South Gloucestershire

Adult Mental Health and Wellbeing Needs Assessment

June 2015

www.southglos.gov.uk
## Contents

Foreword .............................................................................................................................. 1  
Key messages .......................................................................................................................... 1  
Project team .......................................................................................................................... 2  
Acknowledgements ................................................................................................................ 3  
Executive summary ............................................................................................................... 3  

2. Introduction ......................................................................................................................... 9
   2.1. Concepts of mental health, mental wellbeing and mental illness ................................ 9
         2.1.1. Mental Health ........................................................................................................ 9
         2.1.2. Mental Wellbeing ................................................................................................. 10
         2.1.3. Mental Capital ....................................................................................................... 10
         2.1.4. Mental Illness ....................................................................................................... 10
   2.2. The Importance of mental health .................................................................................... 11
         2.2.1. National context and policies ............................................................................... 11
         2.2.2. Local context ....................................................................................................... 14
   2.3. Scope and purpose ......................................................................................................... 14

3. South Gloucestershire Population Profile ........................................................................... 16
   3.1. Population and geography .......................................................................................... 16
   3.2. Population and age ....................................................................................................... 16
   3.3. Population and ethnicity ............................................................................................ 16
   3.4. Population and deprivation ......................................................................................... 17
   3.5. Population projection .................................................................................................. 17
   3.6. Comparator neighbourhoods ...................................................................................... 17

4. Determinants of mental health and wellbeing ..................................................................... 18
   4.1. Introduction ................................................................................................................ 18
       4.1.1 Protective factors .................................................................................................... 19
       4.1.2 Population characteristics .................................................................................... 20
       4.1.3 Wider determinants .............................................................................................. 22
   4.2. Key determinants of mental health using South Gloucestershire data ...................... 24
       4.2.1 Lesbian, Gay, Bisexual and Transsexual people ................................................... 26
       4.2.2 Alcohol ................................................................................................................. 26
       4.2.3 Substance misuse .................................................................................................. 31
       4.2.4 Dual Diagnoses ...................................................................................................... 31
       4.2.5 Offenders ............................................................................................................... 31
       4.2.6 Domestic Violence ................................................................................................. 33
       4.2.7 Gypsies and Travellers .......................................................................................... 34
       4.2.8 Long term conditions ............................................................................................ 35

5. Mental and emotional wellbeing in South Gloucestershire .............................................. 36
   5.1. Self-reported wellbeing ............................................................................................... 36
   5.2. Stigma and discrimination ........................................................................................... 37
   5.3. Social Isolation ............................................................................................................ 38
   5.4. Findings from the Viewpoint Survey .......................................................................... 39
   5.5. Precious Time .............................................................................................................. 41
6. Prevalence of mental health conditions ................................................................. 41
   6.1 Common Mental Disorders .................................................................................. 42
   6.2 Depression ....................................................................................................... 45
   6.3 Psychoses ....................................................................................................... 49
   6.4 Personality Disorders ..................................................................................... 52
   6.5 Learning difficulties including Autism Spectrum Disorder ......................... 52
   6.6 Adult Attention Deficit Hyperactivity Disorder ............................................. 54
   6.7 Self-Harm ...................................................................................................... 55
   6.8 Suicide ........................................................................................................... 59
7. Findings from Public Health England’s Mental Health Intelligence Network and the Care Quality
   Commission’s Thematic Data Review Report .......................................................... 66
   7.1 Introduction .................................................................................................... 66
   7.2 The Mental Health Dementia and Neurology (MHDN) network .................... 66
   7.3 The Care Quality Commission thematic review of mental health crisis care ...... 68
8. Mental Health Services ......................................................................................... 70
   8.1 Avon and Wiltshire Mental Health Services Partnership (AWP) .................... 70
   8.2 The Mental Health Minimum Dataset ............................................................. 78
   8.3 Improving Access to Psychological Therapies (IAPT) ..................................... 80
   8.4 Mental Health Act Assessments including Section 136 referrals ................... 83
   8.5 Spend on Mental Health .................................................................................. 86
   8.6 Prescribing Data ............................................................................................ 87
9. What do local people think? Perspectives from service users and local community and voluntary
   organisations ......................................................................................................... 94
   9.1 Healthwatch Survey ....................................................................................... 95
   9.2 Service user interviews .................................................................................. 96
   9.3 Feedback from Voluntary, Community and Social Enterprise (VCSE) organisations ................................................................. 101
   9.4 South Gloucestershire Mental Health Resources List ...................................... 101
10. Conclusions- key findings and recommendations .................................................. 102
    10.1 Key findings by chapter ............................................................................... 102
    10.2 Recommendations ...................................................................................... 106
Appendix A – Closing the Gap: Priorities for essential change in mental health ............ 108
Appendix B – Summary of demographic information for South Gloucestershire residents admitted
   with mental health conditions 2009/2010 to 2013/2014 inclusive .......................... 109
Appendix C – Summary of data from Public Health England mental health profiles V2 .... 110
Appendix D – Experience and outcomes for people experiencing a mental health crisis for South
   Gloucestershire Council: thematic data review report- Care Quality Commission .... 112
Appendix E – The Mental Health Minimum Database (South Gloucestershire CCG) .......... 114
Appendix F – Interview topic guide for the Service User Consultation ..................... 114
Appendix G – South Gloucestershire Mental Health Resource List (summary version) ..... 115
Appendix H – Websites and electronic resources ..................................................... 117
Foreword

Thank you for reading the South Gloucestershire Adult Mental Health Needs Assessment. This is an important piece of work and the first time that a comprehensive needs assessment of this kind has taken place in South Gloucestershire. It is the product of a lot of work by a lot of people to whom I am very grateful: commissioners, professionals, service users, representatives of the community and voluntary sector, councillors and many others.

So what is the story in South Gloucestershire? At a whole population level mental health outcomes are good and something to be proud of. This is because South Gloucestershire performs well on many of the wider determinants of health and risk factors for mental illness such as employment, homelessness and crime. The acute or crisis response to people with mental health problems is good and is appreciated by service users.

However, if you dig beneath the surface there are other areas where we need to do better. Follow on services after an acute episode of illness are less impressive than the acute response; there are significant performance issues with the Increasing Access to Psychological Therapy service and all services are struggling with increasing demand which is expected to get worse as the population grows and ages. The report also identifies where there are issues with particular groups or those who are vulnerable. On occasion, Service Users and other groups including regulators have expressed concern over engagement, access and quality of care.

Historically investment in mental health in South Gloucestershire has been very low in comparison to the rest of England with almost no investment in community services. South Gloucestershire has a large gap in the provision of support and care for individuals who do not meet therapeutic thresholds.

This report is an attempt to describe the ‘as is’ situation in South Gloucestershire, to take an honest and hard look at how we are performing. It is not an end in itself and will only be of significance if it is used as part of a process to improve things locally. Just as mental health is everyone’s business the responsibility for improvement is everyone’s business be we commissioners, professionals, service users, politicians or members of the public. I encourage you to be part of this process.

Dr Mark Pietroni
Director of Public Health
mark.pietroni@southglos.gov.uk

Key messages

Population level indicators

- In general terms mental health outcomes in South Gloucestershire are better than the England average largely due to good performance on wider determinants of health such as
employment, housing and crime

- Demand for services will increase at least in keeping with population growth
- There has been low investment in mental health in South Gloucestershire compared with the rest of England

Mental health services and provision

- There is increasing demand for the Improving Access to Psychological Therapies (IAPT) programme in South Gloucestershire. However, there are problems with access to these services and the provision of long term support post IAPT is poor
- There is a lack of community based support for people with sub threshold mental health conditions
- There is increasing demand for community and inpatient mental health services
- People with autism face long delays before they can access diagnostic assessment
- People in South Gloucestershire with learning disabilities are less likely to receive community or day care services than the rest of England
- The acute response to mental health crises is good. However, there is less support for longer term care
- Service users and other groups including regulators have expressed concerns about engagement, access and quality of care

Vulnerable groups

- Groups at high risk of mental ill-health in South Gloucestershire include people living in Priority Neighbourhoods, the unemployed, people with disabilities, prisoners, Gypsies and Travellers, substance misusers (including alcohol misusers), smokers, people with long term conditions, people in the Lesbian, Gay, Bisexual or Trans (LGBT) community and victims of domestic abuse
- Young women are at particular risk of non-fatal self-harm; poisoning is the most common method used
- Males have a twofold to threefold increased risk of suicide compared with women. Older men have the highest suicide rates

Project team

Dr Kyla Thomas- Clinical Lecturer/Honorary Speciality Registrar in Public Health, South Gloucestershire Council

Steve Spiers- Programme Lead for Mental Health and Wellbeing, South Gloucestershire Council

Sara Blackmore- Consultant in Public Health, South Gloucestershire Council

Helen Cooke- Public Health Intelligence Analyst, South Gloucestershire Council
Acknowledgements

Many thanks to all the people and organisations who took time to participate in this mental health needs assessment. They include service users and carers, mental health commissioners and voluntary and community organisations. The project team would like to expressly thank the following people for their support:

Fiona Turnbull- Avon and Wiltshire Mental Health Partnership Trust
Will Marchbank- Avon and Wiltshire Mental Health Partnership Trust
Kate Archibald- South Gloucestershire Clinical Commissioning Group
Krishan Mulji- South West Commissioning Support Unit
Caroline McAleese- The Care Forum
Kate Strong- The Care Forum
Nisba Ahmed- South Gloucestershire Council
Robert Carroll- Bristol Self-Harm Surveillance Register/ University of Bristol

Executive summary

Background

In the UK, at least one in four people will experience a mental health problem at some point in their life; at any one time, one in six adults has a mental health problem. People with mental health problems often have few qualifications, find it harder to obtain and stay in work, have lower incomes, and are more likely to be homeless or insecurely housed or live in areas of high social deprivation. People with severe mental illnesses will die on average 20 years earlier than the general population. Mental ill health is very expensive. The cost of mental health problems in the UK is estimated at £105 billion annually; these costs are expected to double in the next 20 years.

Given these sobering statistics, it is not surprising that mental health is high on the national agenda. Since 2011 there have been several mental health related strategies and action plans including ‘No Health without Mental Health (2011)’, ‘Preventing suicide in England- a cross government strategy to save lives (2012)’, ‘Closing the Gap-priorities for essential change in mental health (2014)’ and ‘Achieving Better Access to Mental health services by 2020 (2014)’. Last year, the Chief Medical Officer’s Report focussed on ‘Public Mental Health Priorities: Investing in the Evidence’. Locally, the development of a mental health and wellbeing strategy was identified as a key aim in South Gloucestershire’s first Joint Health and Wellbeing Strategy. Mental health is also a
priority for the Health and Wellbeing Board.

Purpose, scope and methodology

The main purpose of this needs assessment is to examine the mental health needs of South Gloucestershire residents aged 18 years and over. It is the first step in the development of the new Mental Health and Wellbeing strategy.

Information was obtained from a wide range of sources as follows: national data (census, death statistics, Care Quality Commission, Public Health England), local data (from the council, clinical commissioning group (CCG), commissioning support unit, acute hospital trusts and Avon and Wiltshire Mental health partnership (AWP) trust) and primary care data from the Quality and Outcomes Framework. Findings from interviews and focus groups with mental health service users and carers and a locally commissioned Healthwatch mental health and emotional wellbeing survey are also included. We also sought views from professionals and voluntary and community organisations.

The needs assessment excludes children and adolescents and people with dementia although other mental health problems which affect older people are included. It complements other needs assessments, workstreams and strategies including the Alcohol needs assessment and strategy, the Dementia strategy, the Precious Time strategy for reducing social isolation, the Suicide Prevention Strategy and Action Plan, the Partnership against Domestic Abuse workstream, the Child Poverty Needs Assessment and the forthcoming children’s mental health needs assessment.

The main themes arising from the needs assessment are highlighted in the next section. Chapter references are also included.

Recommendations are discussed in Chapter 10.

Main themes- the mental health landscape in South Gloucestershire

- South Gloucestershire’s population will continue to grow over the next decade; the elderly population in particular will grow rapidly (see Chapter 3).

The current South Gloucestershire population (2011 estimate) is 262,767 with a similar age structure to England. A small but growing proportion of the population are from Black and Minority Ethnic (BME) groups. By 2021, the local population size will increase by 10% from the 2011 baseline and there will be an additional 17,500 people aged over 75 years.

- Although South Gloucestershire performs better than England for population level indicators of social, economic and environmental factors (i.e. the wider determinants of health), there are specific groups within the population at high risk of mental ill health (see Chapter 4).
Mental health is influenced by a multitude of factors ranging from individual and population characteristics such as age, gender, ethnicity, sexuality and disability to wider determinants of health such as social, economic and environmental conditions. Overall, South Gloucestershire was found to be an affluent, safe region to live. Compared with the national average South Gloucestershire had a lower unemployment rate, a higher percentage of working age people in employment, a lower percentage of working age people claiming benefits, lower crime and violence rates in the population and low levels of homelessness. However, we identified specific population groups in South Gloucestershire who were likely to be at greater risk of developing mental ill health. These include people living in Priority Neighbourhoods (defined in Chapter 3), the unemployed, people with disabilities, prisoners, Gypsies and Travellers, substance misusers (including alcohol misusers), smokers, people with long term conditions, people in the Lesbian, Gay, Bisexual or Trans (LGBT) community and victims of domestic abuse.

Self-reported wellbeing for South Gloucestershire residents is marginally better than England. Although national surveys suggest improving population attitudes to mental illness, locally, mental health service users continue to face stigma and discrimination. People with disabilities are twice as likely to feel socially isolated. In addition, local service users report that stigma contributes to their social isolation (see Chapters 5 and 9). Self-reported wellbeing is measured nationally using questions which assess people’s overall lives in addition to day to day emotions. Self-reported wellbeing scores for South Gloucestershire residents were marginally better than or similar to the English average. Although national data showed improved attitudes in the general population to people with mental illnesses, stigma was experienced by all of the local service users we interviewed. They gave examples of problems faced with negative attitudes from close relatives, the general public and large agencies such as housing associations, the job centre and Royal Mail. Service users were reluctant to inform potential employers about mental health problems due to concerns that they would be discriminated against. South Gloucestershire’s performance was similar to England for national indicators of social isolation. However, locally, residents with disabilities were twice as likely to feel socially isolated than those without disabilities. Service users also reported that stigma made them feel more socially isolated.

- The prevalence of all common mental health conditions will continue to increase. With the exception of eating disorders, the highest prevalence of mental health conditions was observed in the least affluent populations (see Chapter 6).

The prevalence of all common mental health conditions such as anxiety and depression will increase based on projections until 2020. The highest rate of mental health admissions to hospital were from GP practices located in Priority Neighbourhoods. With the exception of eating disorders, the prevalence of mental health conditions was higher in people from the most deprived socio-economic groups and those from Priority Neighbourhoods. Local data were not available on the prevalence of personality disorders.

- In South Gloucestershire achievement results for depression and mental health indicators in the Quality and Outcomes Framework is worse for GP practices where the majority of patients are from Priority Neighbourhoods (see Chapter 6).

The Quality and Outcomes Framework (QOF) is a voluntary reward and incentive programme for all
GP practices in England which details achievement results by individual practices. In general South Gloucestershire had similar or better achievement results than England for most of the QOF depression and mental health indicators. However, practices where the majority of patients were from Priority Neighbourhoods had worse achievement results than practices where fewer patients were from Priority Neighbourhoods (i.e. a lower percentage of patients with certain mental health issues had a record of specific blood tests, alcohol consumption or screening and fewer people with a new diagnosis of depression had an assessment of severity). Notably, South Gloucestershire patients on the QOF mental health register were less likely to have a care plan than nationally.

- The number of people with learning disabilities is projected to rise by 1% every year over the next decade. However, compared with England, adults with learning disabilities in South Gloucestershire are less likely to live in settled accommodation and more likely to live in non-settled accommodation. They are also less likely to receive community or day care services from the local authority (see Chapter 6).

There are approximately 4100 adults aged 18 to 64 years with learning difficulties in South Gloucestershire. Approximately 1/3 of these individuals will also have an autistic spectrum condition. The Learning Disabilities (LD) profile includes information on the number of people with learning disabilities, the health of these individuals and their access to health care and social services. Based on this profile South Gloucestershire’s performance is worse than England for adults with learning disabilities in settled accommodation (71.1% vs 74.9%- higher is better), adults with learning disabilities in non-settled accommodation (28.3% vs 21.7%-lower is better), adults using day care services supported by the local authority per 1000 people with learning disabilities (256.6 vs 323.7- higher is better) and adults receiving community services supported by local authorities per 1000 people with learning disabilities (592 vs 794- higher is better).

- The prevalence of autism spectrum conditions will continue to increase in South Gloucestershire. However, people face long delays before they can access diagnostic assessment for these conditions (see Chapter 6).

The number of people with autism spectrum conditions is expected to increase. On average people waited 10 months before they were seen for diagnosis of an autism spectrum condition in South Gloucestershire.

- There are no available local data on the prevalence of Adult Attention Deficit/Hyperactivity Disorder (ADHD). A large number of individuals are on the waiting list for the Adult ADHD service although waiting times are shorter than for diagnostic autism assessment (see Chapter 6).

Local data are not available for the prevalence of Adult ADHD. However there were 74 people on the active caseload from April to November 2014; most of these were male and on medication. During the same time period, 61 clients were waiting to be seen by the Adult ADHD service.

- The numbers of working age adults who self-harmed in South Gloucestershire tripled from 2001 to 2010. Young women are at particular risk of non-fatal self-harm and self-poisoning is the most common method used (see Chapter 6).
Hospital attendances and admissions for self-harm increased threefold in the first 10 years of the 21st century; young females have the highest risk of non-fatal self-harm. The most common method was self-poisoning; paracetamol was the most frequently ingested poison. Most patients presenting to hospital for self-harm in South Gloucestershire had a previous history of self-harm or a history of previous psychiatric treatment.

- Male suicide rates in South Gloucestershire were higher in 2010 than 2001. Similar to national figures there are two to three male suicides for every female suicide. Suicide rates are highest in the most deprived socio-economic groups (see Chapter 6).

Due to the small numbers of suicides, there were fluctuations in the trends observed for men and women. However, in general male suicide rates increased from 2001 to 2010. The sex ratio of male to female suicides ranged from two to three, similar to England. From 2008 to 2012, the largest number of suicide deaths occurred in men aged 25 to 44 years. However the highest rate of suicide in the same period was observed in men aged 65 to 74 years. The highest suicide rates were observed in the most deprived population quintiles. Between 2001 and 2012, hanging was the most common mode of completed suicide followed by poisoning. Other methods of suicide were uncommon.

- Similar to the national picture, there is increasing demand for community and inpatient mental health services in South Gloucestershire. Evidence for this is provided by local data which show increased caseload to AWP community mental health services, increased emergency admissions to AWP services (particularly from Priority Neighbourhoods), high bed occupancy rates for inpatient services with high out of locality placements, high out of trust placements and a high percentage of delayed transfers of care in excess of the national target (Chapter 8). Difficulties in accessing services and problems with the consistency and continuity of care were highlighted by service users (see Chapter 9).

There was a 6.3% increase in caseload to the Avon and Wiltshire Mental Health Partnership (AWP) Community Mental Health Services from 2009/2010 to 2013/2014. Emergency admissions to AWP services increased in 2013/2014 and were highest in three age groups (35-44 year olds, 25-34 year olds and 75-84 year olds). The highest numbers of emergency admissions to AWP services were from wards in Priority Neighbourhoods. The number of adult acute beds per 100,000 population was less for all six AWP CCGs (Swindon, Wiltshire, North Somerset, Bath and North East Somerset, Bristol, South Gloucestershire) than nationally. For example, for most of October 2014 inpatient usage for adult acute services exceeded 100% bed occupancy; out of trust placements were also high. In the same month, inpatient usage for older adult acute services was at or above 100% bed occupancy for 13 days, with out of trust placements occurring regularly throughout the month. South Gloucestershire exceeded the national target of 7.5% for delayed transfers of care (DTOC) from August 2013 to January 2014.

- Demand for talking therapies (Improving Access to Psychological Therapies-IAPT) in South Gloucestershire has continued to increase since the service commenced in November 2012. The recovery target of 50% was not achieved from December 2012 to September 2014. Although service users viewed talking therapies positively, they also highlighted issues with access and a lack of information on self-referral (see Chapter 8).
in November 2012. However, the number of people waiting > 28 days to start treatment also increased in the time. Although the number of people completing treatment showed an increasing trend, the recovery rate has decreased over time. Additionally, the national target of a 50% recovery rate has not been achieved since the service began in South Gloucestershire.

Although service users were generally positive about talking therapies, they highlighted issues regarding access and the lack of information on self-referral. Additionally, they were critical of the fact that only Cognitive Behavioural Therapy (CBT) was on offer and that there was a lack of long term support and signposting to other services post IAPT completion.

- Historically, spend per head on mental health services in South Gloucestershire has been low compared to England. Using newer data for South Gloucestershire, spend on the mental health programme is estimated at £153 per head, compared to a national spend of £210 per head (Chapter 8). There is increasing spend on antidepressants, hypnotics, CNS stimulants and Drugs used for Adult Attention Deficit Hyperactivity Disorder (ADHD) in South Gloucestershire (see Chapter 8).

The allocated average spend per head for mental health in South Gloucestershire in 2011/2012 was £147 compared to the English average of £183. This was estimated as the worst spend in England. Using newer 2014 data the mental health spend in South Gloucestershire was £153 per head, compared with a national spend of £210 per head. Spend on antidepressants, hypnotics, CNS stimulants and Drugs used for Adult Attention Deficit Hyperactivity Disorder (ADHD) has increased from 2009/2010 to 2013/2014 in South Gloucestershire.

- Concerns have been raised by the Care Quality Commission regarding mental health crisis care in South Gloucestershire with particular respect to the quality and effectiveness of services (see Chapter 7).

The Care Quality Commission’s thematic review of mental health crisis care in late 2013 identified specific issues that should be examined to improve the provision of mental health crisis care in South Gloucestershire. South Gloucestershire’s performance was worse than England for the percentage of people with severe mental illness with a comprehensive care plan in place, bed occupancy rates, access to Place of Safety, service users’ and carers’ impressions of the quality and effectiveness of services responding to people in crisis including suitability of care provided and whether the services worked well together.

- In South Gloucestershire, Section 136 admissions are most likely to occur out of hours with transfer to the place of safety via police vehicle. Approximately one in two individuals end up waiting more than 12 hours until assessment whereas two in five individuals will receive no mental health follow up with no letter sent to their GP. Improvement in post crisis support has also been identified by service users as a key issue (see Chapters 8 and 9).

Section 136 of the Mental Health Act allows the police to remove a person with mental illness from a public place to a ‘Place of Safety’ either for their own protection or for the protection of others. In South Gloucestershire, most admissions were in men of White British ethnicity. Although it is recommended that transfer to the place of safety occurs via ambulance, all transfers were via police vehicle in South Gloucestershire. In addition almost 50% of individuals waited more than 12 hours until assessment. More than 40% of individuals admitted under Section 136 had no mental
health follow up or letter sent to the GP. Service users felt that post crisis support in primary and community care needed to be improved.

- Service users raised concerns about stigma and discrimination, access to services, continuity of care and post crisis support (see Chapter 9).

The service user consultation identified key issues of importance to service users and carers in South Gloucestershire. Anxiety and depression were the most common mental conditions experienced by the service users interviewed. Service users faced stigma and discrimination and had difficulty accessing services. The lack of community support and the need for more peer support groups was highlighted. Service users also wanted more information on mental health services and community support including information on how these services could be accessed, care that was better coordinated for mental and physical ill health, improved joint working among agencies including better coordination of services and greater involvement in the commissioning of new services.

2. Introduction

2.1. Concepts of mental health, mental wellbeing and mental illness

2.1.1. Mental Health

According to the World Health Organisation (WHO) mental health refers to a broad array of activities which are directly or indirectly related to the mental wellbeing component that is included in the organisation’s definition of health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease.”

Mental health is 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 his or her community.” In their 2013 Action Plan the WHO defined Public Mental Health as “the mental health variations of importance exhibited by populations which consists of (i) mental health promotion, which is primarily concerned with the determinants of mental health, (ii) mental illness prevention, which is concerned with the causes of disease and (iii) treatment and rehabilitation, which includes the use of medical and non-medical interventions and support to aid recovery and rehabilitation.”

In addition to the prevention of mental disorders, mental health also relates to the promotion of wellbeing and the treatment and rehabilitation of people affected by mental disorders. The UK’s Faculty of Public Health uses the term mental health to encompass mental illnesses and disorders, mental wellbeing and all other states of mental health.

1. World Health Organization. Promoting Mental Health: Concepts, Emerging Evidence,
2.1.2. Mental Wellbeing

Mental wellbeing has been defined 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 the community”. The Faculty of Public Health emphasises that mental wellbeing should include the capacity to do all of the following:

- Realise our abilities, live life with purpose and meaning, and make a positive contribution to our communities
- Form positive relationships with others, and feel connected and supported
- Experience peace of mind, contentment, happiness and joy
- Cope with life’s ups and downs and be confident and resilient
- Take responsibility for oneself and for others as appropriate

Resilience or “the ability to cope with the normal stresses of life” is usually an important component of many definitions of mental health and wellbeing as improving resilience will increase mental capital and prevent mental illness.


2.1.3. Mental Capital

Mental Capital is also linked to mental health and wellbeing and is defined as “encompassing a person’s cognitive and emotive resources which includes their cognitive ability, how flexible and efficient they are at learning and their emotional intelligence such as social skills and resilience.”


2.1.4. Mental Illness

Mental Illness is defined as “a diagnosable condition that significantly interferes with an individual’s cognitive, emotional or social abilities e.g. depression, anxiety and schizophrenia. Mental illnesses occur on a spectrum from common to less common and mild to severe. In adults, common mental disorders such as depression and anxiety disorders may affect up to 15% of the population at any time. Anxiety disorders include generalised anxiety disorder, panic disorder, obsessive compulsive disorder, post traumatic stress disorder and social anxiety disorder. Severe and/or
enduring mental health problems are much less prevalent (affecting up to 1-2% of the population) and include individuals who have a mental health problem with the following characteristics:

- Experience a substantial disability as a result of their mental health problems, such as inability to care for themselves properly or sustain relationships at work
- Are either currently displaying obvious and severe symptoms, or have a relapsing/remitting condition
- Have experienced recurrent crisis leading to frequent admission/intervention
- Occasion significant risk to their own safety or that of others

In some definitions the term severe mental illness only includes psychotic disorders such as schizophrenia and bipolar disorder. However, since other non psychotic conditions such as clinical depression can also be serious, these conditions should also be considered to be severe mental health problems if the previously listed characteristics are met.


2.2. The Importance of mental health

2.2.1. National context and policies

Mental health has been identified as a major public health issue. Mental illness has been identified as the largest contributor to burden of disease in the UK due to its prevalence, persistence and breadth of impact. Mental ill health is associated with personal and social costs such as poor physical health, reduced life expectancy, unemployment and social exclusion. Additionally, the economic cost of mental health problems in England has been estimated at £105 billion pounds per year.

In 2011, the Coalition Government launched its new national strategy for mental health- No Health without Mental health. Six shared objectives were agreed as follows:

- 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 good experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination.

These objectives will be measured using relevant indicators for mental health and wellbeing from the three Outcomes Frameworks (Public Health, NHS and Adult Social Care).

Ten priorities have also been identified as markers of successful translation of this strategy:
• Mental health has ‘parity’ of esteem with physical health within the health and care system
• People with mental health problems, and their families and carers, are involved in all aspects of service design and delivery
• Public services improve equality and tackle inequality
• More people will have access to evidence based treatments (such as Psychological Treatments)
• The new public health system includes mental health from day one
• Public services intervene early
• Public services work together around people’s needs and expectations
• Health services tackle smoking, obesity and co-morbidity for people with mental health problems
• People with mental health problems have a better experience of employment
• We tackle the stigma and discrimination faced by people with mental health problems.

Mental health statistics (No Health without Mental Health)

Personal cost
• At least one in four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time.
• Three-quarters of people with lifetime mental health problems first experience symptoms before their mid-20s.
• Almost half of all adults will experience at least one episode of depression during their lifetime.
• About one in 100 people has a severe mental health problem.
• People with severe mental illnesses die on average 20 years earlier than the general population.
• People with mental health problems often have fewer qualifications, find it harder to both obtain and stay in work, have lower incomes, are more likely to be homeless or insecurely housed, and are more likely to live in areas of high social deprivation.
• Some 90% of all prisoners are estimated to have a diagnosable mental health problem (including personality disorder) and/or a substance misuse problem.

Economic cost
• The cost of mental health problems in the UK is estimated to be approximately £105 billion each year; it is estimated that these costs could double in the next 20 years.
• Sickness absence due to mental health problems costs the UK economy £8.4 billion a year and leads to £15.1 billion in reduced productivity.
• Mental ill-health is the most common reason for incapacity benefits claims.
• Approximately 43% of the 2.6 million people on long term health related benefits have a mental or behavioural problem as their primary condition.
• More than £2 billion is spent annually on social care for people with mental health problems.

The new national suicide prevention strategy was published in 2012\(^{10}\) and had two main objectives: a reduction in the suicide rate in the general population in England and better support for those bereaved or affected by suicide. Six priority action areas were identified to support these objectives:

• Reduce the risk of suicide in key high risk groups
• Tailor approaches to improve mental health in specific groups
• Reduce access to the means of suicide
• Provide better information and support to those bereaved or affected by suicide
• Support the media in delivering sensitive approaches to suicide and suicidal behaviour
• Support research, data collection and monitoring.

In January 2014, the Government launched its mental health action plan “Closing the Gap: priorities for essential change in mental health” which identified 25 priorities for action among the following broad areas (see Appendix A) - increasing access to mental health services, integrating physical and mental health care, starting early to promote mental wellbeing and prevent mental health problems and improving the quality of life for people with mental health problems\(^{11}\). It is
expected that changes in local service planning and delivery in these 25 priority areas will have a noticeable impact on people’s lives in the next few years.

The mental health strategy and action plan both focus on encouraging working relationships among local partners with national organisations acting in a supportive role. Local partners include local authorities, clinical commissioning groups (CCGs), providers of mental health services, providers of acute and community health services, primary care services, Health and Wellbeing boards, local Healthwatch, community groups and employers although this list is not exhaustive. This focus on increasing flexibility for local organisations to make decisions based on local needs sits within the context of major policy changes in the NHS, Public Health and Social care which led to the reorganisation of health and social care services in 2013.

Dame Sally Davies published the annual Chief Medical Officer report “Public Mental Health Priorities: Investing in the Evidence” in September 2014, which included 14 recommendations for the public health profession and policy makers. The report cautioned against the concept of wellbeing in mental health and highlighted the lack of evidence for the effectiveness of wellbeing interventions in the primary prevention of mental illnesses. Instead, the WHO approach to public mental health should be followed i.e. mental health promotion, mental illness prevention and treatment and rehabilitation. Key recommendations for Public health commissioners are included in the box below.

### Key recommendations (Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence)

**Recommendation 1**
Commissioners in Local Authorities, Health and Wellbeing Boards and Clinical Commissioning Groups should follow the WHO model in commissioning and prioritising evidence based interventions for mental health promotion, mental illness prevention and treatment and rehabilitation. Wellbeing interventions should not be commissioned in mental health as there is insufficient evidence to support this.

**Recommendation 2**
All Health and Wellbeing Boards should be informed by a Joint Strategic Needs Assessment (JSNA) which includes the information needed to plan services to integrate the mental and physical health needs of their populations. The required information is provided for ease of access by the Mental Health Intelligence Network.

**Recommendation 12**
If GPs suggest using new technologies to improve mental health to patients they should draw these from an approved list of NHS evaluated technologies which have met the standards required by evidence based medicine.

**Recommendation 13**
The evidence based ‘Time to Change’ programme should continue to be funded and should continue to involve and empower ‘people with lived experience’. Time to Change is a government funded campaign in England, led by the charities Mind and Rethink, which aims to challenge mental health stigma and discrimination.

**Recommendation 14**
NHS England should develop a programme of work to agree waiting times and access standards across mental health services, starting with the collection and publication of robust national data to underpin the development and implementation of this programme.

The Government’s commitment to achieving parity of esteem for mental health with physical health was set out in the previous policy documents “No Health without Mental Health” and “Closing the Gap”. However, although timely access to mental health services and then for treatment is one of the main gaps in parity, unlike physical health services there are no waiting time standards for mental health services. Therefore, in October 2014, the Department of Health and NHS England published “Achieving Better Access to Mental Health Services by 2020” which sets out immediate actions to end this disparity by committing an £80 million investment to introduce access and waiting time standards in mental health.
2.2.2. Local context

Mental health and wellbeing has been identified as a key area in South Gloucestershire’s first Joint Health and Wellbeing Strategy (JHWS)\(^{17}\), published in 2013. The JHWS sets out the priorities and actions for the member organisations of the Health and Wellbeing Board to improve the health and wellbeing of people who live and work in South Gloucestershire and to decrease health inequalities over the next three years. The JHWS was informed by the Joint Strategic Needs Assessment\(^{18}\) and the key principles of prevention, early intervention, equity, accessibility, integration, effectiveness and safety and safeguarding. Mental Health is specifically mentioned in Priority themes one-Making the healthy choice, the easy choice and six- Accessing the right services in the right place, at the right time in the JHWS by:

- Supporting the prevention of mental ill health through workstreams which involve building integrated communities, supporting social networks and reducing stigma and discrimination and gives its support for the development of a new Mental health and wellbeing strategy and
- Working in partnership with the South Gloucestershire Mental Health Partnership and the South Gloucestershire Suicide Prevention Group to develop a local strategy and action plan related to the national mental health strategy ‘No Health without Mental Health’.

---


2.3. Scope and purpose

A health needs assessment (HNA) is performed to understand the needs of a population so that appropriate resources and services can be commissioned to improve health and reduce inequalities. It has been defined as “a systematic method of identifying the public health/social care needs of a population and making recommendations for changes to meet these needs”, where need is defined as the ability to benefit from a service or policy intervention\(^1\). Benefits of health needs assessments include better use of resources, improved partnership working and strengthened community involvement in decision making.

The purpose of this needs assessment is to examine the mental health needs of South Gloucestershire residents who are aged 18 and over. It is the first step before the new adult mental health and wellbeing strategy for South Gloucestershire can be developed and will also inform the Suicide Prevention Strategy. The main objectives of this adult mental health and wellbeing needs assessment are:

- To describe the population of South Gloucestershire, including those factors which are likely to increase the risk of mental health problems as well as those factors which will promote good mental health and identify vulnerable groups within the region who are at greatest risk of mental health problems
- To determine the prevalence of common mental disorders and severe/enduring mental illnesses in South Gloucestershire and consider how the burden of mental illness may change in the future
- To describe mental health service activity and uptake in primary care and secondary care (acute and mental health trusts) in South Gloucestershire
- To highlight inequalities in mental health provision and areas where resource allocation and distribution do not match need for services
- To describe the supply of mental health resources and services that are available in South Gloucestershire for adults
- To seek views from service users and carers on mental health service provision
- To identify gaps in intelligence about mental health and mental illnesses in South Gloucestershire
- To provide recommendations which build on current good practice to promote mental health, address risk factors for mental ill-health and deal with unmet need for mental health resources and/or services in South Gloucestershire.

This needs assessment excludes children and adolescents and people with dementia although other mental health problems which affect older people are included. It will complement other needs assessments, workstreams and strategies including the Alcohol needs assessment and strategy, the Dementia strategy, the Precious Time strategy for reducing social isolation in older people, the Suicide Prevention Action Plan, the Partnership Against Domestic Abuse workstream, the Child Poverty Needs Assessment and the forthcoming children’s mental health needs assessment.
3. South Gloucestershire Population Profile

3.1. Population and geography

South Gloucestershire consists of urban and suburban areas within the north and east fringes of Bristol and a larger rural area containing the towns of Yate/Chipping Sodbury and Thornbury and over 30 villages. Sixty percent of residents live in urban fringe suburbs, the remainder either in rural villages or small market towns. According to the 2011 Census, the total usual resident population in South Gloucestershire was 262,767. This includes anyone who on census day was in the UK for 12 months or more, or had a permanent UK address and was outside the UK and intended to be outside the UK for less than 12 months. Students and school borders are counted at their term time addresses. In 2012 there were currently around 266,147 residents (mid year 2012 estimates).

In 2011, the average population size for wards in South Gloucestershire was 7,508 people although there was a large variation in the number of residents among wards. Emersons Green was the largest ward with 12,392 residents and Cotswold Edge was the smallest ward with 3381 residents.

3.2. Population and age

The population-age structure in South Gloucestershire is very similar to the national average with:

- 24.1% aged under 20 years
- 58.4% aged between 20 and 64 years
- 17.5% aged 65 years and over

The wards with the largest proportion of working age residents (15-64 years) were Frenchay and Stoke Park, Bradley Stoke South and Bradley Stoke North (reference Census 2011: population and household estimates analysis at ward level- SGC Corporate Research and Consultation team). Winterbourne, Westerleigh and Downend had the lowest proportion of working age residents. Westerleigh, Winterbourne and Thornbury had the highest proportions of older people. Bradley Stoke South, Bradley Stoke North and Dodington had the lowest proportion of older people.
3.3. Population and ethnicity

A small but growing proportion of the population are from Black and Minority Ethnic (BME) groups: 8.1% according to 2011 compared to 4.1% at the 2001 census. This figure includes all groups in South Gloucestershire apart from White British.

3.4. Population and deprivation

There are six localities in South Gloucestershire that have been defined as Priority Neighbourhoods because they are the most deprived, face the greatest health inequalities and have the greatest need as follows:

- Cadbury Heath
- Filton
- Kingswood
- Patchway
- Staple Hill
- West Yate/Doddington

3.5. Population projection

Figure 3.1 shows the South Gloucestershire population pyramid for 2011 and 2021. The number of residents is projected to rise to 289,457 in 2021 from the 2011 baseline population. However, these figures do not take into account the additional housing growth which will take place in South Gloucestershire. It is expected that 22,545 additional new homes will be built between 2013 and 201721 (reference South Glos Core Strategy).

The elderly population will grow rapidly. Projections suggest that there will be an additional 17,500 people aged over 75 years in ten years’ time.

The population change across South Gloucestershire has not been uniform. In the last 10 years, areas within Frenchay and Stoke Park, Emersons Green and Siston have experienced significant population increases due to high levels of residential development. However, there have been large population decreases in some areas within Thornbury, Dodington and Boyd valley.

3.6. Comparator neighbourhoods

The top 15 statistical neighbours for South Gloucestershire unitary authority are East Riding of Yorkshire, Central Bedfordshire, North Somerset, York, Warrington, Cheshire West and Chester, Bath and North East Somerset, Bedford, Medway, Cheshire East, Swindon, Thurrock, Poole, Plymouth and North Lincolnshire. In this needs assessment we will use comparator regions in the South West: North Somerset, Bath and North East Somerset and Swindon.22


4. Determinants of mental health and wellbeing

4.1. Introduction

Many factors influence mental health and wellbeing. These include individual or familial factors and population characteristics in addition to wider determinants of health such as physical security (housing), meaningful activity (employment), financial security (income) and environment (availability of public spaces and green spaces). These factors may be protective (and promote mental health and wellbeing) or harmful (where they increase the risk of mental illness) see Figure 4.1.23

Figure 4.1- A dynamic model of factors which influence mental health and wellbeing
4.1.1 Protective factors

Core protective factors for mental wellbeing are those which:

- Enhance control (the extent to which individuals and communities have access over their own lives)
- Increase resilience and community assets (the extent to which communities are able to exercise informal
- Facilitate participation (the extent to which people are involved and engaged in activities outside their immediate household, and includes cultural and leisure activities, volunteering, membership of clubs and groups, as well as participation in local decision-making, collective action, voting and other forms of civic engagement)
- Promote social inclusion (the extent to which people are able to access opportunities, for example employment, education, leisure and credit)
Five Ways to Wellbeing

The Five Ways to Wellbeing are a set of actions which can promote people’s wellbeing. These actions were developed by the New Economics Foundation (NEF) a think tank which promotes social, economic and environmental justice, using evidence from the Foresight Project. The Five Ways include: Connect, Be Active, Take Notice, Keep Learning and Give (see box). However, the Chief Medical Officer expressed caution in her latest advocacy report regarding the widespread use of these actions due to an inadequate evidence base.

### Five ways to wellbeing

**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 a 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.

---


### 4.1.2 Population characteristics

Population characteristics which impact on mental health and wellbeing include age, gender, ethnicity/race, socioeconomic position, disability, sexuality and physical health. (see Table 4.1)

<table>
<thead>
<tr>
<th>Population characteristic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main factors- dynamic model</strong></td>
<td>The foundations for good mental health start in the perinatal period and early childhood. In adolescence, protective factors include attachment to school, family, positive peer influence, opportunities to succeed and problem solving skills. The onset and persistence of emotional and behavioural disorders is determined by specific social capital indicators such as having friends, support networks and valued social roles. In older people the main areas that influence mental health are discrimination, participation, relationships, physical health and poverty.</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>Gender influences risk and protective factors for mental health and the way in which mental distress is expressed. Depression, anxiety, parasuicide and self-harm are more prevalent in women while suicide, drug and alcohol abuse and crime and violence are more prevalent in men. However women are more vulnerable than men to domestic and sexual violence and childhood sexual abuse.</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>Observed racial and ethnic differences in levels of mental wellbeing and prevalence of mental disorders are caused by a complex combination of socioeconomic factors, racism, diagnostic bias and cultural differences in the way in which both mental health and mental distress are presented, perceived and interpreted. Different cultures may also develop different responses for coping with psychological stressors. Nationally, there is evidence that (reference Mental health foundation): - African Caribbean people are three to five times more likely than any other group to be diagnosed with schizophrenia. - Suicide is low among Asian men, but high in young Asian women compared with other ethnic groups. - Gypsy and Traveller groups have higher rates of anxiety and depression compared with the English population.</td>
</tr>
<tr>
<td><strong>Ethnicity/race</strong></td>
<td>Socioeconomic position (SEP) refers to the position of individuals and families, relative to others, measured by differences in educational qualifications, income, occupation, housing tenure or wealth. Socioeconomic position shapes access to material resources, to every aspect of experience in the home, neighbourhood, and workplace and is a major determinant of health inequalities. Different dimensions of SEP (education, income, occupation, prestige) may influence health through different pathways; SEP involves exposure to psychological as well as material risks and buffers, and structures our experience of dominance, hierarchy, isolation, support and inclusion. Social position also influences areas like identity and social status, which impact on well-being, for example through the effects of low self esteem, shame, and disrespect.</td>
</tr>
<tr>
<td><strong>Socioeconomic position</strong></td>
<td>Key factors which influence the mental health of people with disabilities include life chances (education, employment and housing), social inclusion, choice, control and opportunities to be independent.</td>
</tr>
<tr>
<td><strong>Disability</strong></td>
<td>There is evidence that gay, lesbian, bisexual and transgender people are at increased risk for certain mental health problems such as anxiety, depression, self-harm and substance misuse. They are more likely to report psychological distress than heterosexual people and are also more likely to experience factors that increase risk such as bullying, discrimination and sexual assault.</td>
</tr>
<tr>
<td><strong>Sexuality</strong></td>
<td>Poor physical health is a significant risk factor for poor mental health. Conversely, mental wellbeing protects physical health and improves health outcomes and recovery rates, notably for coronary heart disease, stroke and diabetes. Poor mental health is associated with poor self management of chronic illness and a range of health damaging behaviours, including smoking, drug and alcohol abuse, unwanted pregnancy and poor diet. For heart disease, psychosocial factors are on par with smoking, high blood pressure, obesity, and cholesterol problems as risk factors.</td>
</tr>
<tr>
<td><strong>Physical Health</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Other factors</strong></td>
<td></td>
</tr>
<tr>
<td>Population characteristic</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Family Circumstances</td>
<td>Family circumstances are generally linked with socioeconomic position. Marriage is associated with positive mental health as it is associated with social, emotional and financial support. Common mental health problems are associated with living alone or being a lone parent. Psychosis is associated with living alone or being separated or divorced.</td>
</tr>
<tr>
<td>Carer responsibility</td>
<td>Carers (i.e. people who look after the sick or disabled, or elderly relatives in a non professional capacity) have an increased risk of mental and physical ill-health.</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>Domestic violence is defined as the use, attempt or threat of violence; whether physical, emotional, sexual, psychological or economic, within an intimate and/or family-type relationship. Domestic violence is a major cause of mental ill health globally and is associated with depressive illnesses, suicidality, anxiety, substance misuse and post traumatic stress disorder (PTSD). Twenty six percent of women who attempt suicide are victims of domestic violence. Also, 33% of women who suffer from domestic violence are diagnosed with anxiety and depression.</td>
</tr>
<tr>
<td>Substance misuse- Drugs and Alcohol</td>
<td>Substance misuse is formally defined as the continued misuse of any mild altering substance that can severely affect a person’s physical and mental health, social situation and responsibilities. There is evidence that increasing alcohol use is associated with an increasing risk of a wide range of physical and mental health problems. Alcohol misuse impacts negatively on the mental wellbeing of individuals as well as their family and the wider community. Mental health problems such as depression and psychosis are also associated with increased alcohol use. Alcohol dependence is the most common form of substance misuse, but other drug misuse, including heroin, cocaine, crack and cannabis and prescription drugs are also included. Misuse of illegal and prescription drugs is also associated with mental illness. ‘Dual diagnosis’ is the term used to describe people with problems with alcohol or other drugs with co morbid mental health issues.</td>
</tr>
<tr>
<td>Smoking</td>
<td>Smoking is twice as common among people with mental illnesses and is even more so in people with more severe disease. In the UK, almost 9 million smokers (~30% of all smokers) have evidence of mental illness. Over the last two decades, smoking rates have remained constant in people with mental illness, in contrast to the decline in smoking which occurred in the general population. Current smoking is associated with an increased risk in the onset of depression and anxiety disorders; also, people with depression and anxiety disorders are themselves more likely to initiate smoking. However, there is no association between former smokers and the onset of common mental disorders.</td>
</tr>
<tr>
<td>Offenders</td>
<td>In one study, approximately 70% of male and female prisoners had two or more mental disorders; almost 20% had four conditions (including psychosis, neurosis, personality disorders, alcohol misuse and drug dependence). Another study of offenders on probation reported that 72% had dual diagnoses (mental illness and a substance abuse problem). 29% of prisoners have experienced interpersonal trauma which includes emotional, physical and sexual abuse (the percentage is higher in women prisoners). Interpersonal trauma is linked with the onset of a range of mental health problems including Post Traumatic Stress Disorder, depression and anxiety disorders and substance misuse. Additionally, the suicide rate in male prisoners is 15 times that of men in the general population.</td>
</tr>
</tbody>
</table>

4.1.3 Wider determinants

Many other factors can impact on mental health and wellbeing. Wider determinants include:

- Physical security (housing, safety at home and in the neighbourhood)

There is an association between poor mental health and high levels of crime and vandalism. The fear of crime and safety issues can cause more stress than the direct experience of crime. The homeless experience a 40-50 fold increased risk of mental health problems compared with the general population and are an important high risk group. One third of prisoners are homeless on entering prison and a further third lose their accommodation because they have been imprisoned.

- Environment (green space, quality of the built environment)

Populations who are exposed to the greenest environments (i.e. with parks, woodland and open spaces) have been shown to have 25% lower all cause death rates and 30% lower circulatory disease compared with those living in areas with low green environment even after controlling for social deprivation. Access to natural environments has mental health benefits due to increased quality of life, social contact and social cohesion.

- Meaningful activity (employment, unpaid/voluntary work)

Work can promote mental wellbeing because it is important for self esteem and identity, provides a sense of fulfilment and opportunities for social interaction. Work also provides the main source of income for the majority of people. Unpaid work such as volunteering can also promote wellbeing as it gives people a sense of meaning and purpose within the context of community.

- Good quality food

Good nutrition is important for both physical and mental health. People with mental illness often have less healthy diets and make poorer dietary choices that those without mental illness. Studies have shown that high sugar, caffeine, nicotine and alcohol can have a negative impact on mental health and wellbeing.

- Leisure (arts and creativity, sport, culture)

Leisure and physical activity can enhance wellbeing by increasing feelings of competency and relaxation in addition to enhancing social inclusiveness and support.

- Education (lifelong learning)

Education protects mental health across the life course. Learning raises employability and income which protects wellbeing and reduced the risk of poor mental health. Low educational attainment is a risk factor for common mental health problems. People with a secondary level qualification have a 5-7% reduced risk of depression at age 42; there is a 50% lower risk of depression for those with the highest qualifications.

- Transport (affordable, accessible, sustainable)
Reducing traffic levels and traffic speed can increase social interaction among residents and improve quality of life.

- Financial security (income, credit, assets)

People with the lowest 20% of household income have an almost three fold increased risk of mental illness compared with those with the highest income. Unemployment is also associated with an almost three fold risk of common mental disorder and a fourfold risk of disabling mental disorder. Job insecurity is a risk factor for poor mental health and debt is associated with an increased risk of mental illness, alcohol and drug dependence. There is strong evidence that unemployment is associated with an increased risk of suicide. A recent review found that long term unemployment is associated with a greater suicide risk. The 2008-2010 economic recession has also been shown to be associated with an increase in suicides in England. Additionally, English regions with the highest unemployment rates also had the largest increase in suicides, particularly male suicides.


4.2. Key determinants of mental health using South Gloucestershire data

Table 4.2 summarises some of the key determinants of mental health including data for South Gloucestershire’s performance compared with nationally (England) based on a red/amber/green (RAG) scale (worse, average or better performance than the national average).

<table>
<thead>
<tr>
<th>Determinant of mental health</th>
<th>South Gloucestershire measure</th>
<th>National measure</th>
<th>Red, Amber, Green (RAG) status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family circumstances</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Census 2011)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living in a couple</td>
<td>63.6%</td>
<td>57.8%</td>
<td>Green</td>
</tr>
<tr>
<td>Married</td>
<td>51.6%</td>
<td>45.7%</td>
<td>Green</td>
</tr>
<tr>
<td>Cohabiting- opposite sex</td>
<td>11.3%</td>
<td>11.2%</td>
<td>Amber SG similar to England</td>
</tr>
<tr>
<td>Cohabiting- same sex or registered same sex civil partnership</td>
<td>0.6%</td>
<td>0.9%</td>
<td>Amber SG similar to England</td>
</tr>
<tr>
<td>Lone parent</td>
<td>9.4%</td>
<td>10.6%</td>
<td>Green</td>
</tr>
</tbody>
</table>

Table 4.2 Key Determinants of Mental Health for South Gloucestershire compared with England
<table>
<thead>
<tr>
<th>Determinant of mental health</th>
<th>South Gloucestershire measure</th>
<th>National measure</th>
<th>Red, Amber, Green (RAG) status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long term health problems or disability</td>
<td>15.6%</td>
<td>17.6%</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Carers</strong> (Census 2011)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All carers</td>
<td>10.5%</td>
<td>10.2%</td>
<td>Amber</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment rate (ONS Population Survey 2013/2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(All)</td>
<td>5.4%</td>
<td>7.5%</td>
<td>Green</td>
</tr>
<tr>
<td>(M)</td>
<td>6.4%</td>
<td>8.0%</td>
<td>Green</td>
</tr>
<tr>
<td>(F)</td>
<td>4.8%</td>
<td>7.0%</td>
<td>Green</td>
</tr>
<tr>
<td>Proportion of working age population in employment (ONS Population Survey 2013/2014)</td>
<td>78.4%</td>
<td>71.9%</td>
<td>Green</td>
</tr>
<tr>
<td>Average annual earnings - median gross pay (ONS Annual Survey of Hours and Earnings 2013/2014)</td>
<td>£27,343</td>
<td>£27,375</td>
<td>Amber SG similar to England</td>
</tr>
<tr>
<td><strong>Working age 16-64 years key benefit claimants (DWP benefits Nov 2013)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total working age benefits claimants</td>
<td>8.5%</td>
<td>13.3%</td>
<td>Green</td>
</tr>
<tr>
<td>Job Seekers</td>
<td>1.5%</td>
<td>2.9%</td>
<td>Green (July 2014 update- Two wards in South Gloucestershire Kings Chase and Staple Hill have a claimant rate above the national average)</td>
</tr>
<tr>
<td>Employment and Support Allowance (ESA) and Incapacity benefits</td>
<td>3.8%</td>
<td>6.2%</td>
<td>Green</td>
</tr>
<tr>
<td>Disabled</td>
<td>1.1%</td>
<td>1.2%</td>
<td>Amber SG similar to England</td>
</tr>
<tr>
<td>Lone parents</td>
<td>0.8%</td>
<td>1.2%</td>
<td>Amber SG slightly less than England</td>
</tr>
<tr>
<td>Carers</td>
<td>0.9%</td>
<td>1.4%</td>
<td>Amber SG slightly less than England</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage achieving 5 or more GCSEs A*-C including English and Mathematics (South Gloucestershire Council, Department Children, Adults and Health)</td>
<td>56.7%</td>
<td>59.2%</td>
<td>Amber</td>
</tr>
<tr>
<td>Not in education, employment or training- 16-18 year olds (South Gloucestershire Council, Department Children, Adults and Health)</td>
<td>3.9%</td>
<td>5.3%</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Homelessness</strong> (Department for Communities and Local Government)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number per 1000 households accepted as being homeless and in priority need (gov.uk Jan to March 2014)</td>
<td>0.23</td>
<td>0.56</td>
<td>Green (134 SG households were accepted as homeless in 2013/2014)</td>
</tr>
<tr>
<td>Rough sleeping counts and estimates (gov.uk October to Nov 2013)</td>
<td>1</td>
<td>2414</td>
<td>Green</td>
</tr>
<tr>
<td>Statutory homelessness- homelessness acceptances per 1000 (PHOF 1.15i 2012/2013)</td>
<td>1.2</td>
<td>2.4</td>
<td>Green</td>
</tr>
<tr>
<td>Statutory homelessness- households in temporary accommodation (PHOF 1.15ii 2012/2013)</td>
<td>0.8</td>
<td>2.4</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Crime</strong> (Home Office Statistics 2013/2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All crime per 1000 population</td>
<td>45</td>
<td>61</td>
<td>Green</td>
</tr>
<tr>
<td>Violence against the person per 1000 population</td>
<td>7</td>
<td>11</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Social isolation</strong> (Public Health Outcomes Framework 2012/2013)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of adult social care users who have as much social contact as they would like (PHOF 1.18)</td>
<td>50.1</td>
<td>43.2</td>
<td>Green</td>
</tr>
<tr>
<td>Loneliness and isolation in adult carers (PHOF 1.18ii)</td>
<td>43.2</td>
<td>41.3</td>
<td>Amber</td>
</tr>
</tbody>
</table>
With the exception of one drugs indicator, percentage treatment completion and re-presentation in non-opiate users (Table 4.2), South Gloucestershire’s performance for key determinants of mental health is good or similar when compared with the English average. There were two wards, Kings Chase and Staple Hill, with a job seekers’ claimant rate above the national average.

### 4.2.1 Lesbian, Gay, Bisexual and Transsexual people

The 2014 South Gloucestershire Lesbian, Gay, Bisexual and Trans (LGBT) health and wellbeing needs assessment reported the following statistics:

- 35.7% of respondents reported that they had mental health conditions or illnesses expecting to last for 12 months or more
- 50% had received medical help for anxiety and depression
- 28.6% had hurt or injured themselves on purpose (deliberate self-harm)
- 54.8% had thought about or tried to kill themselves
- Only 4.8% had ever needed support to address drug and/or alcohol misuse, legal high use or over the counter medication use
4.2.2 Alcohol

Hospital admissions are an indicator of the level of alcohol misuse and the effectiveness of alcohol services to prevent readmission to hospital. Figure 4.2 shows the hospital admission rates likely to be attributable to alcohol in South Gloucestershire from 2006/7 to 2012/13, by sex. Hospital admissions have remained relatively stable for women over the last seven years although they have risen for men, with a peak in 2010/11. However, the rate of admissions for men in 2012/13 was statistically significantly lower than the rate in 2010/11.

Figure 4.2

Source: SUS database of admitted patient care and ONS population statistics

Figure 4.3 shows the age standardised alcohol specific admission rates in South Gloucestershire from 2005/2006 to 2012/2013 by sex. Alcohol specific admissions for men, women and all persons peaked in 2009/2010. Rates declined in men until 2011/2012 although overall there has been a small decline in alcohol specific admissions. Almost a fifth of patients admitted to hospital for a condition specifically related to alcohol misuse are admitted for a second or subsequent time (figure not shown).

Figure 4.3
Figure 4.4 shows the crude rates of persons admitted to hospital for alcohol specific conditions by Priority Neighbourhood status. The highest rates of admissions were seen in Patchway followed by Staple Hill and Kingswood. Rates of admissions were higher in Priority Neighbourhood areas compared with non-Priority Neighbourhood areas and all of South Gloucestershire.

Crude rates do not take into account differences in populations which may influence rates, for example the age structure of wards. In South Gloucestershire, a greater proportion of men admitted for an alcohol specific condition than women, with men between the ages of 30 and 69
accounting for half of all admissions. Figure 4.5 reports on age standardised rates for hospital admissions likely to be attributable to alcohol. The highest rates are seen in Patchway, Kings Chase, Siston, Staple Hill, Filton and Woodstock wards.

Figure 4.5

Source: SUS database of admitted patient care

Figure 4.6 shows drinking behaviour for South Gloucestershire residents compared with comparator local authorities and England. South Gloucestershire had slightly higher levels of increasing risk drinking compared with England but similar levels of binge and higher risk drinking.

Figure 4.6
Hospital admissions relating to drug misuse are not evenly distributed throughout South Gloucestershire but are significantly higher in Priority Neighbourhood areas and the ward of Charfield, as two prisons, Leyhill and Eastwood Park, are located in this ward (see Figures 4.7 and 4.8). Repeat admissions account for 19% of hospital admissions for all drug misuse specific conditions.

Figure 4.7

![Crude rate of hospital admissions relating to drug misuse per 10,000 population by Priority Neighbourhood status, all ages, South Gloucestershire, 2009/10-2010/11. Includes multiple admissions](image)

Source: Local Avon Admitted Patient Care database, population extracted from GP registered population database

Figure 4.8

![Crude rate of hospital admissions relating to drug misuse per 10,000 population by ward, all ages, South Gloucestershire. Includes multiple admissions](image)

Source: Local Avon Admitted Patient Care database, population extracted from GP registered population database
4.2.3 Substance misuse

4.2.4 Dual Diagnoses

The National Drug Treatment Monitoring System (NDTMS) records information about people receiving Tier 3 or Tier 4 services (i.e. structured community based services or residential inpatient services) in England. Dual diagnosis is defined by the NDTNS as “the number of individuals starting a new treatment journey in the reporting period receiving care from mental health services for reasons other than substance misuse.” Clients are counted in this indicator if dual diagnosis is flagged in any episode associated with the treatment journey. There has been an increasing trend in the reporting of dual diagnoses in South Gloucestershire from the first quarter of 2012/2013 to the most recently available data in the final quarter of 2013/2014.

However, this trend may be explained by improved integration between the drug and alcohol services with mental health services in addition to increased confidence of service users in reporting and better data recording.

4.2.5 Offenders

There are three adult prisons in South Gloucestershire, HMP Leyhill, HMP/YOI Eastwood Park and HMP Ashfield. HMP Leyhill is an open category prison holding a maximum of 527 prisoners, who are serving the widest range of sentences (in terms of length and offence) than any other Category D establishment in England and Wales. There is no limit on the number of prisoners serving life sentences who can be accommodated at any one time. Prisoners who have no, or very little involvement with drugs are located in a hostel style environment within the prison grounds. Leyhill has a resettlement role, so many prisoners are allowed out of the prison on licence daily. This includes day release, employment purposes or resettlement leave.

HMP/YOI Eastwood Park is a closed remand prison for women, holding 362 young offenders (those aged 18 to 21) and adults. It holds prisoners of all ages and categories pending their court appearances in addition to women serving sentences up to 12 months. The prison holds remand and convicted prisoners, from those serving a few days to those serving much longer sentences. Many services are provided, including a mother & baby unit, specialist 24 hour health care, a dedicated resettlement unit, drug recovery service and specialist substance misuse unit.

HMP Ashfield is a category C adult male establishment that holds 400 convicted prisoners serving sentences for sexual offences.

Key points regarding prevalence of mental illnesses in the prison populations are presented below
based on the most recent needs assessments:

**Leyhill**

- 2% of men reported having a mental health disorder (self-report)
- 56% of new receptions were referred to the substance misuse team
- The most prevalent primary drug on the substance misuse caseload was alcohol (51%), followed by heroin (15%) and cannabis (13%). No information on dual diagnosis was available
- 32% of substance misusers had previously injected, with 68% never injecting, and none currently injecting

**Eastwood Park**

- 21% of women reported having a mental health disorder (self-report)
- 60% of women on the substance misuse caseload abused opiates; 46% reported heroin as their primary drug of choice, followed by alcohol (27%), crack (9%) and amphetamine (5%)
- 40% of substance misuse clients were currently injecting, 25% had previously injected, 34% had never injected and 1% declined to answer
- There were no official data on dual diagnoses, although between 20 and 30 referrals are made monthly, mostly for depression/low mood
- There were 412 self-harm incidents in the prison in 171 prisoners from January to June 2012; no prisoners presented with prolific self-harm (>20 episodes) in that period

**Ashfield**

- 20% of prisoners had received medication for mental health problems
- 13% of prisoners had tried to harm themselves (in prison)
- 17% of prisoners had tried to harm themselves (outside prison)
- 3% of prisoners felt like self-harming or suicide
- Data were not available on substance misuse. However staff commented that a lot of substance misuse issues were due to misuse of prescription medication in the prison and not use of illicit drugs
- Staff also reported that there was high comorbidity between substance misuse and mental health problems in prison
Commissioning health and social care in prisons

Commissioning health care
From April 2013, NHS England became responsible for commissioning of all health services (with the exception of emergency care, ambulance services and out of hours services and NHS 111 services) for people in prisons (including youth offender institutions) in England. This includes primary care incorporating dentistry and optometry services, preventive and public health services, secondary care, community services, mental health and substance misuse services.

Commissioning social care
From 1st April 2015 Local Authorities became responsible for the provision of social care and support to individuals detained in prisons, approved premises, bail accommodation homes and secure training units. Local authorities also have to make sure they are aware of the needs and support required for young people held in secure accommodation as they approach their 18th birthday to ensure that appropriate transition arrangements for care are in place.

In addition, as part of their responsibility to their local population, Local Authorities are responsible for the continuity of care for offenders with packages of care moving into their authority area on release from prison. The provision of care and support for those in custodial settings is based on the principle of equivalence; therefore, local authorities are required to provide an equivalent level of care and support as provided to the rest of the population, subject to the constraints and circumstances of custodial settings.


4.2.6 Domestic Violence

The crude rate per 1000 of domestic abuse incidents recorded by the police for South Gloucestershire, comparator regions and England are shown in Figure 4.9. Reports of domestic abuse were significantly lower in South Gloucestershire compared with the South West and England.

Figure 4.9
4.2.7 Gypsies and Travellers

South Gloucestershire has a relatively large Traveller population compared to other regions in the South West. In January 2013 there were approximately 200 authorised caravans in South Gloucestershire compared with 20 in Bristol. A smaller number of families live in bricks and mortar accommodation. The health outcomes of Gypsies and Travellers are much poorer than the general population and other ethnic minority groups. One study showed that 38% of a sample of Gypsies and Travellers had a long term illness, compared with 26% of age and sex matched comparators of equivalent socio-economic status. Gypsies and Travellers are over twice as likely to be depressed and three times more likely to suffer from anxiety disorders than others. Additionally, for Gypsies and Travellers, living in bricks and mortar accommodation is associated with long term illness, poorer health state and anxiety with those who rarely travel having the poorest health. However, it is not clear whether accommodation and travelling impact adversely on health or vice versa.

Smoking rates are higher in Gypsies and Travellers than in the general population (56.5% compared with 21.5%). Irish travellers in prison have worse physical and mental health outcomes than other prisoners. In one study, 26.1% of Irish Travellers in prison were identified as having mental health problems whereas approximately 10% of the prison population are estimated to have serious mental health conditions.

4.2.8 Long term conditions

Long term conditions are chronic conditions which cannot be cured but can be managed with medicines and other treatment, for example diabetes mellitus, heart disease, respiratory disease and cancer. In England approximately 15 million people (~30% of the population) are living with a long term condition. The presence of two or more long term conditions (multi-morbidity) is associated with poorer quality of life, higher hospital admissions and greater rates of mortality. As people age they are more likely to develop a long term condition and experience multi-morbidity. The number of people with multi-morbidity is projected to increase from almost 2 million in 2008 to approximately 3 million in 2018 due to the ageing population. There is considerable overlap between physical ill health and mental ill health. It is estimated that 30% of people with long term conditions suffer from depression and anxiety (see box below). Conversely, almost 46% of people with mental health problems also have a long term condition. Physical-mental multi-morbidity is more common among deprived populations.

The presence of co-morbid mental health problems tends to substantially increase patients’ use of health services for their physical illnesses. Research in patients with COPD, cardiovascular disease and diabetes has shown that mental health co-morbidity increases rehospitalisation rates, emergency hospital admissions, length of stay in hospital, use of outpatient services and frequency of GP consultations. Co-morbid mental health problems are estimated to be associated with a 45 to 75% increase in service costs for long term physical health conditions, even after adjusting for the severity of physical illness. The King’s Fund estimates that between £8 billion and £13 billion of NHS spending in England can be attributed to co-morbid mental health problems among people with long-term conditions. On an individual level, the presence of poor mental health increases the average cost of NHS service use for each person with a long term condition from £3910 to £5670 a year.

Common mental disorders and long term conditions: Key statistics
- Depression is two to three times more common in a range of cardiovascular diseases (cardiac disease, coronary artery disease, stroke and angina). Anxiety problems are also common in people with cardiovascular disease.
- People with diabetes mellitus are also at two to threefold increased risk of depression compared with the general population.
- Mental health problems are three times more prevalent in people with COPD than in the general population. Anxiety disorders are particularly prevalent; panic disorder is approximately 10 times more prevalent than in the general population.
- Depression is common in people with chronic musculoskeletal disorders. More than 20% of people aged over 55 years with chronic arthritis of the knee have co-morbid depression.

Table 4.3 shows the prevalence of long term conditions in South Gloucestershire compared with England using data from the Quality and Outcomes Framework registers (QOF) for 2012/2013. South Gloucestershire has a higher prevalence of asthma, cancer, cardiovascular disease, chronic kidney disease and obesity compared to the England average. The proportion of patients aged 18+ on the learning disability register is similar to the national average.
Table 4.3 Prevalence of long term conditions in South Gloucestershire

<table>
<thead>
<tr>
<th>Clinical Area</th>
<th>Prevalence % (England)</th>
<th>Prevalence % (South Glos)</th>
<th>Numbers (South Glos)</th>
<th>Estimated number with depression*</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ages</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>6</td>
<td>6.8</td>
<td>17504</td>
<td>5251</td>
</tr>
<tr>
<td>Cancer</td>
<td>1.9</td>
<td>2.2</td>
<td>5676</td>
<td>1703</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>2.2</td>
<td>2.4</td>
<td>6163</td>
<td>1849</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>1.7</td>
<td>1.4</td>
<td>3625</td>
<td>1088</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>3.3</td>
<td>3.0</td>
<td>7816</td>
<td>2345</td>
</tr>
<tr>
<td>Heart failure</td>
<td>0.7</td>
<td>0.6</td>
<td>1585</td>
<td>476</td>
</tr>
<tr>
<td>Hypertension</td>
<td>13.7</td>
<td>13.9</td>
<td>36122</td>
<td>10837</td>
</tr>
<tr>
<td>Age specific</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Kidney Disease (age 18+)</td>
<td>4.3</td>
<td>5.1</td>
<td>10372</td>
<td>3112</td>
</tr>
<tr>
<td>Diabetes Mellitus (age 17+)</td>
<td>6</td>
<td>5.2</td>
<td>10740</td>
<td>3222</td>
</tr>
<tr>
<td>Epilepsy (age 18+)</td>
<td>0.8</td>
<td>0.8</td>
<td>1535</td>
<td>461</td>
</tr>
<tr>
<td>Learning Disabilities (age 18+)</td>
<td>0.5</td>
<td>0.4</td>
<td>873</td>
<td>262</td>
</tr>
<tr>
<td>Obesity (age 16+)</td>
<td>10.7</td>
<td>11.1</td>
<td>23355</td>
<td>7007</td>
</tr>
<tr>
<td>Osteoporosis (age 50+)</td>
<td>0.2</td>
<td>0.3</td>
<td>290</td>
<td>87</td>
</tr>
</tbody>
</table>

*Based on an estimate of 30% of people with long term conditions having depression

Source Quality Outcomes Framework 2012/2013

5. Mental and emotional wellbeing in South Gloucestershire

5.1. Self-reported wellbeing

The Office for National Statistics (ONS) Measuring National Wellbeing Programme aims to produce accepted and trusted measures of the wellbeing of the nation and includes measures of personal wellbeing i.e. individual’s assessment of their own wellbeing. Data for personal wellbeing are obtained from the Annual Population Survey which includes responses from >165,000 people. Four questions are asked in relation to personal wellbeing as follows:
• Overall, how satisfied are you with your life nowadays?
• Overall, to what extent do you feel that the things you do in life are worthwhile?
• Overall, how happy did you feel yesterday?
• Overall, how anxious did you feel yesterday?

People are asked to respond on a scale of 0 to 10, where 0 is ‘not at all’ and 10 is ‘completely’. The questions allow people to assess their life overall as well as provide an indication of day to day emotions. South Gloucestershire scored marginally better than the England average for life satisfaction, ‘happy yesterday’ and ‘anxious yesterday’ (for the latter a lower score is better). There were no statistically significant differences between the scores for South Gloucestershire compared with the South West or England (Table 5.1).

Table 5.1 Self-reported wellbeing for South Gloucestershire compared with the South West and England

<table>
<thead>
<tr>
<th></th>
<th>South Gloucestershire</th>
<th>South West</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life satisfaction</td>
<td>7.5</td>
<td>7.5</td>
<td>7.4</td>
</tr>
<tr>
<td>Worthwhile</td>
<td>7.7</td>
<td>7.8</td>
<td>7.7</td>
</tr>
<tr>
<td>Happy yesterday</td>
<td>7.4</td>
<td>7.3</td>
<td>7.3</td>
</tr>
<tr>
<td>Anxious yesterday</td>
<td>3.0</td>
<td>3.0</td>
<td>3.1</td>
</tr>
</tbody>
</table>

Source ONS Annual Population Survey 2013

Nationally, the following key points were observed (Refs ONS First annual ONS experimental subjective wellbeing results and ONS measuring subjective wellbeing in the UK-differences in wellbeing by ethnicity):

• Women were more likely than men to report higher levels of subjective wellbeing (life satisfaction, worthwhile, happy yesterday) as well as higher levels of anxiety (anxious yesterday)
• People aged 80 and over had the lowest ratings for ‘life satisfaction’ and ‘worthwhile’
• People from the Black ethnic group (Black/African/Caribbean/Black British) were the least satisfied with their lives out of all broad ethnic groups in the UK although all other ethnic groups gave on average, lower ratings than the White ethnic group when asked about the extent to which they feel the things they do are worthwhile
• Having a partner was associated with improved subjective wellbeing
• People who described having poor health were more likely to report anxiety than people with good health
• People with disability and the unemployed were reported less satisfaction with their lives than non-disabled and employed people
• Local data are not available on subjective wellbeing for the risk groups identified above
5.2. Stigma and discrimination

There are no local data regarding stigma and discrimination in relation to mental illness. However, surveys have been carried out in England since 1994 (annually from 2007) to determine attitudes towards mental illness in adults. The most recent survey was performed in December 2012 and included 1727 individuals aged 16 years and over. The survey found:

- Increased acceptance of people with mental illness taking public office and being given responsibility- the percentage agreeing that ‘people with mental illness should not be given any responsibility’ decreased from 17% to 10% from 1994 to 2012 and the percentage agreeing that ‘anyone with a history of mental problems should be excluded from public office’ decreased from 29% to 18% in the same period.
- Improved attitudes towards integrating people with mental illness into the community- the percentage agreeing ‘no-one has the right to exclude people with mental illness from their neighbourhood’ increased from 76% in 1994 to 83% in 2012.
- Increased percentage of people who would be willing in the future to continue a relationship, work with, live with or live nearby someone with a mental health problem suggesting a marked positive change in attitudes relating to intended behaviour.
- Age and gender impacted on attitudes. Women were more positive and tolerant towards mental illness than men and ageing was associated with increasing understanding and tolerance of mental illness.

5.3. Social Isolation

The Public Health Outcomes Framework 2012/2013 includes two indicators of social isolation 1.18i Percentage of adult social care users who have as much social contact as they would like and 1.18 ii loneliness and isolation in adult carers. In 2012/2013, 50.1% of adult carers in South Gloucestershire reported that they had as much social contact as they would like. There was a slight improvement in the figures since 2011/2012 for South Gloucestershire (46%). In 2012/2013 for the first indicator South Gloucestershire performs statistically significantly better than England (43.2%) and Swindon but is similar to North Somerset and Bath and North East Somerset (Figure 5.1). For the second indicator of social isolation, there were no statistically significant differences between South Gloucestershire (43.2%), England (41.3%) and other comparable regions in the South West (Figure 5.2).
5.4. Findings from the Viewpoint Survey

South Gloucestershire Council commissions BMG Research to manage a resident’s panel known as the ‘South Gloucestershire Viewpoint’. The Viewpoint Survey is undertaken among these panel members every year to examine resident opinions on a variety of local health and wellbeing issues in order to inform the provision of public health services locally. Data are analysed by three locality planning areas (Yate, Severn Vale and Kingswood) and five priority neighbourhood areas (Cadbury...
Heath, Staple Hill, Patchway, Kings Chase and Filton) for six themes, (1) awareness of health and support, (2) alcohol consumption, (3) smoking, (4) healthy lifestyles, (5) healthy eating habits and (6) social isolation. Note that priority neighbourhoods are defined differently for the Viewpoint Survey. Key findings are as follows:

- **Awareness of health and support**: Half of those who responded were aware of where to access help to stop smoking and support for emotional wellbeing. 40% were aware of where to access support for drug and alcohol problems. 37% of respondents were unaware of where to access help and support for social isolation.

- **Alcohol Consumption**: Almost 20% of respondents drink alcohol weekly or 2 to 3 times a week. 14% had a drink containing alcohol 4 or more times a week. Only 8% of respondents drank between five and six units on a typical drinking day with 6% drinking between seven and eight units (the NHS recommends that men should not regularly drink more than 3-4 units a day and women should not regularly drink more than 2-3 units a day). One in five respondents drinks six or more units in one day two or more times a month. 53% of respondents felt that underage drinking was a problem in the area. Almost half of all respondents felt that drinking in public is a problem and that excessive alcohol consumption and drug taking is a problem in their local area. One in four respondents were satisfied with how excessive alcohol consumption was being addressed.

- **Smoking**: 84% of respondents did not smoke. Only 5% of respondents indicated that they personally smoke. Of those that smoked, 1 in 3 smoked in the home. 81% respondents indicated that smoking related litter is an issue in their local area and 66% felt that smoking in public areas was an issue in their local area. The highest levels of dissatisfaction were seen with regard to how the Council is tackling smoking related litter (31%) and people smoking in public areas (28%).

- **Healthy lifestyles**: 19% of respondents stated that on no day in the week prior to the survey had they done 30 minutes or more exercise (the NHS recommends a minimum of 30 minutes of physical activity five days a week for adults). 73% of respondents were unaware of the Walking for Health scheme which is run by the Council to encourage people to become more active and meet new people through group walks.

- **Healthy eating habits**: 91% of respondents indicated that it was easy to access fresh fruit and vegetables in the local area. 80% of respondents thought that excess weight in adults is a problem in the local area. 41% stated that the lack of information about healthy options and lifestyles was a problem. One in four responded that access to indoor and outdoor sports and leisure facilities is a problem. Almost three in five were satisfied with the Council’s efforts to improve access to both outdoor and indoor sports and leisure facilities. 38% of respondents indicated they felt that a supportive built environment where physical activity is encouraged would make a big impact on getting people to become more active.

- **Social isolation**: Loneliness and social isolation can have an impact on people’s health and wellbeing, particularly for older people. 67% of respondents indicated that they had as much social contact with people as they like, 21% indicated that they had adequate social contact, 9% stated that they had some social contact with people but not enough and only 2% felt socially isolated. 39% of people spent as much time as they liked doing the things they enjoyed, 33% felt that they spent enough of their time doing the things they valued or enjoyed, 26% stated that they did some things that they valued or enjoyed with their time, but not enough and only 1% did not do anything they valued or enjoyed with their time.
Working age individuals were more likely than those outside working age to state that they had as much social contact as they wanted with people they liked. However, older respondents, 45 to 64 years and 65 and over years (who were most likely to be retired) were more likely to indicate that they spent their time doing things they valued or enjoyed compared with younger respondents aged 25 to 34 and 35 to 44 years. Respondents with a disability were more likely to indicate that they feel socially isolated compared with those who do not have a disability (5% vs 2%).

Respondents from Priority Neighbourhoods were more likely to indicate that people smoking in public areas, smoking related litter were big issues in their local area and were less likely express dissatisfaction with efforts to tackle smoking related litter compared with those from the rest of South Gloucestershire. Although the Viewpoint survey provides useful insights it is limited by its small sample size; only 887 people (55% of the panel members) responded to the latest questionnaire. Therefore findings may not be generalizable to all South Gloucestershire residents.

5.5. Precious Time

In South Gloucestershire the Precious Time campaign aims to reduce loneliness and isolation in South Gloucestershire, particularly among older people. The campaign aims to bring together the energy and skills of voluntary and community groups, the local authority, the NHS and residents, whatever their age to make a difference to the lives of older people, so that no older person feels lonely or isolated against their wishes. Currently, there is a South Gloucestershire wide partnership and the 2013-2016 Precious Time Strategy is a priority of the Health and Wellbeing Board. Data on social isolation were reported in the previous section.

6. Prevalence of mental health conditions

This section focuses on the prevalence of mental health conditions in South Gloucestershire. The data reported have been obtained from many different sources described in the box below.
Data Sources

• Adult Psychiatric Morbidity Survey 2007 - The main aim of this survey was to collect data on mental health in adults aged 16 years and over living in private households in England. Data from this survey are used by the Health and Social Care Information Centre (HSCIC) to calculate updated prevalence estimates of specific mental illnesses by local authority for its Mental Health Intelligence Network profiles.

• Quality and Outcomes Framework (QOF) - This is a voluntary reward and incentive programme for all GP practices in England which details achievement results by individual practices (there are 26 general practices in South Gloucestershire). The QOF contains five main domains: Clinical, Public Health, Public Health Additional services, Quality and productivity and Patient experience. Each domain consists of a set of achievement measures or QOF indicators, against which practices score points according to their level of achievement. Ten mental health indicators and three depression indicators are included in QOF 2012/2013. Each practice is also required to record the number of patients on specific disease registers (for example patients with depression or patients with diabetes) to estimate the prevalence of these diseases.

• Bristol Self-Harm Surveillance Register- This is a database maintained in the emergency department of the Bristol Royal Infirmary which has been recording detailed information in patients presenting to hospital for self-harm since September 2010. Data have been collected from Frenchay Hospital from April 2013. The data allow rates and patterns of self-harm to be monitored locally including risk factors for repetition and suicide in addition to identifying the medicines which are taken in overdose. In May 2014, services and data collection moved from Frenchay Hospital to the new Southmead hospital.

• Hospital Admissions data – All admissions of South Gloucestershire residents to acute trusts between April 2009 and March 2014 (five financial years) which included a mental health diagnosis were obtained. Appendix B summarises demographic information and trends for South Gloucestershire.

• South Gloucestershire Joint Strategic Needs Assessment (JSNA) - The production of a JSNA is a statutory duty which rests with local authorities. The JSNA provides a picture of the current and future health and wellbeing needs of the local population.

• Office for National Statistics Mortality Data- The National Statistics definition of suicide includes deaths given an underlying cause of intentional self-harm or an injury/poisoning of undetermined intent. Only persons aged 15 years and over are included in UK suicide figures. A coroner’s inquest is always performed if a death is suspected to be suicide.

• South Gloucestershire suicide audit- The suicide case review audit is an audit of all of the latest available information on deaths by suicide and undetermined injury for South Gloucestershire on a case by case basis using the local Coroner’s records.

6.1 Common Mental Disorders

In the 2007 Adult Psychiatric Morbidity Survey, mixed anxiety and depression (prevalence rate 81.2 per 1000) was the most common mental illness in South Gloucestershire residents followed by generalised anxiety disorder (prevalence 36.3 per 1000), all phobias (16.4 per 1000) and major depressive episode (11.4 per 1000) (see Table 6.1). Common mental health problems occurred most frequently in males aged 35 to 49 years and females aged 35 to 44 years.

Table 6.1 Prevalence per 1000 of Common Mental Disorders in 2007
Public Health England has produced synthetic estimates of the prevalence of common mental health conditions for regions in 2012 using data from the 2007 Adult Psychiatric Morbidity Survey. These data are presented in Table 6.2 for South Gloucestershire, England and other comparator regions in the South West. With the exception of eating disorders and Post Traumatic Stress Disorder (where the prevalence is the same as for England), South Gloucestershire reports a lower prevalence than England. Prevalence rates are similar to Bath and North East Somerset and Somerset but lower than Swindon and North Somerset for most of the common mental health conditions.
The numbers of people with common mental health disorders in South Gloucestershire is expected to increase from 2012 to 2021 by approximately 10% for panic disorder, 6% for obsessive compulsive disorder, 5% for depressive episode and mixed anxiety and depressive disorder, 3% for generalised anxiety disorder and 2% for all phobias (Figure 6.2).

Source: Public Health England
http://fingertips.phe.org.uk/common-mental-disorders
Hospital Admissions

The rate of mental health admissions to hospital varies by practice. The highest age standardised rates of admissions were in patients from Kingswood Health Centre, Coniston Medical Practice, Stoke Gifford Medical Centre and the Orchard Medical Centre where rates of admission were statistically significantly higher than the South Gloucestershire average (Figure 6.3). These practices are located in the Priority Neighbourhoods of Kingswood, Filton and Patchway. Further details of age and sex patterns can be found in Appendix B.

![Admissions to Acute Trusts of patients with a mental health code 2009/10 to 2013/14](chart)

Source Hospital admissions data from acute trusts

6.2 Depression

Depression is a state of low mood which is characterised by symptoms such as loss of interest in activities that were once pleasurable, loss of appetite, problems with concentrating, feelings of hopelessness and suicidal thoughts or ideation.
QOF Depression Register

General practices keep a record of patients diagnosed with depression as part of the QOF. In 2012/2013, there were 12,780 people aged over 18 years with depression in South Gloucestershire (6.3% of the registered population). This QOF prevalence was higher than the England average (5.8%).

QOF Depression Indicators

QOF 2012/2013 included the following three depression indicators:

- DEP01-percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on one occasion during the preceding 15 months using the two standard screening questions
- DEP06- In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care
- DEP07-In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 2-12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care

The denominators for the three indicators are restrictive and do not include all patients diagnosed with depression. However, South Gloucestershire performed better than England for all of the indicators (87.2% vs 85.9%, 81.4% vs 79.8% and 66.6% vs 59%). For the DEP06 indicator the percentage of patients receiving the intervention (see previous definition) is statistically significantly less for those practices where most patients are from Priority Neighbourhoods (PNs) compared with other practices where fewer patients are from Priority Neighbourhoods (Figure 6.4).
Hospital admissions

The number of admissions for depression has increased in men and women from 2009/2010 to 2013/2014 (Figure 6.5). In addition, pooled data for the five year period show that rates of admission were higher in women than in men (Figure 6.6).

Figure 6.5 Hospital admissions for South Gloucestershire residents with a diagnosis of depression
Figure 6.6 Age standardised rates of hospital admissions for depression by gender for South Gloucestershire residents

Source: Hospital admissions data from acute trusts

Figure 6.7 shows hospital admissions for depression by Index of Multiple deprivation quintiles (1= most affluent and 5=most deprived).

Figure 6.7 Age standardised rates of hospital admissions for depression by Index of Multiple Deprivation (IMD) for South Gloucestershire residents
Source Hospital admissions data from acute trusts

The practices with the highest numbers of admissions to hospital for depression were Wellington Road Surgery, Coniston Medical Practice, Courtside Surgery and the Orchard Medical Centre (Figure 6.8). These practices are located in Priority Neighbourhoods (Yate and Kingswood).

Figure 6.8

6.3 Psychoses
QOF Mental Health Register

General practices keep a record of patients with schizophrenia, bipolar disorder and other psychoses on the mental health register. In 2012/2013, there were 1283 people on the mental health register in South Gloucestershire (0.5% of the registered population). This QOF prevalence was lower than the national average (0.8%).

QOF Mental Health Indicators

QOF mental health indicators are shown in Table 6.3. South Gloucestershire has a statistically significantly lower percentage of patients on the register with a care plan (MH10) compared with England, 77.6% vs 81.3% (data not shown) and a statistically significantly higher percentage of patients aged 40 years and over on the register with a record of blood glucose or HbA1c (glycated Haemoglobin) in the preceding 15 months (MH20) compared with England, 73.8% vs 66.3%. Achievement results in South Gloucestershire for the other mental health indicators were similar to England. Practices with fewer patients from Priority Neighbourhoods had better achievement results for the QOF mental health indicators than practices with many patients from these neighbourhoods, although the findings were only statistically significant for MH10 and MH17.

Table 6.3

Mental Health QOF2012/13 indicators

<table>
<thead>
<tr>
<th></th>
<th>South Gloucestershire</th>
<th>Practices with many PN patients</th>
<th>Practices with few PN patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patients % lcl ucl</td>
<td>Patients % lcl ucl</td>
<td>Patients % lcl ucl</td>
</tr>
<tr>
<td>MH10</td>
<td>995 77.6 75.2 79.8</td>
<td>343 73.0 68.8 76.8</td>
<td>652 80.2 77.3 82.8</td>
</tr>
<tr>
<td></td>
<td>The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH11</td>
<td>1059 82.5 80.4 84.5</td>
<td>365 77.7 73.7 81.2</td>
<td>694 85.4 82.8 87.6</td>
</tr>
<tr>
<td></td>
<td>The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH</td>
<td>Description</td>
<td>Count</td>
<td>Systolic</td>
</tr>
<tr>
<td>----</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------</td>
<td>----------</td>
</tr>
<tr>
<td>MH13</td>
<td>The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months</td>
<td>1098</td>
<td>85.6</td>
</tr>
<tr>
<td>MH16</td>
<td>The percentage of women aged from 25 to 64, with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years</td>
<td>299</td>
<td>74.8</td>
</tr>
<tr>
<td>MH17</td>
<td>The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months</td>
<td>154</td>
<td>95.1</td>
</tr>
<tr>
<td>MH18</td>
<td>The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months</td>
<td>137</td>
<td>84.6</td>
</tr>
<tr>
<td>MH19</td>
<td>The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 15 months</td>
<td>425</td>
<td>44.1</td>
</tr>
<tr>
<td>MH20</td>
<td>The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 15 months</td>
<td>684</td>
<td>71.0</td>
</tr>
</tbody>
</table>
6.4 Personality Disorders

Personality disorders are conditions that affect a person’s ability to think, perceive, feel or relate to others. Personality disorders usually emerge in adolescence and continue into adulthood and may be associated with genetic or familial factors. Experiences of distress or fear during childhood, such as neglect or abuse are commonly found in people with personality disorders. There are variations in the prevalence estimates of personality disorders which are common conditions in our society. Prevalence estimates range from 1 in 5 to 1 in 20 people at any time.\textsuperscript{45}

People with personality disorders may present with a range of physical, mental health and social problems such as substance misuse, depression and suicide risk, housing problems and long-standing interpersonal problems. Due to the complex nature of the condition, people with personality disorders are likely to be involved with a number of different agencies. Without adequate help and support, there will be a huge burden on these individuals and society as a whole.

There are no local data available for the prevalence of personality disorders. However, locally, women with personality disorders are responsible for most Psychiatric Intensive Care Unit (PICU) admissions and long stays.

\textsuperscript{45} Department of Health. Recognising complexity: Commissioning guidance for personality disorder services. Department of Health 2009

6.5 Learning difficulties including Autism Spectrum Disorder

It is estimated that there are approximately 1.4 million people with learning difficulties in England. The majority (1.2 million) have mild or moderate learning difficulty and 210,000 people have severe or profound learning difficulties\textsuperscript{46}. On average a GP practice with 2000 patients will have almost 44 people with mild to moderate learning difficulties and about 6 people with severe learning difficulties although there will be a wide variation among different practices. The population of people with learning difficulties in South Gloucestershire is projected to rise by 1% per annum over the next 10 years. South Gloucestershire’s JSNA included the following estimates:
• The total adult population of people with learning difficulties is 5028 of whom 4101 are aged 18 to 64 years
• 1048 people aged 18 to 64 are predicted to have a moderate or severe learning disability
• 246 people aged 18 to 64 are predicted to have a severe learning difficulty
• 929 people will be known to statutory agencies
• 327 people will live in care homes, of whom 20 will live in care homes with nursing

Using QOF 2012/2013 data there were 873 people aged 18 and over on the learning disabilities register for South Gloucestershire GP practices (prevalence 0.4%). This is similar to the English average of 0.5%.

The Learning Disabilities 2013 Profile\textsuperscript{47} for South Gloucestershire includes information on how many people have learning disabilities, the health of these individuals and their access to health care and social services. South Gloucestershire’s performance was significantly worse than England for:

• People with learning difficulties living in settled accommodation (71.1\% vs 74.9\%- higher is better)
• People with learning difficulties living in non-settled accommodation (28.3\% vs 21.7\%- lower is better)
• Adults using day care services supported by the local authority per 1000 people with learning disabilities (256.6 vs 323.7- higher is better)
• Adults receiving community services supported by local authorities per 1000 people with learning disabilities (592 vs 794- higher is better)

The 2013 Learning Disability Census\textsuperscript{48} provides a snapshot of people with a learning disability, autistic spectrum disorder and/or behaviour that challenges who were receiving care in an inpatient setting on the 30th September 2013. There were 3250 people receiving care in England on that date; 9 of whom were affiliated with South Gloucestershire CCG by residence.

For all service users included in the Learning Disability census, the main reasons for hospital admission were as follows:

• Learning Disability in 34.8\%
• Mental Illness in 27.6\%
• Challenging behaviour in 21.3\%
• Autistic Spectrum Disorder including Asperger’s Syndrome in 9.9\%
• Personality disorder or self-harm or other in 6.5\%

The majority were white (83.7\%), male (74.6\%) and aged 25-34 years (28.3\%), 18 to 24 years (20.5\%) or 35-44 years (19\%). Most admissions were to a learning disability ward (76.3\%) or mental health ward (20.1\%) at general security level (45.2%).

**Autism spectrum disorder /Autism spectrum**
Autism spectrum disorders (ASD) are developmental disorders. Approximately a third of patients with a learning disability will also have an autistic spectrum condition. Estimates of the prevalence of autism in adults aged 18 years and over are based on data from the 2007 Adult Psychiatric Morbidity Survey and a study of adults with learning disabilities living in private households and communal care establishments in Leicestershire, Lambeth and Sheffield (reference estimating the prevalence of autism spectrum conditions in adults- extending the 2007 adult psychiatric morbidity survey). Key statistics from this report are as follows:

- The overall prevalence of autism is 1.1%
- Prevalence is higher in men than in women (2% vs 0.3%)
- Among adults with severe learning disabilities in private households the prevalence of autism is 35.4%
- Among adults with mild or severe learning disabilities living in communal care establishments the prevalence of autism is 31%
- The number of people with autism spectrum conditions in full-time employment is very low (6% of all people with ASD, 12% of people with Asperger’s syndrome, 2% in people at the lower end of the spectrum)

In 2012, there were an estimated 1546 men and 164 women with ASD in South Gloucestershire (total 1710). By 2030 this figure is expected to increase to 1830.

There were 22 adult referrals from South Gloucestershire GP practices to the Bristol Autism Spectrum Service from April to September 2014. Fourteen diagnostic assessments were completed (8 in males, 6 in females) with the largest number (5) in the 20-29 age group. All referrals were of White British ethnicity. As of the 30th September 2014, there were 42 individuals waiting for diagnostic assessment on the South Gloucestershire waiting list and the average time that people had to wait before they were seen for diagnosis was 10 months.

6.6 Adult Attention Deficit Hyperactivity Disorder

Adult attention-deficit/hyperactivity disorder (ADHD) is a mental health condition characterised by difficulty in maintaining attention, as well as hyperactivity and impulsive behaviour. It may lead to problems such as poor work or school performance, unstable relationships and low self-esteem. Although ADHD starts in early childhood, in some cases the condition may not be diagnosed until later in life. Treatment includes the use of stimulant drugs or other medications (including methylphenidate- Concerta, Metadate, Ritalin, dextroamphetamine-Dexedrine, atomoxetine-Strattera and bupropion-Wellbutrin), psychological counselling (psychotherapy) and treatment for co-existing mental health conditions.

From April to November 2014 there were 62 referrals from South Gloucestershire’s GPs and referral partners to the Adult ADHD service. Referrals from GP surgeries accounted for 67% of all referrals. Other referral partners included Bristol Autism Spectrum Service (BASS) @ South Gloucestershire Autism Services for Adults, Children and Adolescent Mental Health, Primary Care Liaison Service, Recovery, STEPs eating disorder service and South Gloucestershire Intensive Team.

There were 61 clients on the waiting list to be seen by the Adult ADHD service (22 who are on ‘funded’ waiting lists and 39 from ‘unfunded’ waiting lists). For funded referrals, the typical waiting time was approximately three months (range 8-16 weeks). There were 74 people on the active caseload; the majority of these individuals were male (71%). Sixty one (82.4%) of people on the active caseload were currently on medication. Methylphenidate extended release (Concerta) was the most commonly used medication (used in more than two thirds of the active caseload).

6.7 Self-Harm

Deliberate self-harm or intentional self-harm is the act of deliberately causing harm to oneself by either causing a physical injury or putting oneself in dangerous situations and/or self-neglect. The National Institute for Health and Care Excellence (NICE) defines self-harm as “intentional self-poisoning or injury, irrespective of the apparent purpose of the act”51. Self-harm may occur with or without suicidal intent. The UK has one of the highest rates of self-harm in Europe52 (400 per 100,000 population). People who self-harm are at 100 times increased risk of suicide.

Hospital attendance- Bristol Self-Harm Register

From April 2013 to December 2013, there were 808 presentations for self-harm to Frenchay Hospital made by 629 people. Repeat attendances accounted for roughly 1 in 4 of presentations during that period. Almost three quarters (74%) of self-harm presentations to Frenchay came from people living in an area with a South Gloucestershire postcode.

The majority of attendances for self-harm were made by women (female vs male: 63.8% vs 36.2%). Most attendees were of white ethnicity. The median age of patients was 32 years and
presentations were most frequently made by the younger age groups. Incidence was highest among females aged 15 to 24 years whereas the peak in males occurred at age 20 to 29 years. Females presented more frequently in all but two age groups (45 to 49 years and 70 to 74 years). Attendees were also more likely to be unemployed (38.8%) vs unemployed (29.5%) and the unemployment rate was higher than the national average (7%). 11.2% of presenters were full time students, 6.1% were retired and 4.2% were on sickness absence. The majority of attendees lived with family (66.2%) versus lived alone (22.7%).

The median waiting time for self-harm patients between booking in and being assessed in triage was 17 minutes (mean 26, range 0-197). The median waiting time for those patients who self-discharged after triage was only five minutes longer at 22 minutes (mean 26, range 0-109), providing some evidence that self-discharge was not related to prolonged waiting. Median time to be seen by a doctor was longer at Frenchay Hospital compared with the Bristol Royal Infirmary (Frenchay vs BRI: 107 minutes vs 54.6 mins).

The most frequently used method of self-harm was self-poisoning. Self-poisoning alone was used by 73.9% of the 808 episodes at Frenchay. Self-injury alone was used in 18.6% of episodes. 7.3% of episodes involved the use of both self-injury and self-poisoning. Rare methods included the use of jumping (0.5%), car fumes (0.4%) and hanging (0.2%).

Paracetamol was the most commonly ingested drug taken as part of an episode of self-harm (Table 6.4). Over 50% of all self-poisoning episodes included paracetamol in its pure form or as the major component in a medicine (Table 6.5). Antidepressants were involved in 29% of cases of self-poisoning; citalopram or mirtazapine were the most commonly ingested antidepressants. Other medicines, such as statins, antibiotics, insulin and antihistamines accounted for 40% of self-poisoning episodes (Table 6.5).

Table 6.4 Top 10 most frequently ingested poisons

<table>
<thead>
<tr>
<th>Poisons</th>
<th>Episodes (%)*</th>
<th>Median number of pills ingested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paracetamol**</td>
<td>679 (36.8)</td>
<td>20</td>
</tr>
<tr>
<td>Ibuprofen</td>
<td>228 (12.4)</td>
<td>12</td>
</tr>
<tr>
<td>Diazepam</td>
<td>209 (11.3)</td>
<td>13</td>
</tr>
<tr>
<td>Co-codamol</td>
<td>143 (7.7)</td>
<td>18</td>
</tr>
<tr>
<td>Citalopram</td>
<td>137 (7.4)</td>
<td>14</td>
</tr>
<tr>
<td>Zopiclone</td>
<td>129 (7.0)</td>
<td>8</td>
</tr>
<tr>
<td>Tramadol</td>
<td>111 (6.0)</td>
<td>12</td>
</tr>
<tr>
<td>Sertraline</td>
<td>87 (4.7)</td>
<td>14</td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>86 (4.7)</td>
<td>12</td>
</tr>
<tr>
<td>Codeine</td>
<td>81 (4.4)</td>
<td>18</td>
</tr>
</tbody>
</table>

*One episode can involve multiple drugs.
** Paracetamol can be one of a number of compounds in one medicine, paracetamol in forms such as these are not included the number of paracetamol poisonings above.

Source Bristol Self-Harm Register
Table 6.5 Category of drug ingested during self-poisoning

<table>
<thead>
<tr>
<th>Poisons</th>
<th>Episodes* (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paracetamol (pure and compounds)</td>
<td>935 (51)</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>539 (29)</td>
</tr>
<tr>
<td>Non-steroidal anti-inflammatory drugs</td>
<td>333 (18)</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>330 (18)</td>
</tr>
<tr>
<td>Other Analgesics</td>
<td>302 (16)</td>
</tr>
<tr>
<td>Other Minor Tranquilizers</td>
<td>192 (10)</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>160 (9)</td>
</tr>
<tr>
<td>Aspirin</td>
<td>51 (3)</td>
</tr>
<tr>
<td>Other</td>
<td>733 (40)</td>
</tr>
</tbody>
</table>

*The denominator is the total number of self-poisoning episodes at the BRI and Frenchay (n=1846). One episode may involve the ingestion of numerous drugs.

Source Bristol Self Harm Register

Seventy-five percent of patients presenting to Frenchay had a previous history of self-harm, 62.2% had a history of previous psychiatric treatment. The majority had no history of being a previous psychiatric inpatient (76.6%), 6.1% had been a psychiatric inpatient within one year of the current episode and 17.3% had been a psychiatric inpatient previously more than a year before the current admission.

Most episodes resulted in patients being discharged home and/or to GP services (i.e. with no specialities mental health follow-up). Eighteen percent of referrals resulted in referrals to other services such as Child and Adolescent mental health services (CAMHS), drug and alcohol services, Lift psychology and domestic violence and abuse services. Only 5% were referred to the Crisis service.

No suicides were reported in patients who presented to Frenchay Hospital with self-harm. However, since September 2010, 25 suicides have been identified in patients who presented to the BRI for self-harm. Patients who went on to die by suicide were more likely to be older males, use self-injury as part of their episode of self-harm and have a previous psychiatric diagnosis (see Section 6.6).

Hospital admissions for self-harm

The number of hospital admissions for South Gloucestershire by sex from 2001 to 2012 is shown in Figure 6.9. There were more female admissions during the entire period. The number of admissions almost tripled in both sexes between 2001 and 2010 but declined afterwards until 2012.
The numbers of hospital admissions for self-harm were higher in females than males in all age groups (Figure 6.10). The highest number of hospital admissions was seen in 15-19 year old females (similar to the age pattern seen in the Bristol Self-Harm surveillance register) and 35-39 year old males (slightly older than the Bristol Self-Harm register).

Table 6.6 Primary cause of hospital admissions for self-harm 2001-2012
6.8 Suicide

Figure 6.11 shows the trends in the age standardised rates of suicides in the South West region from 1991 to 2010. For every one female suicide, there were two to three male suicides which is consistent with the national sex ratio for suicide deaths. The overall suicide rates in the South West shows a slight decrease in male suicides from 2001 to 2007 although female rates were more consistent.

Figure 6.11 ONS data for directly age standardised rates of suicide in the South West

<table>
<thead>
<tr>
<th>primary cause</th>
<th>male</th>
<th>female</th>
<th>persons</th>
<th>male %</th>
<th>female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poisoning</td>
<td>1515</td>
<td>2683</td>
<td>4198</td>
<td>90.7%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Sharp object</td>
<td>108</td>
<td>150</td>
<td>258</td>
<td>6.5%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Other specified means</td>
<td>15</td>
<td>12</td>
<td>27</td>
<td>0.9%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Hanging /strangulation</td>
<td>10</td>
<td>12</td>
<td>22</td>
<td>0.6%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Jumping from a high place</td>
<td>7</td>
<td>10</td>
<td>17</td>
<td>0.4%</td>
<td>0.3%</td>
</tr>
<tr>
<td>blunt object</td>
<td>3</td>
<td>9</td>
<td>12</td>
<td>0.2%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Smoke, fire or flames</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>0.1%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Drowning / Submersion</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>unspecified means</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>handgun discharge</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>0.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>jumping / lying before moving object</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>0.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>crashing motor vehicle</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>0.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>all causes</strong></td>
<td>1670</td>
<td>2887</td>
<td>4557</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source Hospital admissions data from acute trusts

Figure 6.12 shows the trend in suicide rates is shown for South Gloucestershire compared with the South West region and England. For South Gloucestershire the small numbers of suicides led to fluctuating rates over time. However, there was evidence of an increase in male suicides from 2001 to 2010. Female rates remained at a similar level over the time Figure 6.12 Suicide and undetermined injury in England, the South West and South Gloucestershire.

Figure 6.13 illustrates three-yearly rolling averages of suicide rates across local PCTs, used to smooth out fluctuations resulting from the small numbers. These results are standardised to
account for the different age and sex demographics in the different areas. The results are not adjusted for other known suicide risk factors, such as employment status. For South Gloucestershire figure 3 shows mortality rates (3 year rolling averages) have remained fairly consistent over time (1993-2010) although an increase is seen from 2004-06 to 2008-10 which is a notable difference to the rates (3 year rolling averages) for England during the same time period which have decreased.

Figure 6.14 indicates that the directly age standardised suicide rate per 100,000 population for males in South Gloucestershire is lower than the rate for England, the South West and the ONS comparator of other prospering smaller towns (the differences between South Gloucestershire and England and South Gloucestershire and the South West are statistically significant although it should be noted that due to small numbers the confidence interval is wide). Figure 6.14 indicates that the directly age standardised suicide rate per 100,000 population for women is less than that for England, the South West and other prospering smaller towns although confidence intervals overlap and therefore any differences seen are not statistically significant.

Figure 6.13 South Gloucestershire within a national context

Source Office for National Statistics Mortality Data

Figure 6.14: Mortality rate from suicide and undetermined injury by sex, 2008-2010 pooled
Since 2002-2004, there has been a notable upward trend for most of the age groups with the exception of those aged 75 years and over (Figure 6.15).

Figure 6.15 Trend in suicide and death by unexplained injury by broad age group, three year rolling averages, South Gloucestershire, 2002-2012

Source Office for National Statistics Mortality Data

Figure 6.16 indicates that the crude rate of mortality from suicide and undetermined injury is highest in South Gloucestershire amongst those aged 65-74 years. However in terms of actual number of deaths Table 6.7 shows that for the period 2008-2012 of the 85 deaths from suicide and undetermined injury the age group 25-44 years made up the largest proportion (28 deaths,
33%) followed by age group 45-64 years (26 deaths, 31%). Of the 85 deaths, 75% were males and 25% females.

Figure 6.16 Crude rate of mortality from suicide and undetermined injury by sex and age group, South Gloucestershire, 2008-2012 pooled

![Crude rate of Mortality from Suicide and Injury of Undetermined Intent by Broad Age Group and Sex, South Gloucestershire, 2008-2012 pooled](image)

Source Office for National Statistics Mortality Data

Table 6.7 Numbers of deaths by suicide and undetermined injury, South Gloucestershire, 2008-2012

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age group</th>
<th>15-24</th>
<th>25-44</th>
<th>45-64</th>
<th>65-74</th>
<th>75+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td></td>
<td>8</td>
<td>22</td>
<td>19</td>
<td>9</td>
<td>5</td>
<td>63</td>
</tr>
<tr>
<td>Females</td>
<td></td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>Persons</td>
<td></td>
<td>10</td>
<td>28</td>
<td>26</td>
<td>13</td>
<td>8</td>
<td>85</td>
</tr>
</tbody>
</table>

Source Office for National Statistics Mortality Data

The national average for cases of suicide in contact with mental health services is around 26%. It is difficult to draw conclusions with any certainty, on the trend of whether more cases are in contact with mental health services over time, due to the small numbers involved. Table 6.8 shows the fluctuation in the percentage of suicide deaths occurring where the individual had contact with
mental health services.

Table 6.8 South Gloucestershire suicides and undetermined injury in the PCT area and in contact with mental health services**

<table>
<thead>
<tr>
<th>Year</th>
<th>PCT Deaths</th>
<th>AWPT Deaths</th>
<th>Percentage (%) deaths in contact with AWP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>16</td>
<td>3</td>
<td>18.8</td>
</tr>
<tr>
<td>2002</td>
<td>14</td>
<td>3</td>
<td>21.4</td>
</tr>
<tr>
<td>2003</td>
<td>13</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2004</td>
<td>9</td>
<td>5</td>
<td>55.6</td>
</tr>
<tr>
<td>2005</td>
<td>13</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>2006</td>
<td>15</td>
<td>8</td>
<td>53.3</td>
</tr>
<tr>
<td>2007</td>
<td>14</td>
<td>6</td>
<td>429</td>
</tr>
<tr>
<td>2008</td>
<td>15</td>
<td>4</td>
<td>26.7</td>
</tr>
<tr>
<td>2009</td>
<td>18</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>2010</td>
<td>17</td>
<td>3</td>
<td>17.6</td>
</tr>
<tr>
<td>2011</td>
<td>16</td>
<td>6</td>
<td>37.5</td>
</tr>
<tr>
<td>2012</td>
<td>19</td>
<td>2</td>
<td>10.5</td>
</tr>
</tbody>
</table>

** In contact with mental health services at the time of death or in the previous 12 months
Source South Gloucestershire Suicide Audit

Figure 6.17 illustrates age-standardised rates of suicide per 100,000 population by deprivation quintile. Deprivation quintile 1 is the most deprived, 5 the least deprived. This demonstrates that from 2003 to 2012 the most deprived quintile of the population has the highest rate of suicide and death by injury of undetermined intent. However, due to overlapping confidence intervals, there is no clear trend across categories of deprivation and only weak evidence of an increased rate in the most deprived quintile. It should be noted that the relationship is not linear – the least deprived quintile does not have the lowest rate of suicide or death by undetermined intent.

Figure 6.17 Rate of suicide and death by injury of undetermined intent by local deprivation quintile, 2003 - 2012
Hanging is the most common mode of completed suicide in South Gloucestershire between 2001 and 2012 (Figure 6.18). Completed suicide by poisoning has increased over time. Drowning and firearm discharge appear to be increasing in recent years. Nationally, hanging followed by poisoning are the most common methods of suicide.

Figure 6.18 Trends in the mode of suicide by year in South Gloucestershire
7. Findings from Public Health England’s Mental Health Intelligence Network and the Care Quality Commission’s Thematic Data Review Report

7.1 Introduction

This section summarises data from Public Health England’s Mental Health Dementia and Neurology (MHDN) network and the Care Quality Commission’s (CQC) Thematic review of mental health crisis care. Further data on mental health service provision are reported in Chapter 8.

7.2 The Mental Health Dementia and Neurology (MHDN) network

The MHDN network includes indicator tools which bring together nationally available data that are presented at local level to support benchmarking, commissioning and service improvement. Table 7.1 summarises the indicators for South Gloucestershire compared with England for the following topics: common mental health disorders, severe mental illness, co-existing substance misuse and mental health and community mental health profiles. It includes whether the South Gloucestershire value is higher than, similar to, or lower than England. In Appendix C, a judgement is made regarding whether South Gloucestershire’s performance is better or worse than comparator regions in the South West (North Somerset, Bath and North East Somerset and Swindon as described previously in Chapter 3) and England. Notably, the following indicators were lower in South Gloucestershire than England: spend on mental health in specialist services, percentage of secondary care funding spent on mental health, rate of social care mental health clients receiving services and new social care assessments for mental health clients of working age.

Table 7.1 - Summary of performance of MHDN indicators for South Gloucestershire compared with England

<table>
<thead>
<tr>
<th>Higher than England</th>
<th>Similar to England</th>
<th>Lower than England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression QOF prevalence (18+)</td>
<td>Premature (&lt;75) mortality in adults with serious mental illness: rate per 100,000 population</td>
<td>Number of bed days per 100,000 population</td>
</tr>
<tr>
<td>Metric</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>Satisfaction with social care support: % of service users extremely satisfied or very satisfied with their care and support</td>
<td>Successful completion of drug treatment- opiate users %</td>
<td></td>
</tr>
<tr>
<td>Successful quitters confirmed by biochemical validation- crude rate %</td>
<td>Emergency admissions for self-harm per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>Service users in hospital: % mental health service users who were inpatients in a psychiatric hospital</td>
<td>Successful completion of alcohol treatment</td>
<td></td>
</tr>
<tr>
<td>New cases of psychosis: incidence per 100,000 population aged 16-64</td>
<td>Emergency admissions for self-harm per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>Successful quitters confirmed by biochemical validation- crude rate %</td>
<td>Emergency admissions for self-harm per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>People in contact with mental health services per 100,000 population</td>
<td>Emergency admissions for self-harm per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>Hospital admissions for unintentional and deliberate injuries, ages 0-24, per 100,000 population</td>
<td>Emergency admissions for self-harm per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>Proportion % waiting more than 3 weeks for drug treatment</td>
<td>Admissions for depression: directly standardised rate for hospital admissions for unipolar depressive disorders per 100,000 aged 15 and over</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency admissions for neuroses: indirectly age and sex standardised rate per 100,000 population</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gap in employment: % gap between employment rate of those with mental health disorders and overall population</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social care mental health clients in residential or nursing care during the year aged 18 to 64: rate per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>% gap in employment: % gap between employment rate of those with mental health disorders and overall population</td>
<td>Social care mental health clients in residential or nursing care during the year aged 18 to 64: rate per 100,000 population</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social care mental health clients in residential or nursing care during the year aged 18 to 64: rate per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>Social care mental health clients in residential or nursing care during the year aged 18 to 64: rate per 100,000 population</td>
<td>Schizophrenia emergency admissions: rate per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>Social care mental health clients in residential or nursing care during the year aged 18 to 64: rate per 100,000 population</td>
<td>Proportion % waiting more than 3 weeks for alcohol treatment</td>
<td></td>
</tr>
<tr>
<td>Antidepressant prescribing (ADQs/STAR-PU)</td>
<td>Carers of mental health clients receiving assessments per 100,000</td>
<td></td>
</tr>
<tr>
<td>Carers of mental health clients receiving assessments per 100,000</td>
<td>Spend (£s) on mental health in specialist services: rate per 100,000</td>
<td></td>
</tr>
<tr>
<td>Spend (£s) on mental health in specialist services: rate per 100,000</td>
<td>% secondary care funding spent on mental health</td>
<td></td>
</tr>
<tr>
<td>% secondary care funding spent on mental health</td>
<td>People in Care Programme Approach (CPA) per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>Rate of recovery for IAPT treatment %</td>
<td>Rate of recovery for IAPT treatment %</td>
<td></td>
</tr>
<tr>
<td>Social care mental health clients receiving services during the year: rate per 100,000 population</td>
<td>Social care mental health clients receiving services during the year: rate per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>Social care mental health clients receiving services during the year: rate per 100,000 population</td>
<td>New social care assessments per year for mental health clients aged 18-64: rate per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>Social care mental health clients aged 18-64 years receiving home care during the year: rate per 100,000 population</td>
<td>Self-directed support: % social care mental health clients receiving direct payments</td>
<td></td>
</tr>
<tr>
<td>Self-directed support: % social care mental health clients receiving direct payments</td>
<td>Carer assessments: people who care for an adult with a mental health condition and were assessed during the year per 100,000 population</td>
<td></td>
</tr>
</tbody>
</table>
The Care Quality Commission thematic review of mental health crisis care

The CQC began its thematic review of mental health crisis care in late 2013 to explore the experiences and outcomes of care for people experiencing a mental health crisis. The aims of the thematic review are twofold:

1. To assess the quality of an individual provider’s response to a person experiencing a mental health crisis
2. To explore how different organisations and agencies work together to provide an effective response within a local area

The thematic review focuses on pathways for three key groups, i.e. people who experience a mental health crisis and:

1. Present to accident and emergency departments (with a particular focus on people who self-harm)
2. Require access to and support from specialist mental health services
3. Are detained by police under Section 136 of the Mental Health Act

For the first phase of the review, the CQC has collated available data from providers and other key organisations, plus analysis from service users, carers and local groups involved in mental health crisis care. The analyses is used to describe mental health crisis care for the three pathways previously described. The findings from the initial data review are summarised in Table 7.2. Full details are included in Appendix D. Notably, South Gloucestershire’s performance was worse than England for the percentage of people with severe mental illness with a comprehensive care plan in place, with higher bed occupancy levels compared to expected standards, higher numbers of emergency admissions for mood disorders, schizophrenia and self-harm than expected and higher proportions of negative responses to questions on quality and effectiveness of mental health services on group surveys.

It is important to note that the CQC has not published this information as a judgement on the
quality of mental health crisis care provision in any given local authority area. However, the data highlight certain issues that need to be examined to improve provision and can be used to develop local area declarations and action plans for the Mental Health Crisis Care Concordat. The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. The Concordat sets out how organisations will work better together to ensure that people get the help they need during a mental health crisis and focuses on four main areas:

1. Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously
2. Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency
3. Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment
4. Recovery and staying well – preventing future crises by making sure people are referred to appropriate services

The next few chapters will summarise available services in South Gloucestershire and current service provision as well as provide service user perspectives on mental health services.

Table 7.2 Summary of performance of CQC thematic review indicators for South Gloucestershire compared with England

<table>
<thead>
<tr>
<th>Better performance than England</th>
<th>Worse performance than England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of deaths within 30 days of MHMDS care spell ending</td>
<td>% of people with severe mental health illness with a comprehensive care plan in place</td>
</tr>
<tr>
<td>% of community treatment orders (CTOs) ended by revocation</td>
<td>6 month mortality rate (from all causes) among all patients, compared between those with and without a history of previous MH contact</td>
</tr>
<tr>
<td>Number of spells for people aged 16-17 years on adult wards at specialist MH provide</td>
<td>Ratio of observed to expected number of emergency acute admissions for mood disorders</td>
</tr>
<tr>
<td>Are people taken into Police custody for assessment if not accepted at place of safety?</td>
<td>Ratio of observed to expected number of emergency acute admissions for schizophrenia</td>
</tr>
<tr>
<td>Does the provider believe there is sufficient provision of health based places of safety in the local area?</td>
<td>Ratio of observed to expected number of emergency acute admissions for self-harm</td>
</tr>
<tr>
<td>How many of the following data items are collected? (Age/Sex/Ethnicity/Disability/Other protected characteristics)</td>
<td>% of people who complete treatment and are ‘moving to recovery’</td>
</tr>
<tr>
<td>In 2013 has the Place of Safety been used for another purpose which impacts acceptance of patients?</td>
<td>Ratio of the number of referrals for talking therapies who have waited more than 28 days from referral to treatment</td>
</tr>
<tr>
<td>In 2013 has the Place of Safety had to be closed because of the need to use it as an additional inpatient bed?</td>
<td>% responses to group survey stating impression of quality and effectiveness of services in responding to people in crisis is poor or very poor</td>
</tr>
<tr>
<td>In 2013 have people been turned away from the place of safety due to staffing problems?</td>
<td>% responses to group survey stating support available to people experiencing a crisis out-of-hours is NOT of an equal standard to that available during regular working hours</td>
</tr>
</tbody>
</table>
8. Mental Health Services

This section describes the current mental health service provision in South Gloucestershire. It includes data from the Avon and Wiltshire Partnership (AWP) Mental Health Trust, secondary care data, data on use of inpatient services from the Clinical Commissioning Group, prescribing data and information on improving access to psychological therapies (IAPT).

8.1 Avon and Wiltshire Mental Health Services Partnership (AWP)

Community Mental Health Services

Between the years 2009/2010 and 2013/2014 a total of 166,722 patients were treated. The caseload increased from 31,259 patients in 2009/2010 to 33,218 patients in 2013/2014, an increase of 6.3%. The five most used services accounted for 65% of activity (Table 8.1). The rise in numbers for the Primary Care Liaison Service (PCLS) corresponds to a decline in patients using the Complex Intervention and Treatment (CIT) and Recovery services due to the implementation of a...
service redesign when Primary Care Liaison Teams were set up to triage referrals. Overall, 43.8% of patients were male but there was considerable variation by service. The services with the highest percentage of male patients in the five year time period included the Low Secure Ward (100% male), Improving Access to Psychological Therapies service (100%), Inpatients Learning Disabilities (100%), Medium secure ward (98.6%), Learning Disabilities service (86.9%), Court Assessment and Referral Service (83.8%), Inpatients secure service (82.1%), Forensic Service (80.2%), Ninety-two percent of patients were White, 6% were of Mixed ethnicity, 1% were Asian or Asian British and 1% were Black or Black British.

Table 8.1 Number of patients (South Gloucestershire residents only) using the top 5 AWP community mental health services by financial year

<table>
<thead>
<tr>
<th>Team type</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>All years</th>
<th>% of all referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory service</td>
<td>6,269</td>
<td>7,359</td>
<td>8,716</td>
<td>8,166</td>
<td>4,321</td>
<td>34,831</td>
<td>20.9</td>
</tr>
<tr>
<td>CIT</td>
<td>9,602</td>
<td>8,675</td>
<td>7,661</td>
<td>3,407</td>
<td>3,101</td>
<td>32,446</td>
<td>19.5</td>
</tr>
<tr>
<td>Recovery</td>
<td>2,715</td>
<td>2,463</td>
<td>2,819</td>
<td>5,488</td>
<td>5,048</td>
<td>18,533</td>
<td>11.1</td>
</tr>
<tr>
<td>Psychology service</td>
<td>2,543</td>
<td>2,130</td>
<td>3,126</td>
<td>3,158</td>
<td>2,821</td>
<td>13,778</td>
<td>8.3</td>
</tr>
<tr>
<td>PCLS</td>
<td>536</td>
<td>1,352</td>
<td>3,257</td>
<td>4,355</td>
<td>9,500</td>
<td>5,7</td>
<td></td>
</tr>
</tbody>
</table>

CIT- Complex Intervention and Treatment, PCLS- Primary Care Liaison Service

Admitted patients (emergency admissions)

Table 8.2 shows emergency admissions to AWP services for South Gloucestershire residents from 2009/2010 to 2013/2014. Admissions dropped in 2012/2013 but increased again in 2013/2014.

Table 8.2 Emergency Admissions from South Gloucestershire residents to AWP services by financial year

<table>
<thead>
<tr>
<th>Admission ward type</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>All years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult acute ward</td>
<td>101</td>
<td>100</td>
<td>104</td>
<td>93</td>
<td>113</td>
<td>511</td>
</tr>
<tr>
<td>L3 WARD</td>
<td>87</td>
<td>81</td>
<td>86</td>
<td>59</td>
<td>77</td>
<td>390</td>
</tr>
<tr>
<td>Drug Detox Unit</td>
<td>22</td>
<td>20</td>
<td>31</td>
<td>24</td>
<td>29</td>
<td>126</td>
</tr>
<tr>
<td>PICU</td>
<td>10</td>
<td>12</td>
<td>16</td>
<td>15</td>
<td>22</td>
<td>75</td>
</tr>
<tr>
<td>Rehab Service</td>
<td>18</td>
<td>18</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>48</td>
</tr>
<tr>
<td>MBU</td>
<td>2</td>
<td>3</td>
<td>7</td>
<td>3</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>ED Service</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>11</td>
<td>19</td>
</tr>
<tr>
<td>Adult HDU</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Medium secure ward</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Migration</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Low secure ward</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
The age profile of admitted patients from 2009/2010 to 2013/2014 inclusive is shown in Figure 8.1. Emergency admissions were highest in 35-44 year olds, 25-34 year olds and 75-84 year olds. Similar to the community mental health services, 92% of admitted patients were of White ethnicity, 5% were of Mixed ethnicity, 2% were Black or Black British and 1% were Asian or Asian British. The gender profile of emergency admissions from 2009/2010 to 2013/2014 is shown in Table 8.3. 613 males and 619 females were admitted. However, there was considerable variation in the proportion by admission ward (Table 8.3).

Table 8.3 Gender profile of emergency admissions to AWP services 2009/2010 to 2013/2014 (South Gloucestershire residents only)
### Admission Ward Type and Patient Gender

<table>
<thead>
<tr>
<th>Admission Ward Type</th>
<th>Patient Gender</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>53</td>
<td>53</td>
<td>41</td>
<td>38</td>
<td>41</td>
<td>226</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>Male</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Low Secure Ward</td>
<td>Male</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MBU</td>
<td>Female</td>
<td>2</td>
<td>3</td>
<td>7</td>
<td>3</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>Medium Secure Ward</td>
<td>Male</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Migration</td>
<td>Male</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>PICU</td>
<td>Male</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>9</td>
<td>16</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>Rehab Service</td>
<td>Male</td>
<td>5</td>
<td>9</td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>13</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>27</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>252</td>
<td>247</td>
<td>261</td>
<td>205</td>
<td>267</td>
<td>1232</td>
</tr>
</tbody>
</table>

Readmission by time elapsed since previous admission is shown in Table 8.4. The majority of admissions occurred more than 1 year after the previous admission.

### Table 8.4 Readmission to AWP Services by Time Elapsed Since Previous Admission 2009/2010 to 2013/2014 (South Gloucestershire Residents Only)

<table>
<thead>
<tr>
<th>Readmission Time</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 days or less</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6 months to 1 year</td>
<td>23</td>
<td>19</td>
<td>24</td>
<td>16</td>
<td>24</td>
</tr>
<tr>
<td>More than 1 year</td>
<td>84</td>
<td>95</td>
<td>70</td>
<td>76</td>
<td>107</td>
</tr>
</tbody>
</table>

The numbers of emergency admissions to AWP services by electoral ward from 2009/2010 to 2013/2014 (inclusive) are shown in Figure 8.2. The highest numbers of admissions (>60) were from Kings Chase, Yate North, Patchway, Stoke Gifford and Woodstock wards. Other wards with high admissions (between 40 and 60 admissions) included Downend, Filton, Hanham, Rodway and Yate Central. Many of these wards include Priority Neighbourhoods i.e. Kings Chase, Rodway and Woodstock are in the Kingswood priority neighbourhood, Yate North and Yate Central are in the Yate priority neighbourhood and Patchway is one of the six priority neighbourhoods.

Figure 8.2 Emergency admissions to AWP services by electoral ward from 2009/2010 to 2013/2014 inclusive
Use of inpatient services

This section provides information on the usage of AWP inpatient services. For the six combined AWP areas (which include Bath and North East Somerset, Bristol, North Somerset, South Gloucestershire, Swindon and Wiltshire) there are 14.6 adult acute beds per 100,000 population (national average 20 per 100,000). The total number of adult acute beds per 100,000 population is shown for each CCG in Table 8.4.

Table 8.4 Adult acute beds per 100,000 population by CCG

<table>
<thead>
<tr>
<th>CCG</th>
<th>Total adult beds (2014-15)</th>
<th>Total population (working age) *</th>
<th>AWP Beds per 100,000</th>
<th>National average beds per 100,000 **</th>
<th>Variance from average</th>
</tr>
</thead>
<tbody>
<tr>
<td>B&amp;NES CCG</td>
<td>15</td>
<td>93,472</td>
<td>16.0</td>
<td>20</td>
<td>-4.0</td>
</tr>
<tr>
<td>Bristol CCG</td>
<td>52</td>
<td>447,532</td>
<td>11.6</td>
<td>20</td>
<td>-8.4</td>
</tr>
<tr>
<td>N Som CCG</td>
<td>20</td>
<td>137,496</td>
<td>14.5</td>
<td>20</td>
<td>-5.5</td>
</tr>
<tr>
<td>South Glos CCG</td>
<td>13</td>
<td>102,372</td>
<td>12.7</td>
<td>20</td>
<td>-7.3</td>
</tr>
<tr>
<td>Swindon CCG</td>
<td>18</td>
<td>117,337</td>
<td>15.3</td>
<td>20</td>
<td>-4.7</td>
</tr>
<tr>
<td>Wiltshire CCG</td>
<td>24</td>
<td>188,901</td>
<td>21.7</td>
<td>1.7</td>
<td></td>
</tr>
<tr>
<td><strong>AWP total</strong></td>
<td><strong>129</strong></td>
<td><strong>1,087,109</strong></td>
<td><strong>14.6</strong></td>
<td><strong>20</strong></td>
<td><strong>-5.4</strong></td>
</tr>
</tbody>
</table>

* - weighted population figures based on 2011-12 Health and Social Care Information Centre data

** - average taken from NHS Benchmarking Network report 2013-14, where median is judged to be more reliable than the mean (which is skewed by a small number of Trusts with very high rates)

In all six areas the trust was below the national average. However, the national average should not
be considered a gold standard as other factors such as the level and effectiveness of community provision will help determine the number of beds required in a given area.

Figure 8.3 shows the daily occupancy level of adult acute services in October 2014, including Delayed Transfers of Care (DTOC)\(^54\), ‘out of locality’ placements and ‘out of Trust (OOT)’ placements. There was significant pressure within the system as inpatient usage exceeded 100% occupancy for most of October. In addition, out of trust placements were high across October.

![Diagram of S Glos inpatient usage (Oct 2014): Adult Acute](image)

The total number of older adult beds per 100,000 head of population is shown in Table 8.5, using weighted population figures to adjust for relative levels of morbidity. Overall, the trust has roughly the same number of beds as the national average. However, based on the relative population levels for each CCG, it appears that the beds may be located in the wrong areas. Similar to the results presented previously, the national average should not be considered as the gold standard as other factors such as the level and effectiveness of community provision may have an impact on the level of bed provision required in any given area.

\(^{54}\) A delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed.

Table 8.5 Beds in older adults per 100,000 population by CCG

Older People
<table>
<thead>
<tr>
<th>CCG</th>
<th>Total adult beds (2014-15)</th>
<th>Total population (older people) *</th>
<th>AWP Beds per 100,000</th>
<th>National average beds per 100,000 **</th>
<th>Variance from average</th>
</tr>
</thead>
<tbody>
<tr>
<td>B&amp;NES CCG</td>
<td>12</td>
<td>30,734</td>
<td>39.0</td>
<td>52</td>
<td>-13.0</td>
</tr>
<tr>
<td>Bristol CCG</td>
<td>20</td>
<td>64,115</td>
<td>31.2</td>
<td></td>
<td>-20.8</td>
</tr>
<tr>
<td>N Som CCG</td>
<td>25</td>
<td>40,520</td>
<td>61.7</td>
<td></td>
<td>9.7</td>
</tr>
<tr>
<td>South Glos CCG</td>
<td>22</td>
<td>34,309</td>
<td>64.1</td>
<td>52</td>
<td>12.1</td>
</tr>
<tr>
<td>Swindon CCG</td>
<td>26</td>
<td>30,342</td>
<td>85.7</td>
<td></td>
<td>33.7</td>
</tr>
<tr>
<td>Wiltshire CCG</td>
<td>38</td>
<td>76,404</td>
<td>49.7</td>
<td></td>
<td>-2.3</td>
</tr>
<tr>
<td>AWP total</td>
<td>143</td>
<td>276,424</td>
<td>51.7</td>
<td></td>
<td>-0.3</td>
</tr>
</tbody>
</table>

* - weighted population figures based on 2011-12 Health and Social Care Information Centre data

** - average taken from NHS Benchmarking Network report 2013-14, where median is judged to be more reliable than the mean (which is skewed by a small number of Trusts with very high rates)

The daily occupancy level of older adult acute services in October 2014 is shown in Figure 8.4. There was high pressure within the system and the bed occupancy level was at or above 100% occupancy for 13 days in October. On average, five service users were identified as DTOC every day. Out of trust placements occurred for most of the month.

![Graph of S Glos inpatient usage (Oct 2014): Older People](source: South Gloucestershire CCG)
Delayed Transfers of Care (DTOC)
Figures 8.5 and 8.6 provide further information on DTOC by CCG in the BNSSG (Bristol, North Somerset and South Gloucestershire) area. South Gloucestershire exceeded the national target from August 2013 to January 2014.

Figure 8.5 BNSSG DTOC percentages across the national 7.5% target

![Locality DTOC percentages](image)

Source: South Gloucestershire CCG

The number of DTOC service users in South Gloucestershire has increased from January 2014 to July 2014 (Figure 8.6).

Figure 8.6 BNSSG DTOC number of service users by CCG

![DTOC number of service users by CCG](image)
The total number of DTOC days from April to July 2014 split by CCG and the reason for delay is shown in Figure 8.7. Most delays were caused by waiting for care home (residential or nursing home) placements, although other reasons such as ‘awaiting further NHS care’ were also common.

Figure 8.7

![Total DTOC Days by Reason, by CCG (April - July 2014)](source: South Gloucestershire CCG)

The DTOC delays in South Gloucestershire shown in Figure 8.7 occurred in AWP’s Later Life service, mostly related to Laurel Ward at Callington Road (the dementia ward for both South Gloucestershire and Bristol). During this time, 10% of beds were closed to admissions due to concerns about the safety of patients and staff, driven by difficulties presented by a small but growing number of increasingly challenging patients (younger, fitter, more aggressive males were admitted from both CCGs).

Across AWP, DTOCs are responsible for a total of 11,380 bed days which is equivalent to £5.7 million across the region. The CCG has estimated that the elimination of DTOCs would eliminate OOT placements for older adults and reduce adult acute OOT placements by 25%.

### 8.2 The Mental Health Minimum Dataset

The Mental Health Minimum Dataset (MHMDS) provides information about care delivered to users of NHS funded secondary mental health services. From September 2014, the MHMDS was expanded to cover people in contact with Learning disability services and was renamed the Mental Health and Learning Disabilities Dataset (MHLDDS). For South Gloucestershire local authority at the end of October 2014 there were (note numbers are similar if South Gloucestershire CCG is used Appendix E):
• 1830 people were in contact with mental health or learning disabilities services. Of these 1725 people were in contact with mental health services and 115 people were in contact with learning disability services. These figures combined are higher than the total as a person may be in contact with both services
• 65 people (2.4%)\textsuperscript{65} were inpatients in hospital (using a mid-year population of 266,100). Sixty five people were in hospital on wards for people with mental health needs. No one was in hospital on wards for people with learning disabilities. Nationally, 2.5% of people were inpatients in hospital
• Fifty people were subject to the Mental Health Act 1983
• 66.7% (350/525) of people aged 18-69 who were being treated under the Care Programme Approach, were recorded as being in settled accommodation, while 19.1% (100/525) were recorded as being employed. National figures were 59.2% and 6.8% respectively

During October 2014

• 300 new spells of care began
• There were 25 new admissions to hospital
• Of those who were discharged from hospital during the month, 66.7% (10/15) received a follow up within 7 days from the same provider (74.5% nationally). This is an important suicide prevention measure

Mental Health currencies and payment

Most mental health services for working age adults and older adults are covered by currencies known as care clusters. A care cluster is a global description of a group of people with similar characteristics as identified from a holistic assessment and rated using the Mental Health Clustering Tool. Currencies are the unit of health care for which a payment is made and can take a number of forms covering different time periods from an outpatient attendance or a stay in hospital, to a year of care for a long term condition. Tariffs are the set prices paid for each currency.

For South Gloucestershire CCG:

• 1050 people were in scope for currencies and payment at the end of October 2014. Of these 96.2% were assigned to a care cluster (82% nationally)
• there were 70 initial care cluster arrangements during October 2014. Of these, 75.7% met the red rules for that care cluster. Red rules are the must score items from the Mental Health Clustering Booklet\textsuperscript{56} that should be met when a patient is assigned to a care cluster for the first time
• 1010 care cluster episodes were assigned to people who were in scope for currencies and payment at the end of October 2014. Of these, 955 were within the review period for that care cluster. Note that each care cluster has a review period which is the maximum amount of time a person can spend in a care cluster before they are reassessed. Further details on these maximum cluster review periods can be found in the Mental Health Clustering Booklet (see earlier reference)
8.3 Improving Access to Psychological Therapies (IAPT)

The Improving Access to Psychological Therapies (IAPT) is an NHS programme offering interventions approved by the National Institute for Health and Care Excellence (NICE). Although the IAPT programme was designed to provide services for people with anxiety and depressive disorders, local IAPT services may provide treatment for other psychological disorders. The Bristol and South Gloucestershire IAPT service commenced in November 2012 after a joint procurement led by Bristol Primary Care Trust. At the time of procurement, IAPT was on the any qualified provider list of services. Any Qualified Providers for South Gloucestershire included LIFT Psychology (AWP), Connect Psychology, Group Analytic Network, Missing Link, Nilaari, Oasis-Talk, Off the Record, Penny Brohn Cancer Care, Relate Avon, Second Step, The Green House, The Harbour and Womankind. There are discrepancies in the data reported nationally to the Health and Social Care Information Centre and data obtained directly from South Gloucestershire CCG which commissions the local IAPT service. Data from both sources are presented below.

Using data from the HSCIC IAPT database there were 2480 referrals received for IAPT in South Gloucestershire in 2013/2014. 1695 (68.4%) referrals entered treatment; 295 (17.4%) of referrals entering treatment finished a course of treatment. For 97% of referrals entering treatment in South Gloucestershire, no International Classification of Disease (ICD-10) codes of provisional diagnoses were provided. Nationally, there were 1,118,990 referrals for IAPT of which 709,117(63.4%) entered treatment; 364,343 (32.6%) of those entering treatment finished a course of treatment. Provisional ICD-10 diagnoses codes were not provided for 41.5% of referrals entering treatment. Figure 8.8 shows the time between referral and first treatment appointment for the 1695 referrals entering treatment.

Figure 8.8
Of the 295 referrals in South Gloucestershire with a finished course of treatment in 2013/2014 (HSCIC IAPT database), 38.6% (59.7% nationally) showed reliable improvement (i.e. a reliable decrease in anxiety or depression score between the first and last measurement, and the other clinical state (depression or anxiety) either also reliably decreases or shows no reliable change). 51.9% (30.3% nationally) of these referrals showed no reliable change (i.e. the patient does not show reliable change on both anxiety and depression measures, or has reliable improvement on one whilst having reliable deterioration on the other). 7.5% (6.2% nationally) showed reliable deterioration (i.e. if the patient shows a reliable increase in anxiety or depression score between the first and last measurement, and the other clinical state (depression or anxiety) either also reliably increases or shows no reliable change. Of the 220 referrals assessed as being clinical cases at the start of treatment based on their anxiety or depression scores, 25.5% (45% nationally) recovered (i.e. they were no longer classified as clinical cases when they completed treatment as they scored below the clinical threshold on both anxiety and depression scores at the end of treatment).

Using data obtained directly from the CCG for the financial year from April 2013 to March 2014 inclusive, 5523 individuals were referred for psychological therapies. 3919 (71%) of the active referrals waited more than 28 days from referral to treatment (first therapeutic session). 4785 (86.6%) of referrals entered psychological therapies. Of the 4785 persons entering treatment 3231(67.5%) completed treatment with at least one therapeutic session and a treatment session and 1037 (21.7%) were moving to recovery. 445 people completed treatment who were not at clinical caseness at treatment commencement (where caseness is defined as the threshold at which it is appropriate to initiate treatment) and 202 individuals moved off sick pay and benefits.

Figure 8.9 shows the number of people who have entered psychological therapies from November 2012 to September 2014. The target number for South Gloucestershire is 331 per month. There has been a general increasing trend over time. Additionally, the target has been exceeded every month since September 2013.
Figure 8.10 shows the number of people who have been waiting longer than 28 days to start treatment. The highest number of people waiting >28 days for treatment was 500 in January 2014. However numbers have decreased since then. Although waiting times for groups are often minimal, waiting times for 1-1 support are longer; two thirds of referrals for IAPT are for 1-1 support. The most frequent reason for longer waiting times is patient choice.

Figure 8.10

The number of people who have completed IAPT treatment is shown in Figure 8.11. With a few exceptions (June 2013, May 2014 and September 2014), there has been a general increasing trend in the number of persons completing treatment.

Figure 8.11
The recovery rate for South Gloucestershire from November 2012 to September 2014 is shown in Figure 8.12 (note no data are shown for November 2012 as the service commenced during that month). The national recovery target of 50% was not achieved throughout the time period. At the end of September 2014 the recovery rate for the South Gloucestershire IAPT service was 32.8%.

Figure 8.12

57 Recovery rate from IAPT treatment = number moving to recovery/ (number completed minus the number not at caseness at the start)
8.4 Mental Health Act Assessments including Section 136 referrals

The Mental Health Act 1983 is the law in England and Wales that allows people with a ‘mental disorder’ to be admitted to hospital, detained and treated without their consent either for their own health and safety or to protect other people. Substantial amendments were made to the Act in 2007. People can be admitted, detained and treated under different sections of the Mental Health Act. For example, Section 2 is used to admit someone for assessment whereas Section 3 is used to admit someone for treatment; Section 4 is used if there is an emergency. The Act can also be used to place individuals on Community Treatment Orders (CTOs) following a period of compulsory treatment in hospital.

Mental Health Act Assessments

In South Gloucestershire the number of mental health act assessments more than doubled from 243 in 2011 to 563 in 2014 (a 132% increase). Outcomes from the assessments performed in April 2015 are shown in Table 8.6.

Table 8.6 Outcomes from the Mental Health Act Assessments performed in April 2015

<table>
<thead>
<tr>
<th>Outcomes of Assessment</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Treatment Order</td>
<td>1</td>
</tr>
<tr>
<td>Community Treatment Order Renewal</td>
<td>3</td>
</tr>
<tr>
<td>Guardianship meeting/Guardianship</td>
<td>2</td>
</tr>
<tr>
<td>Informal</td>
<td>3</td>
</tr>
<tr>
<td>Not Admitted</td>
<td>1</td>
</tr>
<tr>
<td>Not Detained</td>
<td>13</td>
</tr>
<tr>
<td>To be treated under Deprivation of Liberty Safeguards</td>
<td>1</td>
</tr>
<tr>
<td>Section 2</td>
<td>17</td>
</tr>
<tr>
<td>Section 3</td>
<td>11</td>
</tr>
</tbody>
</table>

Section 136 referrals

Section 136 of the Mental Health Act allows the police to remove a person with mental illness from a public place to a “Place of Safety” either for their own protection or for the protection of others for the following purposes:

- enabling the individual to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional (AMHP) and
- allowing necessary arrangements to be made for the individual’s care or treatment

Currently, the maximum length of detention is 72 hours. Following a Section 136 referral people may then be placed on Section 2 or 3 of the Mental Health Act, admitted to hospital as an informal.
or voluntary patient, or discharged.

In 2013, the multi-agency mental health act group chaired by the Royal College of Psychiatrists examined best practice with regard to Section 136 and made the following recommendations:

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 that it is used for conveyance unless the person is too disturbed
3. The AMHP and doctor approved under Section 12(2) of the Mental Health Act should attend within 3 h 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

In South Gloucestershire there were 32 Section 136 admissions from the 3rd February 2014 to the 29th April 2014 of which:

- Twenty (62.5%) were male and twelve (37.5%) were female
- Most people (84.4%) were of White British ethnicity
- More than half (56.3%) were aged 26 to 45 years. Four were aged 18 to 25 years, 8 were aged 46 to 64 years and two persons were 65 years or older
- All persons were transferred to the place of safety via police vehicle
- Twenty six persons had one or more repeat admissions; the majority (22) had one repeat admission
- Twenty three (71.9%) admissions were out of hours (between 6 pm and 9 am); nine (28.1%) of admissions were in hours (9 am to 6 pm)
- Six individuals (18.8%) waited 0-4 hours for assessment, seven (21.9%) waited 4-9 hours, four (12.5%) waited 9-12 hours and 15 (46.9%) waited for more than 12 hours until assessment
- Fourteen (43.8%) individuals had no mental health follow up with no letter sent, eight (12.5%) were discharged to the AWP team, four (12.5%) were detained under section 2 for assessment and treatment in hospital, three (9.4%) had no mental health follow up with a letter to the GP and two (6.3%) were admitted informally
- Seventeen individuals (53.1%) stayed longer than 12 hours, six (18.8%) stayed 4-9 hours, 5 (15.6%) stayed 9-12 hours and four(12.5%) stayed less than 4 hours
- Intoxication was the main reason for admissions over 9 hours (36.4% of these admissions)

Using older data from 2012/2013:

- there has been a decrease in Section 136 detentions from 71 in July 2012 to 23 in November 2013
- the most common reason for detention over 10 hours was due to Emergency Duty Team delay followed by delay after assessment and under the influence of drink or drugs
the most common reasons why someone would be taken to custody and not hospital were due to being uncooperative/aggressive and because the hospital was full
the average time from Approved Mental Health Practitioner (AMHP) requested to assessment was 5hrs and 52 minutes

58 A Place of Safety can be a hospital, police station or some other designated place.

### 8.5 Spend on Mental Health

Data from the Community Mental health Profile show that the allocated average spend per head for mental health in South Gloucestershire in 2011/2012 was £147 compared to the English average of £183. This was estimated as the worst spend in England. Using newer 2014 data the mental health spend in South Gloucestershire was £153 per head, compared with a national spend of £210 per head.

The Spend and Outcome tool (SPOT)\(^5\) gives an overview of spend and outcomes across key areas of business. It includes a large number of measures of spend and outcomes from several different frameworks. Four categories are described:

1. Lower spend, better outcome
2. Higher spend, better outcome
3. Lower spend, worse outcome
4. Higher spend, worse outcome

Information from the SPOT tool is provided below for South Gloucestershire Local Authority and South Gloucestershire CCG.

**South Gloucestershire Local Authority**

The total programme spend was £1329 per head; £24 per head was spent on the Public Health Programme which was in the lower spend, better outcome category. Within the Public Health Programme, spend on Smoking, Drugs and Mental Public Health was also located in the lower spend, better outcome category.

**South Gloucestershire CCG**

The total programme spend per head was £1867 per head; the mental health programme was £153 per head, compared to a national spend of £210 per head (see Table 8.7)

**Table 8.7 Top 10 areas by spend per head for South Gloucestershire CCG**

<table>
<thead>
<tr>
<th>Programme</th>
<th>Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

86/118
Looking at the expenditure on mental health compared to clinical outcomes, mental health (MH) had lower spend but better outcomes (see Figure 8.13)

Figure 8.13

8.6 Prescribing Data

The prescribing of mental health medication in South Gloucestershire compared with nationally is reported in this section. Based on the British National Formulary, the main categories of mental health drugs are:

- Hypnotics and Anxiolytics. Hypnotics are used to treat insomnia. Anxiolytics are used to treat anxiety states. The most commonly used anxiolytics and hypnotics are benzodiazepines. These medicines can cause dependence (psychological and physical) and tolerance
- Drugs used in psychoses and related disorders. These include antipsychotic drugs (used to treat schizophrenia), antipsychotic depot injections (long acting medicines which tend to be used when compliance with oral treatment is unreliable) and drugs used for mania and hypomania (for example treatment of bipolar disorder)
- Antidepressant drugs (for treating moderate to severe depression)
- CNS stimulants and drugs used for Attention Deficit Hyperactivity Disorder (ADHD). Usually CNS stimulants are prescribed for children with severe and persistent symptoms of ADHD. However, treatment of ADHD often needs to be continued into adolescence and may need to be continued into adulthood
- Drugs for dementia (data are not reported as Dementia is outside the scope of this needs assessment)

To enable comparison of local data with national data, the Age, Sex and Temporary Resident Originated Prescribing Unit (ASTRO-PU) is used. This is a nationally developed indicator for weighted prescribing volume based on individual GP practice population adjusted for patients’ age, sex and temporary residents. Data were obtained from the Commissioning Support Unit. The data source was ePACT.net.

**Antidepressants**

From Q2 2009/2010 to Q4 2013/2014 there have been increases in the numbers of antidepressant items per ASTRO-PU in South Gloucestershire and England (Figure 8.14). By Q4 2013/2014 antidepressant costs in South Gloucestershire and England were higher than in Q2 2009/2010.

Figure 8.14
Anxiolytics

Figure 8.16 shows the number of items per ASTRO-PU of anxiolytics for South Gloucestershire and England. Anxiolytic prescribing has remained stable over the time period for both South Gloucestershire and England. The cost of prescribing Anxiolytics has decreased over time in both South Gloucestershire and England (Figure 8.17)

Figure 8.16
Antipsychotics

The number of antipsychotic items per ASTRO-PU prescribed from Q2 2009/2010 to Q4 2013/2014 is shown in Figure 8.18. Prescribing in England has remained stable, however prescribing in South Gloucestershire declined sharply from Q4 2010/2011 to Q1 2011/2012 remaining relatively constant until Q4 2013/2014. In South Gloucestershire and England the costs of antipsychotics remained stable from Q2 2009/2010 until Q2 2011/2012, declined from Q2 2011/2012 to Q1 2012/2013, remaining steady until Q4 2013/2014 (Figure 8.19).
Figure 8.19

Hypnotics

For hypnotics the number of items per ASTRO-PU has shown a small decline over time for both England and South Gloucestershire (Figure 8.20). The number of items per ASTRO-PU for South Gloucestershire is less than England for the entire time period (Figure 8.20). The costs of hypnotics increased markedly from Q2 2012/2013 to Q1 2013/2014.

Figure 8.20
Drugs used for hypomania and mania

For these drugs the number of items per ASTRO-PU has remained more or less steady for England and South Gloucestershire although the number of items prescribed in South Gloucestershire was less than England for the entire time period (Figure 8.22). The costs of drugs used in mania and hypomania increased over time in both England and South Gloucestershire (Figure 8.23).

Figure 8.22
For CNS stimulants and drugs used for ADHD there was an increase in the number of items per ASTRO-PU prescribed in South Gloucestershire and England (Figure 8.24). Increases in costs of these items were also seen over the entire time period (Figure 8.25).
9. What do local people think? Perspectives from service users and local community and voluntary organisations

This section summarises service users’ perspectives on mental health services and includes findings from a local Healthwatch survey in addition to findings from interviews and focus groups with mental health service users and carers carried out in 2014. Views from some voluntary and community organisations are included from a service mapping event held in January 2014, in
addition to a mental health services resource list for South Gloucestershire.

9.1 Healthwatch Survey

A mental health and emotional wellbeing survey of mental health service users in South Gloucestershire was carried out by Healthwatch over eight weeks from June to July 2014. Ninety-three responses were received. Demographic data were as follows:

- Forty eight respondents (51.6%) answered the question “How old are you?” Fourteen people (29%) were aged 45-54 years, eight (16.8%) were aged 25-34 years or over 65 years, seven (14.5%) were aged 35-44 years or 55-64 years, three (6.5%) were aged 18-24 years and one person was aged 17 years or under
- Forty seven respondents (50.5%) answered the question “What is your gender?” Fifteen (32%) were male and 31 (66%) were female. One person replied as “Other-transgender”
- Thirty eight respondents answered the question “What is your ethnicity?” All 37 identified with White British, British, White or English; one respondent was Pakistani
- Of those respondents who provided information on the first part of their post code, most (97.7%) were from South Gloucestershire. Only two provided a Bristol postcode

Main quantitative findings from the survey were as follows (the response rate for each question is also included):

- 50.1% of respondents had not received support from voluntary or community groups (61.3% response rate)
- 50.9% of respondents had accessed mental health services in the last 12 months; of these 22.6% had accessed mental health services in the last month (60.2% response rate)
- 57.5% of respondents did not feel that they had contact with mental health services often enough for their needs, 23.7% said yes to some extent they had contact with mental health often enough for their needs and 12.8% said yes definitely that their contact with mental health was sufficient (53.8% response rate)
- The person in charge of organising mental health care and services was a GP in 54% of respondents, wellbeing therapies staff in 16%, a community psychiatric nurse in 4% and social worker in 3% (57% response rate)
- 80% of respondents knew how to contact this person if they had a concern about their care (52.4% response rate)
- 59.5% of respondents thought that this person organised care very well (13.5%) or quite well (46%), 35.2% reported that the person organised care not very well and 5.4% reported that the care organised was not at all well (49.5% response rate)
- 58.8% of respondents received support from a family, friend or other community member (53.8% response rate)
- 56.3% of respondents had their mental health needs reviewed by a GP (51.6%). In terms of whether they thought their mental health needs had been met, on a scale of 1-5, 1 being not at all and 5 being very much so, 65.8% gave a response that was 3 or more on the scale (40.9% response rate)
- 33% of respondents experienced an emergency mental health assessment during or after experiencing a mental health crisis (48.4% response rate). In terms of whether they thought
this assessment met their needs, on a scale of 1-5, 1 being not at all and 5 being very much so, 63% gave a response that was 3 or more on the scale (20.4% response rate)

- 31.2% of respondents received support from talking therapies (including cognitive behavioural therapy), 38.7% of respondents had received medication, 11.8% received support from peer support groups, 6.5% received benefits advice, 5.4% received housing advice, 4.3% received support from faith groups, 4.3% received support from other community organisations, 2.2% received family therapy and 1.1% received debt advice (note that respondents could select all options that applied so the total is >100%)

- In terms of the quality of the early intervention services received, on a scale of 1-5, 1 being extremely bad, 5 being extremely good, 81.5% gave a response that was 3 or more on the scale (40.9% response rate)

- 41% of respondents had used the South Gloucestershire Wellbeing Therapies Service (47.3% response rate). 42% of respondents self-referred into the service, 59% were referred by a GP (20.4% response rate)

- 69% of respondents who used the Wellbeing Therapies support felt it made a difference (17.2% response rate), 76.5% said they would use the service again (18.3% response rate)

- 61.5% of respondents did not have help from the primary care mental health liaison service (47.3% response rate). Of those who had help from the service, in terms of whether their needs were met, 1 being not at all, 5 being very much so, 61.5% gave a response that was 3 or more on the scale (14% response rate)

- 80% of respondents had not used recovery services (48.4% response rate)

- 17% of respondents had been to an Emergency Department as a result of self-harm or an intentional rather than accidental overdose (50.5% response rate). Of those who used these services, in terms of whether their needs were met, 60% gave a response that was 3 or more on the scale (10.8% response rate). 27% of people who attended an Emergency Department received a psychosocial assessment (16.1% response rate)

- 90% of respondents had never been detained under Section 136 of the Mental Health Act (53.8% response rate)

- 82% of respondents did not have a learning disability or learning difficulty (53.8% response rate)

- 74% of respondents had not been in hospital for their mental health (49.5% response rate). Of those who had used these services, in terms of their needs being met, 1 being not at all, 5 being very much so, 53.8% gave a response that was 3 or more on the scale (14% response rate)

9.2 Service user interviews

Twenty-one service users were interviewed (15 women and 6 men) with an age range from 33 to 76 years. Nineteen of the participants were white British, one was white Irish and 1 was British Pakistani. One person was currently ‘sofa surfing’. Anxiety and depression were the most common mental health conditions cited by service users although schizophrenia was also frequently identified as an underlying mental illness. Other mental health conditions that were mentioned included psychosis, bipolar disorder, paranoia, Obsessive Compulsive Disorder and Asperger’s Syndrome. Broad areas were explored during the interview (see Appendix F for the interview questionnaire). The findings from the qualitative interviews are summarised as key themes below:
Triggers for a mental health episode

Relationship breakdown and financial hardship/job loss were the two most commonly cited triggers for a mental health episode. Other triggers included illness and accidents, bullying at school and at work, being a victim of antisocial behaviour and alcohol misuse.

Factors involved in good mental health/Local factors which promote recovery

The general principle of structured time was mentioned by a number of people as key to good mental health and sustained recovery from mental illness. A number of organisations and activities were identified which helped service users to constructively structure their time. These included the following:

- The Church and Church related activities. Five interviewees spoke about the crucial role played by these organisations
- Exercise including programmes such as Exercise on Prescription, Walking for Health and Exercise SG
- Volunteering with mental health organisations as well as external to mental health e.g. animal care, conservation
- Important role of the community and voluntary sector
- Involvement in other activities such as a creative writing group, allotment programme, choir
- Peer support programmes. These were mentioned in positive terms both by people who run these groups and people who attend
- One to one support workers and other support workers including volunteer befrienders, support workers from voluntary sector organisations, social workers and Community Psychiatric Nurses (CPNs). Service users highlighted the importance of having one trusted person to work with over time. Support workers were seen to offer a mixture of emotional and practical support including signposting to other opportunities and advocacy
- Improving Access to Psychological Therapies. The LIFT programme was identified in positive terms by some interviewees
- Family and friends. They were identified as key supporters by five interviewees

“Exercise SG has been great. I am different person after exercise” (MH service user)

“Faith groups have been very helpful to her. This is as a safe (emotionally) place to meet but also for the consistency of the support workers/volunteers in terms of building a relationship over time.” (MH carer)

Support received by service users- what doesn’t work

Although service users identified a number of positive factors which promoted recovery, they expressed concerns regarding the following:

- Duration of provided support. Service users had difficulty with obtaining regular ongoing support and felt that many services were available for too short a period which led to a cycle of crisis, support, crisis. Many interviewees believed that services were not sustained for long enough and that they were not fully included in the plans and timetables for the withdrawal of services
- Managing multiple services. Many interviewees felt that they had to constantly retell their
story to each of the services. This was particularly problematic if they had no one such as a support worker or family member to assist

- Services for people with Asperger’s syndrome. Some interviewees highlighted problems with these services. They felt that there was a lack of specialist knowledge about the condition and the specific support that people with Asperger’s needed to live productively
- GP support. Although many interviewees referred to the excellent support provided by their GPs, the quality of GP support was not consistent. Some interviewees felt that GPs lacked knowledge about local services and tended to only offer medication. Some GPs (and GP receptionists) were perceived to be ‘unsympathetic’ towards mental health in general. One interviewee reporting being told by a GP to ‘pull himself together’ while another GP ‘did not believe Asperger’s existed as a condition’
- Improving Access to Psychological Therapies. Although LIFT was viewed positively by a number of interviewees, others were critical of the fact that only Cognitive Behavioural Therapy (CBT) was offered which they felt was not right for everyone. Many felt that there were issues with respect to long term support and signposting to other services after completion of IAPT

```
'Services worked in isolation, no one person pulling it all together.' (MH service user)
'If you present as clean and functioning you don’t get any support from AWP and some people know this and deliberately present as in crisis to get a service. If you are not in crisis you get little support.' (MH service user)
'Because she is not bothering anyone and not hurting herself she has been left alone to get on with it but over 20 years she has made no progress.' (MH carer)
'The 1 to 1 support worker was excellent because she provided the right mix of emotional and practical support as well as introducing me to lot of other networks. She structured my time and this was really important.' (MH service user)
'LIFT is good once you actually get the service although GPs can be a barrier (was not aware I could self-refer). Gap between LIFT and secondary services. Prevention and early intervention is poor.' (MH service user)
```

Crisis support

The consensus was that quick support was received in times of crisis whether that be from the police, AWP or the ambulance service. The police and ambulance service were both mentioned in positive terms for their sensitive manner and the way that they ensured other services and family members were proactively given information about the crisis event. However, there were several criticisms. Unless an individual presented as being a cause of significant danger to either themselves or others they were unlikely to get much of a tangible response. However, interviewees who had actually ended up in hospital (usually only after a serious suicide attempt) reported very good care. Those who had a level of need below this absolute crisis were left to cope without additional input. This was seen as a particular problem due to increased difficulty in obtaining support from secondary mental health services such that increasing numbers of people are left to cope with little or no support, often leading to a decline in their condition. It was felt that this approach was not very preventative and led to a cycle of crisis, followed by minimal support leading to another, often more serious crisis.

It was strongly felt by many that better GP and community follow up after crisis events were needed to break this cycle. One interviewee commented that ‘support should be early and intensive before long term patterns are set’.

```
'People with long term conditions only get short interventions not ongoing support.' (MH service user)
'After the crisis she was taken home in taxi and left with no follow up. Liaison after leaving hospital was not good with linking to community support.' (MH carer)
'You only get help if you’re off your trolley. It should not be like that. There should be more early intervention.' (MH service user)
```
Information about services

The majority of interviewees felt that GPs (and GP surgeries) were best placed for providing information about services; a large number also mentioned the library as a possible source of information about services. There was a strongly expressed view that hard copies were needed both as a preferred way to get information and because many people did not have easy access to the internet. None of the interviewees had heard of Wellaware (www.wellaware.org.uk), a free information and signposting service for people in this region on health and wellbeing services. The importance of proactively sharing information with people who may be isolated in their homes was also raised.

A number of suggestions for disseminating information widely were put forward including; churches, sports centres, shopping centres, one stop shops, free newspapers and magazines and community notice boards. Many interviewees were unaware of how to access services provided by the voluntary and community sector.

Service user involvement and control of their support

Peer support groups were seen as a positive way for people to take control of their own care and a desire for more of these groups was expressed. While some service users were very clear that they felt well listened to, some were equally adamant they had little say in how they were supported and how the overall system worked. Interviewers believed that there was a need for service users to have more say in designing and commissioning the services they received. One interviewee felt very strongly that current service user involvement was tokenistic and the power was still entirely in the hands of professionals. Interviewees wanted to have the ability to actually influence and play a role in commissioning new services. A number of interviewees felt that the current needs assessment process had been a good opportunity to give their views. However they wanted the approach to be sustained in the longer term.

Coordination of services

As previously mentioned a number of interviewees objected to having to repeatedly re-tell their story. This situation was improved somewhat if there was support worker involvement. One service user said ‘it is my mental health and they are all playing catchy ball with it’ and added ‘they all seem to piss off after 3 weeks- no one will take responsibility’.

Improved joint working between agencies was seen as a key improvement by many interviewees. GPs were seen as the key gatekeepers to accessing other services both in terms of the Primary Care Liaison Service but also for signposting to other services such as Improving Access to
Psychological Therapies and various community based interventions. As noted above there were differences among GPs; some only offered medication while others signposted to a range of interventions.

‘GPs are too rushed to listen and often lack mental health knowledge. Service info not prominent in GP surgeries.’ (MH service user)
‘GPs are the best source of info but it all needs to be in one booklet.’ (MH service user)
‘Not heard of Wellaware but I want one central place to go for information.’ (MH service user)
‘The first GP told me to pull myself together. Subsequent GPs were much better. It is hit and miss but GPs are central to everything. 10 minutes is too short for a mental health consultation.’ (MH service user)
‘I would like more co-production of services. Commissioners should not be afraid of constructive challenge. Service users could be used in training. GP receptionists in particular have poor awareness of mental health.’ (MH service user)

Interviewees also felt that the liaison between hospitals and community services was very patchy; although some interviewees felt it was a smooth process, others felt that the liaison was non-existent.

In general, interviewees felt that good co-ordination was dependent on individual professionals instead of following a standard process which led to inconsistencies in the care received. Those who had good professional support from their GP, social workers, CPN or support worker were often able to better navigate the range of services they faced.

One interviewee put forward the idea of a mental health one stop shop to bring together information about a range of key issues such as benefits, housing employment and health care. Quality would be less reliant on the knowledge of a single professional. The mental health one stop shop could be developed as a permanent site, a mobile resource or a web based resource, or possibly even as a combination of all three.

‘I want one person to pull it all together and not having to re-tell my story over and over again. Continuity is key through transitions’ (MH service user)
‘I have seen various AWP services including the BASS worker, PCLS, a psychiatrist, I have been to LIFT and the GP and have a social worker. They all seem to pass me round the system with no one taking responsibility. It is my mental health and they are playing catchy ball with it’. (MH service user)
‘My social worker has been excellent, pulling everything together, services and support, finding things for me to do putting some structure in my life’ (MH service user)
‘In hospital care was excellent, well-co-ordinated and intensive, helping me sort finances and housing plus get involved in volunteering. The CPNs then reduced support at a good time, they had lots of skills and knowledge’. (MH service user)

BASS- Bristol Autism Service for Adults, PCLS- Primary Care Liaison Service

Stigma

Stigma was experienced in many different forms but all interviewees reported experiencing it at some level. The general public were felt to have very negative attitudes towards people with mental health issues and as a result some interviewees reported that they did not go out very much because they feared negative reactions. Interviewees felt uncomfortable telling others, in particular employers, about their history of mental ill health and felt that having a history of mental ill health had a very negative affect on an individual’s chances of getting a job.

Large organisations such as Merlin (social housing), Job Centre Plus and the Royal Mail were all mentioned in negative terms with regard to how they met the additional needs of mental health service users.
Although the positive influence of support from families was described earlier, interviewees also described facing stigma from family members. One interviewee was not trusted to be alone with a sibling’s children while another was told that s/he was ‘just lazy’. Several interviewees said they would like to be involved in a local campaign to raise awareness and tackle stigma.

| ‘I feel discriminated against by agencies including police, Merlin, JCP and British Gas. None of them have good knowledge of Mental Health or Autism’ (MH service user) |
| ‘My family just think I am lazy and don’t want to work. They don’t understand mental health at all.’ (MH service user) |
| ‘It’s hard to explain but people judge you so I just avoid contact so I am not judged.’ (MH service user) |
| ‘I feel discriminated against in the employment market and don’t know how to explain gaps in my CV.’ (MH service user) |

Use of Direct Payments

The Direct Payments scheme is a UK government Social Services initiative which allows users to directly pay for their own social care, instead of using the traditional route of having a local authority provide this care. Only three (out of 21) interviewees had heard of direct payments. Of those three, only one person was actually receiving a direct payment.

9.3 Feedback from Voluntary, Community and Social Enterprise (VCSE) organisations

In January 2014, a mental health services pathway review event was held. The feedback obtained from the VSCE organisations participating in the event is summarised below.

- VCSE organisations are struggling to sustain their current funding and services
- VCSE organisations are unable to fill gaps in provision and develop innovation due to reduced funding
- VCSE organisations would like more co-production of services to meet explicitly agreed and co-owned aims
- more volunteers are needed by voluntary sector partners
- there are opportunities for co-production and joint funding approaches
- it is difficult to obtain funding for core roles such as evaluation, workforce development, policy development and safeguarding

9.4 South Gloucestershire Mental Health Resources List

The Partnership and Commissioning Division (part of the Department for Children, Adults and Health, South Gloucestershire Council) has developed a detailed mental health resource list. The list was developed to provide residents with information about the mental health support services which are available across South Gloucestershire. It includes information on the following:

- general Services and Advice – general council services available in South Gloucestershire, advice about council tax, housing, debt, libraries and food banks
10. Conclusions- key findings and recommendations

This comprehensive needs assessment has covered mental health and wellbeing in South Gloucestershire’s adult population. The importance of mental health and wellbeing has been recognised nationally and locally. This chapter summarises the key findings from this needs assessment and makes recommendations for local action.

10.1 Key findings by chapter

Chapter 3: South Gloucestershire Population Profile

- The population age structure in South Gloucestershire is very similar to the national average with 58.4% of the population aged between 20 and 60 years and 17.5% aged 65 years and over
- The black and minority ethnic (BME) population has doubled from 2001 to 2011
- Although South Gloucestershire is a relatively affluent region, there are six localities known as Priority Neighbourhoods with high levels of deprivation and which face the greatest health inequalities: Cadbury Heath, Filton, Kingswood, Patchway, Staple Hill and West Yate/Doddington
- The population will continue to grow; the elderly population in particular will grow rapidly

Chapter 4: Determinants of Mental Health and Wellbeing

- In South Gloucestershire, vulnerable groups at high risk of mental ill health include people living in Priority Neighbourhoods, the unemployed, people with disabilities, prisoners, the Lesbian, Gay, Bisexual and Trans (LGBT) group, Gypsies and Travellers, substance misusers (including alcohol misusers), smokers, people with long term conditions and victims of domestic abuse
- There is an increasing trend in the reporting of dual diagnoses of mental illness and substance misuse in South Gloucestershire, possibly due to better integration of drug and alcohol services with mental health services, better data recording or increased confidence of
Chapter 5: Mental and emotional wellbeing in South Gloucestershire

- For self-reported wellbeing, South Gloucestershire scored marginally better than the English average. Nationally, lower levels of subjective wellbeing were seen in men, people aged over 80 years, people from Black ethnic groups, single men and women, people with poor health and people with disability.
- There are no local data regarding stigma and discrimination in relation to mental illness. However, nationally, attitudes towards integrating people with mental illness into the community have improved and more people would be willing in the future to continue a relationship, work with, live with or live nearby someone with a mental health problem. Service users’ views on stigma and discrimination are described in Chapter 9.
- 1 in 2 adult carers in South Gloucestershire have as much social contact as they would like which is better than the national average.
- Two thirds of respondents to the South Gloucestershire Viewpoint Survey indicated that they had as much social contact as they would like.
- Respondents with a disability were more than twice as likely to feel socially isolated compared with those who did not have a disability.

Chapter 6: Prevalence of mental health conditions

- The prevalence of all common mental health conditions such as anxiety and depression will increase, based on projections until 2020.
- The highest rate of mental health admissions to hospital were from GP practices located in Priority Neighbourhoods.
- With the exception of eating disorders, the prevalence of mental health conditions was higher in people from the most deprived socioeconomic quintiles and those from Priority Neighbourhoods.
- The prevalence of depression based on patients on the Quality and Outcomes Framework (QOF) depression register was higher for South Gloucestershire GP practices than nationally.
- Although South Gloucestershire had better achievement results than England for all of the QOF depression indicators, achievement results for some of the depression and mental health indicators were worse for GP practices where the majority of patients were from Priority Neighbourhoods compared with other GP practices.
- Hospital admissions for depression have increased in the last 5 years.
- The QOF prevalence of patients on the mental health register (i.e. people with schizophrenia, bipolar disorder and other psychoses) was lower in South Gloucestershire than nationally.
- South Gloucestershire patients on the QOF mental health register were less likely to have a care plan than nationally.
- There were no local data on the prevalence of people with personality disorders.
- In South Gloucestershire adults with learning difficulties were less likely to live in settled accommodation, more likely to live in non-settled accommodation and less likely to receive community or day care services from the local authority.
- Main reasons for hospital admissions for people with learning difficulties included mental illness, challenging behaviour, autism spectrum conditions, personality disorders and self-harm.
The number of people with autism spectrum conditions is expected to increase.

On average people waited 10 months before they were seen for diagnosis of an autism spectrum condition in South Gloucestershire. Waiting time was less (3 months) for people with adult attention deficit hyperactivity disorder (ADHD).

Hospital attendances and admissions for self-harm have increased in the last 10 years; young females have the highest risk. Self-poisoning was the most common method and paracetamol was the most frequently ingested poison. Most patients presenting to hospital for self-harm had a previous history of self-harm or a history of previous psychiatric treatment.

Three quarters of suicide deaths occur in males. The male suicide rate in South Gloucestershire was higher in 2010 than 2001. Although men aged 25-44 had the highest proportion of deaths, suicide rates were highest in older men. Suicide rates were highest in the most deprived quintile. Hanging was the most common suicide method, followed by poisoning.

Chapter 7: Findings from Public Health England’s Mental Health Intelligence Network and the Care Quality Commission’s (CQC) Thematic Data Review Report

South Gloucestershire was lower than England for the following MHDN indicators: depression QOF incidence in adults, depression and anxiety prevalence, QOF prevalence of mental health problems, spend on mental health in specialist services, percentage of secondary care funding spent on mental health, carer assessments for people who care for an adult with a mental health condition, carers of mental health clients receiving services, emergency hospital admissions per 100,000 individuals for self-harm, depression and neuroses, rate of new social care assessments per year for mental health clients and social care mental health clients receiving home care during the year.

South Gloucestershire was higher than England for the following MHDN indicators: depression QOF prevalence, percentage of mental health service users in hospital, percentage of patients with severity of depression assessed, percentage of Care Programme Approach (CPA) adults in settled accommodation, percentage of CPA adults in employment, percentage employment of people with mental health disorders.

Key findings from the CQC’s Thematic review are as follows. South Gloucestershire’s performance was worse that England for the percentage of people with severe mental illness with a comprehensive care plan in place. Compared with national figures, in South Gloucestershire there was higher bed occupancy compared to expected standards and higher numbers of emergency admissions for mood disorders, schizophrenia and self-harm than expected. More people in South Gloucestershire gave negative responses to questions about the quality and effectiveness of mental health services on group surveys.

Chapter 8: Mental Health Services

There was a 6.3% increase in caseload to the Avon and Wiltshire Mental Health Partnership (AWP) Community Mental Health Services from 2009/2010 to 2013/2014. The most frequently used services were the Memory Service, Complex Intervention and Treatment, Recovery, Psychology service and Primary Care Liaison Service.

Emergency admissions to AWP services increased in 2013/2014 and were highest in three age groups (35-44 year olds, 25-34 year olds and 75-84 year olds). Most readmissions occurred more than 1 year after the original admission.
The highest numbers of emergency admissions to AWP services were from wards in Priority Neighbourhoods.

The number of adult acute beds per 100,000 population was less for all six AWP CCGs (Swindon, Wiltshire, North Somerset, Bath and North East Somerset, Bristol, South Gloucestershire) than nationally.

Inpatient usage for adult acute services exceeded 100% bed occupancy for most of October 2014; out of trust placements were also high.

Inpatient usage for older adult acute services was at or above 100% bed occupancy for 13 days in October 2014; out of trust placements occurred throughout the month.

South Gloucestershire exceeded the national target of 7.5% for delayed transfers of care (DTOC) from August 2013 to January 2014. The number of DTOC service users in South Gloucestershire increased from January 2014 to July 2014. Most of the South Gloucestershire DTOCs occurred in AWPs Later Life service (Laurel Ward at Callington Road) where 10% of beds were closed due to concerns regarding the safety of staff and patients driven by difficulties in caring for a small but growing number of increasingly challenging patients.

In South Gloucestershire, the number of people entering the Improving Access to Psychological Therapies (IAPT) programme increased from November 2012 to September 2014. However, the number of people waiting >28 days to start treatment also increased. Although the number of people completing treatment showed an increasing trend the recovery rate has decreased over time. At the end of September 2014, the recovery rate was 32.8%. The national target of 50% was not achieved throughout the entire time period from December 2012 to September 2014.

There were a small number of Section 136 admissions from February to April 2014 (32). Most were male, of White British ethnicity and aged 26-45 years. All were transferred to the place of safety via police vehicle. The majority of admissions were out of hours. Almost 50% of patients waited >12 hours until assessment and 53% stayed longer than 12 hours overall.

The allocated average spend per head for mental health in South Gloucestershire in 2011/2012 was £147 compared to the English average of £183. This was estimated as the worst spend in England. Using newer 2014 data the mental health spend in South Gloucestershire was £153 per head, compared with a national spend of £210 per head.

According to the Spend and Outcome Tool (SPOT), South Gloucestershire had lower spend on mental health with better outcome.

There is increasing spend on antidepressants, hypnotics, CNS stimulants and drugs used for ADHD in South Gloucestershire.

Chapter 9: What do local people think? Perspectives from service users and local community and voluntary organisations

Service users’ perspectives

- Voluntary Community Social Enterprise (VSCE) organisations were felt to play an important role in promoting recovery.
- Peer support groups were mentioned in positive terms and should be better resourced.
- There were ongoing problems with the consistency and continuity of care received by mental health service users.
- Post crisis support in primary and community care needed to be improved.
There were issues around talking therapies, particularly with respect to access and referrals. The difficulty in receiving 1:1 appointments was highlighted.

Service users found it difficult to access services and be referred to services.

There was uncertainty regarding access to VSCE services. GP knowledge regarding how to access these services varied. Places suggested as good locations for dissemination of information included GP practices, churches, sports centres, shopping centres, one stop shops and libraries. Service users felt that information should be available as hard copies in addition to the internet. The important role of GPs in signposting to services was emphasised.

Service users identified a need for improved joint working across agencies and better coordination of services.

Service users wanted greater involvement and the ability to actually influence and play a role in commissioning new services. They wanted this role to be sustainable.

All service users experienced stigma and felt that the general public had negative attitudes towards people with mental illness. They felt discomfort in telling employers about their history of mental illness. In some instances family members and GPs were unsupportive and dismissive of their mental health issues.

Service users were generally unaware of the Direct Payment Scheme.

Perspectives from VSCE organisations

VSCE organisations identified problems in sustaining their current funding and services. It was difficult to obtain funding for core roles such as evaluation, workforce development, policy development and safeguarding. In addition reduced funding impacted on innovation.

VSCE organisations would like more co-production of services to meet explicitly agreed and co-owned aims.

10.2 Recommendations

The following recommendations should help guide the development of the local mental health strategy and action plan. It is important to note that the World Health Organisation (WHO) defines Public Mental Health as consisting of (i) mental health promotion, which is primarily concerned with the determinants of mental health (ii) mental illness prevention, which is concerned with the causes of disease and (iii) treatment and rehabilitation, which is concerned with medical and non-medical interventions that can lead to recovery and rehabilitation. Too often, mental health strategies focus solely on treatment and rehabilitation, such that opportunities for mental health promotion and mental illness prevention are missed. Our recommendations cover all three areas in addition to presenting overarching themes to enable a more integrated patient/service user experience:

Mental Health Promotion

- Raise whole population mental health awareness and reduce stigma
- Increase involvement of local people with lived experience of mental ill health in awareness campaigns
- Reduce institutional stigma in local organisations and GP practices, for example by providing workforce training on mental health, promoting mental health campaigns and encourage workplaces to sign up to a Mental health charter
• Work with employers and workplaces to support current and potential employees who are experiencing mental ill health
• Work with schools and colleges to raise awareness of mental health issues
• Develop a cohort of local mental health champions in senior public roles
• Promote individual resilience, self-management and positive mental health including the 5 ways to wellbeing
• Increase feedback opportunities for service users, carers and parents on local services and ensure that feedback is acted on
• Improve signposting to mental health and wellbeing services
• Work in partnership to influence wider determinants of mental health and wellbeing e.g. housing, transport, schools and colleges

Mental Illness Prevention

• Improve access to information on currently existing mental health and wellbeing services
• Focus on co-production of services with service users, carers and the VCSE sector
• Proactively work with communities likely to be at higher risk of mental ill health in South Gloucestershire including people living in Priority Neighbourhoods (defined in Chapter 3), the unemployed, people with disabilities, prisoners, Gypsies and Travellers, substance misusers (including alcohol misusers), smokers, people with long term conditions, people in the Lesbian, Gay, Bisexual or Trans (LGBT) community and victims of domestic abuse
• Promote joined up working so that mental health is included in strategies and action plans for the previously listed vulnerable groups
• Develop a more co-ordinated approach to commissioning services which impact on mental health and wellbeing at all tiers and levels of the care pathway. Ensure this is joined up and easily accessible to the public and health care professionals
• Support VSCE organisations to build and sustain capacity in mental health and wellbeing services building on an asset based approach
• Support mental health service users to access preventative services such as exercise on prescription, smoking cessation and substance misuse services
• Support the development of more peer support groups within the community
• Develop a suicide prevention strategy

Treatment and Rehabilitation

• Improve the co-ordination of care between agencies supporting individuals with complex needs with improved information sharing and better communication with carers
• Deliver a more effective IAPT programme, reduce waiting times and increase recovery rates
• Review the effectiveness of services for people with learning difficulties including autism spectrum services and those with ADHD
• Improve support for people who are post crisis to prevent further crises
• Examine the provision of care in AWP services with an aim to reduce delayed transfers of care in AWP services and address the high bed occupancy levels for adults and older adult AWP services
• Reduce delays in assessment for Section 136 referrals and minimise the use of police vehicles in transfers to the place of safety. A review of Section 136 referrals should be undertaken to compare performance with quality standards
• Continue to support the self-harm register and work in partnership to reduce hospital admissions for self-harm
• Undertake further work to understand the reasons underlying the increasing spend on antidepressants, hypnotics, CNS stimulants and drugs used for ADHD in South Gloucestershire

Overarching themes

These should include:

• Communication
• Workforce development
• Service user and carer involvement
• Agreed and jointly owned local indicator set to measure ongoing impact of the mental health strategy and action plan

Appendix A – Closing the Gap: Priorities for essential change in mental health

Closing the Gap: priorities for essential change in mental health

Increasing access to mental health services

1. High-quality mental health services with an emphasis on recovery should be commissioned in all areas, reflecting local need
2. We will lead an information revolution around mental health and wellbeing
3. We will, for the first time, establish clear waiting time limits for mental health services
4. We will tackle inequalities around access to mental health services
5. Over 900,000 people will benefit from psychological therapies every year
6. There will be improved access to psychological therapies for children and young people across the whole of England
7. The most effective services will get the most funding
8. Adults will be given the right to make choices about the mental health care they receive
9. We will radically reduce the use of all restrictive practices and take action to end the use of high risk restraint, including face down restraint and holding people on the floor
10. We will use the Friends and Family Test to allow all patients to comment on their experience of mental health services – including children’s mental health services
11. Poor quality services will be identified sooner and action taken to improve care and where necessary protect patients
12. Carers will be better supported and more closely involved in decisions about mental health service provision

Integrating physical and mental health care

13. Mental health care and physical health care will be better integrated at every level
14. We will change the way frontline health services respond to self-harm
15. No-one experiencing a mental health crisis should ever be turned away from services

Starting early to promote mental wellbeing and prevent mental health problems

16. We will offer better support to new mothers to minimise the risks and impacts of postnatal depression
17. Schools will be supported to identify mental health problems sooner
18. We will end the cliff-edge of lost support as children and young people with mental health needs reach the age of 18

Improving the quality of life of people with mental health problems

19. People with mental health problems will live healthier lives and longer lives
20. More people with mental health problems will live in homes that support recovery
21. We will introduce a national liaison and diversion service so that the mental health needs of offenders will be identified sooner and appropriate support provided
22. Anyone with a mental health problem who is a victim of crime will be offered enhanced support
23. We will support employers to help more people with mental health problems to remain in or move into work
24. We will develop new approaches to help people with mental health problems who are unemployed to move into work and seek to support them during periods when they are unable to work
25. We will stamp out discrimination around mental health

Appendix B – Summary of demographic information for South Gloucestershire residents admitted with mental health conditions 2009/2010 to 2013/2014 inclusive

<table>
<thead>
<tr>
<th>Mental Health Condition</th>
<th>Age and sex pattern</th>
<th>Social Pattern</th>
<th>Priority Neighbourhoods (PN)</th>
<th>Time trends</th>
<th>Repeat admissions</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar disorder</td>
<td>No obvious pattern</td>
<td>Excess seen in most deprived quintile</td>
<td>Statistically significant excess in PNs</td>
<td>Increasing trend</td>
<td>78% had 1 admission, 5% had &gt;3 admissions, Maximum per person 15 admissions</td>
<td>No patients of black ethnicity</td>
</tr>
<tr>
<td>Depression</td>
<td>More prevalent in women, usually peak in 40s, later in men</td>
<td>Strong social pattern, Highest in most deprived quintiles</td>
<td>Statistically significant excess in PNs</td>
<td>Increasing trend</td>
<td>81% had 1 admission, 4% had &gt;3 admissions, Maximum per person 26 admissions</td>
<td>22 (0.8%) of patients of black ethnicity 5 black mixed</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>Most prevalent in young women</td>
<td>Excess seen in the second most affluent quintile</td>
<td>No difference between PNs and non PNs</td>
<td>Increasing trend</td>
<td>71% had 1 admission, 9% had &gt;3 admissions, Maximum per person 26 admissions</td>
<td>3 patients of mixed black ethnicity</td>
</tr>
<tr>
<td>General Anxiety Disorder</td>
<td>More prevalent in women and increasing age</td>
<td>Excess seen in most deprived quintiles</td>
<td>Statistically significant excess in PNs</td>
<td>Increasing trend</td>
<td>80% had 1 admission, 6% had &gt;3 admissions, Maximum per person 43 admissions</td>
<td>10 patients black, 7 mixed ethnicity</td>
</tr>
</tbody>
</table>
### Mental Health Condition

<table>
<thead>
<tr>
<th>Age and sex pattern</th>
<th>Social Pattern</th>
<th>Priority Neighbourhoods (PN)</th>
<th>Time trends</th>
<th>Repeat admissions</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maria</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
<td>1 black Caribbean, 1 mixed ethnicity</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>Most prevalent in females under 50</td>
<td>Excess in most deprived quintile (quintile 4 and 5)</td>
<td>Statistically significant excess in PN</td>
<td>Increasing trend</td>
<td>3 black patients</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Small excess in men compared with women</td>
<td>Excess in most deprived quintile (quintile 5)</td>
<td>Statistically significant excess in PN</td>
<td>Stable trend</td>
<td>1 black patient (0.4%) of patients</td>
</tr>
</tbody>
</table>

### Appendix C – Summary of data from Public Health England mental health profiles V2

<table>
<thead>
<tr>
<th>Indicators</th>
<th>South Gloucestershire (SG)</th>
<th>North Somerset (NS)</th>
<th>Swindon</th>
<th>Bath and NorthEast Somerset (BANES)</th>
<th>England</th>
<th>Summary* (statistical significance based on confidence intervals reported in PHE report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Levels of mental health and illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression QOF prevalence (18+) % 2012/2013</td>
<td>6.3</td>
<td>7.0</td>
<td>6.2</td>
<td>5.6</td>
<td>5.8</td>
<td>SG higher than England and BANES but similar to Swindon. Lower than NS.</td>
</tr>
<tr>
<td>Depression QOF incidence (18+) % 2012/2013</td>
<td>0.9</td>
<td>1.0</td>
<td>1.0</td>
<td>1.1</td>
<td>1.0</td>
<td>SG lower than England.</td>
</tr>
<tr>
<td>Depression and anxiety prevalence (GP surveys) 2012/2013</td>
<td>9.8</td>
<td>11.8</td>
<td>11.5</td>
<td>10.3</td>
<td>12.0</td>
<td>SG lower than England and other comparator regions.</td>
</tr>
<tr>
<td>Mental health problem: QOF prevalence (all ages) 2012/2013</td>
<td>0.52</td>
<td>0.79</td>
<td>0.72</td>
<td>0.80</td>
<td>0.84</td>
<td>SG lower than England and other comparator regions.</td>
</tr>
<tr>
<td>% reporting a long-term mental health problem 2012/2013</td>
<td>3.2</td>
<td>4.0</td>
<td>3.4</td>
<td>3.8</td>
<td>4.5</td>
<td>SG lower than England and NS and BANES but similar to Swindon.</td>
</tr>
<tr>
<td>b. Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients with a diagnosis recorded % 2013/2014 Q1</td>
<td>8.9</td>
<td>13.7</td>
<td>19.3</td>
<td>1.2</td>
<td>17.8</td>
<td>SG lower than England and NS and Swindon but higher than BANES.</td>
</tr>
<tr>
<td>Patients assigned to a mental health cluster % 2013/2014 Q1</td>
<td>77.7</td>
<td>77.5</td>
<td>81.7</td>
<td>78.8</td>
<td>66.0</td>
<td>SG higher than England.</td>
</tr>
<tr>
<td>Patients with a comprehensive care plan % 2012/2013</td>
<td>84.5</td>
<td>84.6</td>
<td>82.7</td>
<td>91.3</td>
<td>87.3</td>
<td>SG is similar to England and NS, lower than BANES but higher than Swindon.</td>
</tr>
<tr>
<td>Patients with severity of depression assessed % 2012/2013</td>
<td>92.7</td>
<td>93.8</td>
<td>92.7</td>
<td>95.1</td>
<td>90.6</td>
<td>SG is higher than England but similar to the other comparator LAs.</td>
</tr>
<tr>
<td>Antidepressant prescribing (ADQs/STAR-PU) 2012/2013</td>
<td>5.7</td>
<td>6.3</td>
<td>6.5</td>
<td>5.7</td>
<td>6.0</td>
<td>SG is lower than England, NS and Swindon but similar to BANES.</td>
</tr>
<tr>
<td>People with a mental illness in residential or nursing care per 100,000 population 2012/2013</td>
<td>15.4</td>
<td>50.9</td>
<td>32.9</td>
<td>27.1</td>
<td>32.7</td>
<td>BANES and Swindon are similar to England. SG is lower than England, NS, Swindon and BANES. NS is statistically significantly higher than England.</td>
</tr>
<tr>
<td>Service users in hospital % mental health service users who were inpatients in a psychiatric hospital 2013/2014 Q1</td>
<td>4.0</td>
<td>2.1</td>
<td>2.3</td>
<td>2.7</td>
<td>2.4</td>
<td>SG is higher than England, NS, Swindon and BANES.</td>
</tr>
<tr>
<td>Detentions under the Mental Health Act per 100,000 population 2013/2014 Q1</td>
<td>13.9</td>
<td>28.5</td>
<td>12.5</td>
<td>28.5</td>
<td>15.5</td>
<td>SG was similar to Swindon and England but lower than NS and BANES which were statistically significantly higher than England.</td>
</tr>
<tr>
<td>Attendances at A&amp;E for a psychiatric disorder per 100,000 population 2012/2013</td>
<td>3.0</td>
<td>16.6</td>
<td>8.3</td>
<td>12.9</td>
<td>243.5</td>
<td>SG is statistically significantly lower than other comparator regions and England.</td>
</tr>
<tr>
<td>Number of bed days per 100,000 population 2013/2014 Q1</td>
<td>2233</td>
<td>3046</td>
<td>3049</td>
<td>3461</td>
<td>4886</td>
<td>SG is statistically significantly lower than other comparator regions and England.</td>
</tr>
<tr>
<td>People in contact with mental health services per 100,000 population 2013/2014 Q1</td>
<td>781</td>
<td>1556</td>
<td>1442</td>
<td>1137</td>
<td>2176</td>
<td>SG is statistically significantly lower than other comparator regions and England.</td>
</tr>
<tr>
<td>Careers of mental health clients receiving assessments per 100,000 population 2012/2013</td>
<td>12.0</td>
<td>215.3</td>
<td>109.9</td>
<td>52.2</td>
<td>68.5</td>
<td>SG is statistically significantly lower than other comparator regions and England.</td>
</tr>
<tr>
<td>Spend (Ex) on mental health in specialist services rate per 100,000 population 2012/2013</td>
<td>15,510</td>
<td>20,599</td>
<td>21,610</td>
<td>22,039</td>
<td>28,756</td>
<td>SG is lower than other comparator regions and England.</td>
</tr>
<tr>
<td>% secondary care funding spent on mental health 2011/2012</td>
<td>8.1</td>
<td>7.8</td>
<td>11.8</td>
<td>10.6</td>
<td>12.1</td>
<td>SG is similar to NS but lower than Swindon, BANES and England.</td>
</tr>
<tr>
<td>c. Outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People in Care Programme Approach (CPA) per 100,000 population 2013/2014 Q1</td>
<td>208</td>
<td>564</td>
<td>413</td>
<td>494</td>
<td>531</td>
<td>SG is statistically significantly lower than other comparator regions and England.</td>
</tr>
<tr>
<td>% CPA adults in settled accommodation 2013/2014 Q1</td>
<td>70.7</td>
<td>64.3</td>
<td>73.9</td>
<td>65.7</td>
<td>61.0</td>
<td>SG is statistically significantly higher than other comparator regions and England.</td>
</tr>
<tr>
<td>% CPA adults in employment 2013/2014 Q1</td>
<td>18.0</td>
<td>7.1</td>
<td>10.7</td>
<td>14.3</td>
<td>7.0</td>
<td>SG is similar to BANES but higher than NS, Swindon and England.</td>
</tr>
</tbody>
</table>
Emergency admissions for self-harm per 100,000 population 2012/2013
140.6 168.0 308.0 298.1 191.0
SG is lower than England and other comparator regions.

Suicide rate per 100,000 2010/2012
7.0 12.6 8.8 8.7 8.5
SG is statistically significantly similar to England, Swindon and BANES but lower than NS which is significantly higher than England.

Hospitals admissions for unintentional and deliberate injuries, ages 0-24, per 100,000 population 2012/2013
100.1 90.2 115.2 126.8 116
SG is similar to NS but lower than Swindon. BANES and England (BANES is significantly higher than England).

Rate of recovery for IAPT treatment % 2012/2013
38.4 37.6 60.0 47.0 46.0
SG is similar to NS but significantly lower than Swindon, BANES and England.

Common Mental Health Disorders Profile

a. Services
Admissions for depression: directly standardised rate for hospital admissions for unipolar depressive disorders per 100,000 aged 15 and over 2009-10/2011-12
8.7 9.0 27.0 10.9 32.1
SG is similar to NS and BANES but lower than Swindon and England.

Emergency admissions for neuroses: indirectly age and sex standardised rate per 100,000 population 2011/2012
10.6 4.5 12.4 9.1 16.8
SG is lower than Swindon and England but higher than NS and BANES.

b. Quality and Outcomes
Satisfaction with social care support: % of service users extremely satisfied or very satisfied with their care and support 2012/2013
65.9 65.0 63.1 63.2 64.1
SG is statistically significantly higher than all comparator regions and England.

Satisfaction with social care protection: % service users who say services have made them feel safe and secure 2012/2013
78.7 87.5 77.9 78.5 78.1
SG is similar to Swindon, BANES and England but lower than NS (which is statistically significantly higher than England).

Employment of people with mental health disorders: % of those with a disorder in employment 2014 Q2
50.0 41.5 56.7 30.5 36.3
SG is higher than NS, BANES and England but lower than Swindon.

Gap in employment: % gap between employment rate of those with mental health disorders and overall population 2014 Q2
29.6 35.9 20.9 42.6 36.8
SG is lower than England, NS and BANES but higher than England.

Mortality from suicide and injury undetermined: standardised rate per 100,000 2011/2013
7.6 9.6 9.3 10.2 8.8
SG is lower than all comparator regions and England.

Severe Mental Illness Profile

a. Services
Social care mental health clients receiving services during the year: rate per 100,000 population 2012/2013
274 89 525 462 404
SG is lower than Swindon, BANES and England but higher than NS.

New social care assessments per year for mental health clients aged 18-64: rate per 100,000 population 2012/2013
83 1032 1021 936 257
SG is statistically significantly lower than England and all regions (NS, Swindon and BANES are statistically significantly higher than England).

Social care mental health clients in residential or nursing care during the year aged 18 to 64: rate per 100,000 population 2012/2013
15.4 50.9 33.5 27.1 32.7
SG is lower than all comparator regions and England (Swindon and BANES are similar to England although NS is significantly higher).

Social care mental health clients aged 18-64 years receiving home care during the year: rate per 100,000 population 2012/2013
12.3 17.0 26.1 85.9 47.6
SG is lower than all comparator regions and England (with the exception of BANES which is higher than England, the other regions are lower).

Social care mental health clients aged 18-64 years receiving day care or day services: rate per 100,000 population 2012/2013
73.8 12.7 108.0 18.1 37.4
SG is higher than NS, BANES and England but lower than Swindon.

Carer assessments: people who care for an adult with a mental health condition and were assessed during the year per 100,000 population 2012/2013
12.0 215.3 112.4 52.2 68.2
SG is lower than all comparator regions and England (NS and Swindon are significantly higher than England).

Schizophrenia emergency admissions: rate per 100,000 population 2009-10/2011-12
9.0 23.0 12.0 17.0 57.0
SG is lower than all comparator regions and England.

b. Quality and Outcomes
COPA adults in employment: % of people aged 18-69 on CPA in employment 2012/2013
22.0 12.9 12.5 16.0 8.8
SG is higher than all comparator regions and England.

COPA adults in settled accommodation: % of people aged 18-69 on CPA in settled accommodation 2012/2013
78.9 67.5 76.8 67.9 58.5
SG is similar to Swindon but higher than NS, BANES and England.

Self-directed payments: % social care mental health clients receiving direct payments or have a personal budget 2012/2013
9.3 18.2 NA 8.4 8.1
SG is similar to BANES and England but lower than NS.

Cases of mental health clients receiving services: cases receiving services or advice or information as % of mental health clients receiving community services 2012/2013
5.8 100 22.1 11.6 19.8
SG is statistically significantly lower than England and other comparator regions.

Mortality from suicide and injury undetermined: standardised rate per 100,000 2011/2013
7.6 9.6 9.3 10.2 8.8
SG is lower than other comparator regions and England.

Excess under 75 mortality in adults with serious mental illness: standardised mortality ratio 2012/2013
372.6 379.2 495.2 350.0 347.2
SG is statistically similar to England, NS and BANES. Swindon is statistically significantly higher than England.

Premature (<75) mortality in adults with serious mental illness: rate per 100,000 population 2012/2013
1535 1703 1726 1329 1319
SG is statistically significantly similar to England, BANES and NS. Swindon is statistically significantly higher than England.

Emergency hospital admissions for intentional self-harm: directly age- and sex-standardised rate
141.9 167.8 315.6 296.4 188
SG is statistically significantly lower than England, Swindon and BANES but similar to NS.

Co-existing substance misuse and mental health issues profile

a. Treatment demand
Number in treatment at specialist drug misuse services 2013/2014
737 710 642 787 193,252
Not comparable.

Number in treatment at specialist alcohol misuse services 2013/2014
155 197 378 343 89,265
Not comparable.

Numbers in stop smoking services 2013/2014
2278 2331 2029 1434 596,337
Not comparable.

Concurrent contact with mental health services and substance misuse services for drug misuse - % 2013/2014
12.0 14.2 15.0 30.0 17.5
SG similar to NS but lower than other comparator regions and England.

Concurrent contact with mental health services and substance misuse services for alcohol misuse - % 2013/2014
14.3 9.7 19.4 21.6 21.2
SG is similar to NS but lower than Swindon, BANES and England.

Indicators for (i) risk and related factors and (ii) prevalence have been included in previous chapters.
Appendix D – Experience and outcomes for people experiencing a mental health crisis for South Gloucestershire Council: thematic data review report - Care Quality Commission

N.B only outlier indicators are included below i.e. where South Gloucestershire is much better or much worse than nationally. Full details can be obtained from http://www.cqc.org.uk/content/thematic-review-mental-health-crisis-care-initial-data-review

Red - statistically significantly worse performance than England
Amber - similar performance to England
Green - statistically significantly better performance than England

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Indicator Score (Red Amber Green)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of people with severe mental health illness with a comprehensive care plan in place</td>
<td>Lower than average</td>
</tr>
<tr>
<td>6 month mortality rate (from all causes) among all patients, compared between those with and without a history of previous MH contact</td>
<td>People WITH MH history higher</td>
</tr>
<tr>
<td>Proportion of 'exceptions' recorded by GPs in QOF indicators for dementia</td>
<td>Higher than average</td>
</tr>
<tr>
<td>Ratio of observed to expected number of emergency acute admissions for mood disorders</td>
<td>Higher than expected</td>
</tr>
<tr>
<td>Ratio of observed to expected number of emergency acute admissions for schizophrenia</td>
<td>Much higher than expected</td>
</tr>
<tr>
<td>Ratio of observed to expected number of emergency acute admissions for self harm</td>
<td>Higher than expected</td>
</tr>
<tr>
<td>% of people who complete treatment and are 'moving to recovery'</td>
<td>Much lower than average</td>
</tr>
<tr>
<td>Ratio of the number of referrals for talking therapies who have waited more than 28 days from referral to treatment</td>
<td>Higher than average</td>
</tr>
<tr>
<td>Indicator Name</td>
<td>Indicator Score (Red Amber Green)</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>% responses to group survey stating impression of quality and effectiveness of services in responding to people in crisis is poor or very poor</td>
<td>High proportion of responses</td>
</tr>
<tr>
<td>% responses to group survey stating support available to people experiencing a crisis out-of-hours is NOT of an equal standard to that available during regular working hours</td>
<td>High proportion of responses</td>
</tr>
<tr>
<td>% responses to group survey stating that services in local area are working A little or Not at all well together to respond to people who may be experiencing a mental health crisis</td>
<td>High proportion of responses</td>
</tr>
<tr>
<td>% responses to carer survey stating they did not feel the care received provided the right response or helped to resolve the crisis for the person cared for</td>
<td>High proportion of responses</td>
</tr>
<tr>
<td>% responses to individual survey stating they did not feel the care they received provided the right response or helped to resolve their mental health crisis</td>
<td>High proportion of responses</td>
</tr>
<tr>
<td>% of community treatment orders (CTOs) ended by revocation</td>
<td>Lower than average</td>
</tr>
<tr>
<td>% of emergency admissions to specialist MH provider that are NOT the main provider commissioned by the CCG</td>
<td>Data not returned</td>
</tr>
<tr>
<td>% responses who stated that the last time they called their local mental health services out of office hours they did not get the help they wanted or they could not get through to anyone</td>
<td>Higher than average</td>
</tr>
<tr>
<td>Number of deaths within 30 days of MHMDS care spell ending</td>
<td>Lower than expected</td>
</tr>
<tr>
<td>Number of spells for people aged 16-17 years on adult wards at specialist MH provider</td>
<td>Much lower than average</td>
</tr>
<tr>
<td>'Number of 'unnatural' deaths of detained patients</td>
<td>Higher than average</td>
</tr>
<tr>
<td>'Snapshot' bed occupancy levels compared to expected standard (85%)</td>
<td>Higher than expected</td>
</tr>
<tr>
<td>Are people taken into Police custody for assessment if not accepted at place of safety?</td>
<td>Positive</td>
</tr>
<tr>
<td>Collect data on the reason people turned away from the place of safety?</td>
<td>Negative</td>
</tr>
<tr>
<td>Does the provider believe there is sufficient provision of health based places of safety in the local area?</td>
<td>Positive</td>
</tr>
<tr>
<td>Has an audit been completed or planned against the requirements of the Inter- Agency Policy (IAP)?</td>
<td>Negative</td>
</tr>
<tr>
<td>How many of the following data items are collected?(Age/Sex/Ethnicity/Disability/Other protected characteristics)</td>
<td>Positive</td>
</tr>
<tr>
<td>How often did the S136 Multi-Agency Group (MAG) meet in 2013?</td>
<td>Negative</td>
</tr>
<tr>
<td>How often has someone not been able to access Place of Safety because it was occupied?</td>
<td>Negative</td>
</tr>
<tr>
<td>In 2013 has the Place of Safety been used for another purpose which impacts acceptance of patients?</td>
<td>Positive</td>
</tr>
<tr>
<td>In 2013 has the Place of Safety had to be closed because of the need to use it as an additional inpatient bed?</td>
<td>Positive</td>
</tr>
<tr>
<td>In 2013 have people been turned away from the place of safety due to staffing problems?</td>
<td>Positive</td>
</tr>
<tr>
<td>In 2013 how often have the MHA assessments in the Place of Safety taken longer than your target time to be started or completed?</td>
<td>Negative</td>
</tr>
</tbody>
</table>
What are the main reasons for delays in either carrying out or completing MHA assessments?

| Negative |

When police arrive are there ever delays in providing staffing levels in accordance with policy?

| Positive |

Appendix E – The Mental Health Minimum Database (South Gloucestershire CCG)

For South Gloucestershire CCG

- 1720 people were in contact with mental health or learning disabilities services. Of these 1630 people were in contact with mental health services and 100 people were in contact with learning disability services. These figures combined are higher than the total as a person may be in contact with both services
- 65 people (2.4%) 60 were inpatients in hospital (using a mid-year population of 266,100). Sixty five people were in hospital on wards for people with mental health needs. No one was in hospital on wards for people with learning disabilities. Nationally, 2.5% of people were inpatients in hospital
- Fifty people were subject to the Mental Health Act 1983
- 67.7% (345/510) of people aged 18-69 who were being treated under the Care Programme Approach, were recorded as being in settled accommodation, while 18.6% (95/510) were recorded as being employed. National figures were 59.2% and 6.8% respectively

During October 2014

- 285 new spells of care began
- There were 25 new admissions to hospital
- Of those who were discharged from hospital during the month, 100% (10/10) received a follow up within 7 days from the same provider (74.5% nationally). This is an important suicide prevention measure

60 South Gloucestershire Council Corporate Research and Consultation Team Briefing Note: ONS 2012- based sub national population projections.

Appendix F – Interview topic guide for the Service User Consultation

Age
Gender
Ethnicity
Postcode

1. What are your existing mental health or emotional wellbeing issues?
2. What support do you get for your mental health or emotional wellbeing needs? This may
   either be from services or less formal supports in your local community and social network
3. Which elements of your support work well and why?
4. Which elements of your support don’t work well and why not?
5. What would you like to see more of from services?
6. Do services respond to your needs quickly and consistently including at times of crisis?
7. Is information about services easy to access and understand?
8. Do you feel you have a good level of involvement/control in choosing the support you
   receive?
9. Is your support well co-ordinated by the various parties involved?
10. Do you feel stigmatised or discriminated against for having a mental health need either in the
    community or by professionals and services?
11. Do you receive a direct payment and if not has this ever been discussed?

Appendix G – South Gloucestershire Mental Health Resource List (summary version)

General Services and Advice

- Council Services- Adult Social Care Customer Services, Council Tax Contact Centre,
  Housing Contact Centre, Housing Benefits
- Debt Advice- Gov.uk, North Bristol Advice Centre, South Gloucestershire Citizens Advice
  Bureau - Staple Hill, Yate, Thornbury Bradley Stoke, Cadbury Heath
- Other Community Services- Wellaware, Shopmobility (South Gloucestershire), South
  Gloucestershire Libraries, Yate and Chipping Sodbury Foodbank

Mental Health Services

- Primary Care- Sirona Care and Health
- Secondary Mental Health Services- Avon and Wiltshire Mental Health NHS Partnership Trust
  (AWP)
- Talking therapies- Talking therapies including LIFT Psychology, Beat- Beating Eating
  Disorders, CRUSE Bereavement Support Bristol and District

Local Community Support

- Live a Healthy, Active Lifestyle- Active South Gloucestershire, Exercise SG (for people who
  use mental health or wellbeing services who are unable to access mainstream activities due
  to their mental health issues), Friendship Clubs, Life Cycle UK- Bike Minded in South
  Gloucestershire, Merlin Housing Activities, Walking for Health, Smokefree South
  Gloucestershire and LIFT, Age UK and Soundstories for isolated older people
- Drugs and Alcohol- Battle against Tranquillisers, Developing Health and Independence (substance misuse services), South Gloucestershire Specialist Drug and Alcohol Service (Avon and Wiltshire Partnership Trust)
- Mental Health peer Support Groups- AWP community services, Changes Bristol, Chase and Kings Forest, Coniston Community Centre LGBT group, Friends Support Group, Guys and Dolls (for older people), Positive Steps, Rethink, Second Step, Self-injury Self Help (SISH), South Gloucestershire Chinese Association
- Growing and Nature Projects- The Tree Life Centre- the Conservation Volunteers, AWP Kingswood Allotment Project, Rethink allotment
- Music and Singing Groups- The music train at the Avon valley railway, Golden Oldies, Juice Community Choir
- Volunteering, Mentoring and Employability- CVS and South Gloucestershire Volunteer Partnership, Breakthrough mentoring (activity based mentoring programme), Kingsmeadow Community Flat
- Advocacy- Advocacy care forum
- Domestic Violence- Survive
- Victim Support- Stand Against Racism and Inequality (SARI), Victim Support Services and helpline

Are you a parent or carer?

- Support for carers- Carers support centre- Bristol and South Gloucestershire, South Gloucestershire Mental health carers support groups
- Support for Mothers- Creativity works (art based therapy for women with post-natal depression), mother and baby group, Womankind (peer support and befriending for women with mental health problems), Mothers for Mothers (post-natal depression)
- Support for parents- Beat- Beating Eating Disorders, Supportive parents (for families of children with Special Educational Needs), South Glos Parents and Carers (parents of children with additional needs and disabilities), Family Intervention Support Service (FISS South Gloucestershire Council ), Southern Brooks Short Breaks Service

Long Term Conditions

- Brain injury- Headway
- Dementia- Alzheimer’s Society
- HIV- Terrence Higgins Trust (THT), Brigstowe Project
- Learning Difficulties and Autism- Brandon Trust, Bristol Autism Spectrum Service (BASS), Milestones Trust, National Autistic Society
- Sensory Impairments- Action for Blind People, South Gloucestershire Deaf Association (SGDA)
- Stroke- Bristol Area Stroke Foundation (BASF)

Helplines

- Bristol Crisis Service for Women
- Carers Support Centre, Bristol and South Gloucestershire
- CRUSE Bereavement Support, Bristol and District
• Mothers for Mothers
• National Autistic Society
• Rethink
• Samaritans
• SANE
• Stand Against Racism and Inequality (SARI)
• Survive
• Womankind

For full details see http://edocs.southglos.gov.uk/mentalwellbeing/

Appendix H – Websites and electronic resources

Care Quality Commission

Thematic review of mental health crisis care: initial data review

http://www.cqc.org.uk/content/thematic-review-mental-health-crisis-care-initial-data-review

Health and Social Care Information System

Autism Spectrum Disorders

http://www.hscic.gov.uk/searchcatalogue?productid=4717&q=title%3a%22Adult+Psychiatric+Morbid+Survey%22&sort=Most+recent&size=10&page=1#top
http://www.hscic.gov.uk/searchcatalogue?productid=2584&q=title%3a%22Adult+Psychiatric+Morbid+Survey%22&sort=Most+recent&size=10&page=1#top

Learning disabilities

http://www.hscic.gov.uk/searchcatalogue?productid=14640&topics=1%2fMental+health%2fMental+health+surveys&sort=Relevance&size=10&page=1#top

Mental Health Minimum Dataset (MHMDS) expanded to create the Mental Health and Learning Disabilities Dataset (MHLDDS) in September 2014

http://www.hscic.gov.uk/mhldsmonthly

Improving Access to Psychological Therapies


http://www.hscic.gov.uk/searchcatalogue?productid=15445&topics=0%2fMental+health&sort=Relevance&size=10&page=1#top
Public Health England Mental Health Dementia and Neurology Intelligence Network

Co-existing substance misuse and mental health issues

http://fingertips.phe.org.uk/profile-group/mental-health/profile/drugsandmentalhealth

Common Mental Health Disorders

http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders

Community Mental Health Profiles

http://fingertips.phe.org.uk/profile-group/mental-health

Severe Mental Illness

http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness

South Gloucestershire Joint Strategic Needs Assessment (JSNA)

http://edocs.southglos.gov.uk/jsna2017

South Gloucestershire Mental Health Resources List

http://edocs.southglos.gov.uk/mentalwellbeing/