem such as low self-esteem or lack of motivation". "It's not so much discrimination that stopped me doing things, it is more my anxiety in the certain situations."

When asked about which groups should be prioritised as a target audience for an anti-stigma campaign the top three answers from service users were first immediate family, followed by employers and neighbours/community. Service users reported close family members being over-protective or patronising. For carers neighbours/local community came out top, followed by employers and then wider family.

The report concluded that stigma and discrimination has a profound impact on the lives of people with mental health problems.

The annual survey on attitudes to mental illness – 2011 survey[102] reported that there had been some significant changes over time:

- The percentage of people agreeing that "Mental illness is an illness like any other' increased from 71% in 1994 to 77% in 2011.
- The percentage saying they would be comfortable talking to a friend or family member about their mental health, for example telling them they had a mental health diagnosis and how it affects them rose from 66% in 2009 to 70% in 2011.
- The percentage saying they would feel uncomfortable talking to their employer about their mental health was 42%, compared to 50% in 2010.
- The percentage of people who agree that anyone with a mental health problem should be excluded from public office fell from 29% in 1994 to 21% in 2011.
- Younger people generally appeared more tolerant of mental health issues than older people.
- In general the report shows that while some improvement can been seen in relation to people's attitudes to mental health problems the changes are not consistent.

## 8.2 Life expectancy and disability free life expectancy

Life expectancy is a crude measure of how society succeeds in meeting the needs of people with mental disorders. Two recent studies have shown that the life

[101] Stigma Shout – Service user and carers experiences of stigma and discrimination Time to change 2008

[102] Attitude to Mental Illness – 2011 survey report. The Health and Social Care Information Centre 2011

expectancy for those with mental health problems is considerable less than for the rest of the population. Walibeck et al[103] reported that in Denmark, Sweden and Finland the life expectancy for men with a severe mental illness was 20 years less than the rest of the population and for women it was 15 years less. In London Chang et al 2011[104] found that all severe mental disorders were associated with lower life expectancy: 8.0 – 14.6 life years lost for men and 9.8 to 17.5 life years lost for women. Highest reductions were found for men with Schizophrenia (14.6 years lost) and women with schizoaffective disorders (17.5 years lost). The authors claim that SMI has a higher impact on life expectancy than smoking, diabetes and obesity although there are no controlling factors mentioned in the paper.

Several explanations for the excess mortality among people with mental disorders have been suggested. These include an unhealthy lifestyle, inadequate access to good-quality physical health care, and a culture of not taking physical disease into consideration when treating psychiatric patients. The excess mortality also reflects multiple vulnerabilities. People with mental disorders are more often poor, unemployed, single and marginalised, all known risk factors for poor health and premature mortality[105].

Estimates prepared by the WHO show that in the UK mental illness now accounts for more Disability adjusted life years (DALYs) lost per year than any other health condition. Thus the figures for 2002, the latest available year, indicate that 20.0% of the total burden of disease in the UK was attributable to mental illness (including suicide), compared with 17.2% for cardiovascular diseases and 15.5% for cancer (WHO 2006). No other condition exceeded 10%.[106]

### 8.2.1 Smoking

Increased smoking is responsible for most of the excess mortality of people with severe mental health problems. Some 70% of psychiatric inpatients smoke compared with 21% of the general population. Furthermore, adults with mental health problems, including those who misuse alcohol or drugs, smoke 42% of all the tobacco used in England. Stopping smoking reduces the risks of developing physical illness, increases life expectancy and may play a role in preventing mental illness. Although smokers with mental illness are just as motivated to stop as the general population, they are less likely to be offered cessation support.[107]

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[103] Wahlbeck, K., Westman, J., Nordentoft, M., Gissler, M., Munk Laursen, T. (2011) Outcomes of Nordic mental health systems: life expectancy ofpatients with mental disorders. British Journal of Psychiatry,199:453-458

[104] Chang, C et al., (2011) Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Care Case Register in London. PLoS ONE http://www.plosone.org/article/info:doi/10.1371/journal.pone.0019590

[105] Wahlbeck, K., Westman, J., Nordentoft, M., Gissler, M., Munk Laursen, T. (2011) Outcomes of Nordic mental health systems: life expectancy ofpatients with mental disorders. British Journal of Psychiatry,199:453-458

[106] World Health Organisation (2006) *Burden of disease statistics.* www.who.int/healthinfo/bod/en/index.html. Cited in Friedl and Parsonage (2007) (2007) Mental Health Promotion: Building the Economic Case. NIAMH.

[107] NICE Public Health Guidance 2013 Tobacco: harm reduction approaches to smoking June/July 2013.

In 2011/2012 Smoking Prevalence in Swindon UA for adults age was 21.2% which was not statistically significantly different from the rate for England which was 20.0%. Source: Integrated Household Survey. The prevalence in 2011/12 for Swindon in routine and manual groups aged 18+ in Swindon UA was 28.8% compared with 30.3% in England. Source: Integrated Household Survey

### 8.2.2 Alcohol and substance misuse

There is a high rate of overlap between substance use and severe psychiatric morbidity. It is estimated that 8% of the annual incidence of schizophrenia is accounted for by cannabis consumption. There is, however, a far more striking impact of heavy drinking and drug taking on the aggravation of psychiatric symptoms and on reductions in social functioning. The greatest risk factors for causing violent injury are hazardous alcohol consumption and alcohol dependency. The effect of alcohol is particularly enhanced in people with co-morbid anti-social personality disorder. Excessive alcohol and drug use is also a risk factor for suicidal behaviour.

Whilst alcohol use is common, the burden of substance abuse falls disproportionately on socially marginalised populations. This can be due to many factors, such as a poor diet and a general poverty, meaning that people in lower socioeconomic groups who do drink heavily, cannot protect themselves as well as those in more affluent groups, against the negative health and social consequences of heavy alcohol use[108]

In Swindon generally the alcohol profile is not statistically different from England:

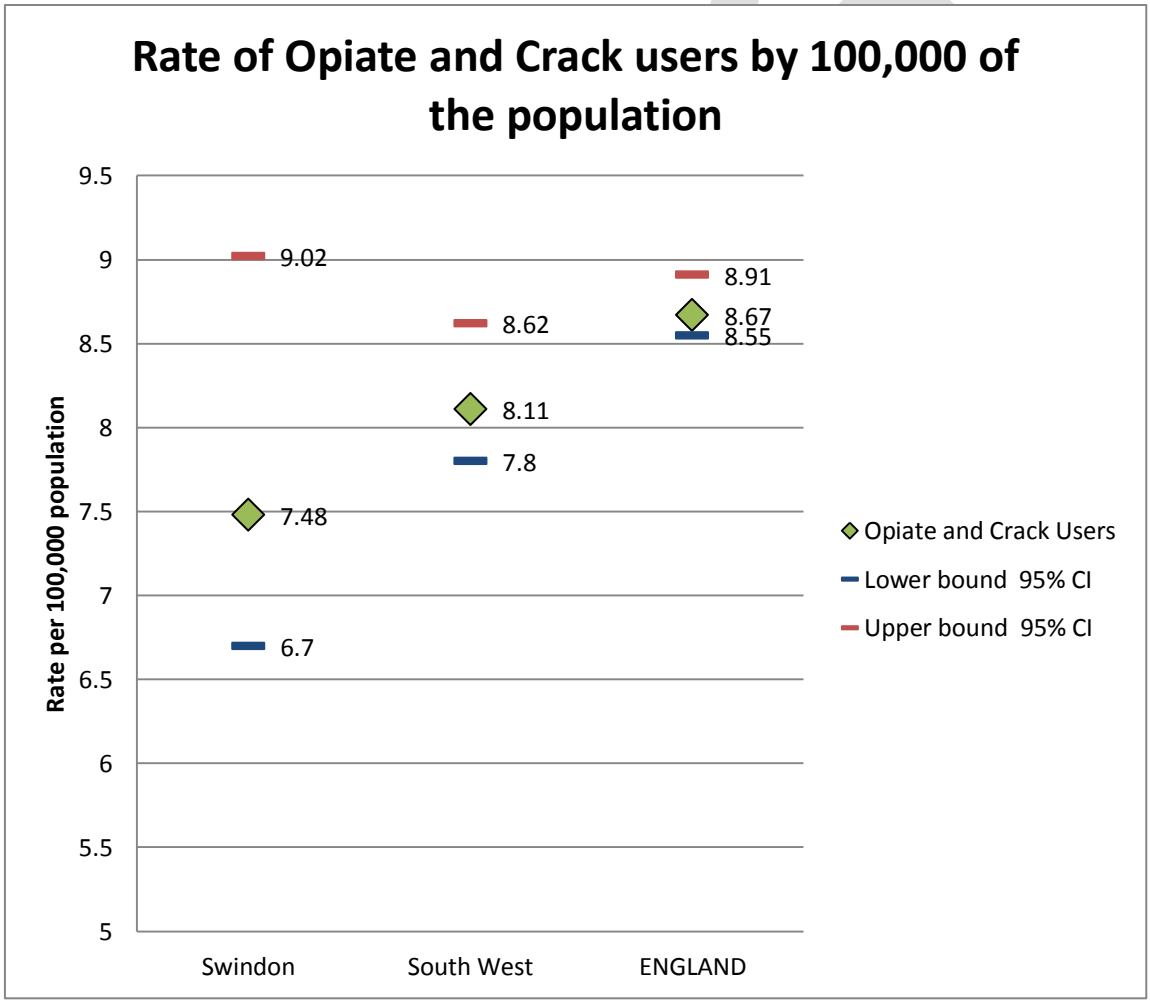
- Increased and higher risk drinking[109]: 23.1% Swindon versus 22.3% England aged 16+ 2008/2009. Not significantly different. Source: Health Profile 2012.
- Hospital stays for alcohol-related harm in 2010/2011. 1855 per 100,000 versus 1895 per 100,000 England. 4,168 cases in Swindon. Not significantly different. Source: Health Profile 2012.
- Binge drinking 20.4% in Swindon UA (twice the daily recommended amount in a single session) (2007-2008) Not significantly different compared with England. Synthetic estimate. Source: LAPE Profiles 2012.
- Alcohol specific mortality in Swindon UA 2008/2010. Males 10.3 per 100,000, Females 6.3 per 100,000. Directly Standardised Rates. Not significantly different compared with England. Source: LAPE Profiles 2012.

[108] NICE 2010 Public Health Guidelines Alcohol use disorders Preventing harmful drinking.
[109] Estimates for increasing or high risk drinking were derived from a statistical model developed to estimate the percentage of abstainers, consumers of >0 to 9 units, 10 to 14 units, 15 to 21 units, 22 to 35 units, 36 to 50 units and >50 units per week in LSOA populations. Increasing risk drinking is defined as usual consumption of between 22 and 50 units of alcohol per week for males, and between 15 and 35 units of alcohol per week for females. Higher risk drinking is defined as usual consumption of over 50 units of alcohol per week for males, and over 35 units of alcohol per week for females

- Alcohol attributable mortality in Swindon UA. Males 28.2 per 100,000, Females 13.9 per 100,000. DSR 2010. Not significant compared with England. LAPE Profiles 2012.

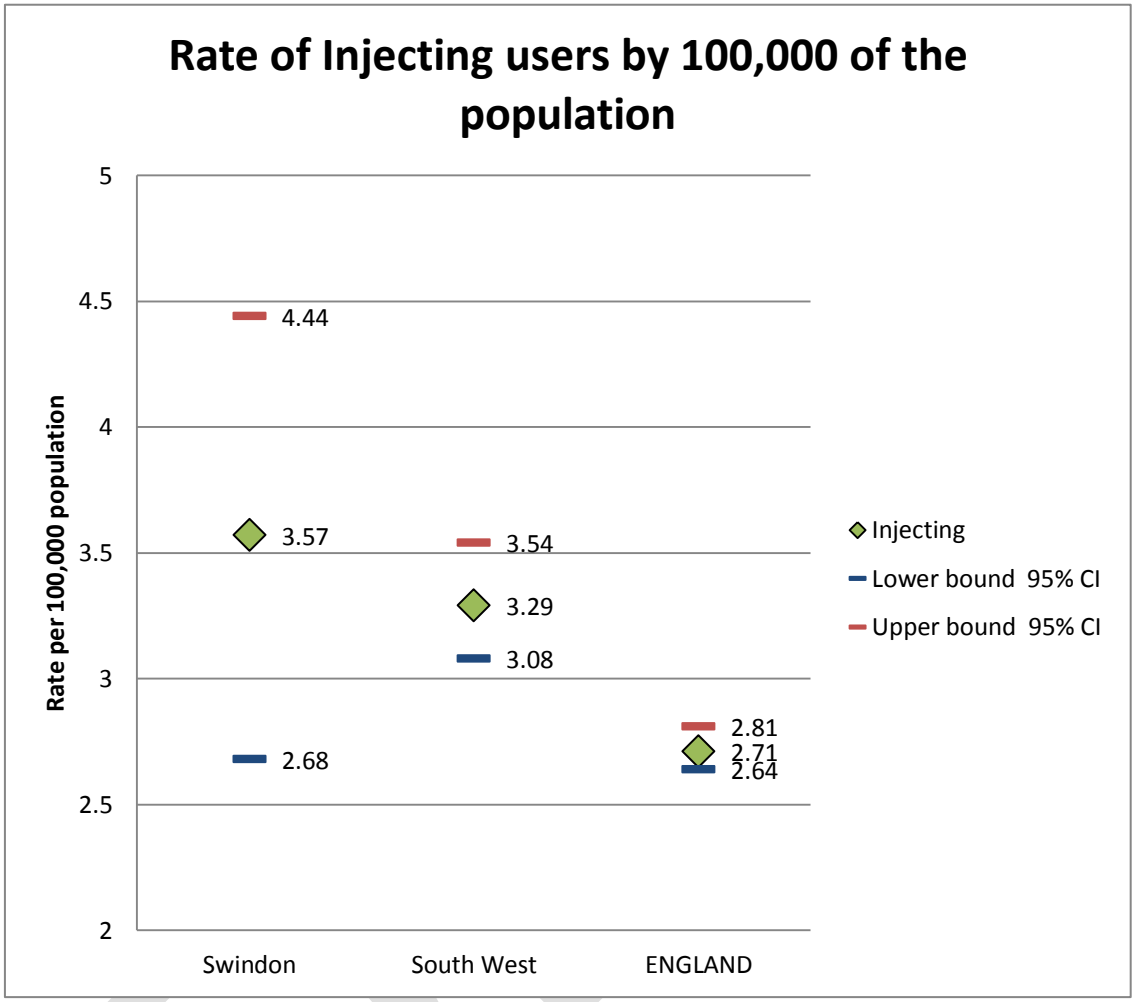
In Swindon the drug misuse profile is not significantly different from the national profile either (Figure 35). In Swindon there are an estimated 1017 Opiate or Crack users with a predominance of opiate use rather than crack. In Swindon we appear to have a high rate of injecting drug user but there is no significantly statistical difference between Swindon and the South West or England (Figure 36). These figures are based on 2010/11 data from the National Drugs Evidence Centre.

Figure 35 Rate of Opiate and Crack Users in Swindon by 100,000 population (2010/11)




Source: National Drugs Evidence Centre

Figure 36 Rate of injection users by 100,000 population for Swindon 2010/11




Source: National Drugs Evidence Centre

### 8.2.3 Physical activity adults

Physical activity can have beneficial effect on all aspects of health through ones' life course, but evidence suggests that it merits particular attention in adulthood. In middle and old age, it can slow or prevent age-related cognitive decline and is associated with a lower risk of dementia. Regular exercise can also protect against the development of depressive symptoms. There is also promising preliminary evidence for the use of exercise programmes in the treatment of anxiety[110]

[110] Hendrickx H and van der Ouderaa F State-of-Science Review: SR-E24

Recommended level of physical activity is defined as participation in moderate intensity sport and active recreation on 20 or more days in the previous 4 weeks (averaging 5 or more times per week). In Swindon 11.5% of the population compared to 11.2% in England, are taking part in the recommended level of physical activity (Health Survey England, 2009 - 2011).

### 8.2.4 Healthy weight and diet

The Royal Collage of Psychiatrists report that people with mental health problems are less likely than average to be a healthy weight. Whilst the reasons for this are not clear for some it may be related to their mental health problems themselves but evidence increasing shows that weight gain can be related to side effect of the treatment. For some an alternative medication may be offered but for others increasing physical activity and improvements in healthy eating may provide the solution.

Daumit et al[111] state that "80% of those with severe mental health problems are overweight or obese, which contributes to them dying at three times the rate of the overall population. They succumb mostly to the same things the rest of the population experiences—cardiovascular disease, diabetes and cancer but even those on medication known to increase weight gain, weight loss can be achieved and maintained with a healthy diet and a physical activity programme".

Some foods have limited evidence to improve mental health. These include Omega 3 fatty acids which the Royal College of Psychiatrists suggest can be used as a supplement for individuals who suffer from mood problems or schizophrenia and may help to prevent relapse in bipolar disorder.

Generally, those with mental health problems should aim to eat a balance diet with plenty of fresh fruit and vegetables and whole grain rather than processed foods is good and individuals should avoid sugary foods which are high calorie and can exacerbate mood swings. Sugary drinks, high caffeine drinks and alcoholic drinks should also be avoided or limited.

In addition to side effects of medication, according to Daumit et al, other factors that preclude people with serious mental illnesses from losing weight include memory impairments or residual psychiatric symptoms that impede learning and adopting new behaviours such as counting calories. Socioeconomics are also a factor as many cannot afford or cannot get to physical activity programs like fitness gyms. Some patients additionally suffer from social phobia or have poor social interactions, and are simply afraid to work out in a public area.

The successful intervention implemented by Daumit et al included six months of intensive intervention consisting of exercise classes three times a week along with individual or group weight loss classes once a week.

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The Effect of Physical Activity on Mental Capital and Wellbeing (2008) part of the Foresight report into Mental Health and Wellbeing.

[111] Daumit et al N Engl J Med 2013; 368:1594-1602April 25, 2013DOI: 10.1056/NEJMoa1214530

## 8.3 Long Term Conditions and Disabilities

### 8.3.1 People with disabilities and/or chronic long-term physical health problems

A long-term health condition (LTC) is a condition that cannot be cured but one that can be managed. Common examples include diabetes, respiratory disorders, cancer, heart disease, musculoskeletal disorders and chronic pain. More than 30% of the population in England are currently living with at least one LTC, equating to 15.4m people[112]. Numbers are increasing and are predicted to continue to escalate[113]. It is recognised that people with chronic physical health problem, have a higher rates of depression and anxiety than physically healthy people. However, the relationship between physical disability and mental health is complex. There are a number of studies indicating that depression is associated with physical disability, yet this view is challenged for its lack of consideration of the social and economic factors that may accompany impairment such as discrimination and restrictions in social roles[114].

Depression can also exacerbate the pain and distresses associated with a physical health problem, as well as adversely affecting its outcome. Depression is generally thought to be a time-limited disorder, but when it accompanies a chronic physical health problem the duration and prognosis of the condition is likely to be longer and more significant [115].

There is, evidently, considerable overlap between mental and physical health[116]. 46% of people experiencing mental health difficulties also have a LTC, and at least 30% of individuals with LTCs also experience poor mental health, such as anxiety and depression[117]. If someone has a LTC, they are 2 – 3 times more likely to be depressed[118]; if someone has more than one LTC, they are 7 times more likely to be depressed[119]. Equally, there is much evidence that mental health difficulties, such as anxiety, increase the risk of poor physical health and reduce quality of life[120, 121]. People with LTCs and co-morbid mental health problems disproportionately live in deprived areas and have access to fewer resources (Department of Health, 2011b).

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[112] Department of Health 2011. Ten Things You Need to Know about Long-term Conditions.
[113] Department of Health 2012. Long-term conditions compendium of Information: 3rd Edition.
[114] Morris, J. 2004. People with physical impairments and mental health support needs: A critical review of the literature. Joseph Rowntree Foundation. http://www.jrf.org.uk/sites/files/jrf/1859352103.pdf
[115] NICE 2010. CG91. Depression with adults with chronic physical health problem: treatment and management. http://www.nice.org.uk/nicemedia/live/12327/45913/45913.pdf
[116] Department of Health (2011a). No Health Without Mental Health Strategy
[117] Cimpean D, Drake RE (2011). 'Treating co-morbid medical conditions and anxiety/depression'. Epidemiology and Psychiatric Sciences, 20 (2), 141–150
[118] NICE 2009. Depression in adults with a chronic physical health problem

[119] Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B (2007). 'Depression, chronic diseases, and decrements in health: results from the World Health Surveys'. The Lancet, (370), no 9590, 851–858
[120] Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B (2007). 'Depression, chronic diseases, and decrements in health: results from the World Health Surveys'. The Lancet, (370), no 9590, 851–858
[121] Department of Health (2011a). No Health Without Mental Health Strategy

Having a mental health problem increases the risk of physical ill health and the risk of dying prematurely. The excess mortality is due to both death from disease and medical conditions as well as due to injury, such as suicide[122]. People with mental health problems have higher rates of respiratory, cardiovascular and infectious disease, obesity, abnormal lipid levels and diabetes. They are also less likely to benefit from mainstream screening and public health programmes (DOH, 2011b).

The cost of such co-morbidity to individuals and services is huge; it increases costs by at least 45%, reflecting the associated distress and negative impact on the individual. £1 in every £8 spent on LTCs is associated with poor mental health, which equates to £8-13b of NHS expenditure[123]. The increased costs are multi-factorial, including: more appointments within primary care, hospital outpatient services, and Accident and Emergency; greater use of medication; and, increased frequency and duration of hospital admissions[124,125,126,127,128.]

Recent policies state that we should be striving to promote and improve the mental health of people living with LTCs, and that we should be intervening early[129]. These advocate better integration and joining up of physical and mental health care, and state that such collaborative care is likely to have significant cost savings[130]. The Department of Health also states that IAPT (Improving Access to Psychological Therapies) services should be developing to encompass the needs of individuals with LTCs, and these interventions should be based on the psychological approach Cognitive Behaviour Therapy (CBT)[131,132,] as this has

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[122] Wahlbeck, K., Westman, J., Nordentoft, M., Gissler, M., Munk Laursen, T. (2011) Outcomes of Nordic mental health systems: life expectancy ofpatients with mental disorders. British Journal of Psychiatry,199:453-458

[123] Department of Health (2010). Improving the Health and Well-being of People with Long-term Conditions. World class services for people with long-term conditions: Information tool for commissioners. London: Department of Health.

[124] Das-Munshi J, Stewart R, Ismail K, Bebbington PE, Jenkins R, Prince MJ (2007). 'Diabetes, common mental disorders, and disability: Findings from the UK National Psychiatric Morbidity Survey'. Psychosomatic Medicine, (69), no 6, pp 543–50.

[125] Fenton WS, Stover ES (2006). 'Mood disorders: cardiovascular and diabetes comorbidity'. Current Opinion in Psychiatry, (19), no 4, pp 421–427

[126] Krein S, Bingham CR, McCarthy JF, Mitchinson A, Payes J, Valenstein M (2006). 'Diabetes treatment amond VA patients with comorbid serious mental illness'. Psychiatric Services, (57), no 7, pp 1016–21

[127] Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B (2007). 'Depression, chronic diseases, and decrements in health: results from the World Health Surveys'. The Lancet, (370), no 9590, 851–858.

[128] Vamos EP, Mucsi I, Keszei A, Kopp MS, Novak M (2009). 'Comorbid depression is associated with increased healthcare utilization and lost productivity in persons with diabetes: a large nationally representative Hungarian population survey'. Psychosomatic Medicine, (71), no 5, pp 501–7.

[129] Department of Health (2011a). No Health Without Mental Health Strategy

[130] Mental Health Network (2012) *Investing in emotional and psychological wellbeing for patients with long-term conditions*. **www.nhsconfed.org/publications**

[131] Department of Health (2011c). Talking Therapies – a 4 year plan of action

been shown to have mental and physical health benefits to individuals in addition to cost savings. CBT is recommended in many guidelines[133].

In Swindon the rate of people whose day to day activities are affected by long term health problems or disability is slightly lower than the national average (Table 37). However, there are still 14,638 individuals who claim that their day to day activities are limited a lot by their long term health problem or disability and 17,664 whose condition limits day to day activity a little.

Table 37 Long term health problems or disability

| | Swindon UA | England |
|---|---|---|
| Total Swindon Population | 209,156 (100%) | 53,012,456 (100%) |
| Day-to-day activities limited a lot | 14,638 (7%) | 4,405,394 (8.3%) |
| Day-to-day activities limited a little | 17,664 (8.4%) | 4,947,192 (9.3%) |
| Day-to-day activities not limited. | 176,854 (84.6%) | 43,659,870 (82.4%) |

Source: Census 2011

However, when you look at those over 65 years census data shows that over fifty per cent say that their day-to-day activities are affected by their long term health problem or disability (Table 38)

Table 38 Long term health problems or disability 65+ 0nly

| | Swindon UA | England |
|---|---|---|
| Total population 65+ | 28,854 (100%) | 8,660,529 (100%) |
| Day-to-day activities limited a lot | 7,521 (26.1%) | 2,326,780 (26.9%) |
| Day-to-day activities limited a little | 7,595 (26.3%) | 2,274,187 (26.3%) |
| Day-to-day activities not limited. | 13,738 (47.6%) | 4,059,562 (46.9%) |

Source: Census 2011

[132] Department of Health (2011a). No Health Without Mental Health Strategy

[133] NICE 2009. Depression in adults with a chronic physical health problem

### 8.3.2 Hearing impairment and sightloss

Whilst all disabilities can have an impact on mental health, deafness can have a profound impact as it impinges greatly on communication and can be socially isolating. Particular attention should be given to ensure that individuals who are deaf can access mental health services[132]. More than 70% of over 70 year-olds and 40% of over 50 year-olds have some form of hearing loss. Approximately 30% of deaf people using British Sign Language (BSL) have mental health problems (primarily mood and anxiety disorders), as opposed to 3.5% amongst registered blind people[134]. This may be due to the association between deafness and social exclusion and reduced educational and employment opportunities. The Department of Health report 'Mental Health and Deafness: Towards Equity and Access' also highlights the difficulties of deaf people in receiving equitable healthcare[135]. 35% of deaf people had problems communicating with their GP; 30% of BSL users avoided going to their GP, and 70% of those admitted to A&E were not provided with a BSL interpreter[136].

It is well documented that people from ethnic minorities in general have significant difficulty in accessing mental health services, and there can be particular issues for deaf people within ethnic minority populations. These relate to cultural sensitivities and to multilingualism within families, which can make it more difficult for an individual to function effectively within their environment[27].

There are more than 10 million people in the UK with some form of hearing loss, or one in six of the population[137]. Data from the GP patient survey suggests that in Swindon CCG area 3.8% of the patients reported deafness or severe hearing impairment[138]. Potentially there may be 2384 people suffering from deafness and a mental health disorder in Swindon.

Sight loss also has a negative impact on individual's mental health and wellbeing. Older people living alone with sight loss are three times more likely to suffer from depression than those without sight loss[139].

### 8.3.3 Learning disability

The interaction between learning difficulties, mental capital and mental wellbeing is profound and important. Estimates of prevalence of mental health problems in people with learning disability vary from 25-40%, depending on the population

[134] Social Exclusion Unit 2004. Mental health and social exclusion. http://www.nmhdu.org.uk/silo/files/social-exclusion-unit-odpm-2004-social-exclusion-and-mental-health.pdf

[135] Department of Health 2005. Mental Health and Deafness: Towards Equity and Access.

[136] Littlewood, R. 2008. Mental Capital and Wellbeing: Making the most of ourselves in the 21st century State-of-Science Review: SR-X5 Comparative Cultural Perspectives on Wellbeing http://www.bis.gov.uk/assets/foresight/docs/mental-capital/sr-x5_mcw.pdf

[137] The Royal National Institute for Deaf People 2011. Facts and figures on deafness and tinnitus; Action on Hearing Loss Information. http://www.actiononhearingloss.org.uk/your-hearing/about-deafness-and-hearing-loss/statistics.aspx

[138] GP practice profiles. http://www.apho.org.uk/PRACPROF/

[139] Evans, J.R., Fletcher, A.E., Wormald, R.P, 'Depression and anxiety in visually impaired older people', Ophthalmology, 114(2): 283-288 (2007)

sampled and the definitions used[140]. It is estimated that approximately 3% of people with a learning disability, compared to 1% of the general population, have schizophrenia[140].

There is persisting concern that many people with a learning disability have poor health due to unequal access to healthcare services. People with learning disabilities may face difficulties in seeking treatment for mental health problems as their problems may be attributed to their learning disability (diagnostic overshadowing) or be classed as challenging behaviour[140,141] .

In 2012 a JSNA for those with Learning Disabilities in Swindon was undertaken which highlighted that:

Adults with learning disabilities identified by their GP had higher prevalence of psychiatric disorders

Anxiety and depression were particularly high among people with downs Syndrome

Schizophrenia rates are 3 times higher in people with Learning Disabilities than in the general population

Adults the Learning Disabilities and ADHD are shown to be more severely affected by mental health problems and less likely to improve over time than people without learning disabilities.

The JSNA also highlighted the need for AWP (mental health service provider) to implement the Green light for mental health: service improvement toolkit[142].

## 9. Mental Health and Wellbeing Services

### Key points

**Service provision**

- There are a wide range of services which support and promote mental health and wellbeing in Swindon. These include services such as the locality teams, Health Ambassador team, housing services; third sector commissioned and non-commissioned services; IAPT+ psychology and counselling services and third sector mental health services.

- There are plans for two new services Swindon Advice Information and Advocacy Hub and Swindon Wellbeing Co-ordination Project which both aim to address perceived weaknesses or gaps in Services. Steps should be taken to ensure interdependent services are acknowledged within these service developments to avoid duplication.

[140] Giraud-Saunders, 2011 Mental health in people with learning disabilities Foundation for People with Learning Disabilities
[141] MENCAP 2004 Treat Me Right Report
[142] Green light for mental health. How good are your mental health services for people with learning disabilities? A service improvement toolkit.

- AWP Secondary Care mental health services have undergone considerable re-organisation over the past 18 months. This was to ensure that people can stay longer in their own homes and receive better support and care wherever they live; reduce people reaching crisis; reducing demand on secondary care services and making seamless transitions and offering personalised support and care.

- The reorganisation appears to have reduced the demand for crisis and specialist mental health services. It also has improved internal referrals which indicates that there may have been an improvement in providing a seamless service.

- However, the introduction of the Primary Care Liaison Service has had a detrimental impact on the IAPT service provided by LIFT. The ethos of the LIFT, Least intervention First Time Service is very patient led not suited to a secondary care step down service. Increasingly, the LIFT service is being used as a secondary care therapeutic services rather than a prevention service with 15% of the current caseload being those with severe and enduring mental health problems. Whilst there is recognition that LIFT should provide a role in secondary prevention the main focus for the service should remain a public mental health service with a focus on those with mild to moderate common mental health problems.

- Department of Health funding for current work undertaken to address mental health issues for those with long term conditions currently ceases at the end of March 2013.

- There are plans to introduce the new payment by results commissioning system which focuses on clustering patients by service requirement and support needs.

- Assertive outreach and Early Intervention services have a higher proportion of BME communities and males than the general population. Those from BME communities are under-represented in specialist services. Females are overrepresented in the Primary Care Liaison services. Overall the white population in Swindon is over represented in mental health services and the Asian/Asian British population under-represented.

- A review of housing provision and floating support for those with mental health problems is currently underway. This should be done in conjunction with all relevant commissioners to ensure that the needs of those being repatriated to the Borough from out of area placements can be met.

### Safeguarding

- In 2011/12 there were 12 recorded safeguarding cases requiring Independent mental health capacity advisors input. In 2012/13 this had risen to 20 cases. This is expected to rise with demographic changes forecast for Swindon in particular in relation to ageing and social isolation.

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- The promotion of advanced care planning is important with regard to the Depravation of Liberty Act.

- A fuller review of Section 136 – mental health capacity act implementation in Swindon is required. There appear to be shortcomings in current provision.

- See the Adult See the Child protocol should be implemented

### Economic Evaluation and Evidence base

- Swindon spent £21,161,000 on adult mental health services in 2010/11 and £22,064,000 in 2011/12 an increase of 4.3%. This was less than the national and regional average but similar to comparator areas. The largest area of spend was on placement accommodation and secure and high dependency placements. The proportionate spend on support services was twice as high as the average for comparator areas in both 2010/11 and 2011/12.

- Swindon spends proportionately more on older people's mental health service residential care than the regional, national and comparator averages.

- Key pieces of NICE guidance are briefly reviewed which point to evidence based interventions including quality standards. Stepped care model is recommended in most areas of mental health. Mental health service user satisfaction in Swindon needs review against the quality standards.

- Evaluation of mental health promotion and prevention initiatives indicates that:
    - early diagnosis and treatment is beneficial
    - alcohol screening in GP practices is beneficial
    - promoting mental wellbeing at work
    - occupational therapy, physical activity and walking schemes are cost effective and beneficial to older people
    - Promotion of Five Ways to Wellbeing
    - Providing settled accommodation for adults receiving secondary mental health services

## 9.1 What services are offered in Swindon?

### 9.1.1 Locality Teams

Localities support and train a team of health and wellbeing workers to secure positive outcomes for residents in Swindon. The team includes:

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**Health Ambassadors,** who are employees who have training and expertise to advise people on steps they can take to improve health and wellbeing. They will build trust and relationships, offer one to one support over a period of time. **Health Befrienders** are people who can motivate, encourage and promote access to opportunities and services that are available to help improve health and wellbeing. They will work informally with individuals and groups to encourage participation and remove barriers. **Health Champions** are people who feel positive about health and wellbeing and can share their enthusiasm and experiences to promote the benefits. They will be a pool of enthusiasts that can be drawn upon as necessary to promote healthy lifestyle messages, specifically supporting national and local campaigns. It is important that these services work closely with LIFT Psychology and Wellbeing Projects.

The team will offer their multi-layered interventions across the Borough of Swindon, with special interests in the most vulnerable groups, including people with mental health conditions. The team will seek to make particular in-roads to communicating and building relationships with organisations that are currently funded to support clients with mental health needs to broaden the scope of participation currently available. The expertise of the team will enable people to consider and act on choices to improve health and wellbeing by offering opportunities which reflect the 5 ways to wellbeing and which help them to:

- Learn about healthier lifestyles (e.g. Let's Get Cooking, children's picnics, physical activity interventions)
- Feel safe and active where they live (e.g. team promotion and awareness raising of what is already available)
- Grow networks (Helping people connect with other people where they live and access local opportunities of interest to them. This may include informal drop ins and coffee mornings, befriending and introductions)
- Take action for change ( Brief intervention work, individual plans and mentoring, promoting smoking cessation and physical activity, befriending for participation)
- Participate – new activities to respond to new interest or new groups, in other cases, people will be supported to take part in opportunities that are already available to them.

The Localities Team, (including the work of Health Ambassadors and Befrienders) can impact greatly on the social support for individuals and families. The localities team play a role in helping people to make connections; to build positive and sustainable relationships and to access mainstream, specialist and peer support. Local drop ins and befriending programmes are a key contributor to people feeling connected to their local community and are a great way of establishing and building friendships and support networks.

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### 9.1.2 Advice, Information & Advocacy Hub Project

As part of the overall Adult Demand Programme, a project has been established to create an integrated Advice, Information & Advocacy Hub for Swindon.

This project has three main elements:

- Development of an Advice, Information & Advocacy Hub Building in the old Sanford House School site in Swindon town centre.

- Co-location of a number of key relevant third sector organisations into the Hub building, with an emphasis on providing collaborative services, improving cross-referrals and developing new ways of working to support people more effectively.

- Creation of a single advice point for all adult health, wellbeing and social care queries (whether relating to statutory or third sector provision) located within the Hub building and can be accessed through a range of routes - in person, by telephone or via a range of social media

The operation of the Advice, Information & Advocacy Hub will be supported through the creation of a new website and service directory that will act as the single point of reference about the services & support available for adult health, wellbeing & social care across all sectors (statutory, private and third). This information will be available to both the public and provider staff across all sectors.

The project will deliver significantly improved access to information, advice, support and services relating to adult health, wellbeing, welfare rights and social care for the people of Swindon. As a result, they will be able to make better choices, live more independently for longer and receive help earlier before crisis points in their lives are reached.

The plan is for a pilot of the single advice point to run from July 2013 and the main Advice, Information & Advocacy Hub to be operational from April 2014.

### 9.1.3 Wellbeing Co-ordination Project

Wellbeing co-ordination is a new approach that uses holistic, person-centered planning to help people:

- Take control of their situation
- Manage their health & wellbeing more effectively
- Build their personal resilience & ability to cope
- Develop their own support networks
- Build their personal independence
- Engage the help they need early in order to avoid reaching crisis points

The approach builds on current best practices across both statutory and third sectors, supports improved joined-up working between organisations and promotes the development of support capacity within local communities. The principles of Five Ways to Wellbeing are central to how the approach has been developed and its ethos.

Recent studies, public consultations and user engagement surveys carried out in Swindon have highlighted a number of reasons people often do not engage help until they reach crisis point:

- Lack of knowledge about the services available
- Difficulty in engaging services – referral routes, criteria, etc.
- Weariness at having to "tell their story" or provide the same information repeatedly
- Lack of co-ordination between service providers
- Carers not being able to leave loved-ones for long enough to engage help
- People lost in "grey areas" where their situation is worsening, but they do not yet meet criteria to get help

We also know that people need additional help when they reach transition points in their lives, such as loss of job, relationship breakdowns, bereavement, onset or worsening of health conditions, discharge from secondary care services.

At the moment, much of the focus within the "system" is on meeting people's clinical needs, but the reasons people struggle to cope are far more holistic – financial issues, social isolation, changes in benefits, etc. People are able to cope with their situation far better if these needs can be met holistically – this approach is about how we can help them to achieve that.

The approach is designed to enable people to take control of their situation and engage the help they need early in order to avoid reaching crisis points. It has been developed around a number of core concepts:

- Sharing of best practices in key working relationships
- Development of person-centred holistic plans
- Adoption of solution focused methodologies
- Ensuring people own plans about themselves
- Improving cross-organisational working
- Avoiding building dependence on services

The aim of the project is to cascade this new way of working across all statutory and principal third sector providers involved in health, wellbeing and social care in Swindon.

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The approach uses the Solution Focus methodology, which focuses on the outcomes people want to achieve rather than historical problems. It builds on the person's past successes, existing resources and support networks to construct incremental steps towards achieving that vision.

Traditionally, there has been a culture of "referral" and "discharge" between the primary and secondary care services, with some signposting to third sector support – this project is about moving to developing far more joined-up collaborative approaches that build on the strengths of each of these services to support an individual at different stages of their journey to wellbeing & independence.

The project aims to address the significant issue of service users' concerns about the transition from secondary mental health care back to primary care services. This will be achieved by a move to a much more integrated approach where there is a phased transition from secondary to primary care services that is perceived by everyone involved as the next stage in an on-going process of recovery.

This new way of working will need key workers in all organisations to focus on the needs of the person's on-going journey, rather than on the services their organisation can provide. As an example, initially a service user may need intensive support in a safe environment provided by one of the sector groups, but over time they will move to being supported in a wider social setting and ultimately into support available within their community. The project is therefore working closely with Swindon Borough Council Locality Teams, Health Ambassadors and local groups to help build support capacity within local communities.

A key element within the approach is that the Wellbeing Co-ordinator acts as a coach/mentor for the person, not a care co-ordinator – the aim is to avoid building dependence on the service and therefore the support provided will be time-limited.

The first stage of implementing this new approach is a pilot looking at 12 people being stepped-down from secondary mental health services back to primary care. This pilot commenced in October 2013 and will run for an initial period of 6 months.

During this pilot, people will be offered a Wellbeing Co-ordinator provided by commissioned third-sector organisations who will work with them as a coach/mentor to develop a personal plan based on their personal priorities and then to help them identify and access the support they need to continue moving forwards.

The Wellbeing Co-ordinator will work with people and their secondary mental health care co-ordinator in the period before step-down to ensure a smooth transition.

The pilot will also establish a centralised register of wellbeing co-ordination plans and the relevant Wellbeing Co-ordinator details, so that when people present to organisations for the first time, there is a way for key workers to check whether plans already exist for them and build on the existing work that is already

underway with that person rather than starting from afresh. It will be important to work with all current services such as LIFT Psychology to ensure that there is a clear understanding of the different commissioned services to avoid duplication and acknowledge interdependencies between services.

If the pilot is successful, the aim is to introduce this new way of working across all relevant organisations involved in health, wellbeing and social care in Swindon.

### 9.1.4 LIFT (Least Intervention First Time) Psychology Service

LIFT (Least Intervention First Time) Psychology service provide primary care psychology and mental health promotion activity in Swindon (and throughout Wiltshire). The service model is based around GP practices with four cluster leads heading up the service for a group of GPs.

The aim of the service is:

"To improve wellbeing and enable clients to cope with life's pressures in an empowering way."

LIFT is an opt in service, so patients are informed about the service and can then choose to make their own appointments. They see anyone over the age of 16 apart from those at acute risk or actively psychotic. The service maintains a 'no wait' policy, and as such patients typically access support from the service within two weeks.

The focus is on brief interventions and most of the interventions provided are based on cognitive behavioural therapy (CBT) or solution focused approaches (although alternative approaches are provided if required).

LIFT run a wide range of psycho-educational courses such as "Stress and Mood Management" or "Emotional Coping Skills" providing an introduction to CBT. Self-help material, bibliotherapy, computer based, courses on Mindfulness, sleep and specific courses for those with learning disabilities are also available. More intense treatments for depression, social anxiety, OCD, PTSD, heath anxiety, phobias, panic with and with agoraphobia, and generalised anxiety disorder.

LIFT also provides Health psychology for those with Long Term Conditions such as diabetes, chronic fatigue syndrome, fibromyalgia, and chronic pain and many others.

In 2012-13, there were 5140 new patients seen in Swindon by LIFT Psychology Service. 35% of these were male and 3% were aged between 16 -18 years old and 6.5% were in the 65 and over age group. 90.3% were White British. 39% of those seen by the service presented with Depression as the main problem, 23% had mixed Anxiety and depression, 16% Generalised Anxiety Disorder.

The service also works with Richmond Fellowship to provided employment support and works with colleges in Swindon to provide mental health promotion advice and psychology support to staff and students.

LIFT Psychology has been providing services in Swindon for 20 years and is an award winning service providing more psycho-educational courses than any other provider. All patients can usually access appointments within two weeks.

The LTCs-developments within LIFT have included:

1. training all of the service's psychology practitioners in providing psychological support to patients who have LTCs with or without co-morbid mental health difficulties (including skills in motivational interviewing and CBT)

2. developing psycho-educational courses for patients for a range of LTCs, which teach them CBT-based techniques to better manage their physical health, with the aim of improving both their physical and mental health functioning (this includes courses for chronic pain, ME / chronic fatigue, diabetes, irritable bowel, obesity, fibromyalgia)

3. providing psychology input on existing (physiotherapy / nursing led) programmes to increase awareness of mental health difficulties and to promote good self-care – these programmes relate to cardiac disease, pulmonary disease, and acute back pain

4. providing individual psychological therapy to individuals with LTCs who are struggling with managing their physical and/or mental health who do not want to or cannot access a suitable psycho-educational course or where they have but are still struggling and therefore require further support

The outcome findings and feedback from patients regarding the service, including the psychological support for people with LTCs, is generally very positive, with large numbers of individuals reporting marked improvements in their mental health and also the self-care regarding their physical health.

This service was setup as a project with timebound funding from the Department of Health and further funding will be required to maintain it in the long term. It should be noted that funding for this work from the Department of Health will currently cease from April 2014.

The service is very focused on prevention and early intervention and promoting mental health and wellbeing in Swindon. This focus should be maintained.

### 9.1.5 Commissioned Voluntary and 3rd Sector Organisations delivering Mental Health Provision in Swindon.

SBC and NHS Swindon have a number of existing contracts in place with the voluntary and third sector to deliver mental health support in Swindon. Existing contracts have not been tendered and have been in place for a long period of time. They are delivering specific posts or projects rather than having an outcome focus. A piece of work is now underway to agree pathways and reshape service to have new contracts in place from 2014.

The focus of new contracts will be to deliver outcomes that support greater independence, that reducing reliance on secondary and primary statutory provision and support the early detection and prevention of mental health.

The third sector mental health provision currently commissioned in Swindon includes:

SWINDON MIND:

- Independent Mental Capacity Advocacy Service (IMCA )
- Independent Mental Health Advocacy Service (IMHA)
- Advocacy, Information and Advice
- What's on Programme, including 121, group support and outreach
- Crisis House

RICHMOND FELLOWSHIP:

- Support people with mental health problems to look and apply for paid work or other job related opportunities. i.e. voluntary work or training.
- Provide assistance to those in employment on managing workplace stress and staying in work.
- Provide guidance and advice to employers of people with mental health problems, including tools on avoiding workplace stress and employment best practice in relation to mental health issues.

MINDFUL EMPLOYER:

- The Mindful Employer Network has been provided in Swindon by Richmond Fellowship.
- Promoting mental health and wellbeing to the employers in Swindon.
- Providing network events and conferences, increasing awareness and knowledge about mental health and sharing good practice.
- Promoting mental health and wellbeing in the work place in the media.
- There are over a 100 employers in the Network, representing 35,000 employees and 24 organisations who have signed the charter for those who are positive about mental health.

TWIGS: (Therapeutic Work In Gardening Swindon)

- Provide occupational opportunities for those who have poor mental health. Including horticultural, wood and contemporary craft tasks.

PHOENIX ENTERPRISE:

- Provide support for people recovering from short and long term mental health through extensive training programs in a work environment

LEAVES: (Local Enterprise and Vocational Employment Schemes)

- Employment and training for people recovering from mental illness.

PASH: (Preservation around self-harm)

- Supporting adults away from self-harm and self-injuring behaviour

### 9.1.6 Non Commissioned Third Sector and associated provision

It is important not to overlook the non-commissioned third sector and voluntary provision in Swindon. There are too many organisations that have a presence in Swindon to list them all in this needs assessment but organisations like Swindon Samaritans; Cruse Bereavement Care; SOBBS etc. make a valuable contribution

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to improving mental health of Swindon residents. There are other organisations both commissioned and non-commissioned which are not directly linked to mental health but contribute to improving wellbeing, for example the Citizens Advice Bureau and Community Legal Advice to name but two.

### 9.1.7 Supported Housing Provision

For people with severe mental illness, housing is an important factor in their mental capital and overall wellbeing. It is therefore essential that we improve access to and take-up of mental health services among homeless people and ensure that such services are designed with the particular needs of these groups in mind and that such services take account of the very diverse range of mental health needs and dual diagnosis and include an outreach element (DoH, 2011a).

Affordable stable housing is a critical need for people suffering from severe and persistent mental illness. There is clear evidence that housing and case management are superior to case management alone. Moreover, there is evidence that clients in housing and support programmes have better quality housing than people receiving standard treatment, or case management including fewer housing problems, better subjective quality of life (regarding housing) and more control over one's housing (Dunn, 2008).

(Dunn (2008) science review for the Foresight report presents a new successful approach in guiding housing provision for people with severe mental illness, which is based on a 'housing first' philosophy, offering a high degree of autonomy and choice for the client. 'Housing first' signals that housing need should precede any other service provision (i.e. addictions and mental illness treatment). In older models, clients would have to demonstrate 'housing readiness' (by being sober or in treatment) before they could gain access to housing and in order to move to greater levels of housing independence (i.e. from group settings to independent living). This older logic has been superseded by an approach that provides housing in independent, scatter-site apartments with flexible supports from trained case-workers, free of any requirement to maintain sobriety or be in treatment.)

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- **Supported housing in Swindon**

Below is a table which shows the number of people with mental health problems in Supported housing in Swindon during 2012/13. (Table 39)

Table 39 Supported housing for people with mental health problems, 2012/13

| **Provider** | **Contract type** | **Number of Clients supported** |
|---|---|---|
| Jephson Homes Housing | MH Long term | 9 |
| Knightstone Housing Association | MH Long term | 10 |
| Stonham Housing Association | MH Long term | 12 |
| Rethink | MH Long term | 7 |
| AWP | MH Floating Support | 61 |
| Jephson Housing | MH Short Term | 14 |
| Knightstone Housing | MH Floating Support | 27 |
| Ridgeway Community Housing Association | MH Short Term Support | 12 |
| Stonham Housing | MH Short term support | 7 |
| Stonham Housing | MH Floating support | 9 |

Source: SBC Housing Commissioner

The total budget spent on housing was £578,140. Short term accommodation averaged a spend of £5,237 per bed; Long term accommodation was provided for an average of £3,898 per bed and Floating support averaged a spend of £295 per head.

The percentage of adults in contact with mental health services in stable accommodation in Swindon is higher than nationally, regionally and by comparator sites. The table below shows the details for 2012/13.

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Table 40 Percentage Adults in contact with Mental Health Services in stable accommodation (2012/13)

| Swindon (UA) | England | South West | Comparator sites |
|---|---|---|---|
| 78.4% | 59.3% | 50.9% | 61.5% |

A review of Supported People support for those with mental health issues is under way and this should be done in conjunction with commissioners looking to repatriate service users who are currently being treated out of area.

### 9.1.8 Secondary Care Services in Swindon

Secondary Mental Health Services are provided in Swindon by Avon and Wiltshire Mental Health Partnership. During 2012/13 AWP introduced their modernisation plan which aimed to ensure that more people will receive support that enables them to manage their mental health effectively within the community and achieve recovery personal to them. This included:

- People with dementia being able to stay longer in their own homes
- People in residential and nursing homes receiving better support for their mental health needs
- Fewer people need support from specialist secondary services including inpatient admissions
- More people supported to continue to live at home as part of their communities
- Less people experience a crisis in their mental health
- People experiencing seamless transitions between services
- Peoples will receive joined up physical health, social care and mental health support both within community and acute hospital settings
- People supported to make choices about their care and receive personalised support.

The new services provided are:

#### 9.1.8.1 All age Primary Care Liaison Service

The aims of the Primary Care Liaison Service (PCLS) are to make available prompt, culturally sensitive, mental health expertise, guidance and information in Primary Care settings. The service can advise, assess and support people experiencing problems with their mental health (and those caring for them in paid and unpaid roles) to recover their mental health and wellbeing.

The PCLS will usually be the first point of contact for people experiencing mental health problems, their carers and their GPs/primary care staff. It is, therefore, a local front door that needs to say “yes” and works alongside people.

The PCLS is an ageless service for all adults and will operate alongside GPs and community/voluntary sector services. Supporting the primary care teams through advice, guidance and signposting will enable a greater number of individuals to receive early and effective mental health support.

The service supports primary care professionals who are concerned about the mental wellbeing of any of their patients, with the overall aim of people getting access to the right care at the right time in a way which suits them.

This approach ensures that the use of secondary specialist mental services is properly targeted and delivered for the most effective time period necessary for the individual. Any transitions back to primary care can then be facilitated with the confidence of mental health expertise as part of the primary care team to support the process.

#### 9.1.8.2 Acute Hospital Liaison Service

The Acute Hospital Liaison team is based at GWH to provide advice and support for clinical colleagues within the acute hospital setting and all age assessment and referral services in ED. The team also provides a treatment service for people on acute wards to manage mental health difficulties and reduce potential delayed transfers of care.

#### 9.1.8.3 Care and Residential Home Liaison Services

The Care Home Liaison Service promotes health and wellbeing for older people. The team offers support and education for staff who provide care to older people in the community. The team provides a flexible and needs-led service which offers specialist advice on mental health issues, including dementia, that affect older people. The service aims to equip staff to better identify and manage problems that arise, and in turn endeavours to reduce hospital admissions and ensure that referrals made to community mental health service are appropriate and timely.

#### 9.1.8.4 Intensive Service

The Intensive service provides a 24/7 safe and supportive alternative to hospital admission for people at a time of mental health crisis in order that wherever possible people can remain at home and can maintain a focus on ordinary living, continue relationships with families and exercise choice and control over the type of help received

The service will ensure that people over the age of 18 requiring emergency assessment get the support and services they need at the right time and in the right place, 24 hours a day, 7 days a week, 365 days a year where one or more of the following apply:

- risk factors require urgent/immediate intensive intervention.
- current support needs significantly greater than those usually required by the service user to remain well within the community.
- significant risk of deterioration with the risk of hospital admission if not addressed.
- an intensive period of treatment is needed to stabilise deteriorating mental health of a service user under the care of a recovery service.

Support, education and advice will be provided for those with mild to moderate needs to support management within primary care.

#### 9.1.8.5 Recovery Service

The aims of the Recovery service are to maximise the control that people with serious mental health problems have over their symptoms, their quality of life and

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the achievement of their ambitions by relieving distress, engendering a sense of optimism and hope for the future and helping people make the most of opportunities to improve their mental health and wellbeing, lead meaningful lives and participate in the wider community.

Whilst the Recovery pathway for each individual will be different key elements of every pathway will focus upon taking a holistic approach towards each person and promoting social inclusion, self-management and independence.

The care pathway will include partnership working with CCGs, Local Authorities and the third sector organisations. Key elements of the pathway are that it:

- Puts the service user needs at the centre of service delivery
- Promotes social inclusion and recovery.
- Delivers choice throughout the pathway.
- Provides the least intervention to be effective first time.
- Provides a "stepped care" approach to delivering assessment and interventions allowing service users to step up and down safely and easily whenever clinically appropriate.
- Facilitates and improves joint working between internal services and external agencies, through the development of shared currency e.g. Recovery Star, Care Clusters

The Recovery Service also incorporates an Assertive Outreach function to service users who need more intensive community services and an Expanded Early Intervention Team, which is designed to engage with young adults in a range of community settings and manage emerging psychoses.

#### 9.1.8.6 Complex Intervention and Treatment Teams (CITTs)

The CITT's offer a range of multidisciplinary services to patients with complex mental health needs (that require CPA or Care Management), and their carers. They are not dementia specific but aimed towards meeting the changing psychosocial and environmental needs of an ageing population and promoting successful ageing. They offer six core components:

- Continuing assessment, intervention & treatment
- risk assessment & risk management
- care planning / care management
- intensive support (preventing hospital admission & facilitating discharge)
- safeguarding
- CPA review of relevant service users

These are supported by Therapy teams supporting both community & in-patient services within that patch.

The overall aim of the service is to enable service users to develop and maintain an optimal level of functioning and quality of life. Every effort will be made to work in a way which respects the person's culture, wishes and values. The needs of

relatives and carers are recognised and they will be offered structured support, education and assessment.

#### 9.1.8.7 Eating Disorder Service.

In Swindon at present there is a very specialist eating disorder service provided at Savernake Hospital by Oxford Health NHS FT. This service provides both inpatient and outpatient services however, it is for those with very severe eating disorders. A community based eating disorder service is provided by the current recovery team as part of the specialist clinical team. However, there is a perceived gap in services for those with less severe eating disorders. Some dieticians at GWH have reported that they have been asked to provide nutritional advice to those with eating disorders without the required psychiatric input. A holistic service which intervenes earlier would improve the quality of life and prevent severe problems for some people. The AWP service specification for community based eating disorder service does not cover the Swindon population.

**9.1.8.8 ADHD and Autism**. At present AWP are commissioned to provide an assessment service for ADHD. The assessment service is based in Bristol and there is no on-going provision for treatment of these individuals. These individuals are referred back to their GPs. Provision within the current service specification with AWP for Swindon residents can be commissioned on a case by case basis.

AWP provide a service to those with Autism however, at present this does not cover Swindon residents.

#### 9.1.8.9 Rehabilitation and Resettlement Service

The rehabilitation element of this service is available to those 18 years and over who may have been retained under the mental health capacity act and have the following:

a) A severe and enduring mental illness. Most clients have treatment resistant psychosis
b) Concurrent complex needs, for example, history of drug and/or alcohol misuse, personality difficulties, autistic spectrum disorder or cognitive impairment (but not dementia)
c) A history of frequent admissions or substantial service intervention or self-neglect and social isolation
d) A considerable degree of functional impairment which results in an inability to perform their activities of daily living and which disrupts relationships.
e) Where assessment has indicated that a structured rehabilitative programme will have a positive impact on the above needs.

The Resettlement element of the service offers care and support to service users, who meet criteria a – c as above and items f & g below

f) Who have been engaged in a structured rehabilitation programme and

g) Have been within an Out of Area placement and require support to reintegrate with local services

#### 9.1.8.10 Inpatient Services

In addition to the Community Services, AWP also provide the following Inpatient Services.

- 18 acute mental health beds (Applewood House)
- 1.6 psychiatric Intensive Care Unit beds (PICU) based in our specialist units in Bristol
- 11 Rehab beds (Windswept House)
- 26 older people beds (Victoria Centre)

#### Adult Acute Inpatient Service

The Adult Acute inpatient service will provide care for Adults in an In-Patient setting, 24 hour, 7 days a week, for people with mental health problems experiencing an acute psychiatric crisis of such severity that cannot be managed at home with the involvement of the Intensive team, Primary Care Liaison and enhanced community services.

The service aims to provide high quality acute care through:

- Comprehensive and co-ordinated acute care services and effective treatments based on the best available evidence
- A service which is safe for everyone
- A safe, clean, comfortable and welcoming physical environment
- Equality of access and experience for all actual and potential service users
- Promote recovery and inclusion for people using acute mental health services.

### 9.2 Commissioning System for Mental Health Services

In 2011/12 a new payment system for mental health services was developed called payment by results (PbR) mandated for use from April 2012[143]. National timescales have slipped and in Swindon work is just beginning on the development and implementation of PbR. In order to implement PbR mental health clusters have been developed[144]. A cluster is a global description of a group of people (i.e. service users) with similar characteristics as identified from a holistic assessment and rated using the Mental Health Clustering Tool (MHCT).

[143] Draft Mental Health Payment by Results Guidance for 2013-14.Department of Health. 2012. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127286/Draft-Mental-Health-PbR-Guidance-for-2013-14-not-accessible.pdf.pdf

[144] Mental health clustering booklet (v.3.0). 2013-2014. Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127287/Draft-2013-14-Mental-Health-Clustering-Booklet.pdf.pdf

They should help to ensure that people coming into contact with all mental health providers will be offered the right package of care, based on best practice, but personalised to meet their individual needs, and focussed on supporting service users to move towards recovery. The clusters are statistically underpinned and definite patterns in the MHCT ratings exist for each. There are 21 clusters arranged under three headings and 8 subheadings. Further details and a description of the care clusters can be found in Appendix 8

### 9.2.1 Mental Health Trust (Avon and Wiltshire partnership) Activity

The overall use of specialist mental health services in Swindon is lower than the national average (see below). However, this does not include out of area placements. This applies to both hospital admissions for mental health disorders and to the number of contacts with community psychiatric nurses. This section looks in more detail at activity provided by the Avon and Wiltshire Mental Health Partnership NHS Trust for Swindon patients in 2011/12 and 2012/13.

#### 9.2.1.1 Community activity

There were a total of 2,483 referrals to community mental health services for adults of working age (AOWA) in 2011/12 and 3056 in 2012/13. This a 23.2% increase due mainly to the introduction of the Primary Care Liaison Service during 2012/13. This will be analysed further below but should be seen in the wider context of an additional 1,198 referrals to mental health liaison services (many of whom are of older people), 812 to services for older adults and 23 to specialist (ADHD and eating disorders) services in 2011/12.

ntion first time approached. It has also put pressure of the LIFT service.

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Table 41 provides a summary of activity over a two year period. Activity appears to have increased between 2010/11 and 2011/12, particularly in the crisis team and 'other' categories. During 2012/13 the new PCLS and Recovery Services were introduced which had some impact on reducing referrals to the crisis team, the early intervention and assertive outreach teams and other services. However, the introduction of this service has meant that individuals are sometimes referred to PCLS rather than LIFT and this has negatively impacted on the least intervention first time approached. It has also put pressure of the LIFT service.

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Table 41 Swindon community mental health referrals, adults of working age 2010/11 and 2011/12.

| Service | 2010/11 | 2011/12 | 2012/13 |
|---|---|---|---|
| **Community mental health team** | 1,231 (58.7%) | 1,215 (48.9%) | PCLS 1895 (62%)<br>Recovery 203 (7%) |
| **Crisis team** | 531 (25.3%) | 771 (31.1%) | 712 (23%) |
| **Early intervention** | 40 (1.9%) | 48 (1.9%) | 30(0.93%) |
| **Assertive outreach** | 36 (1.7%) | 23 (0.9%) | 2 (0.07%) |
| **Other** | 258 (12.3%) | 426 (17.2%) | 214 (7%) |
| **Total** | **2,096 (100.0%)** | **2,483 (100.0%)** | **3056 (100%)** |

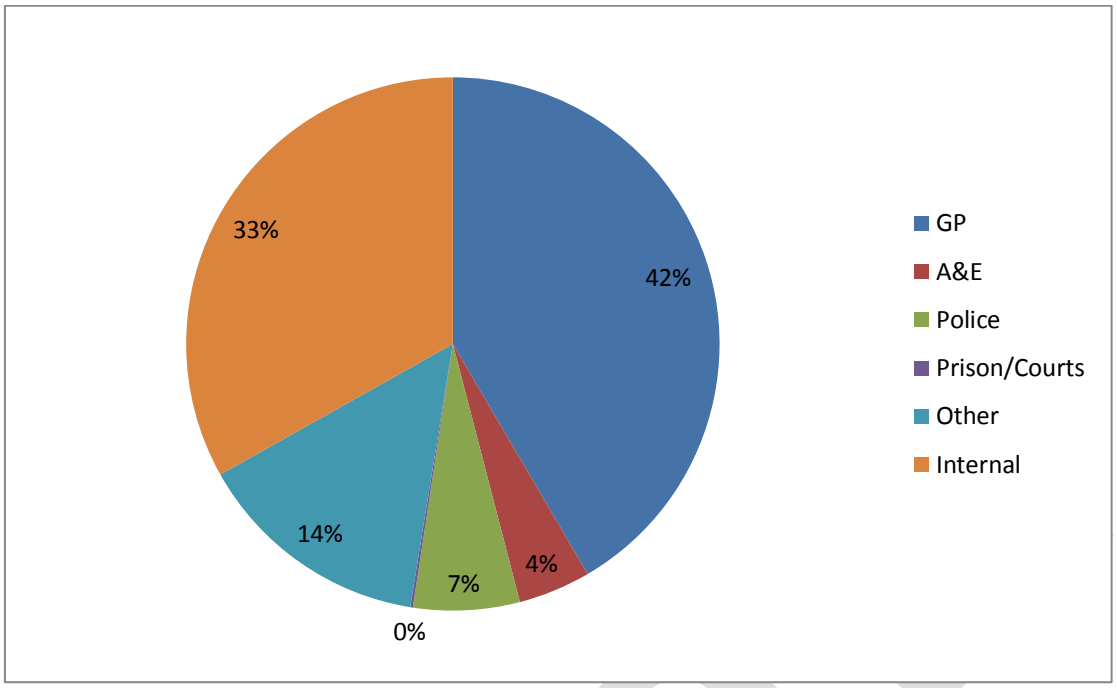
Source: AWP activity data

### Referrals

The biggest single source of referrals to community mental health services is general practitioners, accounting for 2038 (or 67%) referrals in 2012/13. Figure 37 shows that in 2011/12, three quarters of all referrals came from either GPs or internal referrals from within the mental health trust. The pattern varies across specific services, however, with GPs being the source of the large majority of CMHT and crisis team referrals whereas most referrals to 'other[145]' services come from within the mental health trust itself.

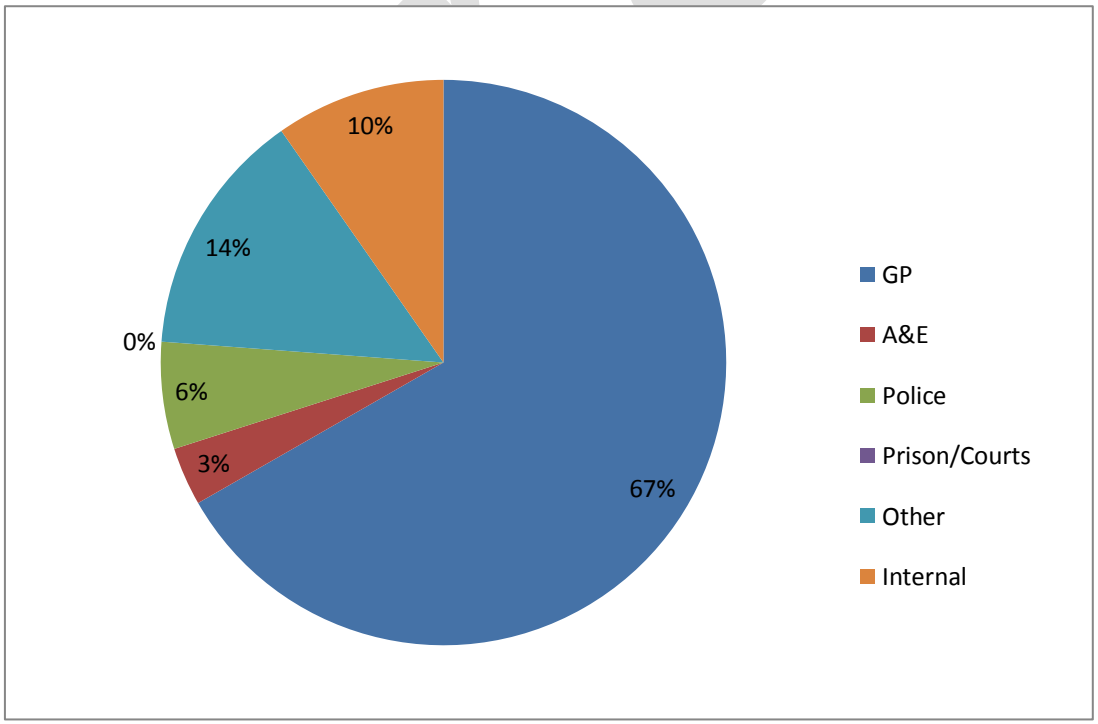
[145] Other services include Psychology and other tertiary services

Figure 37 Source of referrals to Swindon community mental health services for adults of working age, 2011/12.




Source: AWP activity data

Source of referrals to Swindon community mental health services for adults of working age, 2012/13.



At the end of the year 2011/12 there was a total of 1,857 Swindon patients on the AOWA community mental health service caseload (an increase from 1,575 at the end of 2010/11). The caseloads for each service were:

| | |
|---|---|
| Community MHT | 1,207 |
| Assertive outreach | 76 |
| Early intervention | 70 |
| Crisis team | 250 |
| Other[145] | 254 |

At the end of the year 2012/13 there was a total of 1,709 Swindon patients on the AOWA community mental health service caseload (a decrease from 1,857 from the end of 2011/12). The caseloads for each service were:

| | |
|---|---|
| PCLS & Recovery | 1027 |
| Assertive outreach | 47 |
| Early intervention | 57 |
| Crisis team | 185 |
| Other[145] | 393 |

The AWP service redesign model uses a recovery focus which encourages discharge from services when clinically indicated so that patients can engage with primary services where appropriate. It is a step down, step up model which does not retain service users in secondary care treatment longer than necessary.

### Age

Figure 38 gives an overall picture of the age groups served by each community service. The pattern is broadly similar across services with the exception of the early intervention service which predominantly serves a young adult population (under 35 years of age). This reflects the fact that first onset of psychosis is more common in early adulthood than in the older age groups. Note that the percentages in the 18 to 35 year and 35 to 65 year age groups do not always add up to 100% as there can be a small number of services users aged under 18 or over 65 years.

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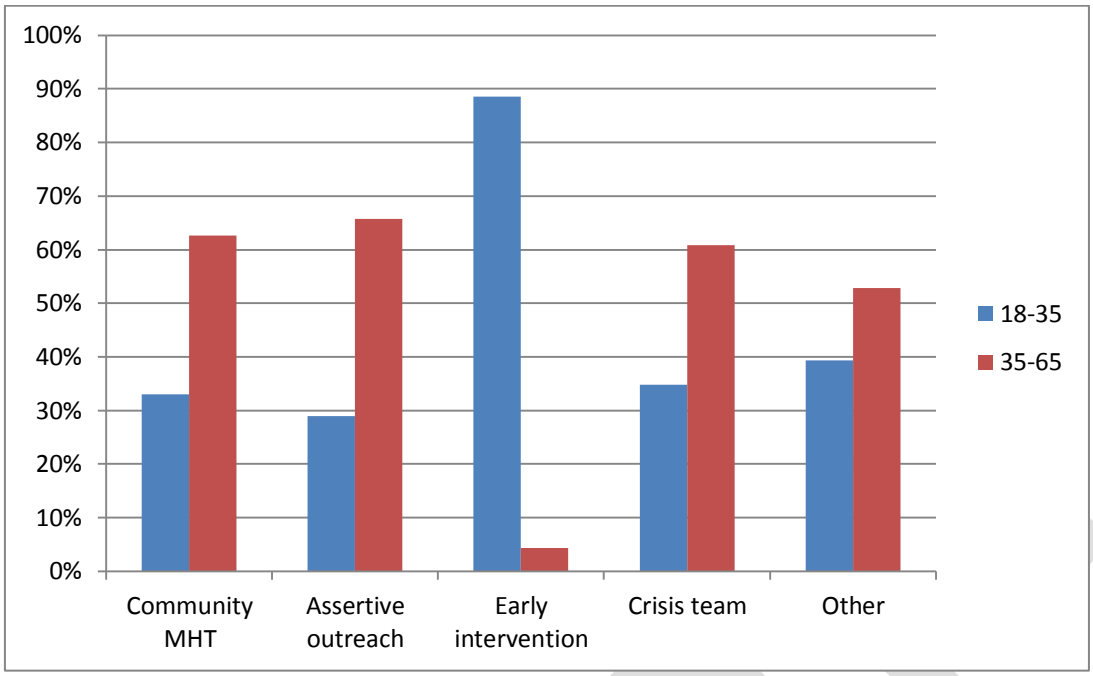
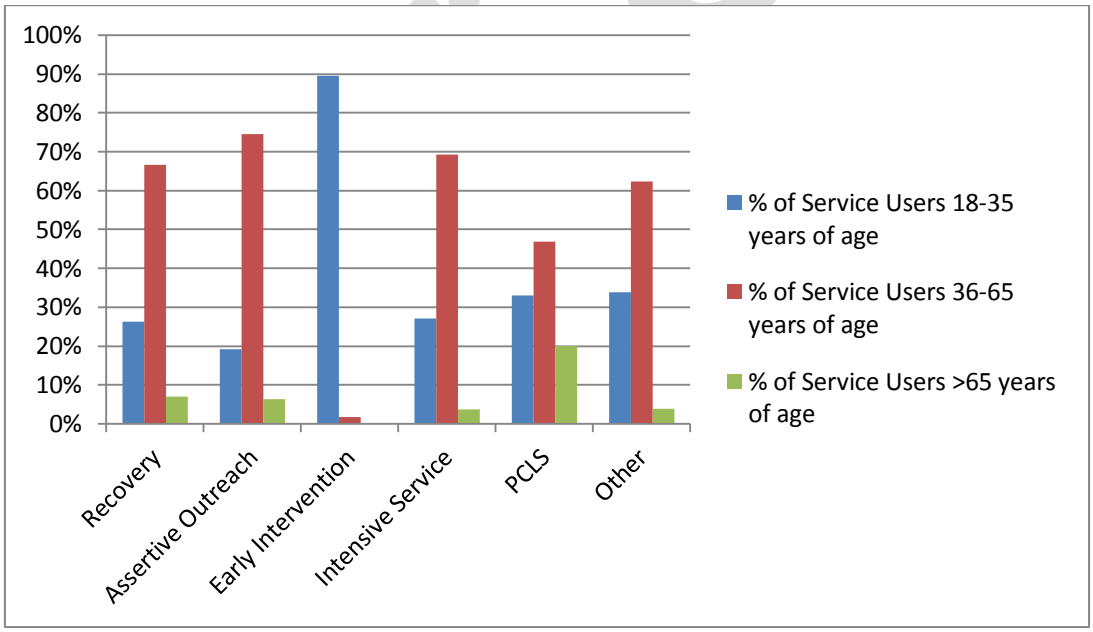
Figure 38 Proportion of Swindon AOWA community mental health services caseloads by broad age group, March 2012[145].




Proportion of Swindon AOWA community mental health services caseloads by broad age group March 2013.




Source: AWP activity data

## Gender and Ethnicity

Figure 39 shows the service caseloads by gender and the proportion in black and minority ethnic (BME) groups. While the total caseload is balanced very evenly between female and male service users the proportions vary across individual services. Assertive outreach, early intervention and crisis team cases are more likely to be male, which is likely to be related to the greater number of people with psychoses being seen by these services. Overall 13.4% of service users were from black and minority groups. However, there was a particularly high prevalence of BME groups represented in the Early Intervention Service (22.9%).

Figure 39 Caseload of Swindon AOWA community mental health services by gender and the proportion from black and minority ethnic groups, March 2012.

| Service | Female | Male | BME Groups* |
|---|---|---|---|
| Community MHT | 54.8% | 45.2% | 14.1% |
| Assertive outreach | 32.9% | 67.1% | 17.1% |
| Early intervention | 41.4% | 58.6% | 22.9% |
| Crisis team | 43.2% | 56.8% | 12.8% |
| Other | 59.4% | 40.6% | 7.1% |
| Total | 51.4% | 48.6% | 13.4% |

Source: AWP activity data

Caseload of Swindon AOWA community mental health services by gender and the proportion from black and minority ethnic groups, March 2013

| Service | Female | Male | BME Groups* |
|---|---|---|---|
| Recovery | 55.9% | 44.1% | 13.6% |
| Assertive outreach | 27.7% | 72.3% | 19.1% |
| Early intervention | 36.8% | 63.2% | 21.1% |
| Intensive team | 45.4% | 54.6% | 17.3% |
| PCLS | 47.1% | 52.9% | 11.9% |
| Other | 50.6% | 49.4% | 11.2% |

*Note: Black and minority ethnic groups are defined here as all groups other than White British.

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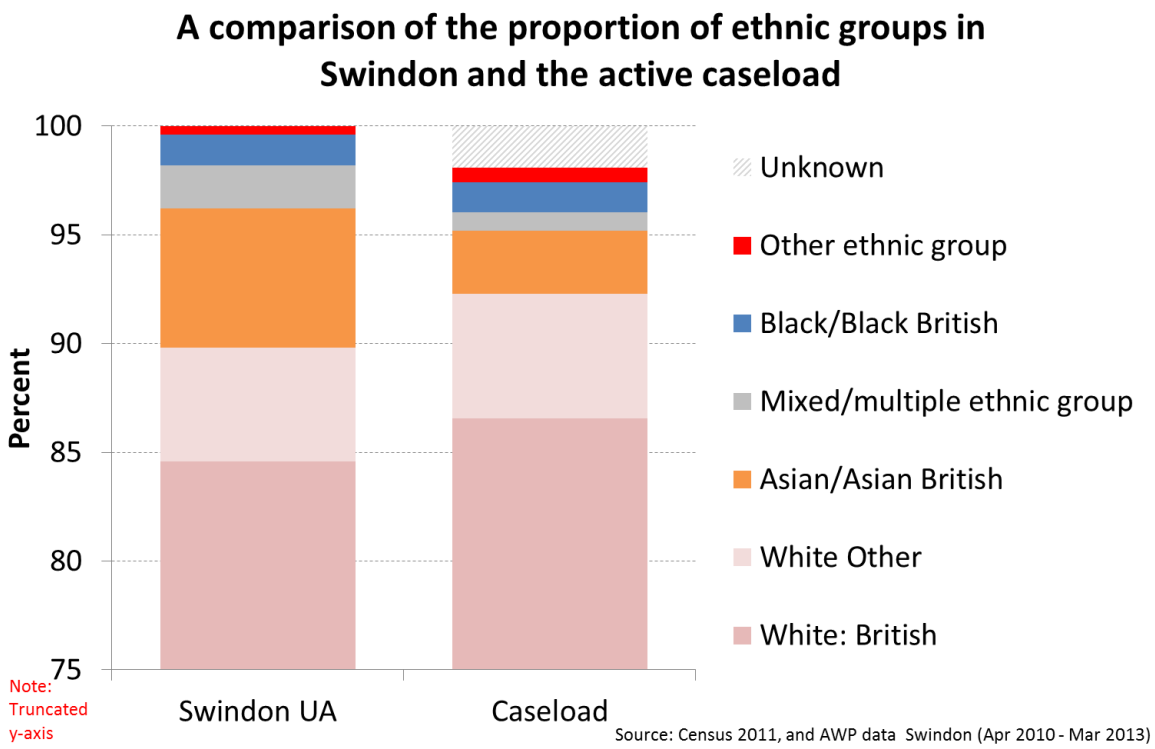
Figure 40 shows a comparison of the proportion of ethnic groups in Swindon in comparison with the active mental health caseload.

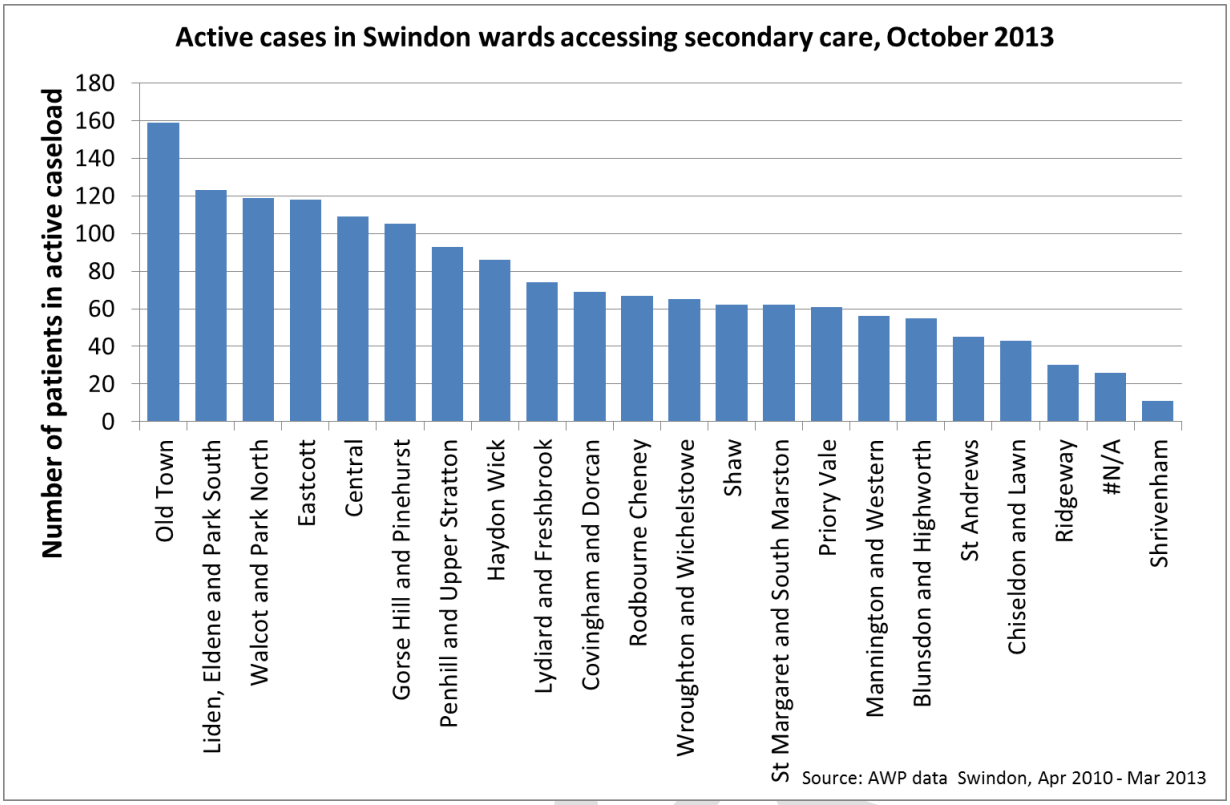



This shows that overall the white population is over-represented in services and the Asian/Asian British population is under-represented in mental health services.

## Place of residence

An analysis has been undertaken of the ward of residents of those on the AWP active caseload (Figure 41). Some supporting housing for those with mental health problems are situated in Old Town which may explain why there are particularly high numbers in this area. The chart demonstrates clearly the association between deprivation and mental health as apart from Old Town, those wards with the highest caseload are amongst the most deprived wards in the Town.

Figure 41 AWP active caseload by ward of residence.




## Length of Stay (or length in treatment)

Most service users are engaged with community health services for some time. The median (middle ranking) length of stay for people still on the caseload in March 2012 was as follows:

| | |
|---|---|
| Community MHT | 251 days |
| Assertive outreach | 666 days |
| Early intervention | 383 days |
| Crisis team | 20 days |
| Other | 100 days |

The pattern had changed quite considerably by March 2013. Whilst the teams are slightly different so caution should be taken with comparing the two years data. However, the Length of treatment for Assertive Outreach had doubled, it had also increased for the Recovery team.

March 2013

| | |
|---|---|
| PCLS | 24 days |
| Recovery | 697 days |
| Assertive Outreach | Figures not available |
| Intensive service | 16 days |
| Other | 80 days |

## Activity by team

Finally, Figure 42 shows the volume of activity undertaken by AOWA community services during the year. The community mental health teams account for just over half (53%) of total activity and some 86% of all activity is carried out in the community rather than day care or outpatient settings in 2011/12. This had decreased slightly during 2012/13 when the PCLS and Recovery Teams accounted for 52% of total activity and 82% of activity was carried out in the community rather than day care or outpatient settings. There was a slight percentage increase in day care contacts during 2012/13 – it was up from 5.5% in 2011/12 to 8.4% in 2012/13.

Figure 42 Activity carried out by the Swindon AOWA community mental health services during 2011/12.

| Service | Community contacts | Outpatient contacts | Day care contacts | Total Contacts |
|---|---|---|---|---|
| Community MHT | 14,567 | 2,680 | 2,008 | 19,255 |
| Assertive outreach | 4,728 | 113 | 0 | 4,841 |
| Early intervention | 3,027 | 82 | 0 | 3,109 |
| Crisis team | 6,428 | 5 | 1 | 6,434 |
| Other | 2,561 | 24 | 3 | 2,588 |
| Total | 31,311 | 2,904 | 2,012 | 36,227 |

Source: AWP activity data

Activity carried out by the Swindon AOWA community mental health services during 2012/13

| Service | Community contacts | Outpatient contacts | Day care contacts | Total Contacts |
|---|---|---|---|---|
| PCLS | 665 | 0 | 0 | 665 |
| Recovery | 11,861 | 2,525 | 0 | 14,386 |
| Assertive outreach | 3,054 | 154 | 0 | 3,208 |
| Early intervention | 1,893 | 111 | 0 | 2,004 |
| Crisis team | 3,465 | 1 | 0 | 3,466 |

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| | | | | |
|---|---|---|---|---|
| Other | 2,793 | 7 | 2,452 | 5,252 |
| **Total** | **23,731** | **2,798** | **2,452** | **28,981** |

#### 9.2.1.2 Inpatient admissions

This section provides a brief summary of admissions of Swindon patients to adult acute mental health wards operated by the Avon and Wiltshire Partnership Trust. There were 211 such admissions in 2011/12 compared to 218 the previous year. Adult acute wards formed the majority of activity in 2011/12, with other admissions of Swindon mental health patients being to older people's services (83 admissions), psychiatric intensive care (20 admissions), and rehabilitation (2 admissions).

Figure 43 Summary of Swindon admissions to adult acute mental health services by age group, gender and ethnicity, 2011/12.Figure 43 provides a summary of the demographic characteristics of patients admitted to adult acute mental health services. The demographic spread of patients is broadly similar to that of the community mental health services users shown above although there is a slightly higher proportion of males admitted and a slightly lower proportion of people from BME groups. This suggests that once people are in the mental health system their age, gender or ethnicity does not substantially affect their likelihood of being admitted to hospital.

Figure 43 Summary of Swindon admissions to adult acute mental health services by age group, gender and ethnicity, 2011/12.

| Characteristic | Proportion of admissions |
|---|---|
| Aged 18 to 34 years | 32% |
| Aged 35 to 64 years | 64% |
| Female | 45% |
| Male | 55% |
| Black and minority ethnic group | 10% |

Source: AWP activity data

Note that there were also a very small number of admissions of patients aged 65+. Again, Black and minority ethnic groups are defined here as all groups other than White British.

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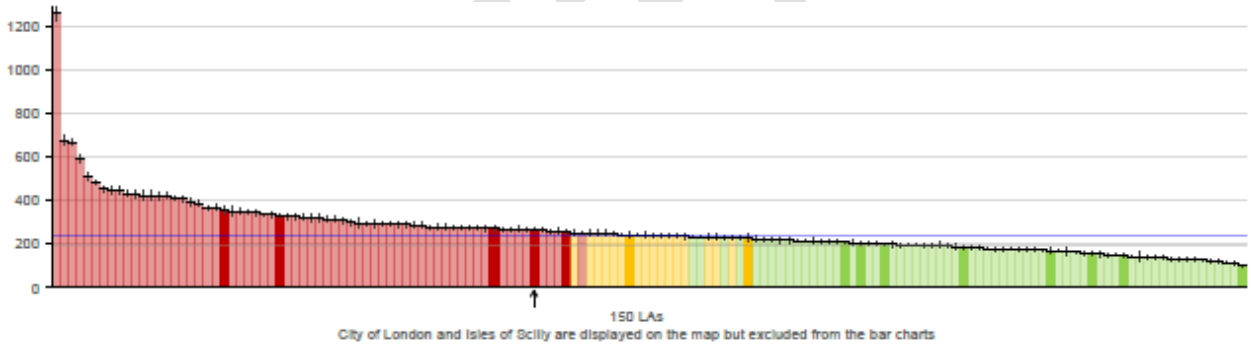
**2012/13**

| Characteristic | Proportion of admissions |
|---|---|
| Aged 18 to 34 years | 24% |
| Aged 35 to 64 years | 69% |
| Female | 40% |
| Male | 60% |
| Black and minority ethnic group | 13% |

The Community Mental Health profile shows that Swindon has statistically higher admission rates compared to England and the South West.

Figure 44 Directly standardised rate from hospital admission for mental health 2009/10 to 2011/12 by ranked by Local Authority (the small arrow indicates Swindon UA)

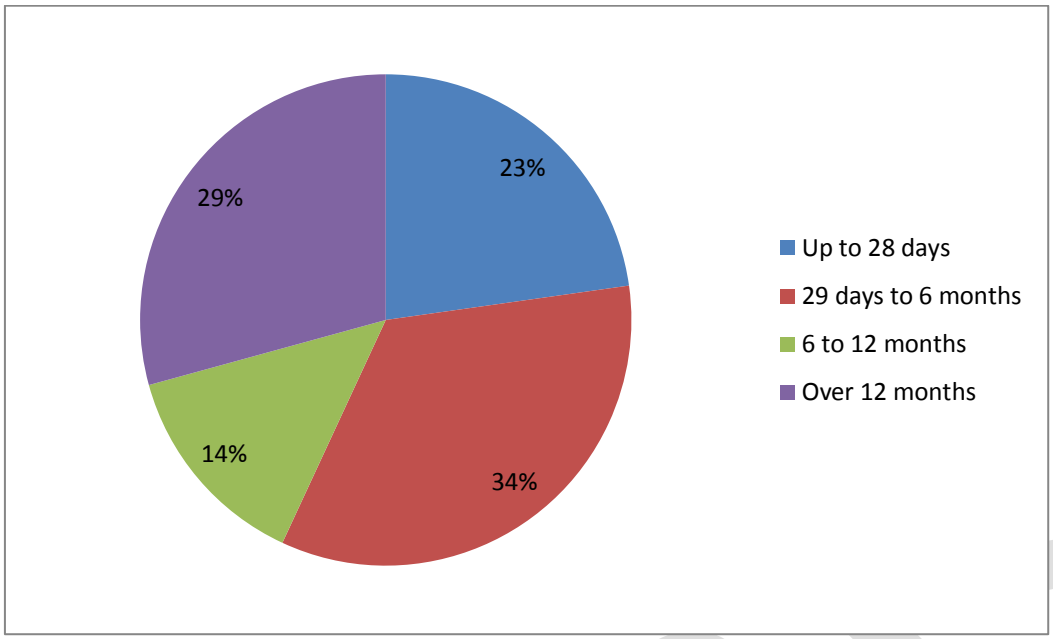



**Data source(s)**
Hospital Episode Statistics, The NHS Information Centre for health and social care, and the Office for National Statistics

Red = Statistically worse, Amber = average and Green= significantly better than the English average. Taken from the Community mental health profile 2013 produced by the North East Public Health Observatory.

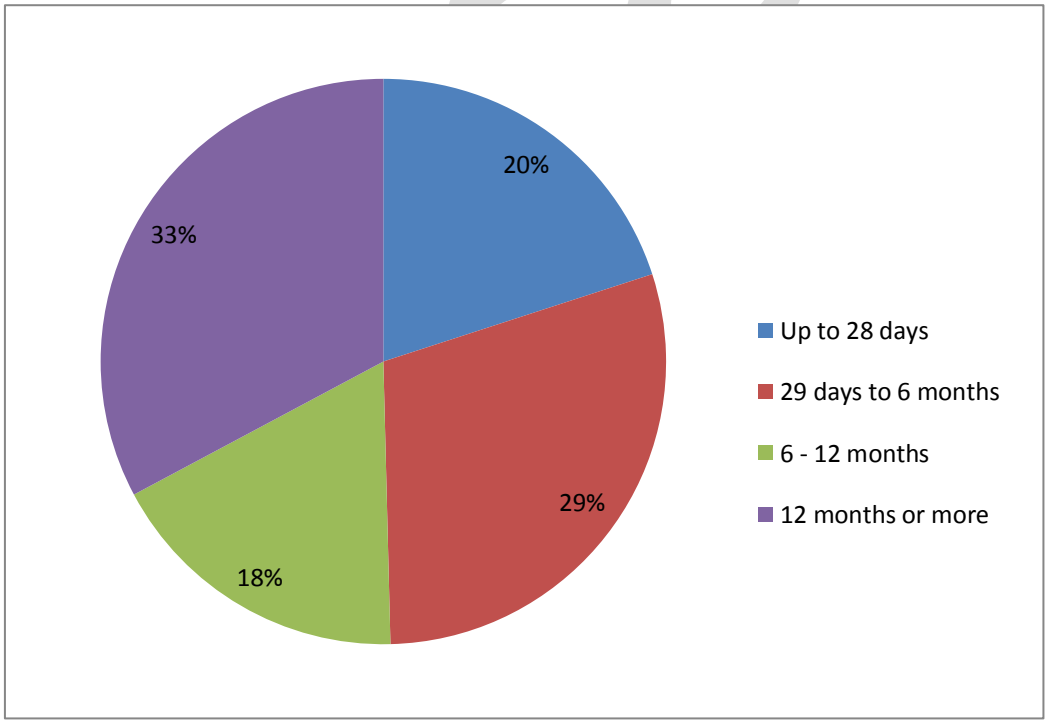
There are 18 adult acute beds allocated to Swindon patients and there was an average of 92% occupancy over the course of 2011/12. This does not include time when patients were on leave from the hospital. Over half (58%) of the admissions during the year were re-admissions. Figure 45 shows that the majority of these re-admissions (71%) had been inpatients within the last 12 months. A small number of these (13 patients) had actually been re-admitted within a week of their last inpatient spell. 106% occupancy 2012/13

Figure 45 Re-admissions of Swindon patients to adult acute mental health wards by the time elapsed since their previous admissions, 2011/12.




Source: AWP activity data.

**Re-admissions of Swindon patients to adult acute mental health wards by the time elapsed since their previous admissions 2012/13**




Secure and high dependency services will, after the 1st April 2013, be part of NHSE Specialised Commissioning portfolio.

#### 9.2.1.3 Out of area placements

A review of out of area placements has been undertaken and the CCG and Borough Council are committed to providing complex care closer to home and reducing the number of people in hospital placements and those who remain in units for long periods. This includes care for those with dual diagnosis learning disabilities/mental health and autism/mental health or challenging behaviour. This review has included changes to commissioning polices and operational plans the decision making process with regard to complex care placements.

### 9.3 Safeguarding

The Mental Capacity Act outlines the requirement for IMCAs (Independent Mental Capacity Advisors) to support people in making decisions about where they want to live, medical treatment, care reviews and in some circumstances managing finances. Following the local Safeguarding Adults at Risk Policy, the safeguarding investigating manager must consider making a referral to the IMCA service if the alleged victim or alleged abuser:

- Is assessed to lack capacity to make a decision that is pertinent to the investigation and there is no one to represent and support the person in his or her decision
- Is assessed to lacked capacity to make a decision that is pertinent to the investigation and although they have family or friends there is evidence to suggest that there is no one who would be capable, appropriate or willing to act in the person's best interest (this only applies in safeguarding situations)
- A request to the IMCA service would be of particular benefit to the person assessed as lacking in capacity.

The Adult Safeguarding Service reported that in 2011/12 there were 12 recorded cases where adult abuse had been alleged and required the input from the IMCA service. In 2012/13 out of a total of around 400 cases referred by the investigating team to the Adult Safeguarding Service, 20 required the input of an IMCA. This does not reflect the number of referrals to the IMCA service from the investigative teams which will be much higher and needs to be seen in the light of an overall 33% increase in safeguarding alerts over the year. In 2011/12 there were 84 referrals to the IMCA service and 78 in 2012-13.

At present there is no benchmarking of the number of cases requiring input from IMCAs on a regional or national level so it is difficult to estimate if the referral rate in Swindon is in line with other areas. However, the Adult Safeguarding Service expressed the view that they thought the number of cases should be higher. During 2013/14 there is a requirement to collect data on this matter and reports will enable us to compare the activity to other areas.

In Swindon the Independent Mental Capacity Service (IMCA) is provided by MIND who has 1 FTE (two workers) post. The number of referrals to the IMCA service has decreased from 84 in 2011/12 to 74 in 2012/13.

In the first three quarters of 2012 the service worked on 12 cases of adult protection, 7 case reviews, 6 cases involving Deprivation of Liberty (39D), 33

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cases regarding accommodation, 5 cases involving Serious Medical Treatment and 1 case of safeguarding. (This needs to be reviewed for consistency.)

Demographic changes in the population of Swindon such as social isolation and family fragmentation and aging, will have an impact on the demand for IMCA services. Advanced care planning should include mental capacity issues particularly when an individual is diagnosed with a condition that is likely to have an impact on mental capacity such as dementia, motor neurone disease, Korsakoff's, brain injury, Parkinson's Disease, Learning Disabilities etc.

With regard to Depravation of Liberty more work should be done to promote the importance of have an advanced care plan which reflects mental capacity. Ensuring networks are in place to ensure that individual's choice is accommodated when/if they are unable to be in charge of their own legacy. Resilience is about how understanding how to make our own wishes known and acted upon. It is about enabling the individual to continue to be the person they always were.

### 9.3.1 See the Adult See the Child

Central to the development of the See The Adult See The Child Protocol is the premise that the provision of appropriate support services to parents reduces the likelihood of difficulties for children in the family and that it is important to assess the needs of all family members and to adopt a whole family approach to assessment. The aim of working together is to address the problems created by professionals working in isolation and sometimes even working at cross purposes with their colleagues in other agencies. The complimentary perspectives of children and families and adult services professionals are essential if a holistic and comprehensive service is to be provided to families.

The See the Adult See the Child protocol specifically addresses the safeguarding of children and young people, including young carers, whose lives are affected by parents/carers using drugs/alcohol or by parents/carers with mental health problems, learning disabilities, domestic abuse or other complex problems. The protocol sets out to establish a clear framework at operational level in Swindon for how and when children's and mental health/substance misuse/CPTLD/ Probation/Domestic Abuse services must work closely together and address issues of:

- The appropriate sharing of information about the needs of parents and children within agencies and across agency boundaries;
- The joint assessment of families' needs by professionals from adult and children's services.

The protocol sets out a good practice for professionals and managers at all levels when working together with vulnerable families and is consistent with the Swindon Local Safeguarding Children Board and Swindon Local Safeguarding Adults Board procedures.

The Swindon Recovery Team which supports adults with chronic mental health problems in Swindon report that 102 individuals on their caseload have children.

### 9.3.2 Mental Health Capacity Act - Section 136

In Swindon it has been recognised that there is increasing pressure to address some of the issues regarding police and mental health. The police are commonly the first point of contact for a person in a mental health crisis and up to 15% of incidents with which the police deal are thought to have some kind of mental health dimension[146]. This figure could well be higher and within police circles a figure of 20% is often quoted.

Table 42 Arrests and Section 136 detentions in Swindon LA area.

| Year | Total number of arrests | Section 136 (number) | Section 136 (percentage of total arrests) |
|---|---|---|---|
| 2010 | 6,918 | 76 | 1.1% |
| 2011 | 6,510 | 64 | 0.9% |
| 2012 | 5,881 | 40 | 0.7% |

Source: Wiltshire Police

Table 42 shows a fall in the number of arrests and the number of Section 136 detentions over the last three years. During 2012 there was a concerted effort within Wiltshire Constabulary to improve officers understanding of the use of 136 and other appropriate powers they might consider as an alternative.

Guidance to commissioners from the Royal College of Psychiatrists on section 136 of the Mental Health Act[147] recommends that:

1. The custody suite should be used in exceptional circumstances only.
2. A vehicle supplied by the ambulance provider should be able to attend promptly so this is used for conveyance unless the person is too disturbed.
3. The AMHP (Accredited Mental Health Professional) and doctor approved under the section 12 (2) of the Mental Health act should attend within 3 hours in all cases where there are not good clinical grounds to delay assessment.
4. The first doctor to perform a Mental Health Act assessment should be approved under Section 12(2) of the Act.
5. A monitoring form should be agreed locally to meet all the national requirements and should be completed in all cases.
6. Commissioners should ensure that there is a multi-agency group meeting to develop, implement and quality assure the agreed policy. This group should review the monitoring data. It should also consider how the need for use of Section 136 might be reduced.

[146] Briefing 36: The police and mental health. Sainsbury Centre for Mental Health Sept 2008

[147] Guidance for commissioners: service provision for Section 136 of the Mental Health Action 183 Position Statement PS2/2013 April 2013.

Section 136 of the Mental Health Act 1983 allows a police officer to remove a person they this is mentally disordered and 'in immediate need of care of control' from a public place to a place of safety, in the interest of that person or for the protection of others. The person may be detained for up to 72 hours so that they can be examined by a registered medical practitioner and interviewed by an approved mental health professional (AMHP) and to make any necessary arrangements for their treatment or care.

Good progress has been made towards achieving some of these recommendations.

Sandalwood Court (AWP) is used as a mental health place of safety (MHPoS) for Swindon. However, this is only for adults 18 years and over. Further work is needed to ensure if this accommodation could meet the needs of those under the age of 18. The nearest place of safety for those under aged 16 – 17yrs is Fountain Way in Salisbury. This facility does not accept individuals from Swindon so those under the age of 18 years in Swindon detained under S136 are taken to custody. Work is currently underway to address this issue. Clarification is required as to the suitability of Swindon's currently MHPoS for the elderly and those with intellectual disabilities.

There is some lack of clarity regarding those individuals who are violent or under the influence of drugs or alcohol. The guidance states that those "individuals who are intoxicated should not be excluded from the MHPoS unless they need acute medical intervention or are too behaviourally disturbed to be safely managed".

At present those detained under Section 136 are transferred by police vehicle to the place of safety this is in contradiction to the guidance which states that individuals should be transferred by the ambulance service provider (which should attend within 30 minutes). The police should accompany the individual to the MHPoS.

It has been recognised that the police have very little training on mental health. For many frontline officers they will have received 1 -2 hours of training during their initial induction and this may have taken place many years ago. Multi-agency Mental Health First Aid training was provided in Swindon in the last few years but uptake from the police at that time was minimal. An e-learning mental health package has also been developed to update front line officers and mental health services have also offered to provide some support with training. A combination of these training options would be beneficial for front line officers in Swindon and Wiltshire. The multi-agency Section 136 monitoring group has been established and has discussed the benefits of work shadowing between agencies so that different service providers can see the issues facing their colleagues in different services and how the responses from each service impacts on each other. Work is on-going to develop further mental health training for police officers, both in-house and with the support and assistance of external agencies.

In order to provide the most appropriate response for an individual under the age of 18, the police have started a S136 pilot with CAMHS, whereby they can contact the service to discuss an individual's needs and in certain circumstances practitioners from CAMHS can speak to the young person and may be able to avert the necessity to detain. This may reduce the number of S135 detentions but the aim is to ensure the best interest of the young person and the most appropriate care to individuals. This will involve very low numbers but may be a model which could be explored for adult services either with AWP Intensive Team or Primary Mental Health Liaison team.

Broader issues regarding mental health include the need for better access to mental health assessment within custody with the possibility of using Court Justice Liaison Service Nursing Staff within custody rather than awaiting attendance at court for this assessment. Health services for custody service, previously

commissioned by the police will now be commissioned by the NHS specialist commissioning service and this will provide a good opportunity to ensure optimum mental health services within custody.

G4S Forensic and Medical Services provide health care services in Wiltshire custody suites. In Melksham, Salisbury and Swindon Custody Suites during 2012/13 there were 1205 mental health assessments undertaken by G4S (this includes 3 formal, 629 mental health state and 573 non-acute mental health assessments[148]). This represents just over 10% of the total number of arrests for Wiltshire, slightly less than the estimated 15 -20% of police workload cited above.

The community policing services may also have a role to play within the community with regard to identifying individuals with possible mental health problems and also offering assurance particularly with regard to anti-social behaviour and security which could provide additional assurance to those with mental health problems who often feel vulnerable. This issue was raised at the mental health service user focus group. At present it is not known how much liaison there is between different Neighbourhood Policing Teams with regard to sharing good practice and each team has their own initiatives in place. Work is on-going to assess current practice within Neighbourhood Policing Teams.

### 9.3.3 Section 136 data from AWP

For the period Jan – June 2012 there were a total of 76 admissions to the 136 suite. Table 43 below shows the age and gender of those admitted during this period.

Table 43 Number of admissions to the 136 suite at Sandalwood Court by age and gender

| Age | Male | Female | Total |
|---|---|---|---|
| 18- 25 | 6 | 11 | 17 |
| 26 – 45 | 23 | 11 | 34 |
| 46 - 64 | 5 | 13 | 18 |
| Over 65 | Less than 5 | Less than 5 | Less than 5 |

[148] **Mental Health Non-acute** includes history of depression, anxiety, learning disabilities or difficulties, and developmental conditions such as Dyslexia or Autism.
**Mental state examination**; previously informal mental health assessment, is used where there are mental health concerns but a formal mental health assessment may not be indicated.
**Formal mental health assessment;** as per The Mental Health Act is an assessment with an AMHP and Section 12 Dr (not provided by G4SFMS) and is only indicated where the patient may need to be sectioned under the Mental Health Act for their, or the public's, safety. As G4SFMS clinicians are not usually involved in these assessments we do not have accurate data for this, the below is only where G4SFMS may have provided input for FMHA.

| | | | |
|---|---|---|---|
| Unknown | | | 4 |
| Total | 35 | 36 | |

Source: AWP

Of the 76 admissions 72 were white British and 3 had no ethnicity recorded. There were no non-white admissions.

Of the 76 individuals 28 were seen within 4 hours and an additional 25 were seen 4 – 9 hours after admission.

| **The reasons for detention were as follows:** | |
|---|---|
| Suicide Ideation | 31 |
| Suicide attempt | 5 |
| Endangering self | 16 |
| Bizarre Behaviour | 11 |
| Paranoia / reported voices/delusional speech | 5 |
| Carrying weapons/Violence/aggression /Damage to property | 4 |
| Unknown | 4 |

| **Place of detention** | |
|---|---|
| General public place | 65 |
| A&E | 3 |
| AWP | 1 |
| Police Station | 2 |
| Private property | 12 |
| Unknown | 4 |

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| Outcome | |
|---|---|
| Discharged to home address | 44 |
| Not recorded | 7 |
| Returned to custody | less than 5 |
| Admitted informally | 12 |
| Admitted section 2 | 9 |

The crisis team was in attendance for 55 of the 76 admissions 6 were not recorded.

Much of the quality standards data is not routinely collected by AWP. From the data shown above, at present the majority of those detained under 136 are not assessed within 4 hours which is the quality standard. A large majority are discharged to their home address but data collected does not show how these individuals are followed up. A more in depth review of Section 136 detentions should be undertaken to ensure that this service meets the quality standards outlined in the NICE clinical guidelines 136.

## 9.4 Economic Review

In 2008 the King's Fund report[149] 'Paying the Price' estimated that the direct costs of mental health in England were £22.5 billion and likely to increase to £32.6billion by 2026, both based on 2007 prices. This excludes the indirect impact such as that on the criminal justice system or business: however cost estimates double if lost earnings are included as well. Part of the increase is likely to be due to more services for people with dementia. 12% of the NHS budget in 2007 was spent on mental health services. In Swindon in 2011/12, 10% of the PCT budget was spent on mental illness, accounting for over £31million[150].

This chapter will look at two aspects of economic review for Swindon:

- Current spend on services and how this compares to other areas

[149] http://www.kingsfund.org.uk/sites/files/kf/Paying-the-Price-the-cost-of-mental-health-care-England-2026-McCrone-Dhanasiri-Patel-Knapp-Lawton-Smith-Kings-Fund-May-2008_0.pdf

[150] http://www.swindon.nhs.uk/Library/Publications/About_us/Annual_reports/Swindon_Annual_Report_11_12.pdf

- Recommended interventions and potential return on investment compared to current service provision

It will also, inevitably, highlight further questions and gaps in both data and information. Research is more widely available on the economic evaluation of mental illness services rather than mental well-being[151] as this is more difficult to measure both in terms of outcomes and over time.

### 9.4.1 Spending on Mental Health Services in Swindon

The data used for this section is based on internal financial monitoring data reflecting spend on mental health services by both Swindon Primary Care Trust (prior to 1st April 2013) and now the NHS Swindon Clinical Commissioning Group (CCG), and Swindon Borough Council (SBC), financial mapping returns to the Department of Health (DoH) reported in the National Survey of Investment in Adult Mental Health Services. Financial mapping returns refer only to adult services but include social services as well as health spend: they are based on expected outturn and collected by local implementation teams, co-ordinated centrally by Mental Health Strategies on behalf of the DoH.

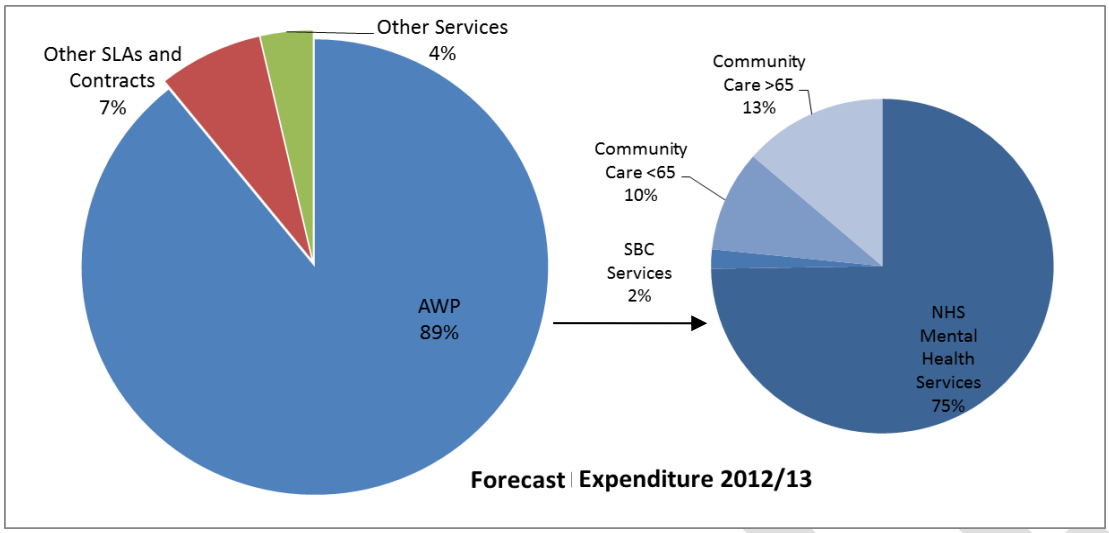
Forecast expenditure for commissioned mental health services in Swindon for 2012/13 is £22million, 89% of which is a block contract with Avon and Wiltshire Mental Health Partnership (AWP). Other services include a contract with Oxfordshire Health Services who provide for people living on the Swindon / Oxfordshire borders and also for doctors providing mental health assessments under Section 12 of the Mental Health Act 1983[152]. Contracts are also needed for services which are provided out of area where there may be specialist expertise not available within Swindon or Wiltshire.

Three quarters of the AWP contract is for NHS Mental Health Services which includes hospital based diagnostic and treatment services including those for people with severe and enduring mental illness. 23% is mental health community care provision.

[151] Zechmeister I, Kilian R, McDaid D (2008) Is it worth investing in mental health promotion and prevention of mental illness? A systematic review of evidence from economic evaluations BMC Public Health 8:20

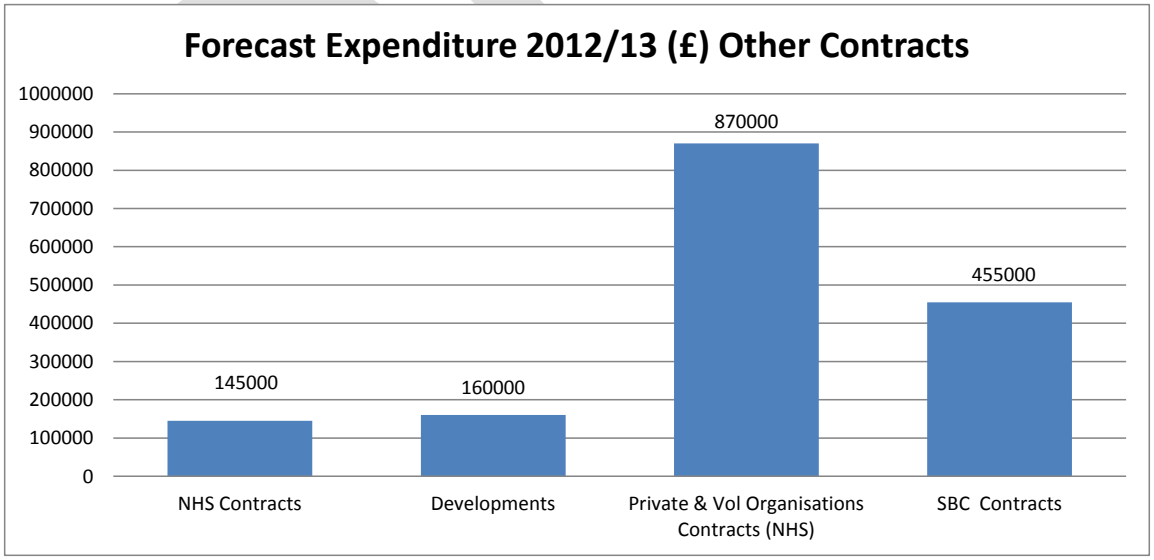
[152] This requires that in those cases where two medical recommendations for the compulsory admission of a mentally disordered person to hospital or for reception into guardianship are required one of the two must be made by a practitioner approved for that purpose under Section12 (2) of the Mental Health Act 1983. http://www.guideweb.org.uk/section12/section121.html

Figure 46: Forecast Expenditure for Commissioned Mental Health Services 2012/13 (S75 Financial Monitoring Returns)




Other services include support for people with less severe mental illness including IAPT (Increased Access to Psychiatric Therapies). According to Sec 75 Financial Monitoring Returns forecast spend for 2012/13 for IAPT services was £584,000. The chart below shows spend on other (non AWP) contracts. NHS Contracts include those patients who access other providers for different specialisms not available locally. Developments includes mental health assessments provided by doctors under Section 12 of the mental health Act. Private and Voluntary Organisations Contracts includes placements for people in specialist care homes, supported living and specialist hospitals such as the Priory.

Figure 47: Mental health commissioned services excluding AWP (S75 Financial Monitoring Returns)

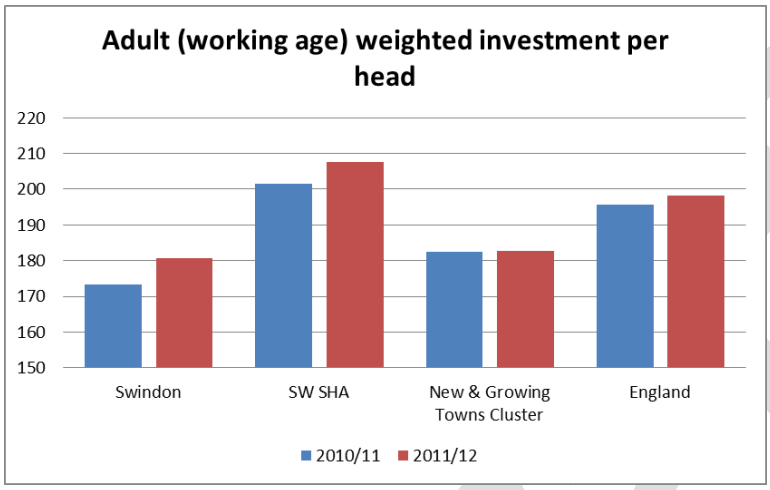



Perhaps more useful in identifying variation is the Finance Mapping Reports on mental health services for working age adults and older people based on returns to the Department of Health. These provide data for Swindon and comparisons with:

- South West Strategic Health Authority
- An ONS Cluster 'New and Growing Towns'
- England

Cost data is provided together with weighted investment per head based on working age population, as well as proportion of spend by type of service. These reports show Swindon spent £21,161,000 on adult mental health services in 2010/11 and £22,064,000 in 2011/12: an increase of 4.3%.

Figure 48: Adults investment per head on mental health (Department of Health Financial mapping Returns)




Weighted investment per head increased from £173.3 in 2010/11 in Swindon to £180.7 in 2011/12. Levels are similar to the new and growing towns cluster but less than South West SHA average.

The largest areas of spend are placements accommodation (19.4% in 2010/11; 18.4% in 2011/12) and secure and high dependency (19.7% in 2010/11; 20.1% in 2011/12). Placement spend is all to the non-statutory sector (voluntary, independent and private).

Whilst spending on secure and high dependency is similar to other areas, both the proportion spent on accommodation and the weighted investment per head is significantly higher than the comparator areas, given the lack of specialist mental health provision in Swindon. This includes low secure, community accommodation which other areas may include as part of a block contract. Secure and High Dependency services will, after the 1st April 2013, be part of the Specialist Commissioning Teams remit rather than the responsibility of the CCG.

The projected cost of out of area placements for 2013/14 is £4.7 million.

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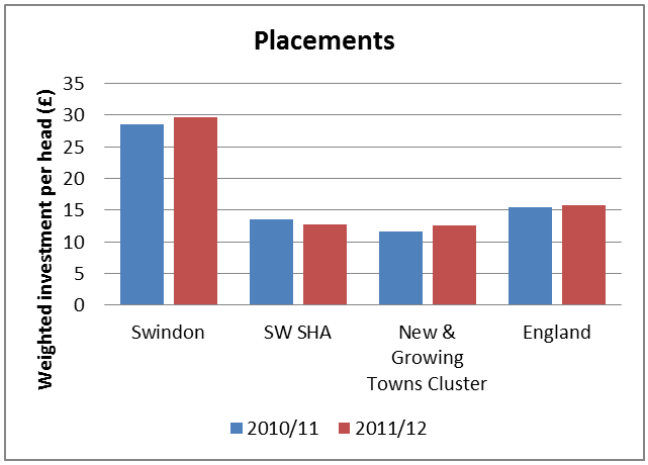
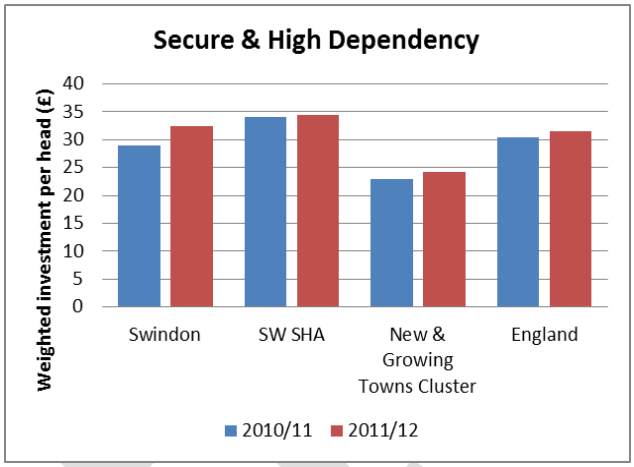
Figure 49: Spend on Adult Mental Health Services for Accommodation and Secure and High Dependency Placements (Department of Health Financial Mapping Returns)



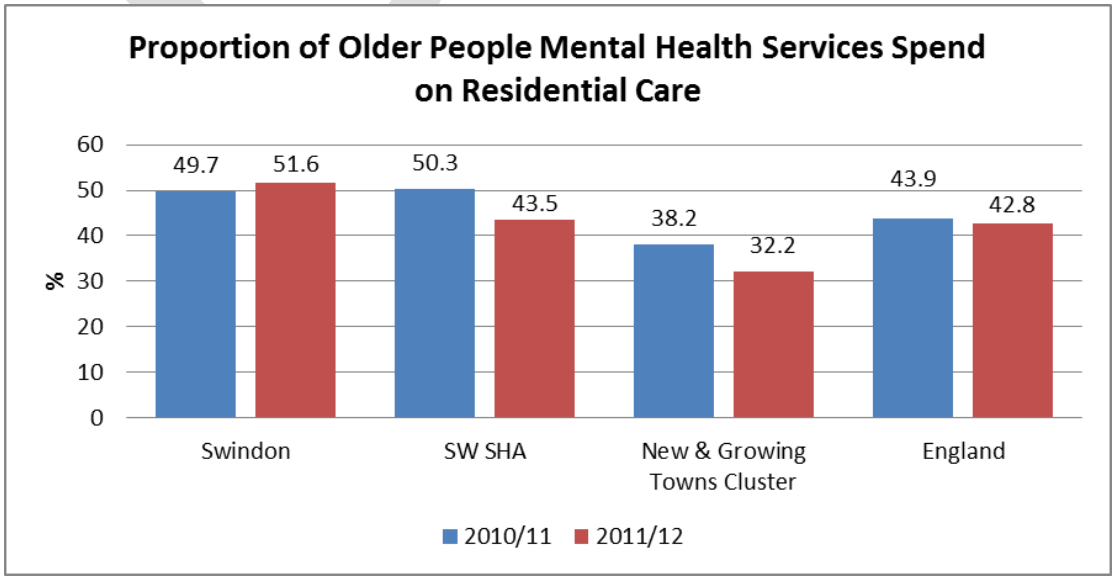




Compared to other areas:

- Proportional of spend and weighted investment per head on clinical services is lower in both 2010/11 and 2011/12
- Proportion of spend on support services is twice as high (2.4% compared to 1.2% on average in both 2010/11 and 2011/12)

Total investment in Older People's adult services was £8,984,000 in 2010/11 and £9,537,000 in 2011/12: an increase of 6.2%. 84% in 2010/11 and 88% in 2011/12 were direct costs. £3,175,000 is spent on 'other specialist Mental Health services', and £3,731,000 on residential care: as a proportion of direct services, spending on residential care in Swindon is similar to the strategic health authority average but higher than that for England in 2010/11. However in 2011/12, it made up a higher proportion of spend than in comparator areas.

Figure 50: Proportion of Spend on Residential Care (Department of Health Financial Mapping Returns)



The National Survey of Investment in Adult Mental Health Services in 2012 found that:

Total investment in adult mental health services in 2011/12 (reported investment plus estimated unreported investment) was £6.629 billion or £198.3 per head of weighted working age population.

The percentage of investment reported in direct services (as opposed to overhead or capital costs) is now at its highest recorded level of 82.9% compared to 81.9% in 2010/11.

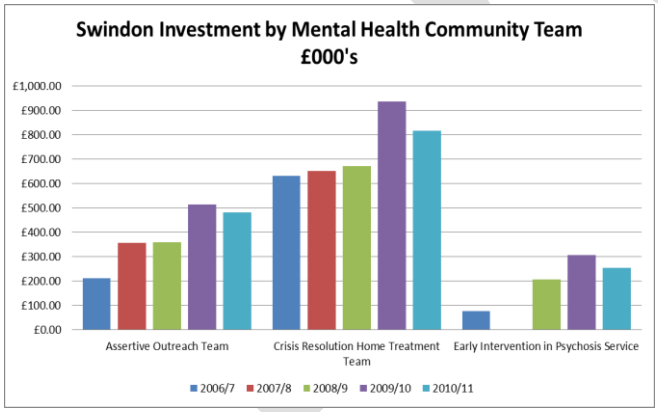
The reported investment in the three traditional priority areas (Crisis Resolution, Early Intervention and Assertive Outreach) overall has fallen for the first time by £29.3 million. Only Early Intervention reported increased investment.

Investment in psychological therapies increased significantly in real terms by 6.0% over the monies in 2010/11 and now forms 7.0% of direct services investment nationally.

For Swindon total reported investment by NHS Swindon as a commissioner in 2010/11 was £17,480,250 with £14,245,570 as direct costs. Table 44 shows the spend in Swindon on mental health by service.

Figure 51 below shows reported spend year on year for Swindon and nationally for Assertive Outreach Teams, Crisis Resolution and Home Treatment Teams and Early intervention in psychosis service. Table 44 shows the spend in Swindon on mental health by service.

Figure 51 Amount spent by mental health team by year.



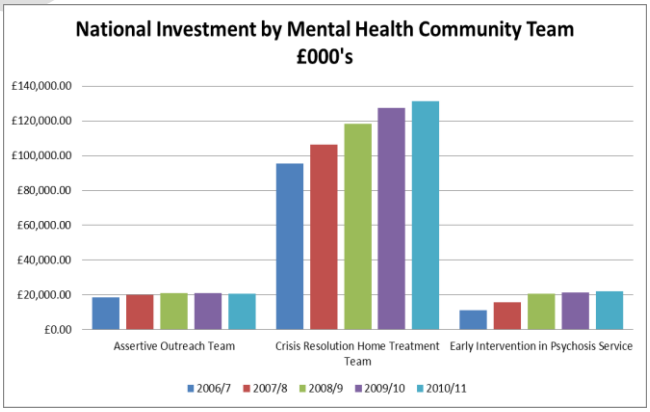




Table 44 The table shows the amount spent in Swindon in 2010/11 by service and the proportion of the total.

| **Swindon** | **2010/11 (£)** | **% of total** |
|---|---|---|
| Access & Crisis Services | 1,667,780 | 9.5 |
| Accommodation | 919,760 | 5.3 |
| Carer's Services | 25,770 | 0.15 |

| | | |
|---|---|---|
| Clinical Services | 1,484,450 | 8.5 |
| Community Mental Health Teams | 1,922,740 | 11.0 |
| Continuing Care | 2,196,350 | 12.6 |
| Day Services | 207,920 | 1.2 |
| Other community and hospital professional teams / specialists | 684,330 | 3.9 |
| Personality disorder services | 80,625 | 0.5 |
| Psychological Therapy services (IAPT) | 655,240 | 3.7 |
| Psychological Therapy services (non IAPT) | 518,390 | 3.0 |
| Secure and High dependency provision | 3,533,070 | 20.2 |
| Services for Mentally Disordered Offenders | 135,000 | 0.8 |
| Support services | 214,150 | 1.2 |
| Direct Costs | 14,245,570 | 81.5 |
| Capital charge | 483,340 | 2.8 |
| Indirect Cost | 2,751,340 | 15.7 |
| Total Reported Investment | 17,480,250 | |

As explained in the chapter on service provision, AWP are restructuring their services to focus on liaison services in hospital, primary care, and nursing and residential homes, and on intensive, recovery and acute community services.

## 9.5 Evidence of effectiveness and cost effectiveness

### 9.5.1 Treatment, NICE and Recovery

#### 9.5.1.1 NICE Quality Standard 8 Depression in Adults Quality Standard – March 2011

The quality standard covers the assessment and clinical management of persistent sub-threshold depressive symptoms, or mild, moderate or severe depression in adults (including people with a chronic physical health problem).

Estimates of the incidence of depression within the population range from 3 – 6% of adults. Mild depression accounts for 70%, moderate depression 20% and

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severe depression 10% of all cases. Those with chronic health problems experience higher rates of depression at about 20%.

The quality standard requires that services should be commissioned from and co-ordinated across all relevant agencies encompassing the whole depression care pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to people with depression. Patient choice and preference should be taken into account during individual consultations when discussing evidence-based interventions.

Statement 1 – People who may have depression receive an assessment that identifies the severity of symptoms, the degree of associated functional impairment and thee duration of the episode.

Statement 2 & 3 – Practitioners delivering pharmacological, psychological or psychosocial interventions receive regular supervision that ensure they are competent in delivering interventions in line with NICE guidance. Practitioners should record health outcomes at each appointment and use the finds to adjust delivery of interventions.

Statement 4 & 5 – People with persistent sub-threshold depressive symptoms or mild to moderate depression receive appropriate low-intensity psychosocial interventions. They should only be prescribed antidepressants when they meet specific clinical criteria in accordance with NICE.

Statement 6 – People with moderate or severe depression (and no existing chronic physical health problem) receive a combination of antidepressant medication and either high-intensity or cognitive behavioural therapy or interpersonal therapy.

Statement 7, 8 and 9 - People with moderate depression and a chronic physical health problem receive an appropriate high-intensity psychology intervention. Those with a chronic physical health problem and severe depression should receive a combination of antidepressant medication and individual cognitive behavioural therapy. Those with moderate or severe depression and a chronic physical health problem with associated functional impairment, whose symptoms are not responding to initial interventions, receive collaborative care.

Statement 10 – People with depression who benefit from treatment with antidepressants are advised to continue with treatment for at least 6 months after remission, extending to at least 2 years for people at risk of relapse.

Statement 11 – People with depression whose treatment consists solely of antidepressants are regularly reassessed at intervals of at least 2 – 4 weeks for at least the first 3 months of treatment.

Statement 12 People with depression that has not responded adequately to initial treatment within 6 – 8 weeks have their treatment plan reviewed.

Statement 13 – People who have been treated for depression who have residual symptoms or are considered to be at significant risk of relapse receive appropriate psychological interventions.

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### 9.5.1.2 Commissioning Stepped care for people with mental health disorders – NICE Published November 2011.

Common Mental Health Disorders as defined in this guidance include:

Depression; generalised anxiety disorder; mixed depression and anxiety; panic disorder; obsessive-compulsive disorder; phobias; social anxiety disorder (social phobia); post-traumatic stress disorder.

The guidance states that in 2007 the annual health and social care cost to treat depression and anxiety disorders were estimated to be nearly £3 billion, with an additional economic impact of around £13 billion in lost earning among people of working age.

The NICE Commissioning and benchmarking tool for common mental health problems estimates that in those over the age of 18, the prevalence of common mental health problems is 17.7%. In Swindon this would equate to 28,756 individuals. 60% of these individuals will be unidentified or will not seek treatment (17,254).

The recommended treatment for common mental health problems follows a stepped care model Table 45. The least intensive intervention that is appropriate for a person is provided first and people can step up or down that pathway according to their needs and responses to treatment. The levels of service are outlined in the table below with estimates of the demand for each level.

Table 45 Stepped Care Model – assessing demand for services in Swindon

| Level of care | Expected prevalence rate for people accessing service | Expected numbers for people accessing services | Actual numbers accessing service in Swindon (2012/13) |
|---|---|---|---|
| Step 1 Active monitoring / psycho-education | 20% | 5751 | 2520 |
| Step 2 Self-help/phone contact/CCBT/support groups/low-intensity group interventions | 9% | 2558 | |
| Step 3 One-to-one psychological | 6% | 1725 | 185 |

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| | | | |
|---|---|---|---|
| interventions/prescribing | | | |
| Step 4 Specialist high-intensity interventions/prescribing | 5% | 1438 | |

Common mental health disorders: Identification and pathways to care (CG123)

The costing template for this guidance includes data on the cost of common mental health disorders:

- the annual health service cost of depression in England in 2007 was £1.7 billion
- the health service cost of anxiety in England in 2007 was £1.2 billion
- the annual health service cost of people who frequently attend a GP for medically unexplained symptoms was £3.1 billion in 2008-09

Therefore effective local initiatives have the potential to make a big difference financially.

The guidance recommends achieving this by measures such as reduced use of hospital-based services as a result of increasing access to services in the local community, reduced use of medication (annual cost of antidepressants is estimated to be £189 to £449 per patient), earlier intervention meaning fewer GP visits, and improving the employability of people recovering from a common mental health disorder.

The Kings Fund and Centre for Mental Health produced a report 'Mental Health and the Productivity Challenge: Improving quality and value for money' (2010). The report makes recommendations for government, clinical teams, provider organisations and commissioners to improve productivity in mental health care, other areas of the NHS and in public spending more widely.

The four areas they highlight for immediate action are:

- Reducing unnecessary bed use in acute and secure psychiatric wards
- Establishing system to review the use of highly expensive out of area treatments

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- Improving workforce productivity
- Strengthening the interface between mental and physical health care particularly for older people and people with long term conditions.

#### 9.5.1.3 Service user experience in adult mental health: improving the experience of care for people using adult NHS Mental Health Services. Dec 2011 NICE Clinical guidelines 136

These guidelines layout key elements which contribute to a clinically effective, safe and person centred mental health service which will lead to users of mental health services having the best possible experience of care. These guidelines are produced alongside Quality Statements which have been developed to give aspirational and achievable quality markers of cost effective care. (A summary of these quality standards can be seen in Appendix 9).

The guidelines promote:

1 Care and support across all points of the care pathway, including: relationships and communication; providing information; avoiding stigma and promoting social inclusion; decision, capacity and safeguarding; involving families and carers; engaging service users in improving care.

2. Access to care – Services should ensure: services users understand what to expect on referral; provision of information explaining the assessment process is sent with appointment letters; joint working with primary care and third sector organisations; services are culturally sensitive.

3. Assessment – Services should ensure service users are: greeted appropriately; understand the assessment process; are allowed enough time to be listened to; given the opportunity to ask questions; provided with written and verbal information on diagnosis and treatment options.

4. Community Care – Services should communicate with patients using the service users preferred method; develop joint care plans including the promotion of social inclusion; support with the implementation of the care plan. The service user should receive a written copy of the care plan and it should have an agreed review date. Services should be person centred with offer of a personal budget or direct payment. For those at risk, a crisis plan should be developed by the user and profession. These plans should be respected and implemented by services. Consistency of service provision should be maintained; psychosocial and pharmacological interventions should be offered in line with NICE guidance and services should be culturally sensitive.

5. Assessment and referral in a crisis – Prior to assessment services should ascertain if the service user: has had previous contact with mental health services; has a crisis plan, advanced statement or decision; would like an advocate. Assessments should be undertaken in a timely way in a setting agreeable to the service user by an experienced and competent crisis care professional. Social circumstances should be taken into account alongside symptoms and diagnosis. Crisis services should be available 24 hours a day 7 days a week and be well publicised to local GPs.

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6. The guidance also outlines level of care that service users should expect for assessment and referral in a crisis, hospital care and assessment and treatment under the Mental Health Act including use of control and restraint and compulsory treatment.

7. Discharge and transfer of care. The guidance outlines the need for planned discharge and transfer between services. These plans should be discussed fully with the service user in a structured and phased way. Social needs of service users should be addressed in the transfer\discharge plan and services should have a 24 hour helpline available to discuss problems post discharge. Written information about services available to support them should be given to service users on discharge.

#### 9.5.1.4 Patient satisfaction questionnaire

Data was not available regarding the patient satisfaction questionnaire for mental health service users. This should be reviewed against the NICE guidance 136 described above.

#### 9.5.1.5 Clinical guidelines for the treatment and management of psychosis and schizophrenia

The Clinical Guidelines for the treatment and management of psychosis and schizophrenia in adults is currently under review and is due to be published in February 2014. NICHE quality standards will be publicised at the same time. The standards act as makers of high quality and cost effective patient care, covering treatment and prevention. The pooled estimate of the annual prevalence rate of psychosis is 4.1 per 1000. The same rate as for Schizophrenia, although estimates varied considerably within the review.

Scoping documents for this review indicate that the cumulative cost of care of individuals with psychosis is high. In 204/5 the total annual society cost of Schizophrenia in England was £6.7 billion, made up of £2 billion in direct cost of treatment and £4.7 billion in indirect costs. The cost of lost productivity owing to unemployment, absence from work and premature death accounted for 72% of the total indirect cost.

When the guidelines are produced early in 2014, these should be reviewed locally and implemented as the financial, sociality and personal cost for those with the condition and their cares and families is so significant.

### 9.5.2 Economic Evaluation of Prevention Interventions

In 2011 the London School of Economics Centre for Mental Health published a report on Mental Health Promotion and Prevention: the economic case[153]. The aim of this was to assess the costs and economic payoffs for different

[153] http://www2.lse.ac.uk/businessAndConsultancy/LSEEnterprise/pdf/PSSRUfeb2011.pdf

interventions which had strong evidence for effectiveness in terms of improving mental health or well-being. Key points:

- some interventions did not have evidence of effectiveness, particularly those looking at well-being at a community rather than individual level
- mental health affects so many aspects of someone's life it can be difficult to identify reliable data which captures the extent of its impact for economic analysis
- return on investment can be short term e.g. school based interventions to reduce bullying, or long term where the benefits is to the criminal justice system over many years
- financial benefit can be to a range of organisations and not necessarily to those whom have invested in the initial intervention. For example the King's Fund report supports more diagnostic and treatment services, commenting "Net savings are likely to occur if treatment is given to those currently not receiving treatment as reductions in lost employment costs should outweigh treatment costs"
- many interventions considered were about diagnosing and intervening early

Those interventions with the highest return of investment (all gains greater than £10 return per £1 expenditure) were:

- Suicide training courses provided to all GPs (£43.00 return per £1 expenditure) and suicide prevention through bridge safety barriers ((£54.45 return per £1 expenditure). This is high as the value of saving a life is costed at £1.45m which includes effects on relatives, lost wages and police time. Whether someone attempts suicide subsequently is also included in the modelling.
- Prevention of conduct disorder through social and emotional learning programmes at school (£83.73 return per £1 expenditure). This is based on a cost of £132 per child per year with benefits to the NHS and crime in the first years and education recouping the cost of intervention within 5 years.
- Early detection (£10.27 return per £1 expenditure) and intervention (£17.97 return per £1 expenditure) of psychosis. Savings relate to a reduction in the number of people who develop full psychosis from early symptoms.
- Screening for alcohol misuse (£11.75 return per £1 expenditure). This is based on universal screening by GPs followed by a 5 minute advice session at a cost of £17.41 per patient, and research which suggests the intervention results in an average 12% reduction in alcohol consumption.

AWP are introducing an all age primary care liaison service which will include a focus on early intervention. In Swindon there is a Directed Enhanced Service (DES) managed by NHS England for GPs to provide alcohol screening.

There is extensive NICE guidance on mental illness prevention, mental health promotion and treatment and support. Some of these, particularly those for clinical guidance, come with attached costing tools which allow local cost savings to be calculated based on national estimates of prevalence and cost, and assumptions around local need and demand. Some examples of public health guidance are provided below:

#### 9.5.2.1 Promoting well-being at work (PH22)

The cost model looks at the cost to an organisation based on the impact on absenteeism and presenteeism[154] due to mental health. It assumes 40% of sick days are attributable to mental ill health, with an estimated cost of £83.25 per day. It also assumes people who come back early and hence take longer to recover are two thirds less effective with a cost impact of £100 per day. 8% of annual staff turnover is also estimated to be attributable to stress. Following NICE recommendations would potentially achieve a 30% saving on the cost of workplace mental ill-health. For example if Swindon Borough Council employs 1500 staff with an average of 5 sick days per member of staff, implementing well-being at work recommendations would result in a potential saving of £247,497.

#### 9.5.2.2 Social and emotional well-being – early years (PH40)

The economic evidence for investing in early years programmes is outlined in the LSE report above and referred to in the NICE guidance, recognising that the return on investment is likely to be long term. NICE also refer to a 2011 research study155 which suggests saving of over £16000 per family from a parenting programme over 25 years.

#### 9.5.2.3 Mental wellbeing and older people (PH16)

The costing statement which accompanies the guidance focuses on three of the recommended interventions: occupational therapy, physical activity and walking schemes. It does not provide specific costs but concludes that "it would seem reasonable to assume that uptake of these recommendations will result in financial savings through increased physical activity and mental wellbeing."

Interventions which reduce high cost care tend to have significant financial benefit. For example Clinical guidance CG136 on service user experience in adult mental health identifies that improving service user experience leads to improved service quality and hence better outcomes. It suggests that effective discharge and transfer of care may reduce length of stay: at a national level in 2009/10, 107,765 people were admitted to hospital for mental health care with an average length of stay of 78 days for men and 68 days for women. If a hospital day is estimated to cost £300, a reduction of 1 day per stay would result in a saving of £32,000,000. For specific conditions the costs can also be significant: for example a recent study in Sweden[156] found that the total annual cost of illness associated with a patient with schizophrenia is €55,100 (about £46,500), 60% of which is due to lost productivity.

#### 9.5.2.4 Five ways to Wellbeing

The Five Ways to Well-being are a set of evidence-based actions which promote people's wellbeing. They are: Connect, Be Active, Take Notice, Keep Learning and Give. These activities are simple things individuals can do in their everyday

[154] Presenteeism is the loss in productivity when employees who are ill attend work and perform at a lower level because of their illness.
[155] See http://www.nice.org.uk/nicemedia/live/13941/61153/61153.pdf for reference
[156] Ekman M, Granstrom O, Omèrov S, Jacob J, Landèn M The Societal Cost of Schizophrenia in Sweden Journal of Mental Health Policy and Economics 16, 13-25 (2013)

lives. These five ways are fundamental to mental health promotion activities and should be considered in all public mental health programmes and more widely throughout the Council and partnerships. (See Appendix 5 for a full description of the Five Ways to Wellbeing)

The Five Ways to Well-being were developed by The New Economic Foundation (NEF) from evidence gathered in the UK government's Foresight Project on Mental Capital and Wellbeing. The Project, published in 2008, drew on state-of-the-art research about mental capital and mental wellbeing through life. It asked NEF to develop the Five Ways to Wellbeing to communicate its key findings.

The Five Ways have been used by health organisations, schools and community projects across the UK and around the world to help people take action to improve their wellbeing. They've been used in lots of different ways, for example to get people to start thinking about well-being, to develop organisational strategy, to measure impact, to assess need, for staff development, and to help people to incorporate more well-being-promoting activities into their lives.

NEF promote the holistic implementation of these 5 ways rather than just one approach to promoting wellbeing.

#### 9.5.2.5 Settled accommodation for adults receiving secondary mental health services

The percentage of adults receiving secondary mental health services known to be in settled accommodation at the time of their most recent assessment, formal review or multi-disciplinary care planning meeting (NI 149) was 6.4% in Swindon in 2009/10 compared to 7.9% in England and 9.3% in the South West (The information centre for health and social care). (See Housing and homelessness section 5 above)

## 10. Gaps in service provision

**Key Findings**

The key gaps or weakness in mental health services in Swindon include:

- Access during acute emotional distress
- Dual diagnosis
- Transition from CAMHS
- ADHD for adults
- Access to advice and guidance
- Military veterans
- Eating Disorders

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## 10.1 Dual Diagnosis

As elsewhere, dual diagnosis (substance misuse and mental health) has been a concern in Swindon and still remains a challenge. AWP Dual diagnosis Strategy 2012 - 15 aims to 'mainstream' dual diagnosis within mental health services so that it is seen as a core component of treatment across all mental health teams and services.

A multi-agency dual diagnosis group was established including commissioners, mental health and substance misuse services, housing providers and other stake holders has been established to ensure that strategies, policies and procedures are developed, implemented and fit for purpose. A dual diagnosis pathway and network has been developed.

An operational multi-agency group has also been established to monitor implementation of strategies and policy and review individual cases. AWP will take the lead as provider of services for those with dual diagnosis and will work with other provider key workers to provide optimal support to individuals.

Key areas of development required are:

- Integrating primary care and IAPT services in the pathway
- Appropriate access to secondary mental health services
- Effective use of the homelessness Community Psychiatric Nurse role
- Sharing expertise across teams by visiting other services and supporting individuals who do not meet the threshold for either mental health or substance misuse services
- How to access support if there is a crisis (Particularly if the person is intoxicated)
- The use of AUDIT as a screening tool

CRI, Swindon's local Drug Service, report that just over 10% of their current clients have been identified as have a significant mental health problem. An audit undertaken by AWP three years ago found that 30% of those in inpatient services, 15% of those under the intensive team and 40% of those under the care of the early intervention team had a dual diagnosis. The most common co-existing substances are alcohol and cannabis.

## 10.2 Transition between Child and Adolescent mental health services (CAMHS) and adult mental health services.

Transition between CAMHS and adult mental health services has been a long standing issue. CAMHS current policy is to review patients 6 months prior to their 18th birthday and as required refer them to adult services, find alternative support or discharge patients back to their GP's Care. There is some flexibility in this and CAMHS do continue to see a very small number of cases 18 yrs + for a short while. Similarly, a new referral to CAMHS of an individual who will shortly be

turning 18 years of age may be passed on to adult services or both services may work together with an individual in partnership.

Difficulties occur when a CAMHS patient does not meet the criteria for adult mental health services and there is a perceived or real gap in service provision. Many of these individuals are referred to LIFT psychology service. Adult mental health wards are not necessarily the most appropriate for young people with an acute episode. However, equally it seems inappropriate to treat a 17 year old parent in a CAMHS setting. Most mental health professionals consulted as part of this needs assessment felt that transition of young adults remained a concern in Swindon and more flexibility in the service was required.

AWP provide a transition service for those aged 17 – 25 with complex needs but this is mainly a service for those with (emergent) personality disorder and there are restrictions on who is eligible for this service. In Oxford they are piloting a broader 17 - 25 transition service which will be provided by Oxford Health as an extension to the CAMHS service. Findings from this pilot should be assessed and consideration given to providing a similar service in Swindon.

Swindon Children and Adolescent Mental Health Service (CAMHS) currently (as of August 2013) has a caseload of 217 adolescents aged 16 – 18 yrs. Of these 126 were 16 years old, 84 were 17 years old and 7 were 18 years old.

There were 265 people aged 16 – 18 yrs, discharged from CAMHS in 2012. Analysis of these individuals found that only 5 were transferred to adult mental health services and 198 were discharged on professional advice. 22 were discharged because they did not attend. 20 were discharged because the care or assessment was complete.

**10.3 ADHD** At present there is an assessment service for Adults with ADHD but there is no on-going support and treatment service in Swindon. Adults identified as having ADHD are referred back to their GP for support and treatment.

### 10.4 Access to advice, information and advocacy

We have seen from the wide range of determinants of mental health and wellbeing that individuals may from time to time require access to information. Numerous consultations with people in Swindon have advocated the need for access to right information at the right time to improve the quality of their lives and maintain independence. For some vulnerable individuals, (and often when we need this information it is because we are vulnerable), it can be even more difficult to follow the trail of different information providers to access the piece of information required.

In Swindon there is a rich provision of effective “third-sector” support services across adult health, wellbeing and social care – it is therefore essential that people in Swindon can find out about and access all of these services (both statutory and third sector) as quickly as possible when they need support. This will contribute to the early intervention approach that aims to reduce the necessity for more expensive interventions further down the line.

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Currently, however, there are a number of challenges to the effectiveness of these services:

- There is currently no single point of contact for people to access advice and information services and there is no single register covering the range of support that is available to people

- It is often unclear to people what routes of engagement they are supposed to use to find out about services - as a result, people often try to engage support and services via multiple pathways

- Organisations currently involved in providing advice and information tend to operate in relative isolation from each other and each uses their own systems & processes

- Cross-referral processes between advice & information providers are sub-optimal, with perceived barriers around data protection issues

- There are multiple service provider directories in operation that are not widely available to either the public or those professionals providing services

- There is evidence that information provided can be out of date and/or inconsistent between providers

- In some cases, it is questionable whether the tone of information given promotes independence

Service users and their carers often report confusion and frustration when they try to engage support. Where people have complex needs, they are often signposted to a number of different organisations – this means that they need to "tell their story" to each of the individual organisations, spend time exploring the degree to which each organisation can help them and build new relationships each time. This can lead to weariness with the process, which often means people stop seeking help even though their needs may not have been adequately addressed and prevents people accessing services early on before a crisis point is reached.

The Connected Care Community Led Commissioning project was carried out in 2011 and involved the communities living in Central, Penhill and Taw Hill wards in the identification of integrated health, housing and wellbeing services which would better meet their needs. The project report highlighted that of the 1,100 people surveyed across the three wards, only 50-61% knew how to access statutory social care services and only 40-55% knew how to access third sector provided services.

**10.5 Acute Emotional Distress** At present there is a gap in service for those facing acute emotional stress putting them at risk of harm. These individuals do not necessarily meet the threshold required for support from current mental health services but are at acute risk of self-harm/suicide. This gap in provision could be contributing to our suicide rate and repeat attendance as ED for self-harm.

**10.6 Eating Disorder Service**. At present there is a specialist eating disorder service provide by Oxford NHS FT and a community service provided by AWP. However, there is a perceived gap in services for those with less severe eating disorders. Some dieticians at GWH have reported that they have been asked to provide nutritional advice to those with eating disorders without the required psychiatric input. A holistic service which intervenes earlier would improve the quality of life and prevent severe problems for some people.

**10.7 Military Veterans** have reported that services are not available to meet their needs. Some work has already been undertaken to ensure that services are more accessible and have a better understanding of the needs of this group. However, we need to ensure that services are reviewed to ensure they meet the needs of this group. This is particularly pertinent to reservists and young men who leave the service early who are at particular risk.

## 11. What local people think?

**Key findings**

- Supporting people to get back into work (meaningful paid activity) was seen as a priority
- Major concerns were expressed about benefit changes and the effect this would had on service users.
- Service users had concerns that changes to the mental health services would reduce capacity and choice.
- Service users should be enabled to access support in their communities rather than through central location.
- Focus should be on early intervention rather than leaving problems to get worse before be able to access services
- More use should be made of volunteers
- Stigma and discrimination was seen as very significant for service users.
- Lack of awareness and understanding amongst many front line workers e.g. some cafes, SBC benefits office and housing departments, ATOS and DWP.
- Service users found it difficult to live a healthy lifestyle – access to physical activity was considered a particular issue due to: the cost of the Swindon Card; having the confidence to access group sessions and keep them up; and the effect of their illness and side effects of medication.

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- Changes to secondary care services were viewed as damaging and service users felt they were being “got rid of”, to be picked up by charity. There was lack of understanding that third sector organisations were commissioned services. They also thought it was difficult to re-access services when they needed them.

- Carers and support staff felt that fast track back into services was not working and the reduction in floating support meant that individuals risk becoming unwell without be spotted early enough.

- Carers thought that social isolation was a particular concern for service users and many felt that service users would be entirely socially excluded without their support.

- Carers felt their voice was not heard particularly with view to GP services and social care services

- Packages of care from mental health and social care services are not as joined up as they are for physical illness

- The needs of military veterans need to be addressed.

- A local mental health service user survey found that:
    - Service users were more likely to report stress outside the workplace that they were unable to cope with in the last 12 months than Swindon residents generally.
    - They were less likely to seek help and support from friends and family and more likely to turn to services for support
    - They felt considerably less safe in the area where they live and the town centre both during the day and at night than other Swindon residents
    - They report less satisfaction in all domains measured other than the amount of free time they had
    - Mental health service users were more satisfied with most statutory services apart from probation and GP reception staff. They were very dissatisfied with AWP primary care liaison service, ATOS and DWP.

In February 2013 a joint consultation with voluntary and community sector organisations regarding mental health services was undertaken on behalf of Swindon Borough Council, NHS Swindon and Swindon Clinical Commissioning Group. The majority of these organisations provide mental health support and all contribute more widely to mental well-being. The consultation ran for 3 months and included 36 meetings involving 250 individuals residents of Swindon including service providers and users.

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The key findings from this consultation were as follows:

1) The need to reduce duplication of service provision
2) A greater use of volunteers
3) Ensure that cost pressures did not lead to cuts in opportunities to intervene early and therefore avoid more costly interventions at a later date.
4) The need for a more coherent rationalisation or clustering of service provision which was at present confusing for service users.
5) The need to decommission current service user engagement and ensure that all providers enable their service users voice to be heard
6) All service users consulted valued the support given by current services and were concerned about seeing a reduction or change in the future
7) Supporting people to get back into work (meaningful paid activity) was seen by many as a priority
8) The real possibility of relapse, never achieving full recovery and the impact of medication should be acknowledged in service redesign
9) The risk that proposed service redesign may reduce choice and capacity and cause distress to service users
10) Lack of identification of military veterans and services to meet their needs
11) The need for more structured approaches to services and clear pathways ensuring that service users do not fall between gaps in services. This will require greater partnership working.
12) Service users are concerned about changes to their benefits and required support and advocacy with regard to this. Advocacy and befriending for older people was also seen as an issue. Access to information on direct payments and personal budgets was also required.
13) The need for service users to be able to access services outside the hours of 9-5 Monday to Friday
14) Service users should be help to access support in their own communities through outreach services rather than services being provided from one location.

### 11.1 Mental health needs assessment focus group

As part of this mental health needs assessment two focus groups were held with service users, a carer and two support staff from several of the voluntary and third sector organisations (6 individuals in all). The main focus of the group was on well-being although individuals were encouraged to discuss issues that were important to them.

Findings from this group:

There was a range of views on what mental wellbeing meant to service users and carers. This included:

- separating carer responsibilities and respite time;
- connecting with the wider world, positive coping mechanisms and a balance outlook;
- coping with the challenges of everyday life, to be accepted by the wider world and not be labelled or stigmatised.
- having access to and assurance of services;
- having the best meds combination to control symptoms and living with the symptoms and side effects left over.

The group highlighted the difficulty of making a maintaining meaningful friendships and the importance of support from those who understood what it was like to experience mental illness.

Stigma and discrimination were seen as very significant for services users. They felt there was a lack of understanding and tolerance by those who had no experience of mental illness. The thought more could be done by services and service users to raise awareness of mental illness and challenge stigma and discrimination using the Time to Change initiative.

Stigma and discrimination was cited not just as the attitude of staff but also the layout of buildings. Some cafés, SBC benefits office and housing department and ATOS and DWP were all cited as having a negative impact on mental health and it can be difficult to access these services effectively. Job Centre Plus, some other Cafes were cited as being particularly welcoming, well laid out and effective in providing services.

"when you come into the council offices you now have to queue for a number which can be daunting and then you have to sit and wait. Screens pop up, you need to find your number and it can be very stressful and daunting" "it is not a welcoming place to go and that is before you even get to the counter". Another service user described the Council Offices as being like a factory "you've got a reception desk which is like a loading bay, then you have the number system which is like a holding area for stock. You have to process that stock or get rid of that stock" "you feel like a piece of stock that is just being moved [through]".

On the other hand Job Centre Plus was cited as an example of good practice. Job Centre Plus has a system where once they know that you have a mental health problem you can be seen in a quiet room and one focus group member said that she is now seen on the 2nd floor which is a lot quieter and her adviser books her in at a quiet time and is very helpful.

Some employers in Swindon were cited as being very fair and supportive of service users and have good policies and protocols in place but this did not stop the attitude of other employees having a negative impact on individuals. The public lack awareness and understanding of how to communicate with and support those with mental health problems and this led to lack of trust.

### Healthy lifestyle advice

Some focus group members tried hard to lead a healthy lifestyle but found it difficult. Information was available on exercise and TWIGs was cited as having a

good outside gym. With regard to leisure services there were conflicting opinions about disclosing you had a mental health problem. The main barriers cited were:

1) the cost of the Swindon Card and activities

2) having the confidence to access a group session and keep it up

3) the effects of both the illness and side effects of drugs.

Exercise on referral and the Twelve Steps programme were both mentioned and service users thought that funding had been withdrawn for this. However, both continue to be funded but are time limited.

> "it is hard to start something and really begin to see the benefits then have the funding withdrawn so you can't do it anymore. That affects your physical and emotional health".

Service users thought that the value of short periods of exercise should also be promoted rather than what can seem like unachievable 30 minutes a day, 5 days a week.

> "more should be done to point out that 10 minutes is better than nothing and can lift your mood".

Some service users lack the confidence to go out and attend groups. Cycle paths outside of the town were also thought to be lacking for example down the A420 or to Highworth. Gym buddies were thought to be a good idea.

Most of the group had heard of the five ways to wellbeing again TWIGs had promoted it widely. The group generally saw the five ways of being beneficial if you are capable of achieving them. Many found that connecting (one of the five ways) very difficult and this could impact on the other 4 ways. Others said that they thought the five ways described what a mentally well person would do but having tried them they did not help him. Learning something new and volunteering were both seen as very beneficial and contributed positively to some of the focus group members.

Changes to the benefits system again were raised as significant – there was a lot of confusion and lack of awareness about the changes and the impact these would have.

> "I must admit I don't really understand all the changes being made. I can't get my head around it….. I can't find the right way to find out information, sometimes I don't know where to ask or look for the information. Links are broken on the SBC website – that does not help."

There were also concerns about access to secondary mental health care services. Patients felt that with the re-organisation of services they were seen as a problem and that the provider just wanted to "get rid of them". They felt they were being discharged with no access back to the service which felt very uncomfortable. Third Sector organisations were valued highly "xx service was a life saver"

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particularly with the changes in secondary service provision. However, there was a lack of awareness that the third sector organisations were commissioned services. Most thought they were entirely funded through charity. LIFT psychology service was also mentioned positively.

The focus group wished to capture the thoughts of other service users were keen to survey other services users. The residents' survey was reviewed with the focus group and a questionnaire was developed focusing on the issues that the services users thought most significant for other mental health service users. The focus group members then asked other service users to complete the questionnaire. The findings are outlined below in section 11.1.1.

In addition residents at one of the accommodation providers in Swindon were also consulted. The key findings from this meeting were that: the residents appreciated activities and facilities that Swindon had to offer – such as cinema, bowling, gyms, parks etc; they also highly valued the activities provided by mental health providers such as poker nights; creative arts; gardening etc.; they appreciated the informal visits by the police to discuss local issues.

The concerns that the residents expressed were with regard to:

- The necessity for referral to support services such as MIND, TWIGs, Active Life
- Being discharged without support in the community and having difficulties re-accessing services when they start to feel unwell rather than having to wait until they are very unwell
- Having access to information provided in a friendly and supportive way
- Having access to voluntary work without the being depended upon and feeling like they have let people down if they are not well enough to attend
- Lack of joined up working between services
- Variation in GP services and some difficulty accessing appointments particularly if these need to be booked early in the morning.

The support staff at the residence also expressed concerns that the "fast track" back into services did not always work; they did not always receive the information they needed to support clients on discharge; reduction in floating support services may mean that individuals who are becoming unwell are not spotted early enough.

### 11.1.1 Mental Health Service User Survey

The service users in the focus group reviewed the residents' survey 2012 which was sent to a cross section of Swindon residents. They identified the questions which they felt were most relevant to service users so a cut down version of the residents' survey was produced. The service users at the focus group then surveyed other service users who used various mental health services in Swindon.

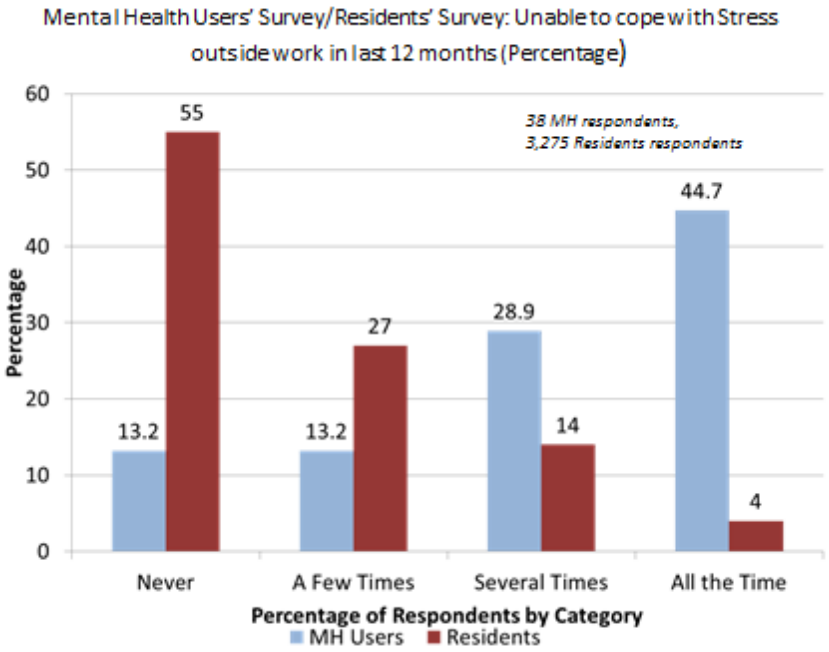
- 45 mental health service users were surveyed in total although not all of them answered all the questions (including the demographic section).
- There were 17 women and 26 men (2 non responders).
- The age ranged from 19 – 69 with an average age of 42.4 years (2 non responders).

- The respondents lived in various geographic areas within Swindon although there were fewer respondents living in the least deprived areas.
- The ethnic mix of the respondents was 33 white British or Irish, 5 mixed ethnicity and 5 Asian or Black. (2 non responders).
- 7 people reported a physical disability, 9 a learning disability, 10 a long term illness and 5 an "other" disability. 7 reported deafness although this may have also been reported under the other categories.
- None of the respondents was in full time employment; 5 worked part-time or were self-employed; 7 were unemployed and available for work; 23 permanently sick/disabled; 10 other categories or non-responders.

For a few categories of the survey a comparison of the findings has been made with the results from the residents' survey. There is a caveat to using this data as the residents survey was a weighted survey, so the findings took into account demographic indicators many of which were highlighted above. Because of the relatively low numbers responding to the residents' survey this weighting has not been applied so there may be some confounding factors e.g. the relatively high numbers not in employment. However, there are some interesting findings that should be noted.

Mental health service users were much more likely to report that they had experienced stress outside their work that they had been unable to cope with in the last 12 months.

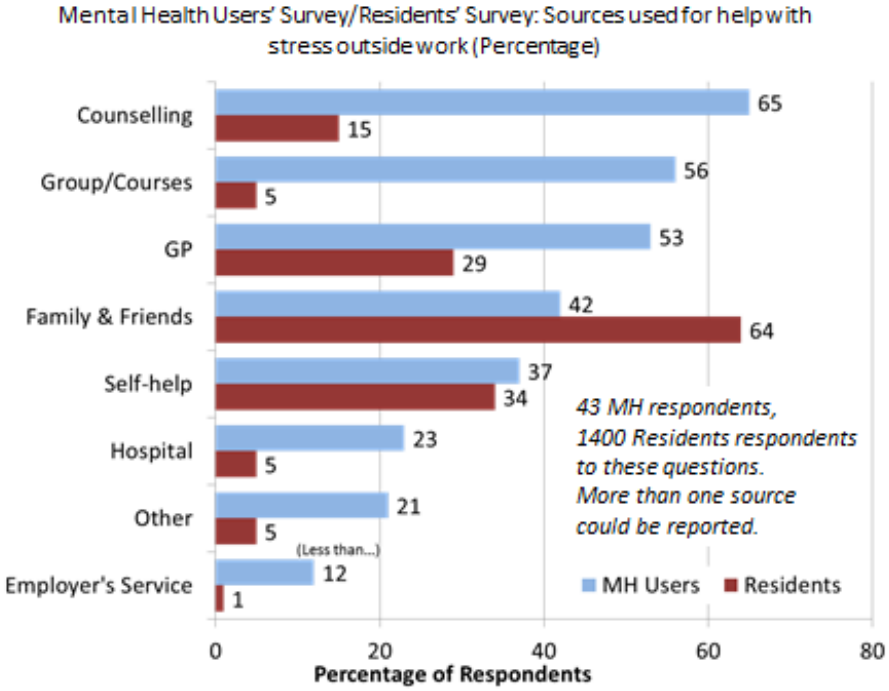
Figure 52 A comparison of levels of stress outside the work place reported in the mental health service user survey compared to the findings of residents survey.




When asked where they turned to for help with stress outside the workplace mental health service users sought support from a wide range of services but reported that they were less likely to seek help from friends and family unlike the

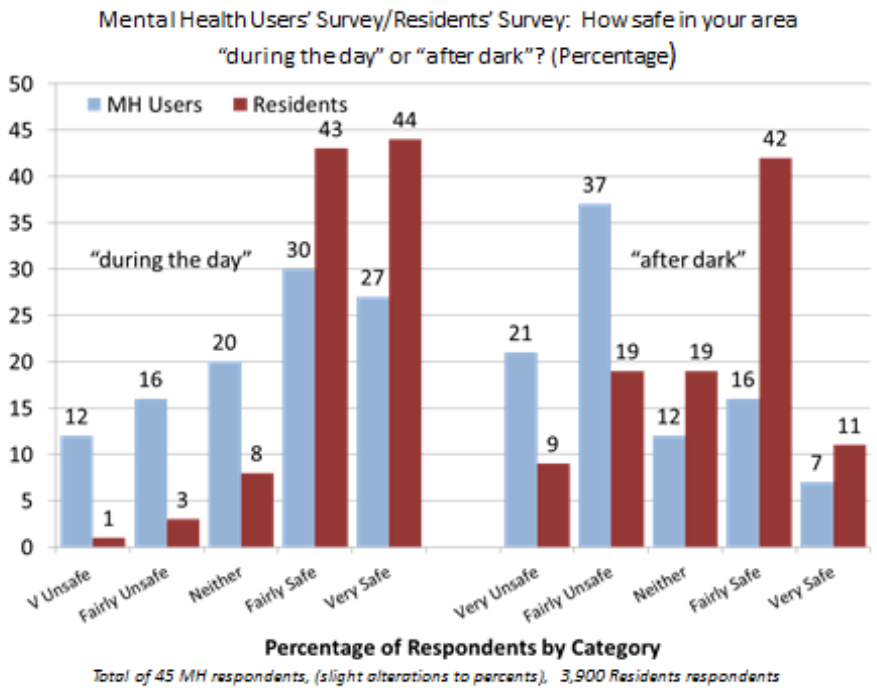
findings of the residents' survey which reported that friends and family was the most likely source of support.

Figure 53 comparison of sources of support reported in the mental health service user survey compared to the findings of residents survey.



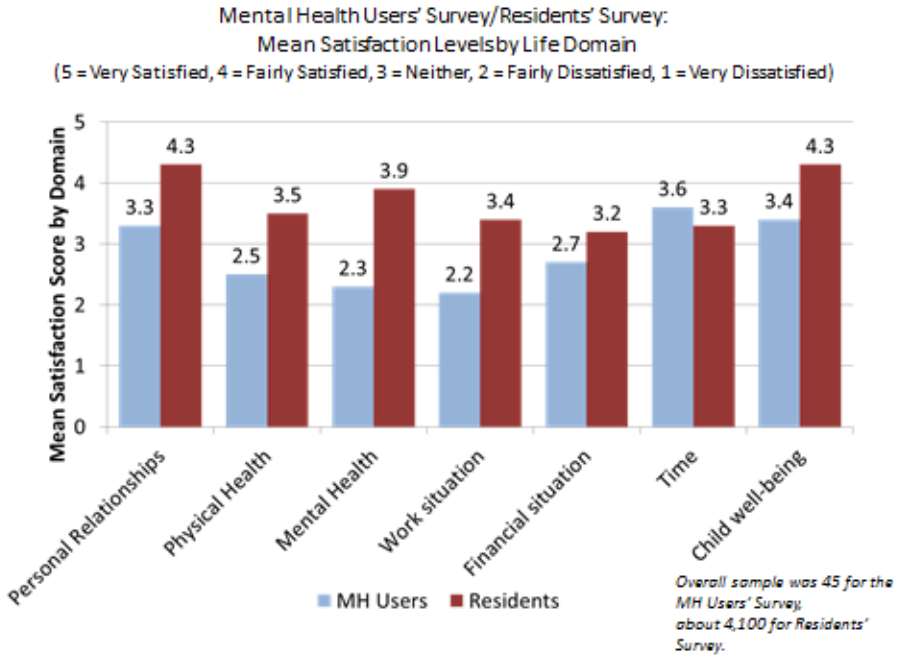

The residents' survey reported higher rates of feeling safe both during the day and after dark in the area in which the respondent lived. 87% of respondents to the residents' survey reported they felt fairly or very safe in their area during the day compared to 57% of those responding to the mental health user survey. 58% of mental health service users surveyed said they felt very or fairly unsafe in their areas after dark compared to 28% of those responding to the residents' survey.

Figure 54 A comparison of how safe respondents to the mental health survey and residents survey felt in the areas where they lived both during the day and after dark.



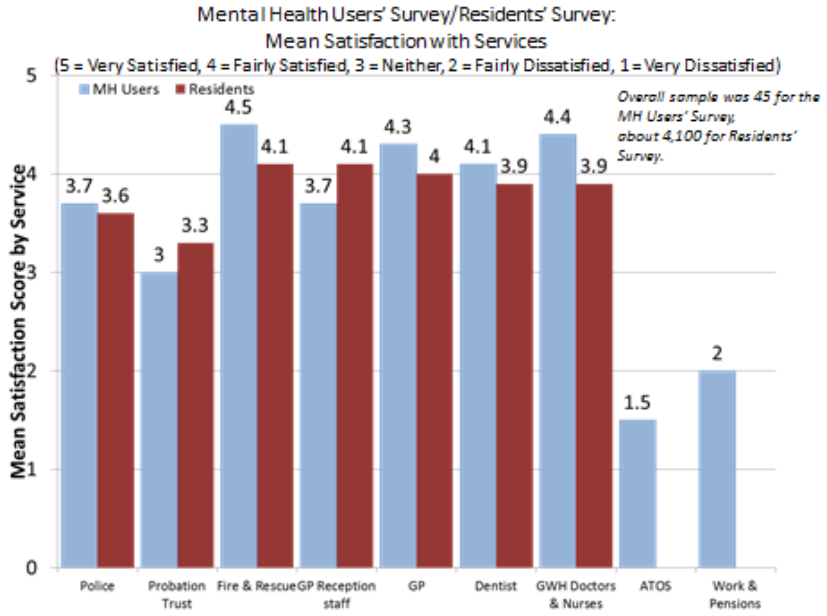

The respondents were asked to rate their satisfaction scores in a number of key domains on a score of 1 -5 (5 being very satisfied and 1 being very dissatisfied). These domains included: personal relationships; physical health; mental health; work situation; financial situation; time and child wellbeing. Those responding to the mental health service users' survey reported less high levels of satisfaction in all domains apart from time than those responding to the residents' survey.

Figure 55 A comparison of how satisfied with key domains of life respondents to the mental health survey and residents felt.




The mental health service users were asked how satisfied they were with a range of services including: probation services; fire services; GP receptionists; GPs; Dentists; LIFT psychology; Dept of Work and Pensions; ATOS; and a range of AWP services including: acute inpatient services, recovery team services, Intensive team services. Generally, mental health service users seemed more satisfied with most services than those responding to the residents' survey. They were more satisfied with the police, Fire and Rescue, GPs, Dentists and GWH doctors and nurses. However, they were less satisfied with probation and GP reception staff. They were very dissatisfied with ATOS and Dept of Work and Pensions and AWP primary care liaison service. There were similar levels of mental health services users reporting satisfaction and dissatisfaction with the acute inpatient services, recovery service and the intensive team.

Figure 56 A comparison of how satisfied respondents to the mental health survey and residents were with a range of services.




## 11.2 Views of Carers of those with mental health problems.

The views of Carers of those with mental health problems have been gained in various ways. Some carers were included in the service user focus group; the views of professional carers were also captured and the Mental Health Carer Representative Group.

- Carers felt that services did not proactively offer support to individuals with mental health conditions. They reported that if carers did not provide the support to the person they cared for, the individual would be completely socially isolated and excluded.

- Social isolation, exclusion and difficulties with engagement were seen as the key issues that carers raised as a barriers to improved quality of life and recovery for service users.

- Carers thought that their voice was often not heard with regard to describing symptoms, treatments, behaviour and diagnosis. Whilst this is still an issue in mental health services it is improving but it still remains a significant issue with GPs and Social Care.

- Packages of care from mental health services and Social Care are not as joined up as they are for those with physical illness.

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- Issues raised relating to secondary mental health services include low moral within the nursing workforce both inpatient and community services. Parking arrangements for those based at Chatsworth House added so much time to travel to and from visits that there is less time spent with patients. It was felt that community nurses had such limited time that by the time they had administered medication and provided some personal care there was little time for therapeutic interventions.

- Issues regarding the cost of parking were also deemed to be problematic with regard to engagement of carers and service users.

- There was a need for a whole person, holistic and personalised service; where care plans were developed, implemented, assessed and evaluated; engagement was facilitated; and medication reviewed with a discussion regarding side effects.

- The Carers Group had strong views on the needs of military veterans and felt that this was going to be a growing issue nationally and locally as it was thought that many veterans choose to settle in Swindon and the impact of different military campaigns. The carers felt that:
    - Some military veterans were misdiagnosed in civilian services
    - Military veterans were treated differently in military services particularly with regard to the Mental Health Act
    - Dual diagnosis was a particular issue for military veterans who often self-medicate
    - There are particular issues for carers with regard to domestic violence when the service user re-lives experiences.
    - The need for engagement, outreach and support and preparation for carers was all particularly significant with regard to military veterans.

## 12. Conclusion and recommendations

This has been a comprehensive needs assessment, covering both mental health and mental wellbeing across Swindon's adult population. There are many factors affecting our mental health and wellbeing, and many possible actions to improve it. While we have used a great deal of national and local evidence there are still some gaps to be filled as the Health and Wellbeing Board continues its work. This section draws some broad conclusions from the assessment and makes recommendations for local action.

### 12.1 Conclusions

It is now well established that mental health and wellbeing is fundamental to our ability to flourish as individuals and as a community. Mental and physical health are intertwined, summed up by the title of the National Mental Health Strategy

‘There Is No Health Without Mental Health’. Recognising the many complex factors affecting mental health, the JSNA has taken a broad look at Swindon and its people.

Swindon often appears to be average or better than average on health and related indicators. For example the index of social deprivation would suggest that the Borough is better off than many local authorities across the country. There are, however, strong inequalities within Swindon and these are reflected in patterns of health status and health service use across the town. There are also some areas such as educational attainment where Swindon’s record is lower than the national average and which will affect mental health and wellbeing. Educational attainment and mental health are interdependent – high levels of mental health, resilience and self-esteem will help to improve educational attainment and the long term benefits of higher educational attainment on mental wellbeing and reliance have been outlined in this document.

Swindon’s increasing size will mean more demands on services and thus higher levels of spending if current trends continue. However, it is not just a question of size – Swindon’s population is becoming more diverse in many ways and this will have a great impact on mental health. For example, the young population is becoming much older, the ethnic profile is becoming much more diverse and there are more people who may have special needs such as carers, people with a long-term health condition or veterans from recent conflicts. Over time it is also likely that more people will be living separately from their families, posing the risk of social isolation.

There are signs that the economy is recovering from recession. This is important in that good quality work is known to be one of the keys to mental wellbeing while being out of work increases the risk of mental health problems such as depression. Initiatives such as Mindful Employer and commissioned third sector support regarding employment are fundamental to improving mental health in the workplace. Reducing inequalities in physical and mental health requires that economic opportunities are spread more evenly. One challenge is that Swindon has a very low proportion of people with mental illness in employment.

Population surveys suggest that people in Swindon have average or slightly better than average levels of mental wellbeing. It is likely that the prevalence of mental health problems is similar to the national average after taking age and gender into account. In this context is noticeable that the prescribing of anti-depressant and hypnotic drugs is relatively high in Swindon. There are some large and unexplained variations between GP practices in prescribing and in referrals to psychological services. The number of people diagnosed with a serious mental illness (such as schizophrenia or bipolar disorder) is lower than average in Swindon.

There is a wide and complex mix of mental health and wellbeing services in place in Swindon, ranging from community and voluntary sector services through local authority and community health services to specialist hospital provision. Most of these services have either been reconfigured recently or are currently under review. It will be important to oversee the various changes and evaluate their

impact. It should not be overlooked that stable, secure, affordable housing and individualised support with a high element of choice and control for service users is key to recovery. [50] [157] Collaborative working is essential between housing services and mental health teams to ensure those with mental health problems who experience periods of being unwell are secure.

Some key projects such as the Information, Advice and advocacy hub and the Wellbeing Coordination Pilot will be key to improving reliance and independence and reducing demand on services. Mental health service users raised the ne dot have access to information provided in a friendly and supportive way and the success of these projects will lie in the accessibility of the service.

This needs assessment complements and recognises the importance of some other key pieces of work. It acknowledges and supports the implementation of the recommendations outlined in pieces of work such as: the Domestic Violence Needs Assessment 2013; the Swindon and Wiltshire Probation Mental Health Needs Assessment 2013; Swindon's Green Infrastructure Strategy 2010 – 2026; Planners should ensure that they recognise the impact of high density housing on mental wellbeing and ensure adequate privacy, access to green space and sound insulation in planning applications. Effective access to good public transport is also important. All decisions affecting services should ensure that mental health impacts assessments are considered.

The evidence of effectiveness and cost effectiveness of mental health interventions is growing and some key findings have been outlined in this report. The varied nature of services and differences in local implementation raise the importance of good monitoring and evaluation. A key component of this is finding out the views of service users and carers. This needs assessment process has involved users and highlighted concerns raised in focus groups and surveys. It summarises the results including the need for clear information to help people access the services they need.

There have been some key areas that this needs assessment has not reviewed which need to be addressed in future pieces of work. These include: the mental health and wellbeing of children and young people in Swindon; the health needs of Military Veterans; current provision and expertise for peri-natal mental health including education and support for partners and families of mothers identified with risk of post-partum depression; and strategic plans to enhance and support the role of carers to enable a positive caring experience particularly in light of demographic changes predicted for Swindon.

## 12.2 Recommendations

The following recommendations are put forward to support the Health and Wellbeing Board in developing a strategic approach to mental health and

[157] 48 in main document. Dunn J Housing as a Determinant of Mental Captital. State of Science Review: SR-E27 2008 Foresight mental capital and wellbeing: Making the most of ourselves in the 21st century. Government Office for Science, London.

wellbeing in Swindon. They involve action throughout the mental health service and beyond.

### 12.2.1 A Strategic Approach

1) There needs to be a co-ordinated approach to commissioning services which impact on mental health and wellbeing. These include but are not restricted to secondary mental health services, third sector mental health services, CAMHS, substance misuse services, Public Health Initiatives, social care services and housing services. A co-ordinated approach would ensure that the commissioning intentions of one commissioner are not at odds with those of another for example a reduction in housing support at the same time as a drive to resettle out of area placements. Coordination would ensure a reduction in duplication and safeguard against gaps in services.

2) Wellbeing is not equally distributed throughout the town. Wellbeing of those in Central ward, Parks and Penhill is statistically significantly worse than the wellbeing in other areas of Swindon. In addition those in the Town Centre and North Swindon are least satisfied with where they live. Wellbeing initiatives should focus on improving wellbeing in these areas. The ethnicity of the populations in these areas should be taken into account when developing initiatives.

3) An innovative approach to promoting these Five Ways to Wellbeing should be sort and built in to work delivered by all staff in all organisations in Swindon. www.fivewaystowellbeing.org.

4) Swindon demography has many risk factors for social isolation – a new and growing population possibly without family links to the area; a growing Black and Minority Ethnic population including gypsies and Irish travellers; increasing numbers of migrants and an ageing population. Recommendations from the Foresight Report with regard to "The influence of demographic: social and physical Factors on ageing and the mental health of older people" should be reviewed and a strategy developed to implement those most pertinent to Swindon. Ensuring that older people are actively engaged in society will be key to dealing with problems associated with an aging population. The Five Ways to Wellbeing should be used as a foundation for the strategy and for initiatives to improve mental wellbeing of older people. Initiatives to encourage social integration such as work carried out by the Health Ambassadors and locality teams should be continued and enhanced. The Health Ambassador teams should target socially isolated groups. Social Isolation can lead to radicalisation and Mental Health Service providers should be aware of radicalisation and potential threat to their patients. Training on the Channel Process has

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been rolled out in Swindon and those who provide support to those with mental health conditions should access this training.

5) Mental Health Services should undertake an equality impact assessment to facilitate access to marginalised groups. As there is a strong association between mental health problems and deprivation, both prevention and treatment services should be targeted and accessible to those living in the most deprived communities. As there is a strong association between deprivation and BME groups, mental health services should be configured to facilitate access to the increased BME population in Swindon. The audit should include all equality groups including those with hearing and sight loss and Learning Disabilities. The mental health needs of the homeless should be addressed through this audit.

6) Changes to benefit entitlement have had a big impact on those with mental health conditions. Those working with individuals in relation to benefits – be those employment, disability, housing or other benefits, should be aware of the needs of this client group and they should make reasonable adjustments to ensure that individuals can access the support and benefits they are entitled to. Health and social care providers, mental health services and financial sectors are aware of the impact of debt on mental health and ensure they are linked to debt advice services as required.

7) Those providing services to adults should ensure the voice of their young carers are heard and the needs of the whole family considered. See the Adult See the Child protocols should be followed. At the same time services need to work with carers to assess their needs and provide access to a range of psychological services to maintain their personal health and wellbeing should be embedded in standard practice. There should be links to the Health Ambassadors.

8) The needs assessment has highlighted the inequalities experienced by those with mental health problems. A review of the physical health needs of those with mental health should be undertaken within AWP and other mental health service providers. Health improvement initiatives should be promoted more effectively. Physical illness of those with mental health problems should be recognised and addressed.

9) A local Time For Change group should be established and supported to raise awareness of mental health issues and tackle the stigma associated with it. The work of this group should complement the work than many statutory and voluntary sector organisations undertake.

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10) Further work should be undertaken to ensure that the mental health needs of those aged 16 – 25 yrs are met and that the transition between CAMHS and Adult services is facilitated. A review of the CAMHS pilot described in section 10.2 should be undertaken.

11) A full review of section 136 should be undertaken to ensure that this service meets the quality standards outlined in the NICE clinical guidelines 136. This has implications for both mental health services (place of safety for adults and young people) and the police. With regard to the police a review of the mental health training and protocols for the police services should be undertaken as between 15 - 20% police incidents involve an element of mental health issues. Mental Health First Aid training and ASIST suicide prevention training or alternatives should be offered. In conjunction with NHS England a review of mental health services and practices impacting on mental health and wellbeing should be under taken.

12) Rates of admission for self-harm are high in Swindon for both adults and younger people, work should continue to gain further insight into these admission rates and to address the rates by improving access to community services. This ideally should be done by funding the development of a self-harm register within the emergency department at GWH. Admission rates are particularly high in Central Ward and further work needs to be undertaken to understand if this relates to ethnicity. There should be recognition that self-harm is high amongst victims of domestic violence and those providing support to those presenting with self-harm should be aware of domestic violence protocols and services available locally – this includes mental health services.

13) Collaborative work with MAPPA needs to be undertaken to support the repatriation of forensic placements back to Swindon and ensure measures are in place to reduce the risk. This will address the disproportionate spend on out of area placements and improve the services delivered to individuals.

14) Swindon has high rates of prescribing for anti-depressants and hypnotics. Further work needs to be undertaken to understand the reasons for this and to reduce the prescribing rates where appropriate alternatives exist or can be developed.

15) Ensuring the Dual Diagnosis pathways are implemented and evaluated to ensure that the needs of this vulnerable group including those on probation are met. This pathway should include those with Korsokoffs.

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16) A review of AWP services following the restructuring should be undertaken to ensure the restructure successfully achieved its aims. Service users reported the feeling of being discharged without support and having difficulty re-accessing services when they started to feel unwell rather than having to wait until they were very unwell. Residential care staff also reported concerns that the "fast track" back into services did not always work, they reported that they did not always receive information they needed to support clients on discharge. An evaluation of the impact of the various changes in mental health services should be undertaken and the results used to inform future plans. In addition an evaluation of the redesign on different elements of the service should be undertaken to ensure that the redesign has not had a detrimental impact on elements of the services that were previously functioning well. The views of mental health services users should be captured by service providers and reported to commissioners on a regular basis.

17) The current LIFT Psychology Service which includes IAPT, is very focused on prevention and early intervention and promoting mental health and wellbeing in Swindon. This is a strength of the service. The service should maintain its open access and public mental health approach of least intervention first time. AWP service redesign has challenged this approach as referrals via the Primary Care Liaison Service by definition are not least intervention first time. However, it should recognise that for some, the self-referral criterion makes the service less accessible. Any service redesign of secondary care services should ensure funding transfers between different levels of service to ensure this focus can be maintained.

### Service Gaps

18) Work should continue in supporting those with long-term physical health conditions in addressing mental health issues they may experience. This may require a review of current funding. Mental health needs should also be considered with end of life care

19) Eating Disorder Integrated pathways have been developed but these need reviewing and implementing. Consideration should be given to commissioning a community eating disorder service or ensuring the present service is fit for purpose, visible and accessible.

20) A review of ADHD provision should be undertaken to ensure it meets the needs of adults with ADHD. A broader piece of work to support carers of people with enduring mental health needs and complex learning disabilities and/or ADHD needs to be undertaken.

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21) The gap in service for those who are acutely emotionally distressed but not necessarily mentally ill needs to be addressed. This could have a positive impact in reducing suicide and admissions for self-harm. This work could be tied to a review of crisis support services, providing short-term inpatient therapeutic interventions and follow-up outpatients support with links to Health Befrienders. This should include strong links to the Hospital Based Psychiatric liaison service.

### 12.2 Priority for action

From these recommendations there are some that need to be prioritised in order to reduce risk and reduce costs. These include:

1. Providing a service to those experiencing acute emotional distress who may not yet be known to mental health services. These individuals may be at risk of harming themselves or becoming more seriously unwell.
2. Repatriating mental health service users currently inappropriately on out of area placements and ensuring they have appropriate accommodation and support locally for effective recovery.
3. Improving communication between commissioners where there is overlap in services areas commissioned. This is particularly important in the current climate where cost savings are being sort and lack of communication can lead to duplication or gaps in services what may lead to additional costs.
4. The gaps in services outlined above should be reviewed and addressed. These include: Eating Disorders; Dual Diagnosis; ADHD and ensuring that the continued funding for psychological support for those with long term conditions is identified; and those in transition from CAMHS.
5. Reviewing current restructured AWP services to ensure they are achieving the aims of the restructure without negatively impacting on other areas of service.
6. Ensure more rigorous monitoring and review of self-harm admissions in order to reduce re-attendance.
7. Address issues raised with regard to social isolation and the promotion of mental wellbeing through the Five Ways to Wellbeing.

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## Appendix 1 Abbreviations

ADHD = Attention Deficit Hyperactivity Disorder

AOWA = Adults of Working Age

AWP = Avon and Wiltshire Partnership

BME = Black & Minority Ethnic Groups

BSL = British Sign Language

CAB = Citizen Advice Bureau

CCG = Clinical Commissioning Group

CMD = Common Mental Disorder

DH = Department of Health

DLA = Disability Living Allowance

EMPHO = East Midlands Public Health Observatory

IAPT = Improving Access to Psychological Therapies Programme

IB = Incapacity Benefit

IMD = Index of Multiple Deprivation

JSA = Jobseekers Allowance

LA = Local Authority

LIFT = Swindon, Wiltshire, Bristol and South Gloucestershire Psychological Service

LSOA = Lower Super Output Area

LTC = Long-term Health Condition

MIND = Mental Health Charity

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MHCT = Mental Health Clustering Tool

NHS = National Health Service

NI = National Indicator

NICE = National Institute for Health and Care Excellence

NOMIS = National Online Manpower Information System (Official labour market statistics)

POPPI = Projecting Older People Population Information

PANSI = Projecting Adult Needs and Service Information

PTSD = Post-Traumatic Stress Disorder

OCD = Obsessive-Compulsive Disorder

ONS = Office for National Statistics

OSC = Overview and Scrutiny Committee

PbR = Payment by Result

$R^2$ = Coefficient of Determination

SD = Standard Deviation

SDA = Severe Disablement Allowance

UA = Unitary Authority

WHO = World Health Organisation

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Appendix 2 Definitions

| | |
|---|---|
| Affective disorder | mental disorder characterized by dramatic changes or extremes of mood. Affective disorders may include manic (elevated, expansive, or irritable mood with hyperactivity, pressured speech, and inflated self-esteem) or depressive (dejected mood with disinterest in life, sleep disturbance, agitation, and feelings of worthlessness or guilt) episodes, and often combinations of the two. Persons with an affective disorder may or may not have psychotic symptoms such as delusions, hallucinations, or other loss of contact with reality. |
| Neurosis | A psychological or behavioural disorder in which anxiety is the primary characteristic; defence mechanisms or any of the phobias are the adjustive techniques that a person learns to cope with this underlying anxiety. In contrast to the psychoses, people with a neurosis do not exhibit gross distortion of reality or disorganization of personality. |
| Self-harm | self-poisoning or self-injury, irrespective of the apparent purpose of the act |
| Personality Disorder | Personality disorders are longstanding, ingrained distortions of personality that interfere with the ability to make and sustain relationships. Antisocial personality disorder (ASPD)and borderline personality disorder (BPD) are two types with particular public and mental health policy relevance.<br><br>ASPD is characterised by disregard for and violation of the rights of others. People with ASPD have a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence. They account for a disproportionately large proportion of crime and violence committed.<br><br>BPD is characterised by high levels of personal and emotional instability associated with significant impairment. People with BPD have severe difficulties with sustaining relationships, and self-harm and suicidal behavioural is common. |
| Psychoses | *Psychoses are disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. The main types are schizophrenia and affective psychosis, such as bi-polar disorder. |

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Appendix 3 Demographic profile of Swindon

Table 46 Swindon LA population by age and sex, Census day 2011.

| | Person | Male | Female | M:F |
|---|---|---|---|---|
| 0 – 4 | 14,083 | 7,232 | 6,851 | 1.1 |
| 5 – 9 | 12,273 | 6,304 | 5,969 | 1.1 |
| 10 – 14 | 12,433 | 6,296 | 6,137 | 1.0 |
| 15 – 19 | 12,424 | 6,369 | 6,055 | 1.1 |
| 20 – 24 | 12,859 | 6,341 | 6,518 | 1.0 |
| 25 – 29 | 15,075 | 7,433 | 7,642 | 1.0 |
| 30 – 34 | 15,172 | 7,711 | 7,461 | 1.0 |
| 35 – 39 | 16,297 | 8,506 | 7,791 | 1.1 |
| 40 – 44 | 16,869 | 8,676 | 8,193 | 1.1 |
| 45 – 49 | 16,371 | 8,375 | 7,996 | 1.0 |
| 50 – 54 | 13,822 | 7,066 | 6,756 | 1.0 |
| 55 – 59 | 11,634 | 5,862 | 5,772 | 1.0 |
| 60 – 64 | 10,990 | 5,413 | 5,577 | 1.0 |
| 65 – 69 | 8,453 | 4,119 | 4,334 | 1.0 |
| 70 – 74 | 6,707 | 3,207 | 3,500 | 0.9 |
| 75 – 79 | 5,633 | 2,554 | 3,079 | 0.8 |
| 80 – 84 | 4,266 | 1,842 | 2,424 | 0.8 |
| 85+ | 3,795 | 1,312 | 2,483 | 0.5 |
| **All ages** | **209,156** | **104,618** | **104,538** | **1.0** |

Source: ONS, Census 2011

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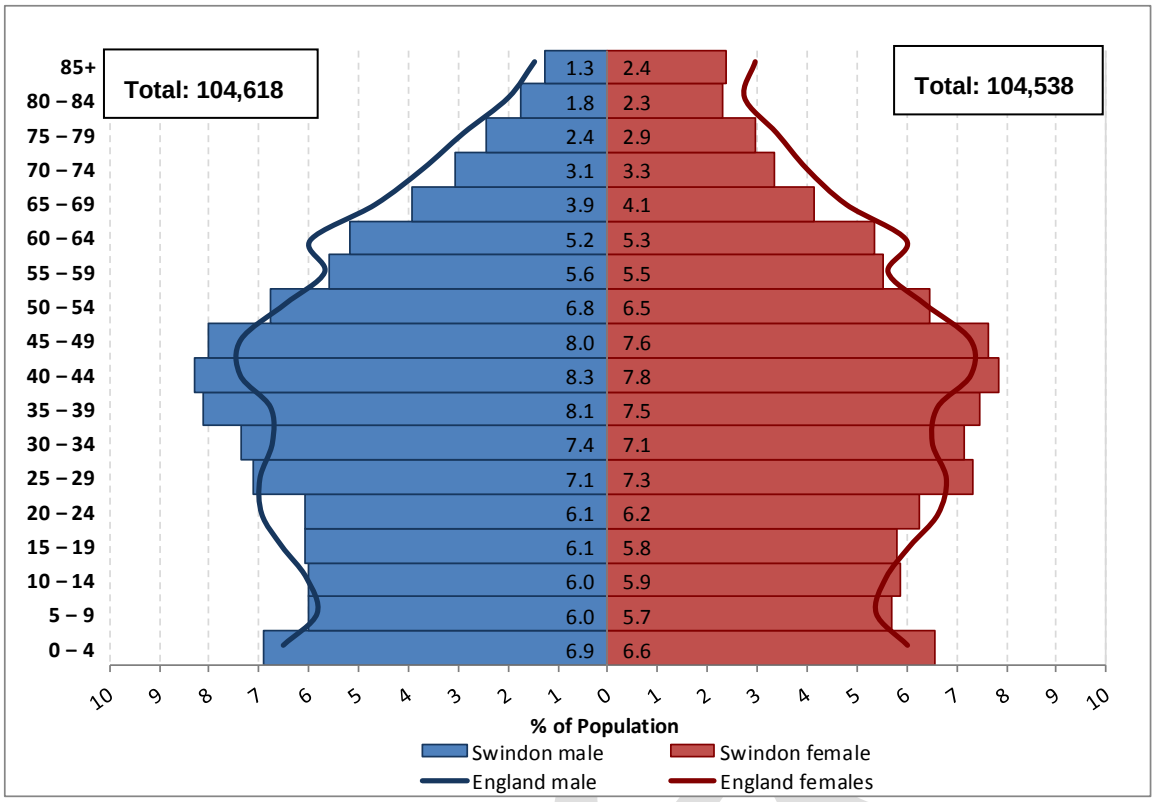
Figure 57 Swindon LA area population pyramid, Census day 2011.




Source: ONS, Census 2011

Table 47 Swindon's ward population by broad age band, Census 2011.

| Ward name (2010) | Number | | | | Percentage | | | |
|---|---|---|---|---|---|---|---|---|
| | 0-19 | 20-64 | 65+ | All ages | 0-19 | 20-64 | 65+ | All ages |
| Abbey Meads | 5,965 | 13,577 | 678 | 20,22 | 29.5 | 67.1 | 3.4 | 9.7 |
| Blunsdon | 732 | 1,944 | 684 | 3,360 | 21.8 | 57.9 | 20.4 | 1.6 |
| Central | 2,679 | 7,773 | 1,001 | 11,45 | 23.4 | 67.9 | 8.7 | 5.5 |
| Covingham & Nythe | 1,782 | 5,211 | 1,749 | 8,742 | 20.4 | 59.6 | 20.0 | 4.2 |
| Dorcan | 2,100 | 5,307 | 1,277 | 8,684 | 24.2 | 61.1 | 14.7 | 4.2 |
| Eastcott | 2,060 | 7,668 | 1,050 | 10,77 | 19.1 | 71.1 | 9.7 | 5.2 |
| Freshbrook &Grange Park | 2,547 | 6,506 | 836 | 9,889 | 25.8 | 65.8 | 8.5 | 4.7 |
| Gorse Hill & Pinehurst | 2,472 | 5,923 | 1,219 | 9,614 | 25.7 | 61.6 | 12.7 | 4.6 |
| Haydon Wick | 2,504 | 6,225 | 1,540 | 10,26 | 24.4 | 60.6 | 15.0 | 4.9 |
| Highworth | 1,784 | 4,770 | 1,705 | 8,259 | 21.6 | 57.8 | 20.6 | 3.9 |
| Moredon | 2,533 | 5,852 | 1,459 | 9,844 | 25.7 | 59.4 | 14.8 | 4.7 |
| Old Town & Lawn | 2,568 | 7,417 | 2,247 | 12,23 | 21.0 | 60.6 | 18.4 | 5.8 |
| Parks | 2,940 | 5,853 | 1,488 | 10,28 | 28.6 | 56.9 | 14.5 | 4.9 |
| Penhill | 1,895 | 3,518 | 915 | 6,328 | 29.9 | 55.6 | 14.5 | 3.0 |
| Ridgeway | 807 | 1,949 | 570 | 3,326 | 24.3 | 58.6 | 17.1 | 1.6 |
| Shaw & Nine Elms | 2,484 | 6,195 | 659 | 9,338 | 26.6 | 66.3 | 7.1 | 4.5 |
| St Margaret | 2,301 | 5,921 | 2,052 | 10,27 | 22.4 | 57.6 | 20.0 | 4.9 |
| St Philip | 2,083 | 5,187 | 1,825 | 9,095 | 22.9 | 57.0 | 20.1 | 4.3 |
| Toothill & Westlea | 1,774 | 4,822 | 959 | 7,555 | 23.5 | 63.8 | 12.7 | 3.6 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Walcot | 2,160 | 4,362 | 1,249 | 7,771 | 27.8 | 56.1 | 16.1 | 3.7 |
| Western | 2,634 | 7,350 | 1,348 | 11,33 | 23.2 | 64.9 | 11.9 | 5.4 |
| Wroughton & Chiseldon | 2,409 | 5,759 | 2,344 | 10,51 | 22.9 | 54.8 | 22.3 | 5.0 |
| **Swindon** | **51,213** | **129,089** | **28,854** | **209,1** | **24.5** | **61.7** | **13.8** | **100.** |

Source: ONS, Census 2011

**2011 Census: Ethnic group, local authorities in England and Wales (Table KS201EW)**

**Source: ONS**

http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-286262

| Ethnic group | Census 2011 | | | | | |
|---|---|---|---|---|---|---|
| | Numbers | | | Percentage | | |
| | Swindon UA | South West | England | Swindon UA | South West | England |
| **White: English/Welsh/Scottish/Northern Irish/British** | **177,028** | 4,855,676 | 42,279,236 | **84.6** | 91.8 | 79.8 |
| **White: Irish** | **1,852** | 28,616 | 517,001 | **0.9** | 0.5 | 1.0 |
| **White: Gypsy or Irish Traveller** | **180** | 5,631 | 54,895 | **0.1** | 0.1 | 0.1 |
| **White: Other White** | **8,838** | 156,506 | 2,430,010 | **4.2** | 3.0 | 4.6 |
| **Mixed/multiple ethnic group: White and Black Caribbean** | **1,506** | 25,669 | 415,616 | **0.7** | 0.5 | 0.8 |
| **Mixed/multiple ethnic group: White and Black African** | **568** | 8,550 | 161,550 | **0.3** | 0.2 | 0.3 |
| **Mixed/multiple ethnic group: White and Asian** | **1,163** | 21,410 | 332,708 | **0.6** | 0.4 | 0.6 |
| **Mixed/multiple ethnic group: Other Mixed** | **989** | 16,255 | 283,005 | **0.5** | 0.3 | 0.5 |
| **Asian/Asian British: Indian** | **6,901** | 34,188 | 1,395,702 | **3.3** | 0.6 | 2.6 |
| **Asian/Asian British: Pakistani** | **1,292** | 11,622 | 1,112,282 | **0.6** | 0.2 | 2.1 |
| **Asian/Asian British: Bangladeshi** | **936** | 8,416 | 436,514 | **0.4** | 0.2 | 0.8 |
| **Asian/Asian British: Chinese** | **954** | 22,243 | 379,503 | **0.5** | 0.4 | 0.7 |
| **Asian/Asian British: Other Asian** | **3,282** | 29,068 | 819,402 | **1.6** | 0.5 | 1.5 |
| **Black/African/Caribbean/Black British: African** | **1,718** | 24,226 | 977,741 | **0.8** | 0.5 | 1.8 |
| **Black/African/Caribbean/Black British: Caribbean** | **807** | 15,129 | 591,016 | **0.4** | 0.3 | 1.1 |
| **Black/African/Caribbean/Black British: Other Black** | **336** | 10,121 | 277,857 | **0.2** | 0.2 | 0.5 |
| **Other ethnic group: Arab** | **188** | 5,692 | 220,985 | **0.1** | 0.1 | 0.4 |
| **Other ethnic group: Any other ethnic group** | **618** | 9,917 | 327,433 | **0.3** | 0.2 | 0.6 |
| **Total population** | **209,156** | **5,288,935** | **53,012,456** | **100** | **100** | **100** |

| Broad ethnic group | Census 2011 | | | | | |
|---|---|---|---|---|---|---|
| | Numbers | | | Percentage | | |
| | Swindon UA | South West | England | Swindon UA | South West | England |
| **White British** | **187,898** | 5,046,429 | 45,281,142 | **89.8** | 95.4 | 85.4 |
| **White Other** | **10,870** | 190,753 | 3,001,906 | **5.2** | 3.6 | 5.7 |
| **Asian/Asian British** | **13,365** | 105,537 | 4,143,403 | **6.4** | 2.0 | 7.8 |
| **Mixed/multiple ethnic group** | **4,226** | 71,884 | 1,192,879 | **2.0** | 1.4 | 2.3 |
| **Black/Black British** | **2,861** | 49,476 | 1,846,614 | **1.4** | 0.9 | 3.5 |
| **Other ethnic group** | **806** | 15,609 | 548,418 | **0.4** | 0.3 | 1.0 |

## Appendix 4 Prevalence of maternal mental health problems

Based on the number of registered births in 2011-12 estimated rates are:

Based on the number of registered births in 2011-12 estimated rates are:

| | **Rates per 1,000 births** | **Swindon (2946 births)** |
|---|---|---|
| Major depressive illness | 100 | 300 |
| Moderate to severe depression | 50 | 150 |
| Need for referral to psychological therapies | 80 | 240 |
| Need for referral to psychiatric services (new episode of postnatal disorder) | 20 | 60 |
| Need for referral to psychiatric services in pregnancy | 20 | 60 |
| Need for admission with puerperal psychosis | 2 | 6 |
| Need for admission with non-psychotic conditions | 2 | 6 |
| Need for admission with chronic serious mental illness. | 2 | 6 |
| Need for admission to a mother and baby unit | 4 | 12 |

Source: Maternal Mental Health Provision in Wiltshire MSLC Sarah Weld 2012.

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Appendix 5 Educational Attainment by Ward 2011

Highest level of qualification gained of working age population (16+ years) by Swindon wards, Census 2011.

| | No qualifications | Level 1 and 2 | Level 3 | Level 4 and above |
|---|---|---|---|---|
| Penhill | 38.7 | 38.9 | 7.5 | 6.7 |
| Parks | 35.0 | 39.0 | 7.6 | 8.6 |
| Gorse Hill & Pinehurst | 30.3 | 36.6 | 9.4 | 12.1 |
| Walcot | 28.7 | 35.9 | 9.5 | 14.9 |
| Moredon | 27.7 | 36.6 | 11.8 | 14.3 |
| St Philip | 27.0 | 35.4 | 10.7 | 15.7 |
| St Margaret | 22.9 | 35.6 | 11.7 | 18.5 |
| Wroughton & Chiseldon | 22.5 | 29.0 | 10.8 | 28.2 |
| Dorcan | 22.1 | 40.1 | 10.2 | 17.9 |
| Covingham & Nythe | 21.7 | 37.9 | 12.0 | 17.7 |
| Toothill & Westlea | 21.6 | 38.4 | 12.0 | 17.8 |
| Blunsdon | 21.2 | 30.7 | 11.3 | 28.1 |
| Highworth | 21.1 | 30.9 | 12.2 | 26.4 |
| Western | 20.5 | 36.1 | 11.6 | 20.0 |
| Central | 18.4 | 33.2 | 9.4 | 19.2 |
| Haydon Wick | 17.2 | 36.1 | 12.8 | 23.2 |
| Freshbrook & Grange Park | 15.8 | 38.6 | 13.2 | 23.8 |
| Eastcott | 14.2 | 28.6 | 12.0 | 33.8 |
| Old Town & Lawn | 13.8 | 26.3 | 11.9 | 39.3 |
| Ridgeway | 13.0 | 28.2 | 11.8 | 39.5 |
| Shaw & Nine Elms | 10.7 | 37.4 | 14.6 | 28.9 |
| Abbey Meads | 7.3 | 35.4 | 16.0 | 33.9 |

Source: ONS

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Appendix 6 Warwick Edinburgh Mental Wellbeing Scale seven questions

These the seven WEMWS questions included in the residents survey.

Q39 Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last two weeks. **Please tick one box per row**

| | None of the time | Rarely | Some of the time | Often | All of the time |
|---|---|---|---|---|---|
| I've been feeling optimistic about the future | ☐ | ☐ | ☐ | ☐ | ☐ |
| I've been feeling useful I've been feeling useful | ☐ | ☐ | ☐ | ☐ | ☐ |
| I've been feeling relaxed | ☐ | ☐ | ☐ | ☐ | ☐ |
| I've been dealing with problems well | ☐ | ☐ | ☐ | ☐ | ☐ |
| I've been thinking clearly | ☐ | ☐ | ☐ | ☐ | ☐ |
| I've been feeling close to other people | ☐ | ☐ | ☐ | ☐ | ☐ |
| I've been able to make up my own mind about things | ☐ | ☐ | ☐ | ☐ | ☐ |

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# Appendix 7 Five Ways to Wellbeing (NEF)

**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.

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

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

**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.

**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 creates connections with the people around you.

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Appendix 8 Mental Health Service Care Cluster Descriptions

Mental Health Service Care Cluster Descriptions (organic is not relevant to this needs assessment)

| | Care Cluster | Description | Likely diagnoses | Percentage of AWP caseload (number of cases in brackets) (Quarter 1 2013/14 snapshot) |
|---|---|---|---|---|
| NON PSYCHO | 1 | This group has definite by minor problems of depressed mood, anxiety or other disorder but they do not present with any distressing psychotic symptoms | May not attract a formal diagnosis but may include mild symptoms of: F32 Depressive Episode, F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F50 Eating Disorder. | 0.2 % (10) |
| | 2 | This group has definite but minor problems of depressed mood, anxiety or other disorder but not with any distressing psychotic symptoms. They may have already received care associated with cluster 1 and require more specific intervention or previously been successfully treated at a higher level but are re-presenting with low level symptoms. | Likely to include: F32 Depressive Episode, F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F50 Eating Disorder. | 1.2% (52) |
| | 3 | Moderate problems involving depressed | Likely to include F32 Depressive Episode | 4.2% (183) |

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| | | | | |
|---|---|---|---|---|
| **T I C** | | mood, anxiety or other disorder (not including psychosis). | (non psychotic), F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F50 Eating Disorder. | |
| | **4** | This group is characterised by severe depression and/or anxiety and/or other increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks. | Likely to include: F32 Depressive Episode (Non-Psychotic), F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders, F50 Eating Disorder | 7.5% (328) |
| | **5** | This group will be severely depressed and/or anxious and/or other. They will not present with distressing hallucinations or delusions but may have some unreasonable beliefs. They may often be at high risk for Non-accidental self-injury and they may present safeguarding issues and have severe disruption to everyday living. | Likely to include: F32 Depressive Episode (Non-Psychotic), F33 Recurrent Depressive Episode (Non-Psychotic), F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders, F50 Eating Disorder | 1.6% (72) |

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| | | | | |
|---|---|---|---|---|
| | **6** | Moderate to very severe disorders that are difficult to treat. This may include treatment resistant eating disorder, OCD etc., where extreme beliefs are strongly held, some personality disorders and enduring depression. | Likely to include: F32 Depressive Episode (Non-Psychotic), F33 Recurrent Depressive Episode (Non-Psychotic), F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders, F50 Eating Disorder and some F60. | 2.5% (111) |
| | **7** | This group suffers from moderate to severe disorders that are very disabling. They will have received treatment for a number of years and although they may have improvement in positive symptoms, considerable disability remains that is likely to affect role functioning in many ways. | Likely to include: F32 Depressive Episode (Non-Psychotic), F33 Recurrent Depressive Episode (Non-Psychotic), F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders, F50 Eating Disorder and some F60. | 9.3% (408) |
| | **8** | This group will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat | Likely to include F60 Personality disorder. | 1.7% (73) |

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| | | | | |
|---|---|---|---|---|
| | | deliberate self-harm and/or other impulsive behaviour and chaotic, over dependent engagement and often hostile with services. | | |
| | **9** | **Blank** | **Blank** | |
| **P S Y C H O S I S** | **10** | This group will be presenting to the service for the first time with mild to severe psychotic phenomena. They may also have depressed mood and/or anxiety or other behaviours. Drinking or drug-taking may be present but *will* not be the only problem. | Likely to include (F20-F29) Schizophrenia, schizotypal and delusional disorders, Bi-polar disorder. | 3.3% (147) |
| | **11** | This group has a history of psychotic symptoms that are currently controlled and causing minor problems if any at all. They are currently experiencing a period of recovery where they are capable of full or near functioning. However, there may be impairment in self-esteem and efficacy and vulnerability to life. | Likely to include, (F20-F29) Schizophrenia, schizotypal and delusional disorders F30 Manic Episode, F31 Bipolar Affective Disorder | 10.4% (455) |
| | **12** | This group have a history of psychotic symptoms with a significant disability with major impact on role functioning. They are likely to be vulnerable to abuse or exploitation. | Likely to include, (F20-F29) Schizophrenia, schizotypal and delusional disorders, F30 Manic Episode, F31 Bipolar Affective Disorder | 7.7% (340) |
| | **13** | This group will have a history of psychotic symptoms which are not controlled. They | Likely to include, (F20-F29) Schizophrenia, Schizotypal and | 4.5% (196) |

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| | | | | |
|---|---|---|---|---|
| | | will present with severe to very severe psychotic symptoms and some anxiety or depression. They have a significant disability with major impact on role functioning. | delusional disorders, F30 Manic Episode, F31 Bipolar Affective Disorder. | |
| | **14** | They will be experiencing an acute psychotic episode with severe symptoms that cause severe disruption to role functioning. They may present as vulnerable and a risk to others or themselves. | Likely to include, (F20-F29) Schizophrenia, schizotypal and delusional disorders, F30 Manic Episode, F31 bipolar Affective Disorder | 0.3% (14) |
| | **15** | This group will be suffering from an acute episode of moderate to severe depressive symptoms. Hallucinations and delusions will be present. It is likely that this group will present a risk of Non-accidental self-injury and have disruption in many areas of their lives. | Likely to include, F32.3 Severe depressive episode with psychotic symptoms. | 0% (1) |
| | **16** | This group has enduring, moderate to severe psychotic or affective symptoms with unstable, chaotic lifestyles *and co-existing* Problem drinking or drug taking. They may present a risk to self and others and engage poorly with services. Role functioning is often globally impaired. | Likely to include, (F10-F19) Mental and behavioural disorders due to psychoactive substance use (F20-F29) Schizophrenia, schizotypal and delusional disorders, Bi-Polar Disorder | 1% (48) |
| | **17** | This group has moderate to severe | Likely to include, (F20-F29) | 0.5% (20) |

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|---|---|---|---|---|
| | | psychotic symptoms with unstable, chaotic lifestyles. There may be some problems with drugs or alcohol not severe enough to warrant dual diagnosis care. This group have a history of non-concordance, are vulnerable & engage poorly with services. | Schizophrenia, schizotypal and delusional disorders, Bi-Polar | |
| **O R G A N I C** | **18** | People who may be in the early stages of dementia (or who may have an organic brain disorder affecting their cognitive function) who have some memory problems, or other low level cognitive impairment but who are still managing to cope reasonably well. Underlying reversible physical causes have been rule out. | Diagnoses likely to include: F00 – Dementia in Alzheimer-s disease, F01 – Vascular dementia, F02 – Dementia in other diseases classified elsewhere F03 – Unspecified Dementia, Dementia with lewy bodies (DLB), | 17.3% (758) |
| | **19** | People who have problems with their memory, and or other aspects of cognitive functioning resulting in moderate problems looking after themselves and maintaining social relationships. Probable risk of self-neglect or harm to others and may be experiencing some anxiety or depression. | Likely to include: F00 – Dementia in Alzheimer's disease, F01 – Vascular dementia, F02 – Dementia in other diseases classified elsewhere, F03 – Unspecified Dementia, F09 – unspecified organic or symptomatic mental disorder, Dementia with lewy bodies (DLB), Frontotemporal dementia (FTD) | 16.8% (740) |
| | **20** | People with dementia who are having significant problems in looking after themselves and whose behaviour | Likely to include: F00 – Dementia in Alzheimer's disease, F01 – Vascular dementia, F02 – Dementia in other | 5.6% (247) |

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| | | may challenge their carers or services. They may have high levels of anxiety or depression, psychotic symptoms or significant problems such as aggression or agitation. The may not be aware of their problems. They are likely to be at high risk of self-neglect or harm to others, and there may be a significant risk of their care arrangements breaking down. | diseases classified elsewhere, F03 – Unspecified Dementia, F09 – unspecified organic or symptomatic mental disorder, Dementia with lewy bodies (DLB), Frontotemporal dementia (FTD). | |
| | **21** | People with cognitive impairment or dementia who are having significant problems in looking after themselves, and whose physical condition is becoming increasingly frail. They may not be aware of their problems and there may be a significant risk of their care arrangements breaking down. | Likely to include: F00 – Dementia in Alzheimer's disease, F01 – Vascular dementia, F02 – Dementia in other diseases classified elsewhere, F03 – Unspecified Dementia, F09 – unspecified organic or symptomatic mental disorder, Dementia with lewy bodies (DLB), Frontotemporal dementia (FTD) | 3.8% (167) |

AWP non clustered caseload 0.6% (25).

Appendix 9 Quality statements from NICE guidelines of service users experience in adult mental health in the NHS in England.

These quality statements are from the NICE quality standard on service user experience in adult mental health in the NHS in England, which was developed from the recommendations in this guidance. Recommendations, or parts of recommendations, that underpin the development of the quality statements and associated measures are denoted **[QS]**.

| No. | Quality statements |
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| 1. | People using mental health services, and their families or carers, feel optimistic that care will be effective. |
| 2 | People using mental health services, and their families or carers, feel they are treated with empathy, dignity and respect. |
| 3. | People using mental health services are actively involved in shared decision-making and supported in self-management. |
| 4. | People using community mental health services are normally supported by staff from a single, multidisciplinary community team, familiar to them and with whom they have a continuous relationship. |
| 5. | People using mental health services feel confident that the views of service users are used to monitor and improve the performance of services. |
| 6. | People can access mental health services when they need them. |
| 7. | People using mental health services understand the assessment process, their diagnosis and treatment options, and receive emotional support for any sensitive issues. |
| 8. | People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it. |
| 9 | People using mental health services who may be at risk of crisis are offered a crisis plan. |
| 10 | People accessing crisis support have a comprehensive assessment, undertaken by a professional competent in crisis working. |
| 11 | People in hospital for mental health care, including service users formally detained under the Mental Health Act, are routinely involved in shared decision-making. |
| 12 | People in hospital for mental health care have daily one-to-one contact with mental healthcare professionals known to the service user and regularly see other members of the multidisciplinary mental healthcare team. |
| 13 | People in hospital for mental health care can access meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm. |
| 14 | People in hospital for mental health care are confident that control and |

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| | restraint, and compulsory treatment including rapid tranquillisation, will be used competently, safely and only as a last resort with minimum force. |
| 15 | People using mental health services feel less stigmatised in the community and NHS, including within mental health services. |



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