Adult Mental Health and Emotional Wellbeing

Health Needs Assessment for Wiltshire
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Executive Summary

Background

- Mental health is everybody’s business and there is no other area of health that combines mental health’s frequency of occurrence with its persistence and breadth of impacts.
- Mental health is a significant cause and effect of health inequalities. Thus reducing mental health inequalities is an important part of tackling wider population inequalities.
- Working towards parity of esteem for mental health is a key goal enshrined in both local and national policy.
- The national guiding principles for mental health service provision are that
  - Decisions must be locally led.
  - Care must be based on the best available evidence
  - Services must be designed in partnership with people who have mental health problems and with carers
  - Inequalities must be reduced to ensure all needs are met, across all ages
  - Care must be integrated – spanning people’s physical, mental and social needs
  - Prevention and early intervention must be prioritised
  - Care must be safe, effective and personal, and delivered in the least restrictive setting
  - The right data must be collected and used to drive and evaluate progress
- These principles are in line with local policies developed by Wiltshire Council and Wiltshire CCG.
- This mental health and wellbeing needs assessment takes a traditional epidemiological, corporate and comparative approach and aims to provide information and analysis that allows Wiltshire Council and Wiltshire CCG to better meet their strategic aims.
- This needs assessment does not focus on dementia or those with learning disabilities as these are substantive issues outside the scope of this document.

Local Demographics

- The population of Wiltshire is 486,000. In the next 25 years the population is expected to grow by 61,000 people (13% increase).
- The Wiltshire population structure has a higher proportion of older people than the national average and projections suggest that in 2026 the number of people over 65 will exceed the number under 20.
- Military rebasing is a significant driver of population growth; by 2020 it is expected there will be ~18,000 serving military personnel many of whom will have spouses and children.
- Approximately 6.6% of the population is BME which is around a third of the proportion observed nationally (20.2%).
• 90% of the county is classified as rural.
• The county is relatively affluent. However, there has been an increase in relative deprivation since 2004 and there are substantial pockets of deprivation. Salisbury St Martin Central is in the 10% most severely deprived areas in the country.

Factors Protective to Mental Health
• There is an important role for protective factors in promoting positive mental health and wellbeing in the population.
• The 5 Ways to Wellbeing Model is an established framework for considering protective factors that comprises
  o Connect
  o Be Active
  o Take notice
  o Keep learning
  o Give
• For Wiltshire, in the area of connect, there are some community areas with a very high risk of loneliness in the older population. A higher proportion of Wiltshire carers report feelings of isolation than the national average.
• In terms of physical activity, Wiltshire generally performs better than average although there are still significant portions of the population recorded as inactive.
• Wiltshire benefits from a large amount of green space although community area satisfaction with provision of green space is variable ranging from 70% to 88%.
• Education and employment levels in Wiltshire are generally good and above the national average, but there is a higher than average proportion of 16-17 year olds who are unemployed.
• There is little formal data available on volunteering levels in the county and it is hard to assess the level of protection being achieved in the “give” category.

Risk Factors for Poor Mental Health
• There are a number of risk factors for experiencing poor mental health. The relationship between risk factors and mental health is often complex with many factors being both causes and effects of poor mental health.
• An understanding of local risk factors and their distribution allows services to be tailored to effectively manage local need.
• Risk factors can occur at a number of levels and this means that there are certain groups at increased risk of poor mental health as well as broader societal factors that can put people at risk.
• At risk populations may share some common characteristics but are diverse groups with diverse needs that need to be addressed at the individual level if services are to be effective. As a result, services need to be culturally competent to cope with diverse groups.
• Within Wiltshire key high risk groups include minorities, older people, carers, military and veterans, those with other issues such as poor physical health or learning disabilities and those at transition points e.g. moving out of care.
• The broader societal factors that increase the risk of poor mental health are complex and interconnected and will require a whole systems approach to amelioration.

Health Inequalities and Deprivation

• Health inequalities are variations in health between population groups resulting from a variety of societal and economic processes that are unequally distributed within or between populations. They are avoidable and unfair.
• Those who experience poor mental health often experience health inequalities as a result of this. Ultimately, those with severe mental health conditions die between 15-25 years earlier on average than the general population.
• Additionally, there are inequalities in the distribution of risk factors for mental health such as smoking, harmful alcohol use and poor physical health and in the ability to access mental health services.
• Locally barriers to access include geographical inequalities and difficulties with getting transport to services.

Population Need: - The Prevalence of Mental Health Problems In Wiltshire

• The main source of prevalence data used is from the Adult Psychiatric Morbidity Survey 2014 whose results were published in September 2016. This allows national estimates of prevalence split by age and sex to be applied to the Wiltshire population to provide local prevalence estimates.

CMD
• There are an estimated 67,000 people in Wiltshire experiencing a common mental disorder.
• The prevalence rates for CMDs are growing faster in women than men.
• Treatment seeking habits are changing with 37% of cases receiving treatment compared to 23% seven years ago. This increase in treatment is seen across the number of prescriptions, GP consultations, community care appointments and IAPT.
• Applying the 37% treatment rate to Wiltshire, we would expect around 25,000 people to be receiving treatment for a CMD.

PTSD
• Within Wiltshire, based on national prevalence rates, we can expect around 15,000 people to be experiencing PTSD.
• Adjusting for the military and veteran population this number may be even higher. This population is believed to be largely undiagnosed currently.
• Many of those with PTSD have other co-existing mental health issues making them complex cases requiring more specialist treatment.

Eating Disorders
• There are an estimated 6,000 people in Wiltshire with eating disorders of whom the majority are younger women. Prevalence rates are thought to be growing.
• It is estimated 8/10 people nationally with eating disorders currently receive no treatment representing a large, under-served population.
Psychotic Disorders
- Nationally the rates of psychotic disorders are thought to be stable at around 0.5%, translating to an estimated 2,100 cases in Wiltshire.
- National incidence rates suggest we would expect to see 243 new cases in Wiltshire per year.
- This figure based on national prevalence, may slightly overestimate the local prevalence due to Wiltshire’s lower than average BME population.

Personality Disorders
- There are an estimated 22,000 people in Wiltshire with a personality disorder.
- According to national data around two thirds will not be receiving treatment although around 10-15% will have requested treatment. Again, this represents an underserved population.

Bipolar Disorder
- There are an estimated 7,700 people in Wiltshire living with bipolar disorder.
- This is a lifelong condition that can have significant impact on a person.

Suicide and Self-harm
- The reported prevalence of self-harm is rising particularly amongst young women; a quarter of 16-24 year old women report self-harming. Overall, there are estimated to be around 29,000 cases of self-harm in Wiltshire a year. Most go unreported.
- There is also a slight increase in the rate of reported suicidal thoughts and attempts.

Drug and Alcohol misuse
- There are an estimated 12,200 harmful drinkers in Wiltshire. The prevalence is growing in 55-64 year olds and falling in 16-24 year olds. This is a change and one services will need to adapt to.
- There are an estimated 12,100 people with a drug dependence in Wiltshire (includes cannabis, legal highs, opioids etc).

Demand: Service Use Data
- The quality and quantity of service use data that is available is suboptimal for comprehensively assessing the gap between need and demand for mental health services in Wiltshire.
  - The data available is often specific to monthly management monitoring or national recording protocols and does not allow a detailed understanding of the broader service flows.
- A number of services e.g. Primary Care Liaison Services (PCLS) appear to show a very high proportion of returned referrals. A greater understanding of this discrepancy is required as it is likely to represent a large gap between provision and demand and it is important to understand at what level this is occurring.
- For those conditions where it is possible to compare expected local prevalence with service use (e.g. eating disorder, new onset psychosis, personality disorder, self-harm) there appear to be very low rates of service use compared to expected prevalence (even compared to national expected treatment rates). Whether these are real differences or issues in data recording and interpretation are unclear.
• The available IAPT data show that treatment outcomes are less good than nationally. However, the data available do not take into account recent service changes.
• Perinatal IAPT services appear to have less good reported outcomes than general IAPT services locally.

Demand: Service User and Carer Perspectives
• Service users and carers generally felt that finding out about local services was relatively easy and cited that they generally used trusted personal networks or health professionals to provide information on services.
• The majority of respondents felt the mental health services they received were helpful but a sizeable number were ambivalent or felt services were unhelpful. The main drivers of positive feelings were around good communications, empathetic staff and services being well organised.
• The majority of respondents felt that mental health services in Wiltshire did not consider their needs holistically. It was felt voluntary services might be better at this than medical services for whom reported experiences were more mixed.
• Only 34% of respondents agreed it was easy to access the services they felt they needed. Waiting times, difficulty accessing services using public transport, and out of hours’ access were frequently cited as barriers to access.
• Two thirds of respondents felt services did not link up well. The effect of poor links and poor communications were described as “literally soul destroying”. A number of carers referred to themselves as “communication managers” and worried for those who did not have such advocates. When communications were good and services linked the experience was commented on very positively.

Demand: Provider Feedback
• Providers emphasised the importance to them of services taking a person centred approach tailored to the needs of the user.
• Providers expressed they felt there was a need for more “pre-crisis” services.
• Providers recognised the importance of easy access to services but expressed concern around geographic barriers to some services, and the delays introduced by requiring a primary care referral back into a service if a previously well person was becoming unwell again.
• Providers felt services could be more joined up in terms of data sharing and combating the stigma around mental health, as well as in terms of patient care.
• Provider aspirations for services and user aspirations generally overlapped.

Evidence Review of What Works
• There is a wide range of evidence around what works in mental health.
• From a clinical treatment perspective NICE produces guidelines around what treatments are effective clinically.
There have been some economics studies around investigating what interventions are cost effective and these are due to be updated by PHE within the next 12 months.

In terms of public health mental health interventions, there is little evidence in the form of randomised controlled trials. Rather the evidence tends to come in the form of policy initiative supported by cases studies.

In terms of public health interventions they can be grouped into life course interventions and those that are place based.

For each type of intervention there tend to be a number of recommended universal interventions and a number of targeted interventions that are aimed at those who are most high risk.

Support Currently Offered

- There are a wide range of commissioned, voluntary and community services available in Wiltshire to support those with mental health or emotional wellbeing needs.
- There are identified gaps in services for those with personality disorders, and anecdotal gaps in inpatient care places more generally.
- There is a concern that as funding pressures mount, some voluntary and community based services will cease to be able to continue operating leaving more gaps in service provision.
- Appendix A provides a list of services as currently delivered.

Summary of Recommendations

- Ensure the impact of Wiltshire’s changing demographics are considered when planning and providing mental health services
  - Older people, carers, military, BME groups
- Use protective and risk factors to inform a preventative approach
- Ensure inequalities have been considered when providing and planning services
  - Geographical, cultural competence, risk factors, referral routes
- Ensure services are focussed on those with the greatest need and those with an identified high unmet need
- Ensure services are equipped to manage service user complexity
  - E.g. Dual diagnosis; DA; multiple physical, mental and social care needs
- Ensure care and referral pathways are clear and that transition points are an area of active focus
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- Bipolar Disorder
- Suicide and Self Harm
- Co-occurring substance misuse and mental health

Service Use Data

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- Community Mental Health Services
- IAPT Services
- Revival services
- Perinatal Services
- Early Intervention in Psychosis Service
- Eating Disorders
- Personality Disorders
- Suicide and Self Harm
- Co-occurring substance misuse and mental health
- Acute Inpatient Services

Section B: Service users’ and carers’ perspectives

- Accessing information about mental health services
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Evidence Review of what Works

Public Health Interventions

Life Course Interventions

Place based interventions

The Economic Perspective

The National Institute for Health and Care Excellence Perspective
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Background and scope

Key points

- Mental health is everybody’s business and there is no other area of health that combines mental health’s frequency of occurrence with its persistence and breadth of impacts.
- Mental health is a significant cause and effect of health inequalities meaning reducing mental health inequalities is an important part of tackling wider health inequalities.
- Working towards parity of esteem for mental health is a key goal enshrined in both local and national policy.
- The national guiding principles for mental health service provision are that
  - Decisions must be locally led.
  - Care must be based on the best available evidence
  - Services must be designed in partnership with people who have mental health problems and with carers
  - Inequalities must be reduced to ensure all needs are met, across all ages
  - Care must be integrated – spanning people’s physical, mental and social needs
  - Prevention and early intervention must be prioritised
  - Care must be safe, effective and personal, and delivered in the least restrictive setting
  - The right data must be collected and used to drive and evaluate progress
- These principles are in line with local policies developed by Wiltshire Council and Wiltshire CCG.
- The mental health and wellbeing needs assessment takes a traditional epidemiological, corporate and comparative approach and aims to provide information and analysis that allows Wiltshire Council and CCG to better meet their strategic aims.
- This needs assessment does not focus on dementia or those with learning disabilities as these are substantive issues outside the scope of this document.

What is mental health and wellbeing?

Mental health is everybody’s business. The World Health Organisation\(^1\) defines mental health as:

“a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.”

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As the above definition makes clear, mental health is more than simply the absence of disease and there is now an increasing emphasis on positive mental health and wellbeing. However, the traditional focus has been on managing ill health, and much of the readily available data reflects this focus. Mental ill health is a broad term which encompasses a wide spectrum of difficulties ranging from everyday stress and worry through to severe depression or acute psychosis. The spectrum spans conditions managed mainly by primary care and community organisations, to conditions that are almost exclusively managed by highly specialist referral centres.

**What is the size and scope of the issue?**

During their lifetime, around a quarter of the population will experience a significant mental health problem that disrupts their life, work and relationships. This high prevalence makes mental health the largest single cause of disability in England and those with severe mental illness die around 20 years earlier than the general population. The personal costs of poor mental health are high, and the financial and economic costs are similarly significant with the annual cost to England being more than £105 billion.

The impacts of poor mental health are large and far reaching and they illustrate why tackling mental illness and promoting mental wellbeing is essential not just for individuals, but for families and society as a whole. The national strategy for mental health “No Health without Mental Health” highlights the following points and these key statistics around mental health provide a clear rallying call to action.

- At least 1 in 4 people will experience a mental health problem at some point in their life
- 1 in 6 adults have a mental health problem at any one time
- Almost half of adults will experience at least one episode of depression during their lifetime
- Mental ill health represents up to 23% of ill health in the UK and is the largest single cause of disability
- People with severe mental illnesses die on average 20 years earlier than the general population
- The NHS spends around 11% of its budget on mental health. This is almost double the amount spent on cancer
- The estimated cost of mental ill-health in England in 2009/10 was £105.2bn

There is no other area of health that combines mental health’s frequency of occurrence with its persistence and breadth of impact.

In addition to the above, the stigma attached to mental ill health and the social barriers that surround it amplify its direct effects and damage the life chances of people with mental health problems. The link between mental health problems and social exclusion is intricate; mental ill-health can be both the cause and the

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consequence of social exclusion, leading to a vicious cycle of homelessness, unemployment, and worsening physical and mental health.

Mental health and Inequalities:

Mental health problems can also contribute to perpetuating cycles of inequality both within and through generations. Some of the key inequalities experienced by people with mental health problems are:

- Poorer physical health and increased mortality from some diseases
- Increased prevalence of health risk factors such as smoking, substance abuse and obesity
- Barriers to accessing health services
- Low levels of employment
- Social exclusion arising through stigma, discrimination and difficulties in maintaining social and family networks

It therefore follows that reducing mental health inequalities is an important part of tackling wider health inequalities.

National Policy Context

Wider Health Policy context:
As the magnitude and far reaching impacts of poor mental health become better understood mental health has moved up the policy agenda and the approach to managing it has evolved. Over the last 10-15 years, the government’s mental health policy has moved from being primarily focussed on consistent and measurable standards for delivery of healthcare to those with mental illness⁴, to including more focus on well-being, quality and accessibility of services as detailed in “New Horizons: A Shared Vision for Mental Health”⁵. “New Horizons” included discussion of factors that affect wellbeing as well as everyday strategies for preserving and boosting it. It also set out the benefits of this approach, including the economic benefits.

In 2011, the coalition government introduced ‘No Health Without Mental Health: A cross government mental health outcomes strategy for people of all ages’⁶. This stated that ‘good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential’. The strategy placed greater emphasis on outcomes and greater clarity on delivery. It details six key strategic principles:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health

4. More people will have a good experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

Following on from this, in 2012, the principle of ‘parity of esteem’ was enshrined in law by the Health and Social Care Act. This required that mental health be given equal priority to physical health.

**Five Year Forward View**

The ‘Five Year Forward View’ was published in October 2014. It presented a strategy for the NHS in the context of the increasing funding gap (projected to be £30 billion by 2020). The report highlights a number of key priorities including preventing ill health by preventative public health work, ensuring service users have control of their health, breaking down service provision barriers and working with new care delivery options. It emphasised that without thinking differently about how services are provided and run, the NHS may not be viable in the longer term.

Following on from this a specific “Five Year Forward View for Mental Health” was published in February 2016. This outlines three priority areas

1) 24/7 access to care
2) Integrated mental and physical healthcare
3) Promoting good mental health and preventing poor mental health.

The report acknowledges achieving this is likely to require an extra £1bn of funding. The report recommends eight principles to underpin reform:

1. Decisions must be locally led
2. Care must be based on the best available evidence
3. Services must be designed in partnership with people who have mental health problems and with carers
4. Inequalities must be reduced to ensure all needs are met, across all ages
5. Care must be integrated – spanning people’s physical, mental and social needs
6. Prevention and early intervention must be prioritised
7. Care must be safe, effective and personal, and delivered in the least restrictive setting
8. The right data must be collected and used to drive and evaluate progress

**Sustainability policy:**

The “Five Year Forward View” alludes to the broader national policy focus on sustainability, with a view to safeguarding health care for future generations despite limited NHS resources. There is now a legal requirement for the NHS to consider the economic, social and environmental value of provisions not just the price. It is recommended that commissioners adopt the four basic principles of sustainability (as set out by the Centre for Sustainable Healthcare) and apply these principles in every commissioning exercise:

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1. Prioritise prevention
2. Empower individuals and communities
3. Improve value
4. Consider carbon

Local policy context

Wiltshire Council Business Plan:
This health needs assessment ultimately aims to support Wiltshire Council’s vision to “create stronger and more resilient communities and make Wiltshire an even better place to live, work and visit”. As outlined earlier in this introduction, those with poor mental health and wellbeing are often the most vulnerable in society, have reduced employment prospects and often experience social exclusion. Through gathering data on Wiltshire’s mental health and emotional wellbeing needs, and using this to inform recommendations for future interventions, this health needs assessment directly contributes to the Wiltshire Council Business Plan priorities to:

- protect those who are most vulnerable
- boost the local economy; and,
- bring communities together to enable and support them to do more for themselves

Wiltshire CCG Operational Plan 2017-2019
This comprehensive assessment of the mental health needs of adults living and working in Wiltshire will inform Wiltshire Clinical Commissioning Group in delivering the three key strategic objectives:

- Increased investment and support into developing and maintaining personal responsibility – focus on education, prevention and support to develop and maintain healthy and independent living
- Enhanced and integrated community care with broader range of services provided in a local setting
- Improved productivity and effectiveness of care with a reduced reliance on bed-based solutions

With one in four adults experiencing at least one diagnosable mental health problem in any given year, Wiltshire CCG is committed to delivering the Five Year Forward View for Mental Health alongside access and quality standards so that there is genuine parity of esteem with access to physical health care and treatment. This needs assessment will inform where additional investment should be targeted, with Sustainability and Transformation Plan partners in BaNES and Swindon to:

- Create locally integrated teams supporting primary care
- Shift the focus of care from treatment to prevention and proactive care
- Redefine the ways we work together to deliver better patient care
- Establish a flexible and collaborative approach to workforce
• Design our strategy to further enable collaboration and sustainability

**Wiltshire Mental Health and Wellbeing Strategy 2014-2021:**
The seven year joint strategy sets out strategic priorities for adult mental health and wellbeing provision in Wiltshire and the focus for delivering services, facilities and opportunities that empower people and enable independence. The strategy was developed with stakeholders and was written to meet the aims of the national strategy “No Health Without Mental Health”, as well as the aims of the broader Wiltshire Health and Wellbeing strategy.

The strategy’s stated aim for Wiltshire is to create environments and communities that will keep people well across their lifetime, achieving and sustaining good mental health and wellbeing for all. It identifies six areas of activity:

1. Prevention and early intervention
2. Promoting emotional wellbeing and improving understanding about mental ill health
3. Personalised recovery based services
4. Effective and efficient use of resources
5. Closer engagement with service users, families and carers in the development of services
6. Integrated working between statutory services with wider community and voluntary sector involvement

The strategy outlines a model for mental health and wellbeing that is community based and which will focus on:

• Strengthening social capital with local partners and organisations, optimising the opportunities offered by community campuses, area boards and other community resources such as voluntary and support groups. We will utilise community facilities where appropriate.
• Enhanced seven day primary care and community based solutions with improved multidisciplinary services wrapped around general practice reducing reliance on acute care..
• A simple point of access to health and social care and for these multidisciplinary teams to share data and information with increasing use of shared technology to avoid duplication in assessments.
• Encouraging personal responsibility.
• Addressing the wider determinants of poor mental health and well-being especially in vulnerable individuals, groups and communities.

In order to strengthen successful implementation of this strategy it has been identified that a robust mental health and emotional wellbeing needs assessment is required to:

• Improve up to date understanding of the local epidemiology of mental health
• Provide a comprehensive overview of current services
• Provide quality data to underpin planning and future service provision
• Provide evidence around what a good mental health system for Wiltshire should look like

This health needs assessment has been produced to fulfil these identified objectives.

**Wiltshire Transformation Plan/STP**

The Sustainability and Transformation Plan sets out the challenges across health inequality, quality and performance, and finance for the area that includes Swindon, Bath and North East Somerset and Wiltshire. It considers ways in which these challenges can be met across the footprint area.

It sets out the five key priorities for change across B&NES, Swindon and Wiltshire as:
1. The development of locality-based integrated teams supporting primary care.
2. Shifting the focus of care from treatment to prevention and proactive care.
3. Redefining the ways we work together to deliver better patient care.
4. Establishing a flexible and collaborative approach to workforce.
5. Further enabling acute collaboration and sustainability.

The STP is determined to embed parity between mental and physical health care. Thus there is the implicit assumption that all the above initiatives relate equally to mental and physical health and social care.

**Purpose and scope**

The Mental Health Needs Assessment is an epidemiological, corporate and comparative assessment that aims:

• To understand and describe the population of Wiltshire
• To understand and describe the protective factors for mental health and wellbeing in Wiltshire
• To understand and describe the risk factors for mental ill health in Wiltshire
• To understand and describe the prevalence of mental illness and mental disorder in Wiltshire
• To map current service provision and identify potential service gaps
• To assess demand upon current services
• To determine whether the current mental health service provision meets the identified needs and demands
• To understand and describe inequalities experienced by those with mental health problems and consider how these may be addressed

This health needs assessment will not specifically focus on mental health issues in connection with dementia or in people with learning difficulties. These areas merit their own separate health needs assessment. In addition, beyond where issues are mentioned in the context of the life course approach to mental health, this document will not specifically focus on the needs of children and young people but will focus on the adult population. A children’s and young people mental health needs assessment was produced in 2016.
Methodology

The traditional model of epidemiological, corporate and comparative healthcare needs assessment has been developed by Stevens and Rafferty\(^8\). This health needs assessment draws on all three approaches. Epidemiological need looks at the severity and size of the health problem. Corporate need looks at the perceptions of the service providers, commissioners and users while comparative need looks at the data in comparison to other localities/sub groups and national targets\(^9\).

**Epidemiological approach:**
This section gathered existing data from a range of sources that provided information on the prevalence and distribution of mental health risk factors as well as factors protective to mental health and emotional wellbeing. Data on the prevalence of mental health disorders was also gathered.

In addition, current services that address the issues of mental health and wellbeing were identified, and mapped against the areas they serve.

**Corporate approach:**
This section involved gathering qualitative data through workshop style sessions with service providers and brief questionnaires and world café style\(^10\) focus groups with mental health service users and carers. Purposive sampling methods were used to ensure a range of views were heard.

**Comparative approach:**
This component involved analysis of available data and comparing performance against relevant benchmarks. Benchmarks included national averages as well as within locality comparators to identify differences between specific subgroups where possible. The findings were compared against expressed need (demand).

A further comparison was made by considering the current situation against current best practice as identified through an evidence review. The evidence review looked at what public health interventions are supported by evidence of effectiveness, what national mental health guidelines recommend and what mental health interventions have been shown to have a positive economic impact.

Following review and analysis of all data gathered recommendations were made based on the needs assessment’s findings.


The figure below gives a visual overview of the process used to drive the production of this mental health and wellbeing needs assessment.

**Figure 1 Flow chart to summarise the process steps in carrying out the Mental Health and Emotional Wellbeing Health Needs Assessment for Wiltshire**

**Limitations of the data**
Mental health conditions are a complex area and the data are often patchy and based on estimates and projections rather than actual numbers. This is in part due to the complexity of the service provision for mental health and also because of confidentiality and data sharing arrangements. We have attempted to bring together multiple sources of data, with valuable local data helping to create a more comprehensive picture of adult mental health in Wiltshire. However, as identified throughout the document, the data available is frequently not perfect.
Local Health Needs

Section A: Local demographics

Key points

- The population of Wiltshire is 486,000. In the next 25 years the population is expected to grow by 61,000 people (13% increase).
- The Wiltshire population structure has a higher proportion of older people than the national average and projections suggest that in 2026 the number of people over 65 will exceed the number under 20.
- Military rebasing is a significant driver of population growth; by 2020 it is expected there will be ~18,000 serving military personnel many of whom will have spouses and children.
- Approximately 6.6% of the population is BME which is around a third of the proportion observed nationally (20.2%).
- 90% of the county is classified as rural.
- The county is relatively affluent. However, there has been an increase in relative deprivation since 2004 and there are substantial pockets of deprivation. Salisbury St Martin Central is in the 10% most severely deprived areas in the country.

General Description of population

There are an estimated 486,000 people living in the Wiltshire Local Authority area. The population of Wiltshire accounts for 8.88% of the total South West population. Wiltshire is a large, predominantly rural and generally prosperous county. Almost half of the population resides in small towns and villages of less than 5,000 people in size, and a quarter live in villages of fewer than 1,000 people. With 149 people per square kilometre, Wiltshire has a lower population density than both the South West and England as a whole.

Approximately 90% of the county is classified as rural and there are significant areas with a rich and diverse heritage of national and international interest, such as Stonehenge and Salisbury Cathedral. The relationship between the City of Salisbury and the larger towns in Wiltshire and the rest of the county has a significant effect on transport, employment, travel to work issues, housing and economic needs.

In terms of overall deprivation level, Wiltshire compares favourably against the national benchmark. However, the county has seen an increase in relative deprivation since 2004. For the first time, Wiltshire now has one geographic region in the 10% most severely deprived in England (Salisbury St Martin – central).

Wiltshire Council was formed in 2009, combining the previous County Council and four District Councils into one single unitary authority. Within Wiltshire, the Council and local partners have identified twenty Community Areas, forming eighteen Local Area Boards. A map of the community areas is given below.

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Wiltshire’s Community Areas

Map created by Simon Hodson, Public Health Intelligence Officer.
1:340,000 © Crown copyright and database rights 2013 Ordnance Survey 100048050
Age
The age structure of Wiltshire is similar to the South West region. However, Wiltshire has a slightly smaller proportion of 20 to 24 year olds which might be a reflection of a lack of a university.

Figure 3 depicts the most recent population pyramid of Wiltshire and the South West region.

**Figure 3: Population pyramid for Wiltshire and South West region**

The chart below shows the total population by community area with a breakdown by broad age bands.

**Figure 4 showing population age distribution by community area**
Sex

51% of the population is female. The table shows the breakdown of the population by sex and broad age bands. In line with national trends, due to different life expectancies there are significantly more women aged 65+ than men.

Figure 5 showing Wiltshire population split by sex

<table>
<thead>
<tr>
<th></th>
<th>Wiltshire</th>
<th>South West</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>% of Pop</td>
<td>Number</td>
</tr>
<tr>
<td>Age 0-17</td>
<td>104,046</td>
<td>21.4</td>
<td>1,082,081</td>
</tr>
<tr>
<td>Age 18-64</td>
<td>282,861</td>
<td>58.2</td>
<td>3,220,145</td>
</tr>
<tr>
<td>Age 65+</td>
<td>99,186</td>
<td>20.4</td>
<td>1,168,954</td>
</tr>
<tr>
<td>Total</td>
<td>486,093</td>
<td>100</td>
<td>5,471,180</td>
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<table>
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<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>% of Pop</td>
<td>Number</td>
</tr>
<tr>
<td>Age 0-17</td>
<td>52,906</td>
<td>22.0</td>
<td>553,785</td>
</tr>
<tr>
<td>Age 18-64</td>
<td>141,992</td>
<td>59.1</td>
<td>1,602,476</td>
</tr>
<tr>
<td>Age 65+</td>
<td>45,395</td>
<td>18.9</td>
<td>531,835</td>
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<td>Total</td>
<td>240,293</td>
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<td>2,688,096</td>
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<table>
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<th>South West</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>% of Pop</td>
<td>Number</td>
</tr>
<tr>
<td>Age 0-17</td>
<td>51,140</td>
<td>20.8</td>
<td>528,296</td>
</tr>
<tr>
<td>Age 18-64</td>
<td>140,869</td>
<td>57.3</td>
<td>1,617,669</td>
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<tr>
<td>Age 65+</td>
<td>53,791</td>
<td>21.9</td>
<td>637,119</td>
</tr>
<tr>
<td>Total</td>
<td>245,800</td>
<td>100</td>
<td>2,783,084</td>
</tr>
</tbody>
</table>

Black Asian and Minority Ethnic Groups

Ethnicity has been defined as:

"the social group a person belongs to, and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry and physical features traditionally associated with race."

Wiltshire is predominantly White British (93%). People in minority groups are often not present in Wiltshire in sufficient numbers to form recognisable groups. According to 2011 Census figures, ethnic minorities make up 6.6% of the population (31,256 people). Wiltshire has a lower proportion of ethnic minorities than the South West region as a whole (6.6% vs 8.2%) and a considerably lower proportion than for England as a whole (6.6% vs 20.2%). The proportion of the population from ethnic minority groups in Wiltshire has increased by 129% between 2001 and 2011.

---

12 Data sourced from Wiltshire JSA health and wellbeing 2013/14 demographics:ethnicity
compared to 114% in the South West and 74% in England. Obtaining accurate information on ethnicity between censuses is difficult.

**Figure 6 showing Black, Asian and Minority Ethnic groups in Wiltshire and the South West**

![Percentage of black, Asian and minority ethnic groups, 2011](chart)

Source: 2011 Census Table KS201EW, ONS

**Figure 7 to show estimated population change by ethnic group 2001-2011**

<table>
<thead>
<tr>
<th>Area</th>
<th>Total population</th>
<th>White</th>
<th>Mixed</th>
<th>Asian</th>
<th>Black</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wiltshire</td>
<td>+9%</td>
<td>+7%</td>
<td>+96%</td>
<td>+180%</td>
<td>+181%</td>
<td>+32%</td>
</tr>
<tr>
<td>South West</td>
<td>+7%</td>
<td>+5%</td>
<td>+92%</td>
<td>+132%</td>
<td>+137%</td>
<td>+88%</td>
</tr>
<tr>
<td>England</td>
<td>+8%</td>
<td>+1%</td>
<td>+85%</td>
<td>+88%</td>
<td>+64%</td>
<td>+157%</td>
</tr>
</tbody>
</table>


**Projected Population Growth**

Over the next 25 years the population of Wiltshire is expected to grow by around 12%, an addition 58,000 people. This is summarised in the table below and illustrated graphically in figure 8

The steeper rise of the male population between 2014 and 2019 reflects the impact of the military rebasing that is expected to occur. Current estimates suggest that there are 14,452 army service personnel in Wiltshire and that by 2020 this number will be between 18,000 and 19,000. The ONS projections have not adjusted for accompanying spouses and children, and so are likely to be an underestimate of the true population. It is locally estimated there will be around 1,400 spouses and 1,800 children. Including additional military spouses and families would take the projected increase in population from 12% to at least 13%, or an additional 61,000 people in total.
Figure 8 showing projected population growth for Wiltshire.

![Population Growth Graph]

Figure 9 showing projected Wiltshire population growth by gender

<table>
<thead>
<tr>
<th>Year</th>
<th>People</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population (K)</td>
<td>% Increase</td>
<td>Population (K)</td>
</tr>
<tr>
<td>2019</td>
<td>499</td>
<td>3.2%</td>
<td>248</td>
</tr>
<tr>
<td>2024</td>
<td>511</td>
<td>5.9%</td>
<td>254</td>
</tr>
<tr>
<td>2029</td>
<td>522</td>
<td>8.1%</td>
<td>259</td>
</tr>
<tr>
<td>2034</td>
<td>532</td>
<td>10.1%</td>
<td>263</td>
</tr>
<tr>
<td>2039</td>
<td>541</td>
<td>11.9%</td>
<td>267</td>
</tr>
</tbody>
</table>

It is projected that the population pyramid in Wiltshire will become top heavy with a larger proportion of elderly people. Projections suggest that in 2026 the number of people over the age of 65 will for the first time outnumber those under the age of 20.

This is significant in the context of a mental health and wellbeing needs assessment for two reasons. Firstly the older population tends to have a significant risk of mental health problems that can have a profound effect on their lives and that can differ both in presentation and the optimum service configuration required when compared to the younger population. Secondly, as the population ages the number of carers is likely to increase and this often results in mental health pressures on carers. Both these issues are discussed in more depth later in the document.
GP registered population statistics

When considering population size from a healthcare need perspective, as well as looking at the overall population, it can be useful to consider the size of the population registered with a general practice (GP). Wiltshire Council and Wiltshire Clinical Commissioning Group (CCG) are responsible for services for people resident or GP registered within the county. Some people may live outside of Wiltshire but be registered with a Wiltshire GP. Conversely, some people may live in Wiltshire but be registered with GPs elsewhere or not registered at all for a variety of reasons. The GP unregistered population often includes groups like people with drug and alcohol dependence, the homeless, gypsy and traveller communities, holiday makers, temporary residents, or people using private healthcare. Individuals who are not registered with a GP are likely to be excluded from mainstream health services.

Overall, the majority of the Wiltshire population are registered with GPs. The Wiltshire GP registered population at April 2016 is a total of 483,489 people. This is close to the general population estimate of 486,000. The breakdown of the GP registered population by age and sex is given below.

**Figure 10 showing the Wiltshire GP registered population by age and gender**

<table>
<thead>
<tr>
<th>People</th>
<th>Wiltshire</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>% of Pop</td>
</tr>
<tr>
<td>Age 0-17</td>
<td>98,890</td>
<td>20.5</td>
</tr>
<tr>
<td>Age 18-64</td>
<td>281,653</td>
<td>58.2</td>
</tr>
<tr>
<td>Age 65+</td>
<td>102,946</td>
<td>21.3</td>
</tr>
<tr>
<td>Total</td>
<td>483,489</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Males</th>
<th>Wiltshire</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>% of Pop</td>
</tr>
<tr>
<td>Age 0-17</td>
<td>50,443</td>
<td>21.4</td>
</tr>
<tr>
<td>Age 18-64</td>
<td>137,844</td>
<td>58.5</td>
</tr>
<tr>
<td>Age 65+</td>
<td>47,318</td>
<td>20.1</td>
</tr>
<tr>
<td>Total</td>
<td>235,605</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Females</th>
<th>Wiltshire</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>% of Pop</td>
</tr>
<tr>
<td>Age 0-17</td>
<td>48,447</td>
<td>19.5</td>
</tr>
<tr>
<td>Age 18-64</td>
<td>143,809</td>
<td>58.0</td>
</tr>
<tr>
<td>Age 65+</td>
<td>55,628</td>
<td>22.4</td>
</tr>
<tr>
<td>Total</td>
<td>247,884</td>
<td>100</td>
</tr>
</tbody>
</table>

Numerating exactly how many people are not registered with a doctor, and therefore do not have access to primary care services, is not simple. There are several discrepancies between the number of residents registered with a GP and the overall resident population. For example, the number of people registered with a GP can be artificially inflated if people who move away from the area do not register with another doctor.
Overall, as outlined in this section Wiltshire is a relatively affluent county of around 490,000 people. Compared to the national picture there are fewer black and ethnic minority people and the overall population is older than the national average. In addition, the high proportion of military and ex-military personnel has an impact on the population composition, and rebasing will have a considerable impact on population growth over the next decade.

The next sections will go on to consider the distribution within the population of specific characteristics that either protect against or increase the risks of poor mental health and emotional wellbeing.

**Recommendations arising from this section**

- All service planning needs to be future proofed to ensure it fits the changing needs of Wiltshire’s evolving demographics. In particular, service planning needs to ensure it is prepared for:
  - An aging population and their associated carers
  - Increasing military numbers
  - A small but growing BME population
  - A predominantly rural population with pockets of urban deprivation
- Planning and provision of services should ensure inequalities in access to services for such groups are assessed
- Given the pivotal role of GPs in routine access to mental health services, access routes for those who are not GP registered should be considered
Section B: Protective factors for mental health and emotional wellbeing

Key points

- There is an important role for protective factors in promoting positive mental health and wellbeing in the population.
- The 5 Ways to Wellbeing Model is an established framework for considering protective factors that comprises
  - Connect
  - Be Active
  - Take notice
  - Keep learning
  - Give
- For Wiltshire, in the area of connect, there are some community areas with a very high risk of loneliness in the older population. A higher proportion of Wiltshire carers report feelings of isolation than the national average.
- In terms of physical activity, Wiltshire generally performs better than average although there are still significant portions of the population recorded as inactive.
- Wiltshire benefits from a large amount of green space although community area satisfaction with provision of green space is variable ranging from 70 to 88%.
- Education and employment levels in Wiltshire are generally good and above the national average, but there is a higher than average proportion of 16-17 year olds who are unemployed.
- There is little formal data available on volunteering levels in the county and it is hard to assess the level of protection being achieved in the “give” category.

No Health without Mental Health emphasises that the field of mental health should not be viewed exclusively in terms of disease treatment and targeted vulnerable populations. It stresses that there is an important role for protective factors and promoting positive mental health and wellbeing in the population.

The diagram below graphically illustrates how an increase in protective factors can shift the population mental health spectrum to the left. This results in a big decrease in the overall number of people with mental disorders or those “languishing” on the brink of mental disorder.
This suggests that documenting the level and distribution of mental health and wellbeing protective factors is an important step in understanding the whole picture of potential mental health and wellbeing need. High levels of protective factors can help predict where good mental health and wellbeing are likely to occur, and also mitigate the impact of risk.

There is a growing body of evidence relating to protective factors to facilitate positive mental health and emotional wellbeing. The Joint Commissioning Panel for Mental Health describes a wide range of protective factors that are associated with wellbeing\(^\text{15}\). These include:

- Genetic and early environmental factors
- Socioeconomic factors including higher income and socio-economic status
- Living environment
- Good general health
- Education
- Employment including autonomy, support, security and control in an individual’s job
- Activities such as socialising, working towards goals, exercising and engaging in meaningful activities
- Social engagement and strong personal, social and community networks
- Altruism (doing things for others)

---


• Emotional and social literacy life skills, social competencies and attributes such as communication skills, cognitive capacity, problem-solving, relationship and coping skills, resilience and sense of control
• Spirituality is associated with improved wellbeing, self-esteem, personal development and control
• Positive self-esteem
• Values

The associated concept of resilience can be defined as the ability to recover from setbacks, adapt well to change, and keep going in the face of adversity. It is considered a broad protective factor for mental health. Resilience is strongly associated with positive wellbeing and can also help safeguard mental wellbeing, particularly at times of adversity.

Resilience comes from the interaction between factors at the individual, family and community level. Different levels of emotional and cognitive resilience or ‘capital’ will include a myriad of factors as illustrated below:

**Figure 12. Diagram to illustrate the components of resilience**

![Diagram](image)

- Environmental: features of natural and built environment which enhance community capacity for wellbeing
- Social: includes networks and resources that enhance trust, cohesion, influence and cooperation
- Physical health
- Spirituality: sense of meaning, purpose and engagement as well as religious belief for some
- Emotional and cognitive: includes optimism, self-control and positive personal coping strategies

At the big picture level, efforts have been made to quantify general wellbeing and these can be used to estimate its prevalence as a protective factor. However, this research area is still in its early stages and the first national population survey looking at subjective wellbeing was only carried out in 2013.

The Office for National Statistics (ONS) produced estimates from the Subjective Well-being Annual Population Survey (APS). This gives estimates on; life satisfaction, extent people feel things in their lives are worthwhile, how happy people felt yesterday and how anxious people felt yesterday. Broadly speaking, as shown in
the table below, Wiltshire has higher well-being scores than England. The percentage of people in Wiltshire saying they were satisfied with their lives (a score of 7 or higher) went up between 2012 and 2013, however the percentage saying they were happy (a score of 7 or higher) went down.

**Figure 13: Well-being Annual Population Survey, Wiltshire and England**

<table>
<thead>
<tr>
<th></th>
<th>Wiltshire</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied with life (% scoring 7+ out of 10)</td>
<td>81.2%</td>
<td>76.8%</td>
</tr>
<tr>
<td>Worthwhile (% scoring 7+ out of 10)</td>
<td>NA</td>
<td>80.6%</td>
</tr>
<tr>
<td>Happy yesterday (% scoring 7+ out of 10)</td>
<td>72.8%</td>
<td>71.3%</td>
</tr>
<tr>
<td>Anxious yesterday (% scoring 4+ out of 10)</td>
<td>34.5%</td>
<td>38.8%</td>
</tr>
</tbody>
</table>


**The Five Ways to Wellbeing**

At a more granular level, there has been work to try to formalise thinking around what components contribute to the overall construct of wellbeing. Recently the Five Ways to Wellbeing\(^{16}\) has emerged as a nationally recognised framework and as a tool to support promotion of emotional wellbeing. The five ways to wellbeing were developed by the New Economics Foundation from evidence gathered in the UK government’s Foresight Project on Mental Capital and Wellbeing in 2008. The Five Ways to Wellbeing\(^{15}\) are a set of evidence-based actions which aimed at improving people’s mental health and wellbeing.

The five way to wellbeing framework comprises:

1. *Connect*
2. *Be Active*
3. *Take Notice*
4. *Keep Learning and*
5. *Give*.

A description of each aspect is summarised in the diagram below.


The rest of this section focuses on reviewing the prevalence of protective factors for adult mental health and wellbeing in Wiltshire. The following discussion of the distribution of mental health and wellbeing protective factors will be structured in terms of the “Five Ways to Wellbeing” themes.

**Connect**

Connecting with people around you such as family, friends, colleagues and neighbours is important to wellbeing. Building connections and strong personal, social and community networks can support people and communities, increasing their resilience and giving them cornerstones to guide them throughout their lives. These ‘connections’ start from very early in life and continue to be important at every phase of life.

The following sections contain data to help assess local prevalence of protective factors that relate to ‘Connect’

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Social Contact

The Adult Social Care User survey provides a source of data that can help contribute to a better understanding of the levels of connectedness in Wiltshire. Adult Social Care run an annual user experience survey of clients every year and every other year they also run a survey with carers. Both of these surveys ask about the amount of social contact individuals feel that they have.

Figure 15: Graph to show the proportion of adult social care users who reported as much social contact as they would like

The chart shows that around half of adult social care service users in Wiltshire have as much social contact as they would like. This suggests that there is significant scope to increase the proportion of users benefiting from good levels of social contact.

The proportion of carers benefiting from sufficient social contact is lower than for service users and lower than both national and regional averages. This is of concern as carers are considered at higher risk of mental health issues and this, in combination with low levels of protective factors increases the likelihood of poor mental health.
Loneliness

Loneliness represents the opposite end of the spectrum to connectedness and can be considered an inverse measure of connectedness. Age UK have estimated the percentage of the over 65 population at risk of loneliness. The distribution of risk of loneliness is illustrated in the chart below.

Source: Age UK, map of loneliness

This above diagram illustrates that the benefits of social connectedness are not evenly distributed within the county, with very different rates of loneliness risk being observed (from 7% to 75%). Areas such as Tidworth and Salisbury with their very high risk of loneliness are not benefiting from the protective effects of connectedness in the way that areas like Southern Wiltshire and Malmesbury are. These areas with high loneliness and probable poor connectedness may be at higher risk of poor mental health and wellbeing.
Breast Feeding
Another aspect that feeds into attachment and the connect theme is whether the mother breastfeeds her infant. Breastfeeding has been linked to positive emotional and physical health outcomes for children and also mothers. Investing in breastfeeding and relationship building is well recognised as a positive, proactive mechanism to promote mother-infant attachment behaviours. It also positively contributes to positive mental health and well-being for both the mother and the child. ¹⁸

The Wiltshire average for breastfeeding initiation in 2014/15 was 80.1%, which is higher than the national average of 74.3% and the South West regional average of 79%.

For the same period, 2014/15, 49.4% of babies in Wiltshire were being breast fed at 6-8 weeks, which is again higher than both the national and regional average (43.8% and 48.3% respectively).

Figure 18 to show breastfeeding initiation rates in Wiltshire 2009/10 to 2014/15:

Source: Department of Health Statistical Releases on Breastfeeding

Women from disadvantaged groups are less likely to breastfeed their baby than those who are better off financially. In Wiltshire 73% of mothers in the most deprived quintile initiated breastfeeding compared with 83% in the least deprived quintile (2014/15). By 6-8 weeks the gap widens with only 40% of those in the most deprived communities breastfeeding compared with 56% in the least deprived.

Age of mother has a strong significant impact upon breastfeeding initiation rates. The initiation rate of 59% amongst mothers aged 15-19 and 65% amongst mothers aged 20-24 are significantly lower than in any other age group and well under the all age

average of 81%. At 6-8 week breastfeeding rates are again lowest amongst infants of mothers aged 15-19 at only 16%, and this is a strongly significant difference compared to older age groups. It is less than half of the Wiltshire average rate. Infants of mothers aged 20-24 (24%) also have significantly lower 6-8 week breastfeeding rates compared with infants of older mothers.

Overall, it can be seen that while the general rates of breast feeding in Wiltshire are higher than the national average, they are still lower than the targeted rate. In addition, for the most deprived and the youngest mothers, who are also those often at highest risk of poor mental wellbeing outcomes, the rates of breast feeding are lowest. Thus the potentially mental health and wellbeing protective effects of breast feeding are not evenly distributed and are likely to be lowest in those most at risk.

Be Active

There is a considerable body of evidence about the positive effects of physical activity. Regular exercise such as team or individual sports, walking, cycling, and swimming can all improve concentration and reduce stress and anxiety.

NHS guidelines recommend that to stay healthy, adults aged 19-64 should try to be active daily and should do:

- at least 150 minutes of moderate aerobic activity such as cycling or fast walking every week, and
- strength exercises on two or more days a week that work all the major muscles (legs, hips, back, abdomen, chest, shoulders and arms).

The Public Health England Fingertips data provide a source of information on levels of physical activity in Wiltshire.
This data suggests that while Wiltshire performs well compared to the national average, there is still scope for improvement in physical activity to help maximise the protective mental health benefits for the population.

While the PHE fingertips data provides a snap shot of the current situation, the annual active people survey performed by Sport England can help provide trend data on levels of physical activity.

**Figure 20** Diagram to show the trend in active people as measured by the Active People Survey.
2014 saw an increase in the number of active people within Wiltshire, which is now higher than the South West average, it also remains higher than the England average.

**Figure 21** showing the breakdown of the Wiltshire figures into levels of activity as measured by minutes of Moderate or Vigorous intensity Physical Activity (MVPA).

This shows there has been a reduction in the inactive range with consequential increases in the more active groupings.

Together these two indicators suggest an encouraging trend for an important mental health protective factor. However, it is important to ensure that those who would benefit most are included in the increasing levels of activity.

**Take Notice**

Taking notice means “connecting with the world around you, being aware of yourself, others, the environment and what your feelings are about those things”. Research has shown that being trained to be aware of sensations, thoughts and feelings for 8 to 12 weeks has been shown to enhance well-being for several years\(^{19}\). Growing evidence suggests that contact with the natural world is also thought to have benefits for mental health and there is support for the hypothesis that green space reduces mental fatigue, ensuring that we are more able to assess and deal with life issues.\(^{18}\)

Access to green spaces

Wiltshire is a predominantly rural county with many green spaces. The map below details the designated areas of outstanding natural beauty and national parks in Wiltshire.

The Wiltshire “What Matters to you” survey was carried out between October and December 2013. It asked Wiltshire residents to comment on a range of topics that affect life where they live. As part of this survey views on parks and green spaces were surveyed.
Figure 22: Diagram showing satisfaction levels with public green spaces in Wiltshire by community area

![Diagagram showing satisfaction levels with public green spaces in Wiltshire by community area]

Source Wiltshire Intelligence Network, Environment section What matter to you report 2014 environment

The above data suggest that the majority of Wiltshire respondents (78%) were satisfied (either very satisfied or fairly satisfied) with the network of public green space in the local area. Of the community areas, Bradford on Avon had the highest satisfaction figure with 88% and Westbury the lowest with 70%. Just a slightly higher proportion of females than males (80% compared to 77%) were satisfied. There was no significant variation amongst the age groups.

Respondents were also asked whether they felt the natural environment was getting better or worse. The percentage of respondents that believed that the natural environment had got better (much better or better) in Wiltshire was 9%. The largest percentage (61%) thought that it was neither better nor worse, and 29% that it had got worse (worse or much worse). These results are similar to the ‘What matters to you 2011 survey’. There was hardly any variation between male and female responses. The community area that had the highest percentage of respondents who believed that the natural environment had got better was Calne (14%). Conversely, Westbury had the highest percentage of respondents who perceived that the natural environment had got worse (42%).

Continuing to maintain, and where possible improve on high levels of satisfaction with and use of public green spaces is important to ensure people can benefit from the mental wellbeing opportunities they offer.
There is a certain amount of conflicting evidence about the impact of digital and social media on mental health and emotional wellbeing. There is likelihood that long periods of time absorbed in digital or social media can have an impact on a persons’ ability to notice other things going on around them. However, it can also undoubtedly provide a rich source of information which contributes to lifelong learning.

There is very little local data on digital and social media engagement. However, the Wiltshire Emotional Health and Wellbeing School Health Survey 2015 can provide some data on post-secondary school age young adult behaviour patterns.

**Figure 23: Pie chart showing breakdown of time spent online by post-secondary school young adults**

Approximate time spent online/playing computer games last night

- <2 Hours
- 2-4 Hours
- >6 hours

Source: Wiltshire Emotional Health and Wellbeing School Health Survey 2015

Around a quarter of those surveyed reported spending more than six hours a night online. Not only does this represent a significant amount of time in which the respondents are less likely to be taking notice of the world around them; it also represents a potential loss of sleep which will further erode overall ability to take notice. Finding ways to get the very best out of digital engagement and to minimise its potentially negative impact looks set to continue to be a challenge for society as a whole.

**Keep learning**

Learning takes many forms, and includes formal learning as well as learning new things for fun, watching TV documentaries, reading or taking part in organised...
activities. Learning can take place a number of environments. Along with formal educational settings, the workplace is another common setting for learning new skills.

The following sections will focus primarily on education and employment.

**Employment**

Being in employment in a job which gives you some element of financial stability and job satisfaction is a protective factor against poor mental health. Conversely, being unemployed is a risk factor for poor mental health and wellbeing.

Job satisfaction and learning opportunities are often associated with higher tier jobs. As a county Wiltshire has a higher proportion of people employed in top tier jobs compared to the national average, and a correspondingly smaller proportion in the lowest tier.

**Figure 24: Table to show employment by occupation**

<table>
<thead>
<tr>
<th>Employment by occupation (Apr 2015-Mar 2016)</th>
<th>Wiltshire (Numbers)</th>
<th>Wiltshire (%)</th>
<th>South West (%)</th>
<th>England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soc 2010 Major Group 1-3</td>
<td>124,300</td>
<td>51.5</td>
<td>45.1</td>
<td>45.1</td>
</tr>
<tr>
<td>1 Managers, Directors And Senior Officials</td>
<td>39,300</td>
<td>16.2</td>
<td>11.4</td>
<td>10.6</td>
</tr>
<tr>
<td>2 Professional Occupations</td>
<td>48,000</td>
<td>19.8</td>
<td>19.4</td>
<td>20.0</td>
</tr>
<tr>
<td>3 Associate Professional &amp; Technical</td>
<td>37,100</td>
<td>15.3</td>
<td>14.2</td>
<td>14.3</td>
</tr>
<tr>
<td>Soc 2010 Major Group 4-5</td>
<td>44,700</td>
<td>18.5</td>
<td>22.0</td>
<td>21.1</td>
</tr>
<tr>
<td>4 Administrative &amp; Secretarial</td>
<td>22,600</td>
<td>9.3</td>
<td>9.9</td>
<td>10.6</td>
</tr>
<tr>
<td>5 Skilled Trades Occupations</td>
<td>22,000</td>
<td>9.1</td>
<td>12.0</td>
<td>10.4</td>
</tr>
<tr>
<td>Soc 2010 Major Group 6-7</td>
<td>35,400</td>
<td>14.7</td>
<td>17.0</td>
<td>16.7</td>
</tr>
<tr>
<td>6 Caring, Leisure And Other Service Occupations</td>
<td>20,100</td>
<td>8.3</td>
<td>9.6</td>
<td>9.1</td>
</tr>
<tr>
<td>7 Sales And Customer Service Occupations</td>
<td>15,300</td>
<td>6.3</td>
<td>7.3</td>
<td>7.5</td>
</tr>
<tr>
<td>Soc 2010 Major Group 8-9</td>
<td>36,900</td>
<td>15.3</td>
<td>16.0</td>
<td>17.1</td>
</tr>
<tr>
<td>8 Process Plant &amp; Machine Operatives</td>
<td>12,900</td>
<td>5.3</td>
<td>5.5</td>
<td>6.4</td>
</tr>
<tr>
<td>9 Elementary Occupations</td>
<td>23,900</td>
<td>9.9</td>
<td>10.4</td>
<td>10.7</td>
</tr>
</tbody>
</table>

Source: ONS annual population survey. Numbers and % are for those aged 16+. Percentage is a proportion of all persons in employment.

Since 2013 unemployment has been decreasing and the levels in Wiltshire remain below the national and regional average.
The age split of out of work benefit claimants in Wiltshire is given below. The percentage of Wiltshire claimants aged 16-17 are higher than the national average, with all other age bands being lower. These individuals are likely to be missing out on the protective factors associated with being in employment and continual learning and are also vulnerable to a number of other pressures such as financial and self-esteem issues that may make them particularly vulnerable to poor mental health.

Of those in Wiltshire who are economically inactive 34.1% want a job compared to 24.5% nationally\textsuperscript{20}. This suggests both that these people who want jobs but don’t have them may be at particular risk of the mental health downsides of not having a job and also that if job opportunities could be created they would be taken up and the protective benefits gained.

\textsuperscript{20} Nomis web data. www.nomisweb.co.uk
Education

Achieving 5 or more GCSEs at grades A*-C including English and Maths is associated with a reduced risk of depression at the age of 42 by five percentage points\(^{21}\).

The chart below shows comparative achievement levels for GCSE for Wiltshire against those for the South West and England as a whole.

Figure 27: Pupils Receiving 5 or more GCSE's at Grade A*-C

![Chart showing GCSE achievement levels in Wiltshire, South West, and England]


Amendments to the definition of this indicator were introduced in 2013 and, as a result, only annual data since the introduction of this change is presented in order to allow effective comparison between years. In 2015, the percentage of pupils in Wiltshire achieving 5 or more GCSE's including English and Mathematics at grades A*-C at the end of secondary school (Key Stage 4) was higher than that reported both regionally and nationally and has improved when compared against the previous year. Improvements shown in 2015 mean that Wiltshire now ranks in the top 25% of all Local Authorities in England.

The Adult Population survey provides data on education achievement levels nationally. This data shows Wiltshire to have a lower than average number of people with no qualifications.

Figure 28 Table showing educational qualification attainment in Wiltshire

<table>
<thead>
<tr>
<th>Qualifications (Jan 2015-Dec 2015)</th>
<th>Wiltshire (Level)</th>
<th>Wiltshire (%)</th>
<th>South West (%)</th>
<th>England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Levels</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NVQ4 And Above</td>
<td>107,100</td>
<td>37.4</td>
<td>37.3</td>
<td>36.8</td>
</tr>
<tr>
<td>NVQ3 And Above</td>
<td>174,600</td>
<td>61.0</td>
<td>60.4</td>
<td>57.1</td>
</tr>
<tr>
<td>NVQ2 And Above</td>
<td>223,700</td>
<td>78.1</td>
<td>77.6</td>
<td>73.4</td>
</tr>
<tr>
<td>NVQ1 And Above</td>
<td>255,700</td>
<td>89.3</td>
<td>89.7</td>
<td>85.0</td>
</tr>
<tr>
<td>Other Qualifications</td>
<td>14,600</td>
<td>5.1</td>
<td>4.8</td>
<td>6.6</td>
</tr>
<tr>
<td>No Qualifications</td>
<td>16,100</td>
<td>5.6</td>
<td>5.5</td>
<td>8.4</td>
</tr>
</tbody>
</table>

Source ONS annual population survey. Available from Nomis Web

Qualification levels in the table above are defined as follows:
- **No qualifications** - No formal qualifications held.
- **Other qualifications** - includes foreign qualifications and some professional qualifications.
- **NVQ 1 equivalent** - e.g. fewer than 5 GCSEs at grades A-C, foundation GNVQ, NVQ 1, intermediate 1 national qualification (Scotland) or equivalent.
- **NVQ 2 equivalent** - e.g. 5 or more GCSEs at grades A-C, intermediate GNVQ, NVQ 2, intermediate 2 national qualification (Scotland) or equivalent.
- **NVQ 3 equivalent** - e.g. 2 or more A levels, advanced GNVQ, NVQ 3, 2 or more higher or advanced higher national qualifications (Scotland) or equivalent.
- **NVQ 4 equivalent and above** - e.g. HND, Degree and Higher Degree level qualifications or equivalent.

When interpreting the above data it should be noted that the variables show the total number of people who are qualified at a particular level and above, so data in the tables are not additive.

Overall, this data suggest that Wiltshire achieves higher than national average levels of attainment in formal education and has higher than average numbers in satisfying employment. Such factors are likely to be protective for good mental health.

**Give**

This refers to making links to the wider community which can be incredibly rewarding and create lifelong connections to the people around an individual. It includes things like doing something nice for a friend, or a stranger, thanking someone, volunteering and joining a community group. Such activities have an individual benefit and foster increased social capital and community cohesion.

A number of volunteering opportunities are promoted throughout Wiltshire and more information can be found at http://www.wiltshire.gov.uk/communityandliving/voluntarycommunitysector/volunteering.htm
It is also important to reflect that, whilst ‘giving’ can have a positive impact on a person’s wellbeing, there is considerable evidence that caring responsibilities can have a negative impact. This suggests that the type of “giving” and the context are important.

There is little formal data available around this indicator making it hard to gauge the potential protective impact of “giving” as a construct and the extent to which it may be protective in Wiltshire. In addition, there is anecdotal evidence that some who experience mental health issues are put off volunteering due to concerns that engaging with volunteering will be interpreted by the DWP as indicating that the individual is fit to work.

**Recommendations arising from this section**

- Use evidence based research around protective and risk factors to inform all mental health and wellbeing prevention interventions
- Ensure protective factor based activities can accommodate those with mental health issues on a recovery path
- Consider interventions to ensure carers feel supported and connected
- Work with local areas to reduce loneliness in highest risk area
- Build on the recent momentum to further increase and consolidate physical activity levels in the county. Consider targeted interventions to ensure those who will benefit most are increasing their physical activity
- Work with local communities to develop an inclusive approach to the use of green spaces
- Work with the unemployed, particularly 16/17 year olds, and ensure that the support they receive includes a focus on resilience and mental wellbeing
Section C: Risk factors that impact emotional health and mental wellbeing

**Key points**

- There are a number of risk factors for experiencing poor mental health. The relationship between risk factors and mental health is often complex with many factors being both causes and effects of poor mental health.
- An understanding of local risk factors and their distribution allows services to be tailored to effectively manage local need.
- Risk factors can occur at a number of levels and this means that there are certain groups at increased risk of poor mental health as well as broader societal factors that can put people at risk.
- At risk populations may share some common characteristics but are diverse groups with diverse needs that need to be addressed at the individual level if services are to be effective. As a result services need to be culturally competent to cope with diverse groups.
- Within Wiltshire key high risk groups include minorities, older people carers, military and veterans, those with other issues such as poor physical health or learning disabilities and those at transition points e.g. moving out of care.
- The broader societal factors that increase the risk of poor mental health are complex and interconnected and will require a whole systems approach to amelioration.

The previous section discussed some of the protective factors that can have a positive impact on mental health and wellbeing. This chapter will consider the risk factors that are associated with mental health problems.

Whilst anyone can develop mental health problems or experience poor mental wellbeing, some groups are at higher risk due to their background or circumstances. They may benefit from specific or targeted interventions to improve mental health. Other groups may need to be considered due to specific health needs such as maternal mental health, mental health of veterans and transition between adolescent and adult services.

Dahlgren and Whitehead developed a model that can be used to consider the many levels at which health can be impacted and this is shown below.
In this model risk factors can be considered at the level of
1. Person specific factors
2. Individual lifestyle factors
3. Social and community level factors
4. General socio economic, cultural and environmental conditions

This section will focus primarily on the person specific factors and those more upstream issues that have not already been considered in their positive form in the context of the discussion of protective factors. For example, unemployment will not be discussed as a risk factor having already been covered in terms of the positive protective effects of secure employment in non-routine occupations.

**Specific population groups considered at risk of poor mental health and wellbeing**

**Ethnic Minority Groups**

At the national level, ethnic minority groups are known to be at increased risk of certain mental health conditions such as schizophrenia and psychotic disorders. The lower than national average proportions of black and ethnic minority populations in Wiltshire may mean that simply applying mental health prevalence data to the Wiltshire population will overestimate the prevalence of such conditions in Wiltshire. Conversely, the relatively rapid growth in ethnic minority groups means that current service levels and mix may not be sufficient for future populations. This balance will need to be borne in mind when planning services.
Refugees and Asylum seekers

An asylum seeker is a person who has applied for asylum under the 1951 Refugee Convention on the Status of Refugees on the grounds that if he or she is returned to his/her country of origin s/he has a well-founded fear of persecution on account of race, religion, nationality, political belief or membership of a particular social group. Once the application for asylum has been accepted the person becomes a refugee.

Many asylum seekers and refugees have undergone significant trauma and this has psychological sequelae. Common mental health issues experienced include issues such as post-traumatic stress disorder (PTSD), traumatic bereavement issues, depression and anxiety. The issues can relate both to experiences from the originating country, the journey to the UK or to the potentially isolating environment in which they now find themselves.

As of the end of 2016 there were 21 people settled in Wiltshire under the Syrian Vulnerable Persons Resettlement Scheme. This number is estimated to grow to around 50 by December 2017.

In addition to Syrian refugees there are a further 2 asylum seekers in receipt of Section 95 funding from Wiltshire Council. Section 95 support is the funding provided to asylum seekers whose claims are ongoing and who are currently excluded from working or seeking other benefits.

There is often significant stigma attached to mental health issues in many cultures asylum seekers come from, meaning such groups may be less likely to seek help and only present late with more complex needs.

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22 Data sourced from Wiltshire JSA health and wellbeing 2013/14 demographics:ethnicity
Overall, in Wiltshire, while the numbers of affected individuals may be small it is rising and, as a group, asylum seekers are likely to need culturally competent, mental health and wellbeing support capable of managing some complex health needs.

Currently Wiltshire Council Health Trainers working with individuals from this group of people report issues around the availability of culturally appropriate information which is hindering those in need from effectively accessing services and potentially isolating them.

**Migrants**

Migrants are people who choose to move and live in a different country not because of a direct threat of persecution or death, but mainly to improve their lives by finding work, or in some cases for education, family reunion, or other reasons. Again, this is a diverse population but it is generally recognised that by nature of being migrants they are at risk of worse mental health and wellbeing than UK born individuals.

The precise number of people who have come to Wiltshire as migrants since 2001 is unknown. The information presented here is based on data from 2009 and so may not accurately reflect the present situation.

Between January 2002 and December 2009 a total of 14,190 National Insurance Numbers were allocated to migrant foreign nationals starting work in Wiltshire. The EU A8 Accession states\(^{23}\) accounted for 6,650 of these migrant registrations. Poland is the most frequently occurring country of migrant origin with 5,405 nationals receiving UK National Insurance numbers. This number is likely to have risen in line with national trends since 2009.

The effects of Brexit on such populations remains to be seen. There has been a national increase in reported violence against and stigmatisation of migrant populations which may have negative mental health sequelae. Language barriers often make it difficult for these groups to access services and language may be a particularly acute barrier to participation where psychological talking therapies are required.

**Pregnant women and new parents**

Perinatal mental health problems are very common, affecting between 10-20% of women at some point during the perinatal period. They are important not just because of their adverse impact on the mother, but also because they have been shown to compromise the healthy emotional, cognitive and even physical development of the child, with serious long-term consequences.

Failure to treat perinatal disorders may result in long lasting and prolonged adverse effects on the relationship between the mother and other family members and on the child’s psychological, social and educational development. In addition, the economic impact of such disorders is large.

\(^{23}\) These comprise the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, and Slovenia
The long term cost of untreated perinatal mental health problems is estimated at £8.1bn a year. For Wiltshire this translates to an annual societal cost of £53 million, of which about £10m is borne by the public sector\(^{24}\).

There are a number of factors that are known to increase a woman’s risk of poor perinatal mental health. However it is important to note that the causes of perinatal mental illness are complex and heterogeneous, and these are risk factors rather than determinants of illness. Risk factors for poor perinatal mental health include\(^ {25}\):

- history of mental illness
- family history of mental illness
- psychological disturbance during pregnancy (e.g. anxiety or depression)
- lone parent or poor couple relationship
- low levels of social support
- recent adverse or stressful life events, this may include traumatic childbirth, having a still birth or infant mortality
- socio-economic disadvantage
- teenage parenthood
- early emotional trauma/childhood
- abuse
- unwanted pregnancy

In addition to the above, domestic abuse is independently associated with poor mental health. Domestic abuse can start or worsen in pregnancy and this can be an additional risk factor for issues such as depression, anxiety and PTSD.

The table below gives estimated rates of mental health problems in new mothers extrapolated for Wiltshire.

**Figure 31: Table to show estimated rates of mental health problems in new mothers in Wiltshire**

<table>
<thead>
<tr>
<th>Perinatal psychiatric disorder</th>
<th>Rates per 1000 maternities</th>
<th>Wiltshire estimates based on approx. 5,378 births</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Severe/known history</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postpartum psychosis</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Chronic serious mental issues</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Severe depressive illness</td>
<td>30</td>
<td>160</td>
</tr>
<tr>
<td><strong>Mild to moderate</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild to moderate depressive illness and anxiety states</td>
<td>100-150</td>
<td>540-810</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>30</td>
<td>160</td>
</tr>
<tr>
<td>Adjustment disorders and distress(^ {[1]} )</td>
<td>150-300</td>
<td>810-1,620</td>
</tr>
</tbody>
</table>

---


\([1]\) Local mental health specialists advised that many cases of adjustment disorders and distress are likely to fall under the category of mild rather than moderate concern.
Source: Joint Commissioning Panel for Mental Health (2012) Guidance for commissioners of perinatal mental health services.

As the table illustrates, there is a range of mental health issues that a woman can experience in the perinatal period with differing severity levels.

The most common perinatal mental health issue is perinatal depression affecting around 15% of women who give birth to live babies in the UK.

Around 4 in 1000 live births result in the need for admission to a specialist mental health mother and baby unit.

While occurring relatively infrequently, perinatal suicide is a serious public health concern given its devastating impact. One of the key findings of the triennial reports of the Confidential Enquiry into Maternal and Child Health (CEMACH) is that, until the most recent review, perinatal suicide was persistently the leading cause of maternal mortality in the UK.\(^{26}\)

Receiving appropriate perinatal mental health treatment remains an issue at a national level. A recent report for the Centre for Mental Health written in conjunction with the London School of Economics\(^ {27}\) has suggested that nationally about half of all cases of perinatal depression and anxiety go undetected. The Royal College of Obstetricians and Gynaecologists has estimated that only 7% of women who experience a perinatal mental health problem receive specialist referral.\(^ {28}\) This suggests a huge unmet need at a national level and it seems reasonable to assume that the local picture will be similar.

Nationally 29% of midwives reported receiving no specific pre-registration training in mental health and 42% of GPs said they lacked knowledge of specialist perinatal mental health services. Currently, there is also no specific perinatal mental health training for IAPT providers.\(^ {29}\) Locally, mental health training for health visitors is currently being rolled out.

Partners as well as mothers are also affected by the changes associated with having a new baby. This area is relatively under researched. A recent Royal College of Obstetricians and Gynaecologists survey has shown that 12% of women’s partners experienced a mental health problem during or after the pregnancy and were provided with little support.\(^ {30}\) In Wiltshire this would equate to approximately 675 partners per annum.

\(^{26}\) National Perinatal Mental Health Project Report

\(^{27}\) https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=4af7fe96-ca63-4f15-9c20-bf354a8b727f


\(^{29}\) Prevention in Mind, All Babies Count: Spotlight on Perinatal Mental Health, NSPCC

Care Leavers
The national mental health strategy, No Health without Mental Health (February 2011), highlights looked after children and care leavers as a group whose mental health needs are greater than those of the general population. Children often enter the care system with a poorer level of physical and mental health than their peers, and their longer-term outcomes can be worse. Estimates vary for the prevalence of mental health disorders in looked after children ranging from about half up to around three quarters for those in residential care.

The number of children looked after in the county fluctuates daily; the 12 month average figure for June 2015 to May 2016 was 405 children. If the percentages identified in the national studies are applied to the Wiltshire population we would expect the following:
- 182 children assessed as having a mental health disorder (45%)
- 150 children with conduct disorders (37%)
- 49 children with anxiety disorders (12%)
- 28 children with hyperactivity (7%)

Clearly only a proportion of children will leave care each year, but this represents an important group when planning services. Statutory guidance on Promoting the Health and Well-being of Looked After Children (November 2009) highlights the importance of care leavers being able to continue to obtain health advice and services, including mental health services. As discussed in the following section some children can fall between the gaps when transitioning from children’s to adult services. For looked after children this transition may be even more complex and the impacts even more pronounced with many aspects of life changing simultaneously. A Wiltshire “Care leavers Covenant” is currently being drawn up and ensuring mental health is considered as part of this should be a priority.

Those transitioning from children’s to adult’s mental health services
For many reasons, transition into adulthood and adult services can be a difficult time for vulnerable young people. Many children who experienced mental health or emotional wellbeing issues in childhood will go on to experience problems in adulthood.

In Wiltshire, children and young people who are receiving Child and Adolescent Mental Health Services (CAMHS) and are approaching their 18th birthday will usually be referred for transfer across to the adult service provider AWP. This is recognised to be a difficult transition and some young people will not meet the threshold for the adult equivalent services.

In 2015/16 the Oxford Health was subject to a CQUIN which stipulated an audit be conducted of patients who transitioned to adult services in AWP which included numbers referred to AWP and accepted. The Audit showed that out of 35 referrals from Wiltshire only 17 (49%) were accepted onto adult services. This means a
significant number of young people transition into adulthood with a level of mental health support that is much reduced from the level they had been living with and these people may be left feeling abandoned by health services at a difficult time.

For patients who were over 18 and did not meet the criteria for adult services, they were usually helped as much as possible and directed towards services like IAPT, or ADHD/Autism services in Bristol.

When talking to providers as part of the needs assessment process it became clear that there is still significant frustration around this transition period. It is felt that little progress has been made in the past decade as this still remains a point of concern despite having been identified before. One issue is that there appears to be a lack of clarity around perceived thresholds for acceptance into AWPs adult mental health services and how best to support those who are not taken on by AWP. A second issue is that despite the 0-25 team, customers often only become known to adult services a short time before their 18th birthday, at which point it is hard to plan an effective transition.

People with learning disabilities
The presence of a learning disability is associated with increased risk of mental health problems. There is also an increased likelihood of associated physical health problems e.g. epilepsy which may also impact upon mental health and wellbeing.

Figure 32: Table showing summary Wilshire statistics around prevalence of learning disabilities

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Wilshire Count</th>
<th>Wilshire Value</th>
<th>England Count</th>
<th>England Value</th>
<th>Worst/Lowest</th>
<th>Range</th>
<th>Benchmark Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning disability: QOF prevalence (All ages)</td>
<td>2014/15</td>
<td>1,906</td>
<td>0.40%</td>
<td>0.47%</td>
<td>0.44%</td>
<td>0.21%</td>
<td></td>
<td>0.78%</td>
</tr>
<tr>
<td>Adults (16 to 64) with learning disability getting long term support from Local Authorities</td>
<td>2014/15</td>
<td>905</td>
<td>3.20</td>
<td>3.67</td>
<td>3.73</td>
<td>1.78</td>
<td></td>
<td>7.29</td>
</tr>
<tr>
<td>Children with Moderate Learning Difficulties known to schools</td>
<td>2014</td>
<td>1,513</td>
<td>21.0</td>
<td>22.4</td>
<td>26.6</td>
<td>6.6</td>
<td></td>
<td>66.4</td>
</tr>
<tr>
<td>Children with Severe Learning Difficulties known to schools</td>
<td>2014</td>
<td>254</td>
<td>3.52</td>
<td>3.91</td>
<td>3.80</td>
<td>1.12</td>
<td></td>
<td>8.31</td>
</tr>
<tr>
<td>Children with Profound &amp; Multiple Learning Difficulty known to schools</td>
<td>2014</td>
<td>-</td>
<td>*</td>
<td>1.25</td>
<td>1.29</td>
<td></td>
<td></td>
<td>Insufficient number of values for a spine chart</td>
</tr>
<tr>
<td>Children with Autism known to schools</td>
<td>2014</td>
<td>948</td>
<td>13.1</td>
<td>9.9</td>
<td>10.8</td>
<td>4.1</td>
<td></td>
<td>25.1</td>
</tr>
<tr>
<td>Children with learning disabilities known to schools</td>
<td>2014</td>
<td>1,767</td>
<td>24.5</td>
<td>27.6</td>
<td>33.7</td>
<td>4.5</td>
<td></td>
<td>71.4</td>
</tr>
</tbody>
</table>

Source: PHE fingertips data

The prevalence of mental health problems in adults with a learning disability is considerably higher than found in the general population. Estimates of prevalence range between 30% to 50%31. Unsurprisingly, a disproportionately high prevalence of mental health issues also occurs in children with learning disabilities. The

prevalence of psychiatric disorders among children with learning disabilities is 36%, compared to 8% among children without learning disabilities.

People with learning disabilities and mental health problems can have the full range of mental illnesses seen in the general population such as schizophrenia, bipolar disorder, depression, anxiety disorders, specific phobias, agoraphobia, obsessive compulsive disorder and dementia.

In addition, a significant number of people with learning disabilities display behaviour problems that are described as challenging. These include aggressive behaviour directed towards others, self-injurious behaviour, and a range of socially unacceptable behaviours. Some of these behaviours may be sufficiently severe to lead to contact with the criminal justice system. Behaviour described as challenging should not be confused with mental health problems, although people may have both and the presence of the former can make accessing suitable mental health services harder. There is also a high prevalence of autism spectrum disorders in people with learning disabilities. Autism is not considered a mental health disorder.

**Figure 33 Diagram to show the complex and overlapping mental health needs of people with learning disabilities**

![Diagram](image_url)

Source: “Mental health services for people with learning disabilities” Joint commissioning panel for mental health;

From figure 33 above, it can be seen that there are an estimated 1,906 people of all ages with learning disabilities in Wiltshire and 905 adults with learning disabilities getting long term support.
Applying the suggested 30-50% prevalence of mental health problems to the adult number provides an estimate of between 300 and 450 adults in Wiltshire with learning difficulties who have co-existing mental health problems. These people are often deemed to be complex cases and thus may find accessing appropriate, holistic care difficult.

As might be expected, the support services needed by people with these complex and overlapping needs can often be complex and expensive. The mental health needs of this group should not be considered in isolation from their other needs. However, there are often boundary disputes between services, and this results in poorer outcomes for the individuals involved.32

**Older people and those with dementia**

Although age-related decline in mental wellbeing should not be seen as inevitable, older people form the majority of people using general health and social care services. Like other health problems, mental health problems also often increase with age.

The five key factors that affect the mental health of older people are illustrated in the diagram below.

**Fig 34. Diagram to show 5 key factors that influence the mental health of older people**

![Diagram](image)

The 5 key factors that affect the mental health and wellbeing of older people are: discrimination, participation in meaningful activities, relationships, physical health and poverty. (Age Concern and the Mental Health Foundation, 2006)

This suggests that times such as retirement when a person may lose participation in meaningful activity, lose the benefit of work relationships and experience a reduction in income are likely to be particularly high risk times for poor mental health. Bereavement is another point in life where older people are at particularly high risk of suffering mental health problems.

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Contrary to some perceptions, the majority of the mental health morbidity in older people is not dementia, but other functional illnesses such as depression and psychosis though these can, and frequently do, co-exist with dementia.  

The most common presenting conditions for older people are depression, schizophrenia and memory problems.

**Depression** is common in people over the age of 65. Depression affects around 22% of men and 28% of women aged 65 years and over, yet it is estimated that 85% of older people with depression receive no help at all from the NHS.  

**Schizophrenia** is common in older people, with 20% of people over 65 developing psychotic symptoms by age 85. Older people with schizophrenia include those who have grown old with the condition and those who have developed the illness in later life. Paranoid ideas and delusions can also occur with a dementing illness, and people with these needs require care along the same lines as other people with dementia. Differentiating between the two requires specialist expertise.

**Dementia** is known to affect around 800,000 people in the UK. This is expected to almost double within 30 years. In addition, only 40% of cases of dementia are currently diagnosed and as this increases there will be an additional increase in those seeking treatment. Memory assessment services specialise in the diagnosis and initial management of dementia and are often the single point of referral for people with a possible diagnosis of dementia.

This health needs assessment will not focus on dementia.

**Suicide**: Historically older people were at greater risk of suicide, but more recent data suggests a similar risk compared to younger adults. However, a suicide attempt in an older person is more likely to be successful than in younger people. Depression, pain and physical disability are all associated with increased risk of suicide. When older people are treated for depression, quality of life improves. Higher suicide rates may not be a characteristic of old age depression but rather a consequence of a failure to diagnose and treat it.

Wiltshire currently has a percentage of residents aged over 65 that is higher than the national average (20.4% for Wiltshire vs 17.7% nationally). Projections suggest that in 2026 the number of people over the age of 65 will for the first time out-number those under the age of 20.

The over 65 age group represents a population subgroup who are likely to need significant mental health and wellbeing support in an age appropriate form that can cater to their specific needs.

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34 https://www.mentalhealth.org.uk/statistics/mental-health-statistics-older-people
LGBT communities

Studies show that lesbian, gay and bisexual people show higher levels of anxiety, depression and suicidal feelings than heterosexual men and women\(^\text{36}\).

Rates of drug and alcohol misuse have also been found to be higher in some studies. However, the picture is uncertain because of the reluctance of some patients to disclose their sexuality, exacerbated by the fact some healthcare staff feel uncomfortable asking the question\(^\text{26}\).

Nationally, poor levels of mental health among gay and bisexual people have often been linked to experiences of homophobic discrimination and bullying. Although society is changing and homophobic prejudice is less common than it used to be, many lesbian, gay and bisexual people have experienced a range of difficulties in their lives. These can contribute to mental health problems. For some, other factors such as age, religion or ethnicity can further complicate mental distress. Many gay people have experienced:

- hostility or rejection from family, parents and friends
- bullying and name calling at school
- rejection by most mainstream religions
- danger of violence in public places
- harassment from neighbours and other tenants
- casual homophobic comments on an everyday basis
- embarrassed responses (and occasionally prejudice) from professionals, such as GPs
- no protection against discrimination at work
- negative portrayal of gay people in the media

Experiencing these difficulties can mean many gay and bisexual people face mental health issues, including:

- difficulty accepting their sexual orientation, leading to conflicts, denial, alcohol abuse and isolation
- trying to keep their sexuality a secret through lying, pretending or leading a double life
- low self-esteem
- increased risk of self-harm and suicide attempts
- damaged relationships or lack of support from families
- post-traumatic stress disorder and depression from long-term effects of bullying

There is a significant lack of statistical information about sexual orientation and this knowledge gap is acknowledged at national level (the Equalities Review, Fairness and Freedom, 2007). Moreover, the 2011 Census did not include questions on sexual orientation.

\(^{36}\) NHS choices from http://www.nhs.uk/Livewell/LGBhealth/Pages/Mentalhealth.aspx
Some surveys have been conducted at national level or in specific geographic areas but none can really be used to estimate the number of lesbian, gay, and bisexual individuals in Wiltshire.

The table below contains the results of the Integrated Household Survey, April 2009 to March 2010 and it shows that 1.8% of the population in the South West reported that they were gay/lesbian or bisexual; the second highest figure of the English regions.

Figure 35: Table to show sexual identity by Government Office Region In England (As at March 2010)

<table>
<thead>
<tr>
<th></th>
<th>Heterosexual/Straight</th>
<th>Gay/Lesbian, Bisexual</th>
<th>Other</th>
<th>Don’t know/refusal</th>
<th>Non response</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td>96.7</td>
<td>1.1</td>
<td>1.5</td>
<td>1.3</td>
<td>0.4</td>
</tr>
<tr>
<td>North West</td>
<td>95.5</td>
<td>1.5</td>
<td>0.3</td>
<td>2.2</td>
<td>0.4</td>
</tr>
<tr>
<td>Yorkshire and The Humber</td>
<td>95.4</td>
<td>1.5</td>
<td>0.5</td>
<td>2.1</td>
<td>0.4</td>
</tr>
<tr>
<td>East Midlands</td>
<td>96.0</td>
<td>1.1</td>
<td>0.4</td>
<td>2.3</td>
<td>0.3</td>
</tr>
<tr>
<td>West Midlands</td>
<td>93.3</td>
<td>1.2</td>
<td>0.7</td>
<td>4.3</td>
<td>0.5</td>
</tr>
<tr>
<td>East of England</td>
<td>95.0</td>
<td>1.1</td>
<td>0.4</td>
<td>3.2</td>
<td>0.3</td>
</tr>
<tr>
<td>London</td>
<td>92.3</td>
<td>2.2</td>
<td>0.6</td>
<td>4.2</td>
<td>0.6</td>
</tr>
<tr>
<td>South East</td>
<td>94.7</td>
<td>1.5</td>
<td>0.6</td>
<td>2.8</td>
<td>0.5</td>
</tr>
<tr>
<td>South West</td>
<td>95.4</td>
<td>1.8</td>
<td>0.4</td>
<td>2.0</td>
<td>0.4</td>
</tr>
</tbody>
</table>


Overall, while the precise picture of mental health need at the Wiltshire level remains uncertain for the reasons outlined above, it is likely that the LGBT community has higher than average mental health and wellbeing need as well as higher than average barriers to accessing support.

Feedback from the Wiltshire and Swindon Public Sector LGBT forum has suggested that areas of particular local need are around access to culturally competent services to address bullying, suicide, eating disorders (particularly in gay men) and relationship breakdown and bereavement. The forum also raised the points that there is a local lack of adult support groups and high rates of local self-identity issues. There are very limited local LGBT community social hubs, which increases
the use of internet dating sites and the resulting mental health pressures that arise from reliance on such social media based forms of socialising.

**Military**

Wiltshire has a significant military population and this is expected to grow. (see demographics section). Military personnel and dependants are estimated to constitute over 20% of the total population in Bulford, Durrington, Upavon, Warminster East, Lyneham, Nettleton and Colerne wards, with this figure reaching 75% in Tidworth.

Most British military personnel do not experience mental health problems while they are in service, or afterwards in civilian life. However they face unique risks in service and, if they do experience mental health problems, they may require particular treatments and particular mental health services. Wiltshire Council is signed up to the Military Covenant which is designed to ensure military personnel are treated fairly and not disadvantaged for serving on behalf of the nation.

The mental health problems experienced by military personnel are the same as the general population, although experiences during service and the transition to civilian life mean that their mental ill health may be triggered by different factors. Post-Traumatic Stress Disorder (PTSD), depression, anxiety and substance abuse affect a significant minority of service personnel and veterans.

**Serving personnel**

A number of UK studies have found links between active service and mental health problems in armed service personnel involved in recent conflicts. A recent study\(^{37}\) of 10,000 serving personnel (83% regulars; 27% reservists) found common mental disorders and alcohol misuse were the most frequently reported mental health problems among UK armed forces personnel. In particular, levels of alcohol misuse overall were substantially higher than in the general population. Levels of PTSD were lower than expected. The main findings were:

- 4% reported probable post-traumatic stress disorder
- 19.7% reported other common mental disorders
- 13% reported alcohol misuse
- regulars deployed to Iraq or Afghanistan were significantly more likely to report alcohol misuse than those not deployed
- reservists were more likely to report probable post-traumatic stress disorder than those not deployed
- regular personnel in combat roles were more likely than were those in support roles to report probable post-traumatic stress disorder
- experience of mental health problems was not linked with number of deployments

Current estimates suggest that there are 14,452 army service personnel in Wiltshire and that by 2020 this number will be 17,910. While numbers of RAF and Navy

personnel are hard to estimate it is thought there may be around 1,000 based in MOD locations around the county.

**Veterans**

In the UK, a veteran is anyone who has served for at least one day in the Armed Forces (regular or reserve), as well as Merchant Navy seafarers and fishermen who have served in a vessel that was operated to facilitate military operations by armed forces.

Military veterans are a largely hidden population. A significant number of those who have served in the UK armed forces would not even identify themselves as veterans; younger veterans may describe themselves as ‘ex-military’, but would associate the term veteran with the older generation as seen in Remembrance Day parades.

In the UK there are approximately 5 million veterans, around half of whom left the Services before 1960. This means that on average, around 8% of the national population comprises veterans. However, those geographical areas with strong historical ties to the Armed Forces can be expected to have a significant proportion of service personnel retiring from the Armed Forces. Wiltshire is one such area.

It is very difficult to accurately assess the number of veterans in Wiltshire or indeed anywhere in the UK. The Royal British Legion (RBL) has undertaken national estimates based on Office of National Statistics and other data sources, such as pension and compensation payments. In 2014 Wiltshire Council undertook its own local research and produced a report titled: “Veterans population in Wiltshire.” This states:

“This report, can with confidence account for approximately 70% of veterans in Wiltshire, based on an estimated population of 53,603. (This is equal to 11.6% of the population of Wiltshire).”

**Figure 36; Table to show estimate of veteran population in Wiltshire**

<table>
<thead>
<tr>
<th>Significant data source used</th>
<th>Number in Wiltshire</th>
<th>% of estimated veteran population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armed Forces Pension Scheme (AFPS) recipients</td>
<td>11,615</td>
<td>22%</td>
</tr>
<tr>
<td>Male Wiltshire population aged 72 and over (adjusted) (who will have completed National Service)</td>
<td>23,000</td>
<td>43%</td>
</tr>
<tr>
<td>RBL beneficiaries</td>
<td>2,495</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total accounted for</strong></td>
<td><strong>37,109</strong></td>
<td><strong>70%</strong></td>
</tr>
<tr>
<td><strong>Total veteran estimate for Wiltshire</strong></td>
<td><strong>53,603</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

When staff leave HM Forces, their healthcare transfers from the military to the NHS. Assessing the mental health need of veterans is complex. Around 0.1% of regular

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38 [https://www.mentalhealth.org.uk/a-to-z/a/armed-forces-and-mental-health](https://www.mentalhealth.org.uk/a-to-z/a/armed-forces-and-mental-health)
service personnel are discharged annually for mental health reasons. However, some veterans develop mental health problems after leaving service, many of whom will be experiencing PTSD. Until recently, little was known about these veterans. What is known is that only half of those veterans experiencing mental health problems sought help from the NHS, and those that did were rarely referred to specialist mental health services.

Veterans’ mental health problems may be made worse or caused by post-service factors, such as the difficulty in making the transition to civilian life, marital problems, and loss of family and social support networks. Younger veterans are at high risk of suicide in the first two years after leaving service. Ex-service personnel are also vulnerable to social exclusion and homelessness, both of which are risk factors for mental ill health. Alcohol misuse is also high further contributing to the mental health risk.

Taken together this evidence suggests that veterans make up a sizeable proportion (11.6%) of Wiltshire’s population and that they are a heterogeneous and mainly hidden population who are likely to have complex and often unmet mental health needs.

Service Families
Service families require access to the same primary and community health care services as the general public but may have additional needs unique to service families.

Many service families are young families, lacking the support of nearby extended family networks and having to cope with long periods of separation from their loved ones deployed overseas or on training. In addition, surges in demands on maternity services are frequently seen following the return of military units from operational deployments. These pregnant women will experience the heightened mental health risks discussed under pregnant women and new parents, but their issues may be compounded by their partners returning to active service and not being present as co-parents.

This suggests that areas with a high military presence, and thus high concentration of service families may require additional mental wellbeing support services.

Carers
‘Carers’ refers to people who provide unpaid care to a child, relative, friend or neighbour who is in need of support because of age, addiction, mental or physical disability or illness. There are currently around five million people in England providing support to relatives or friends in need of care, with approximately 70% providing care to older people. The majority of carers are of working age but 1 in 6 are older people themselves.

Many carers gain satisfaction from their role, however there are also negative aspects to care-giving. For example, there is plenty of evidence that poor carer health is particularly associated with supporting older people with cognitive impairment.
The 2011 Census found there were an estimated 47,000 (unpaid) carers in Wiltshire (1 in 10 people). With the number of older people estimated to grow this figure is also likely to rise. In line with national trends, we are also likely to see a rise in the number of “sandwich carers” who care both for young children and older adults.

The statistics around mental health and caring vary. A 2013 Carers UK survey\(^{39}\) found that 92% of carers said that their mental health has been affected by caring with only 1% saying that caring has improved their mental health. The Joint Commissioning Panel for Mental Health\(^{40}\) have suggested that 30% of carers will suffer from depression at some stage. Such problems have ramifications not just for the carer but also for the cared for as carer breakdown has been found to be a trigger for people entering long term formal care.

Carers UK have suggested five ways in which carers can be better supported to improve their own wellbeing. These are:

- Ensure better access to support and information.
- Deliver services and workplaces that support carers to juggle work and care.
- Act urgently to prevent carers’ financial hardship.
- Ensure carers are able to achieve the best health outcomes possible.
- Deliver high quality care and improve the interface between health and social care services.

The recent local carer survey (see section on “connect” as a protective factor) has shown that Wiltshire carers report lower than national and regional average levels of satisfaction with their level of social contact. Given the known importance of social contact in maintaining emotional wellbeing there is a real concern that the large and growing numbers of Wiltshire carers may be at heightened risk of poor mental health when compared not just to the general population but also to other carers nationally.

**Offenders and Ex-Offenders**

The relationship between mental health and offending is complex and not fully understood. Poor mental health may make offending more likely and vice versa.

**Offenders:**

It is widely acknowledged that the prevalence of psychiatric morbidity and substance misuse is higher among prisoners than the general population. Some studies suggest the prevalence in prisoners of mental disorders (including personality disorders and substance misuse) is as high as 90%\(^{41}\).

Wiltshire has a single category C prison, HMP Erlestoke, which holds adult male sentence prisoners with a maximum capacity of 494 and an annual turnover of approximately 630.

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\(^{39}\) https://www.carersuk.org/for-professionals/policy/policy-library/the-state-of-caring-2013


\(^{41}\) Singleton et al, 1998
A local health needs assessment\textsuperscript{42} found that prisoners feel mental health issues (depression/anxiety and self-harm) are a significant issue at the prison and this was supported by the focus group discussion. Since being in prison, approximately a third felt their mental health was better, a third the same and a third felt their mental health was worse.

Prevalence of dual diagnosis (mental health problems combined with drug and/or alcohol problems) among prisoners with mental health problems is recognised to be high, however the health needs assessment noted that “services are not well organised to meet this need”. Many people with ‘dual diagnosis’ have multiple needs: including isolation, exclusion and marginalisation, experience of trauma and abuse, homelessness, a history of offending, and contact with the criminal justice system.

The majority of prison health needs assessment survey responses regarding the mental health service were broadly positive, and comments about the service and Mental Health Nurse Specialists (MHNS) were complementary. However, remarks were made in both the survey and focus groups regarding difficulty in accessing the service. Prison mental health has recently been in the news agenda with rising rates of prison suicides being reported nationally.

\textbf{Probation:}
Probation Trusts across the country supervise offenders over the age of 18 who are given a community order by the courts or are released from prison on licence. They also work with the victims of serious crimes.

Probation service users are a vulnerable group who are likely to experience health inequalities. Data suggest that four in ten offenders in the community have mental health problems. Women on probation appear to have higher levels of mental health need than men: one in three women compared to one in five men. This population are more likely to experience problems with mental health, drug and alcohol misuse.

A local health needs assessment of the needs of probation service users\textsuperscript{43} found

\begin{itemize}
  \item A general consensus amongst Probation staff and service users that alcohol, drugs and mental health are the ‘greatest’ health problems for this population.
  \item 20\% of the caseload had emotional wellbeing linked to risk of reoffending.
  \item Accommodation, finance and alcohol were found to be significantly associated with mental health of this client group.
  \item Those with emotional well-being linked to risk of reoffending are more than twice as likely as those without to have alcohol use recorded as a significant problem.
  \item More than 1 in 10 on the caseload was recorded as having no fixed abode or transient in accommodation.
\end{itemize}


Those who self-defined problems with managing money or dealing with debts were 59% more likely to have emotional wellbeing linked to risk of reoffending than those who did not consider this as an issue.

Research shows that 35% of people on probation experience depression. This is compared to an estimate of 8-12% in the general population. Results from the HNA estimated that 35% (based on the survey) to 38% (based on OASys data) experience depression whilst on Probation.

14% of the caseload were identified as at risk of deliberate self harm.

Dual diagnosis (a mental health condition co-occurring with substance misuse) featured as a major issue.

Literature shows that those screened as positive for a mental illness also tend to have drug problems and that the majority have alcohol problems.

Locally, dual diagnosis was seen as a main barrier to accessing mental health service.

This suggests that probationers are a group with high mental health needs complicated by co-existing substance misuse problems, and other social and emotional needs. Addressing these needs will benefit not just the individuals but society as a whole.

**Those in contact with police services**

Wiltshire police have a number of interfaces with mental health services. These include the control room triage team, the mental health and liaison service and involvement in section 136 detentions.

*Control room Triage Service:*
This service evolved from the street triage pilot and following its success as a pilot programme was commissioned as a substantive service. It provides a mental health professional based in the police control room to assist with ensuring an individual in mental health crisis receives the most appropriate support, achieved by offering professional advice, accessing health information and liaising with other care services.

*Police mental health liaison and diversion service:*
The Mental Health Liaison and Diversion Service from AWP provides mental health practitioners who work in the custody units and provide assistance for those in custody suspected of having a mental health issue. They aim to offer timely and comprehensive assessments for individuals with mental health issues, providing reports to inform sentencing decisions, appropriate diversions from custody and liaison with treatment providers.

Between April 2016 and March 2017, 232 cases were referred to the police mental health liaison service of which the majority (82%) were male. Of these referrals 88% engaged with the service, which is a higher rate than the national average of 76% engagement. Of the 232 referred cases 84% were identified as having a mental health need with the top identified conditions being depression, schizophrenia, anxiety/phobia/panic disorder/OCD/PTSD and personality disorder. Only 67% of the referrals were already known to mental health services.
The police mental health liaison nurses reported a local need for increased ease of referral to services addressing homelessness, drug and alcohol problems and a clear pathway for people with personality disorders.

_Section 136 procedures_

Section 136 is the section of the Mental Health Act that authorises the police to take someone to a place of safety from a public place. A person can be detained for 72 hours during which time a mental health act assessment will be performed. Since the introduction of the control room triage service the number of section 136 procedures has decreased and the proportion that result in hospital admissions has increased. In Wiltshire, recent analysis shows 62% of section 136 detentions resulted in the person being hospitalised for treatment.

The Policing and Crime Act (likely to be in force from May 2017) will bring changes to both how and where section 136 powers can be used. The Wiltshire Police have expressed concerns this may lead to extra pressure on the force. Specifically there is a concern that if pressure on health and social care services grows police will be increasingly called on by health professionals to use their section 136 powers. Any potential impact resulting from the changes will need to be monitored and managed appropriately.
Figure 37 A summary of Wiltshire police mental health liaison service data.
Broader societal factors associated with increased risk of poor mental health and wellbeing

Housing and homelessness

Housing and mental health

Good quality, affordable, safe housing underpins our mental and physical well-being.

The mental health strategy for England, No Health Without Mental Health, stresses the importance of housing for everyone’s mental health and particularly for those recovering from mental health problems.

Compared with the general population, people with mental health conditions are nationally one and a half times more likely to live in rented housing, with greater uncertainty about how long they can remain in their current home. They are twice as likely as those without mental health conditions to be unhappy with their housing and four times as likely to say that it makes their health worse. Mental ill health is frequently cited as a reason for tenancy breakdown and housing problems are often given as a reason for a person being admitted, or readmitted, to inpatient care.

Poor housing can be both a cause and effect of poor mental health. People with mental health problems, particularly those with a serious mental illness, can sometimes find it difficult to secure and maintain good quality accommodation. Those who experience mental health problems can sometimes find that becoming unwell unwittingly ends up with the breakdown of a tenancy. Losing a job, and hence the ability to pay their mortgage or rent, may also lead to the loss of a family home. Being homeless, on the streets, or insecurely housed, can further exacerbate mental and physical ill health. It is estimated that up to half of those sleeping rough have mental health problems. (Shelter www.shelter.org.uk)

Housing and accommodation can contribute to poor mental health via factors such as

- Problems with neighbours
- Poor quality housing e.g. damp, mould, unreliable utility supplies
- Poor relationships with those you share a house with
- Financial pressures resulting from keeping up with rent or mortgage payments

There are limited sources of local data around accommodation and mental health problems in Wiltshire.

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44 NHS confederation at http://www.nhsconfed.org/~media/Confederation/Files/Publications/Documents/Housing_MH_021211.pdf
45 NHS confederation at http://www.nhsconfed.org/~media/Confederation/Files/Publications/Documents/Housing_MH_021211.pdf
The data that is available only covers those with more severe mental health issues who come under the care of secondary mental health services. To further complicate matters, the available data only refers to patients managed under the Care Programme Approach (CPA). This is a level of care planning which is only indicated for patients who are more severely unwell and with more complex needs. As a result, we lack information for those who have a mental health problem that may be very significant in terms of impairment but which does not meet the threshold for secondary care services. As at the end Q2 2015/16 the number of people in Wiltshire on a CPA was 2,755, representing roughly 47% of mental health service users.

**Fig 38 Chart to show the percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation in Wiltshire**

![Chart showing percentage of adults in contact with secondary mental health services](image)

- **Male**: 52.5%
- **Female**: 49.9%

**Source PHE Fingertips PHOF data**

Overall, the data suggests that 51.3% of adults on CPA (aged 18-69 years) were living in stable and appropriate accommodation in Wiltshire in 2014/15. Expressed another way, almost half of adults on a CPA are not in stable and appropriate accommodation. This is liable to have a significant impact on their ability to improve their state of mental health and wellbeing.

**Homelessness**
As discussed above, deteriorating mental health can result in homelessness and we know many homeless people suffer mental health problems. It is estimated that up to half of those sleeping rough have mental health problems. (Shelter www.shelter.org.uk)

Defining homelessness can be a complex issue and some have sought to make a distinction between being roofless (commonly considered as “sleeping rough”) and the bigger issue of those who are homeless in the sense they lack a secure and stable home e.g. are sofa surfing or in temporary accommodation such as B&Bs. Both states of homelessness have implications for mental health.
Public Health outcomes framework data for 2015/16 estimate there are 23 homeless (roofless) people in Wiltshire leading to a crude rate of 0.1 per 1000 households being considered to be homeless. This is lower than national figure for England of 0.9 per 1,000 households. The number of households considered statutory homeless and in temporary accommodation in Wiltshire in 2015/16 was 127 or a crude rate of 0.6 per 1,000 households. Again, this is significantly lower than the national average of 3.1 per 1,000 households.

An up to date list of organisations assisting homeless people can be found at http://www.homeless.org.uk/homeless-england/search?search_api_views_fulltext=wiltshire&field_homeless_link_member=All

The police mental health liaison service report that finding accommodation for individuals who have been detained by the police and have no fixed abode to return to is a significant problem locally. Often such people are deemed unsuitable for temporary or hostel accommodation due to complex issues such as mental health, drug and alcohol abuse or combinations of the above.

Crime
A previous section has looked at the links between criminal offending and mental health. There are also links between local crime rates and the mental wellbeing of residents. The evidence shows that crime causes considerable mental distress to residents and that property crimes have the greatest impact with violent crime also having an impact. The impact is greater for women than for men and is mainly related to depression and anxiety. The impact is relatively large with an increase in mental distress following a one standard deviation increase in local crime being 2-4 times as large as the impact of a one standard deviation decrease in local employment.

As illustrated in the diagram below Wiltshire experiences relatively low rates of crime as a county. This however masks the facts that there are pockets of high crime, and in these regions the mental health impact on residents can be expected to be large.

46 http://www.ucl.ac.uk/~uctpb21/Cpapers/Crime_and_Mental_Health%20EJ.PDF
47 http://www.ucl.ac.uk/~uctpb21/Cpapers/Crime_and_Mental_Health%20EJ.PDF
Domestic abuse
Domestic violence and abuse is: any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality.

Men and women with mental health disorders, across all diagnoses, are more likely to have experienced domestic violence than the general population.

Poor mental health can be both a risk factor for experiencing and indeed perpetrating domestic violence, as well as the result of experiencing domestic violence. In addition, as well as affecting those directly linked to the domestic violence there can be a knock on effect on the mental health of children who witness or live in households affected by domestic abuse.

Compared to women without mental health problems, women with depressive disorders were around two and a half times more likely to have experienced domestic violence over their adult lifetime (prevalence estimate 45.8%). Women with anxiety disorders were over 3 and a half times more likely to have experienced domestic violence (prevalence estimate 27.6%); and women with post-traumatic
Adult Mental Health and Emotional Wellbeing: Health Needs Assessment for Wiltshire

stress disorder (PTSD) were around 7 times more likely (prevalence estimate 61.0%) 48.

Domestic violence commonly results in victim self-harm. National research found that one third of women attending emergency departments for self-harm were identified as survivors. Nationally, around 500 women who have experienced domestic violence in the last six months commit suicide every year. Of those, just under 200 attended hospital for domestic violence on the day that they committed suicide 49.

The mental health effects of domestic abuse have an impact on the next generation. The mental health of a mother suffering domestic abuse is the most significant determinant of her child’s resilience. Domestic violence impairs children’s emotional, behavioural and cognitive development. Its effects include anxiety, fear, withdrawal, highly sexualised and aggressive behaviour, reduced educational achievement, failure to acquire social competence, anti-social behaviour, and the use of drugs. All of which go on to have long term emotional health and well being consequences.

For older adults mental health factors such as depression and dementia have been found to increase the risk of abuse within a care giving relationship.

The mental health needs of perpetrators are complex. An early study suggested that 88% of male perpetrators and 65% of female perpetrators had mental health problems 51. Recognising and effectively treating the underlying mental health issues may be an important part of breaking the cycle of abuse.

Within the domestic abuse arena there is a recognised phenomenon of the “toxic trio” where domestic abuse, mental health issues and drug and alcohol abuse co-occur. In this context, drugs and alcohol can be a coping strategy, an exacerbating factor in abuse and a reason why assistance is harder to access.

In Wiltshire there were just over 3,300 incidences of domestic abuse reported to the police in 2015/16. In line with national trends, the rate of domestic abuse reports to police is increasing year on year. Whether this represents an increase in occurrences or an increase in the proportion of occurrences reported is unclear.

As can be seen in the chart below, the Wilshire rate of reported domestic abuse incidents is lower than the national average but in line with the regional average.

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48 Trevillion, K. et al. ‘Experiences of domestic violence and mental disorders: a systematic review and meta-analysis’ PLOS ONE http://dx.plos.org/10.1371/journal.pone.0051740
51 https://www.rcpsych.ac.uk/pdf/Domestic%20Violence%20Roxane%20Agnew-Davies.pdf
## Debt

As with many of the other issues discussed in this section debt can be both a contributor to poor mental health and a result of it.

- One in two adults with debts has a mental health problem\(^5^3\).
- One in four people with a mental health problem is also in debt.

A 2010 study from the Royal College of Psychiatrists found that half of UK adults in problem debt are also living with mental ill health\(^5^4\). The mental health problems

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\(^5^3\) Royal College of Psychiatrist data, [http://www.rcpsych.ac.uk/healthadvice/problemdisorders/debtandmentalhealth.aspx](http://www.rcpsych.ac.uk/healthadvice/problemdisorders/debtandmentalhealth.aspx)

\(^5^4\) [http://www.rcpsych.ac.uk/healthadvice/problemdisorders/debtandmentalhealth.aspx](http://www.rcpsych.ac.uk/healthadvice/problemdisorders/debtandmentalhealth.aspx)
experienced ranged from a consistent feeling of anxiety and low moods, to diagnosed mental health disorders.

Much of debt-related anxiety can be due to a lack of support from creditors and from the individual's surrounding family, friends and employers. Debt can be a considerable burden, made worse by dealing with it alone.

It is known that people diagnosed with mental health problems such as bipolar and depression are more susceptible to debt problems, but there are also other ways mental ill-health can affect the management of finances. A lack of energy can make it harder to keep track of money, and rash or unwise decisions, can result in spending money on things people cannot actually afford. In more serious cases, taking time off of work due to poor mental health may cause a sudden reduction in a person's income and being admitted into hospital can also make it harder to keep up to date with bills.

Specialist debt and mental health support is available through local and national organisations, but often people are unaware of this and so continue to struggle without assistance leading to worse problems in the long run.

Wiltshire Citizens Advice is one agency that offer debt assistance to local residents in Wiltshire. They report a concerning trend change in the type of debt that people or seeking help for. The majority of advice is now around the priority debt area of household bills with the three main areas being Council tax arrears, rent arrears and water bills. This change is illustrated below:

**Fig 41 Chart to show how debt enquiries to Citizens Advice have changed over recent years:**

Recommendations arising from this section

- Use evidence based research around protective and risk factors to inform all mental health and wellbeing prevention interventions.
- Plan services to be culturally competent to work within the context of Wiltshire’s current ethnic mix and its projected changes.
  - This will include issues such as language services (Polish), coping with the specific needs of refugees etc.
- The area of perinatal mental health is complex covering many agencies. Ensure leadership is clear and that there are clear pathways to facilitate early identification of those at risk and a robust evaluation of services.
- Points of transition be they moving from children’s services to adult services or leaving care continue to be a source of frustration. There needs to be an unrelenting focus on getting this right.
  - Work with care leaver task and finish group to ensure mental health support is written into the Care Leavers Covenant.
- Mental health services need to be culturally competent and flexible enough to appropriately accommodate those with learning difficulties.
  - Ensure mental health teams work towards the “Transforming Care” recommendations and can provide a tailored service for people with learning disabilities.
- Mental health services need to be able to cater to the needs of older people and where appropriate, specialist old age services should be provided. Preventative interventions to reduce the prevalence of poor mental health in old age will be important given the context of the aging local population.
- There is currently a limited understanding of the mental health needs of the local LGBT community and more research could be undertaken to ensure current mental health services are culturally competent and address the community’s needs.
  - Peer support groups and good service signposting have been raised as areas of immediate need.
- The military (and ex-military) makes up a sizeable proportion of Wilshire’s population. Effective multiagency working including third sector groups will be required to provide effective services and support. Alcohol misuse and trauma related issues should be an area of focus.
- The number of carers is likely to continue to grow. Effective support to protect mental and emotional wellbeing is necessary.
  - Service sign posting, peer support groups and adequate social contact have been raised as areas of immediate need.
- Many of the most vulnerable have multiple complex needs including dual diagnosis and social issues as well as mental health issues. Mental health services need to be equipped to deal confidently with such cases.
- Mental health services need to continue to strengthen links with the police, domestic abuse and housing services so that frontline staff are equipped get people the mental health support they need.
Section D: Health Inequalities and deprivation

Key points

- Health inequalities are variations in health between population groups resulting from a variety of societal and economic processes that are unequally distributed within or between populations. They are avoidable and unfair.
- Those who experience poor mental health often experience health inequalities as a result of this and, ultimately, those with severe mental health conditions die between 15-25 years earlier on average than the general population.
- Additionally, there are inequalities in the distribution of risk factors for mental health such as smoking, harmful alcohol use and poor physical health and in the ability to access mental health services.
- Locally barrier to access include geographical inequalities and difficulties with getting transport to services.

Health inequalities are variations in health between population groups resulting from a variety of societal and economic processes that are unequally distributed within or between populations. They are avoidable and unfair.

Health inequalities can occur at a number of levels including exposure to risk factors, health services provision and utilisation, health outcomes and life expectancy. They are often strongly associated with levels of deprivation with those with the least in terms of socio economic status suffering the most in terms of poor health.

1) Deprivation
Mental health and deprivation are closely linked. Deprivation is thought to have an impact as both a cause and a consequence of poor mental health.

The lifestyle factors which influence health inequalities are sometimes referred to as the "proximate" causes of health inequalities, because they are the immediate precursors of disease, as opposed to the 'distal', 'upstream' or 'wider determinants', such as poverty, housing or education. They include smoking, alcohol consumption, lack of physical activity and poor diet among a myriad of other factors.

Many of the individual risk factors have been considered separately in the section on risk factors. Lifestyle factors often vary by socio-economic gradient, with those in more deprived areas being more likely to be exposed to risky lifestyle factors. There is often a cumulative impact of the individual risk factors and, as a result, it is important to look at deprivation as a whole and its impact on inequalities and mental health more broadly.

Wiltshire overview and review of deprivation by community area
This needs assessment uses the Indices of Deprivation 2010 to measure deprivation levels. The Index of Multiple Deprivation (IMD), combines a number of other indices,
and gives an overall score for the relative level of multiple deprivation experienced in small geographical areas. To produce the Overall IMD there are 38 separate indicators that are combined and weighted. Broadly, the indicators fall across seven domains. These are:

- Income
- Employment
- Health and Disability
- Education, Skills and Training
- Barriers to Housing and Services
- Crime
- Living Environment.

The Indices provide scores and ranks for all 32,482 LSOAs in England for the seven deprivation domains and for a combined Index of Multiple Deprivation (IMD). This ranking allows relative levels of deprivation in Wiltshire to be compared with the rest of England. The LSOAs are ranked with 1 being the most deprived and 32,482 being the least deprived. Wiltshire compares well against the rest of the country in terms of overall deprivation; the average IMD rank for Wiltshire’s LSOAs in the 2010 Indices of Deprivation is 22,229.

While, Wiltshire compares favourably against the national benchmark, the county has seen an increase in relative deprivation since 2004. For the first time, Wiltshire now has one LSOA in the 10% most severely deprived in England (Salisbury St Martin – central). This area is in the 10% most deprived in England with regards to health deprivation and disability. The map shown below shows the levels of deprivation for all of Wiltshire’s LSOA’s.

The correlation between poor mental health and wellbeing and deprivation means that the most deprived areas in Wiltshire are likely to be those with the greatest mental health needs.
Community areas

More local, in depth analysis of population deprivation pyramids helps identify areas with sub populations at potential increased mental health risk that might otherwise be overlooked if only the higher level indicators are used. For discussion purposes some areas of interest will be highlighted below. In all analysis presented, Q1 is the most deprived and Q5 most well off quintile.
Illustrative discussion of specific community areas
Full information and a breakdown of all Wiltshire’s community areas by population pyramid and deprivation quintile can be found at http://www.intelligencenetwork.org.uk/EasysiteWeb/getresource.axd?AssetID=55849&type=full&servicetype=Attachment under demographics: population and deprivation pyramids. The benefits of considering areas at the community level are that specific issues relating to deprivation can be identified that may highlight particular mental health needs locally.

Salisbury
The pyramids for Salisbury show that Salisbury has higher proportions of deprived people, older people and older deprived people than Wiltshire. Older populations and deprived populations are considered at increased risk of mental health problems.

Fig 43 Salisbury and Wiltshire population and deprivation pyramids

Trowbridge
The pyramids for Trowbridge show that Trowbridge has a higher proportion of deprived people. However, in contrast to Salisbury, Trowbridge’s deprived population is concentrated at a younger age range, with peaks between the ages of 25 to 29 and 40 to 44 years. Trowbridge also has a much higher proportion of children aged 0 to 4 living in deprived areas than Wiltshire overall.
Fig 44 Trowbridge and Wiltshire population and deprivation pyramids

Calne
The deprivation pyramids for Calne show a very pronounced ‘spike’ of young women age between 10 and 19 in quintile 2. This could highlight an important group to target in terms of risky behaviours, such as substance misuse and teenage pregnancy, which are more prevalent amongst deprived populations and have significant long and short term mental health implications.

Figure 45 Calne and Wiltshire population and deprivation pyramids

2) Inequalities in distribution of risk factors
As described at the beginning of this section, health inequalities can occur at several levels with many of the inequalities clustering with relative deprivation. In addition to considering deprivation as a broad and inequitable risk factor for mental health issues, it is also helpful to individually consider some of the key risk factors for poor mental health and how they are distributed in the population.

a) Smoking
Cigarette smoking has been described as the greatest preventable cause of morbidity and mortality in the UK. Whilst population levels of smoking have
decreased dramatically over the last 20 years, this trend has not been replicated across all societal groups, creating significant healthcare inequalities. For example, the prevalence is higher in routine and manual occupations groups and is much higher amongst those with mental health problems.

Smoking has been considered as both a cause and an effect of mental disorder. The relationship between smoking and mental is both complex and bidirectional. Smoking has been shown to increase the risk of developing a mental health problem and clear links have been shown between the amount of tobacco smoke and mood and anxiety symptoms in those with and without a mental disorder. There is good evidence that smoking cessation can improve mental health and it has been shown to improve mood, quality-of-life and to reduce symptoms of depression and anxiety. The impact of smoking cessation on depression and anxiety symptoms has been shown to be as significant as that of antidepressant medication.

Over the last 20 years, the prevalence of smoking amongst those with mental disorder has changed very little despite an overall population decrease in smoking prevalence. Cigarette smoking is twice as common amongst people with a mental disorder compared to those without. Prevalence increases further with severity of disorder and the highest levels are found amongst mental health inpatients (up to 70% prevalence). Overall, it is estimated that 33% of cigarettes smoked in England are smoked by those with a mental disorder. This figure rises to 42% if the definition of mental disorder is expanded to include those with alcohol or drug dependence, gambling problems and those who have made suicide attempts in the last year.

Smoking prevalence from the 2015 Annual Population Survey (APS) reflects the proportion of adults aged 18 years and over who self-report as smokers. In 2015, this measure reported a prevalence of 14.3% for Wiltshire. This compares to a 2014 Adult Psychiatric Morbidity Survey national smoking prevalence of 16.9% and South West regional prevalence of 15.5%.

Smoking prevalence from the GP Patient Survey (GPPS) reflects the percentage of the population (aged 18 years and over) who classify themselves as either occasional or regular smokers. In 2015/16, this measure reported a prevalence of 13.5% for Wiltshire.

Smoking prevalence from the Quality and Outcomes Framework (QOF) reflects the percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months. In 2015/16, this measure reported a prevalence of 15.7% for Wiltshire.

These prevalence estimates are similar and differences may relate to methodology. The QOF estimate is the largest but this also includes 15-18 year olds which may account for some difference.

Smoking prevalence for adults with a serious mental illness in Wiltshire is reported as 40.1% for 2014/2015 which is comparable to both national and regional estimates. This figure refers only to adults under the care of secondary mental health services who have serious mental illness and are being managed under the
care programme approach i.e. those with the greatest perceived complexity and risk. This figure will exclude other individuals under the care of secondary mental health care services, individuals managed within primary care and individuals who have a mental disorder but are not currently receiving treatment.

To truly understand both the scale and the complexity of the local problem, more detailed information is needed from both primary and secondary care to more accurately determine the prevalence of smoking and to link this with comorbid mental disorder. This data is not currently available. Having this data would permit a more accurate definition of the problem and subsequent needs. Data has been requested from the secondary mental health care provider who routinely collects data about smoking status as part of a physical health CQUIN.

The effects of the inequality in the distribution of smoking are stark. It is well documented that those with severe mental illness die up to 20 years earlier than those without severe mental illness. It is also recognised they carry a greater burden of chronic physical health problems with 2 to 3 times the associated mortality and morbidity. Much of this risk is attributable to smoking which is a major and modifiable risk factor. However, it is also increasingly evident that smoking reduces life expectancy in other mental disorders including depression, anxiety, personality disorder; alcohol use disorders and opioid use disorders.

**Fig 46 Smoking prevalence of people with diagnosed mental health conditions**

![Graph showing smoking prevalence of people with diagnosed mental health conditions]

Source: NICE, Smoking and Patients with Mental Health Problems, 2004

Smoking is associated with a number of disease processes and premature mortality, especially due to cardiovascular disease, respiratory disease, and cancers. The potential years of life lost due to smoking-related illness in adults aged 35 to 74 years in Wiltshire was 1107 per 100,000 in 2013-15. This was lower than both...
national and regional figures. However it is not possible to split this figure into those with and without a mental disorder. Given the greater prevalence of smoking amongst those with a mental disorder, it is highly likely these individuals are overrepresented.

Healthcare professionals routinely assess risks associated with self-harm and suicide in those with mental disorder and attempt to mitigate them. The mortality related to smoking and its associated downstream harms could be argued to be a similarly important clinical and public health concern that does not receive the same clinical priority. For example, lifetime suicide risk in schizophrenia has been estimated at up to 10% whereas death due to cardiovascular disease (for which smoking is a major risk factor) has been estimated at 60%.

As well as the public health case for helping those with mental health and well being issues stop smoking there is also an economic case. Smoking is associated with a number of significant psychiatric drug interactions and can lead to patients requiring increased doses of certain medications. This exacerbates physical health risks as many of these medicines carry significant dose dependent side effects. It has been estimated that smoking increases the financial costs of psychotropic drugs to the NHS by up to £40 million per annum. Stopping or reducing smoking represents an opportunity to reduce this financial cost in addition to reducing the medication burden for individual patients with its potential adverse effects.

Smoking cessation services in Wiltshire are provided by GP surgeries and pharmacies. No specialist mental health provision is currently offered and mainstream provision does not routinely collect this data. Therefore, no local data is available regarding smoking cessation in those with mental disorder.

Overall, the evidence suggests that smoking contributes significantly to mental health inequalities and that smoking cessation for those with mental health issues could therefore be considered a priority area both for tackling inequalities and for improving mental health outcomes.

Within Wiltshire, actions are being taken to address this inequality. In line with national policy, the local mental health trust (AWP) is currently preparing for a transition to smoke free services. It is anticipated that this will come into effect at the end of 2017. Preparation and training for this transition is being supported by local public health team and includes a request for smoking and smoking cessation metrics to be routinely collected and available to support future assessment of needs and service planning.

b) Drug and alcohol misuse and abuse

“People with a dual diagnosis are in effect a kind of mental health underclass. They find that their needs are not severe enough to meet the criteria of any single agency, so they can fall just below the threshold of all ‘helping services.’”

- Turning point, Psychiatrist.
As with many of the issues discussed in this needs assessment the relationship between drug and alcohol abuse and mental health is complex and two-way. There are many reasons why people with mental health issues use drugs and alcohol, and evidence suggests that many people misusing drugs and alcohol have mental health issues. People with mental health issues resort to drugs and alcohol in some cases because they provide a form of ‘self-medication.’ This is to help them cope with experiences or symptoms of their condition. A dependency on drugs or alcohol can make the symptoms of mental ill health worse. Certain drugs such as cannabis can also increase the likelihood of individuals developing mental health conditions in the first place.

As the negative issues facing a person increase so too do the negative outcomes and inequalities experienced. Health and wellbeing determinants such as physical, social and financial wellbeing are likely to be worse for those with co-existing drug/alcohol and mental health issues. They may experience family breakdown and be unable to hold down a job or relationship, be at increased risk of suicide and experience low self-esteem, and find themselves homeless. Misuse of alcohol and drugs can lead to risky behaviour and may expose people to violent situations. Individuals may also struggle to break away from their friends who engage in drug use or excessive drinking, delaying their recovery.

This group also face particularly poor health outcomes: research evidences the link between alcohol misuse and multiple types of cancer. Such factors decrease an individual’s life chances and increase the risk of premature death. People with serious mental health problems live 15 to 20 years less than the rest of the population and the figure is 9 to 17 years less in those who misuse alcohol and drugs. For those that experience both these issues the effects are likely to be magnified.

Other negative impacts of dealing with a mental health issue combined with drug and alcohol misuse include the strain on family relationships. If individuals are left without support of loved ones they can face an increased chance of ending up homeless or in prison. This results in a significant cost to the individual and wider society.

Traditionally health care services have not been adequately configured to address the needs of those with dual diagnosis. The overall impact is that this group is often unjustly excluded from services and isolated in society. Because of the barriers that exist, their needs escalate to become even more complex and costly to address.

Within Wiltshire, actions are being taken to address these inequalities. Within Turning Point, the local drug and alcohol service provider, work has been done to define the criteria for dual diagnosis, ensuring that there is a dual diagnosis care coordinator and active involvement with mental health services. There has also been work undertaken to support staff understanding of what the criteria for dual diagnosis is.

55 http://www.turning-point.co.uk/media/1138757/dual_dilemma.pdf
56 http://www.turning-point.co.uk/media/1138757/dual_dilemma.pdf
Work has been undertaken to build relationships with AWP via links with the primary care liaison team, intensive team and older adults’ team. In addition, each of the hubs has identified a dual diagnosis link worker (to liaise with AWP) and to meet on a monthly basis to ensure regular communication. A drug and alcohol outreach worker provides drop-in support at Beechlydyne Ward and Ashdown Ward at Fountain Way. Fountain Way is an inpatient facility.

A formal service specification for dual diagnosis work is currently being developed.

c) Poor physical health conditions

Poor physical health is associated with increased risk of associated poor mental health leading to an inequality in the burden of mental health disease distribution.

There are significant co-morbidities with a range of physical health needs. For example, 50% of people with Parkinson’s disease suffer depression, 25% following stroke, 20% with coronary heart disease, 24% with neurological disease and 42% with chronic lung disease. Depression is often difficult to diagnose and treat in these groups and requires sustained, expert management.

This inequality of distribution means that joined up, physical and mental health services that consider the person as a whole become of the utmost importance.

3) Inequalities in access to health services

As well as inequalities in risk factors inequalities can also occur at other levels such as in access to and through services.

Health services, such as mental health services, can affect inequalities at a number of levels such as:

Access to care
- Physical access (availability)
  - For example registration of patients with GP.
  - For example poorer facilities in more deprived communities.
- Financial access
- Cultural access
  - Knowledge, awareness and cultural acceptability of services

Access through care
- Navigating the health system
  - For example absence of interpreters
- Equal treatment according to wants / needs
  - For example differential referral depending on age, gender or ethnicity or other co-morbidities which may be perceived as excluding the person from other services (eg substance misuse)

Adequate access is also linked to timeliness and the quality of services.
"Appropriate access to health care for a diverse population requires more than simply providing the service. Provision alone cannot ensure access to care for all people, regardless of their religion, culture, or ethnic background."  

Equal access to health care has been a central objective of the NHS since it began. However, inequalities in health care access still persist. The inverse care law, first described by Julian Tudor Hart in 1971, states: “The availability of good medical care tends to vary inversely with the need for it in the population served”

Equality of access requires that, for different communities:
- Travel distance to facilities is equal.
- Transport and communication services are equal.
- Waiting times are equal.
- Patients are equally informed about the availability and effectiveness of treatments.
- Charges are equal (with equal ability to pay).

There is limited quantitative data around the inequalities in access to and through mental health care in Wiltshire. At the national level, inequalities have been identified and in the 2014 Adult Psychiatric Morbidity Survey those most likely to report use of treatment were female, White British, and in midlife (especially aged between 35 and 54). While not a simple extrapolation, this suggests that men, ethnic minorities and those at either end of the age distribution may be missing out on treatment. Socioeconomic inequalities in who receives treatment were less evident and more mixed. Employed people with CMD were less likely to receive treatment than those who were economically inactive. People with CMD living in lower income households were more likely to have an unmet treatment request than those living in higher income households. High income household may access private treatment.

Qualitative data from stakeholders suggests that inequalities do exist in Wiltshire. Evaluating and then minimising such inequalities should be a focus for future work.

Geographic inequalities:
As discussed above, Wiltshire’s population is predominantly rural and for people living in rural areas, access to health services can be difficult due to distance to services and the time taken to travel to those services. Lack of public or private transport may mean that people living in rural areas cannot easily use available services. Access to advice via the internet and telephone may be an advantage to people living in rural areas.

Co-morbidity inequalities and barriers between services:
As outlined earlier, research has shown, the existence of co-morbid mental health problems alongside long-term physical health conditions is a particularly common

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form of multi-morbidity. Physical, mental and social health are closely related and affect each other in a number of ways summarised in the diagram below.

Source *Bringing together physical and mental health: A new frontier for integrated care*. The Kings Fund

Integrated care is becoming an area of increasing focus in the NHS and documents such as the NHS five year forward view makes the case for what has been called ‘triple integration’ – integration of health and social care, primary and specialist care, and physical and mental health care. The Mental Health Taskforce has also highlighted the importance of integrated care spanning people’s physical, mental and social needs. A number of factors have made it difficult to respond to physical and mental health needs in an integrated way, including institutional and cultural barriers, separate payment systems for physical and mental health care, and the trend for increasing sub-specialisation in professional education. As a result, people using services commonly find that their physical and mental health needs are addressed in a disconnected way.

A limited number of data indicators to measure how well mental and physical health integration is occurring are available.

At the top level, PHE Fingertips mental health data show that in Wiltshire the 2014/15 ratio of observed to expected excess under 75 mortality rates in adults with serious mental illness is 432%. This is comparable to a national average of 370%. This means there are over 4.3 times as many deaths observed in those under 75 with severe mental illness than might otherwise be expected.

QOF data gives some information on those with severe mental health issues such as schizophrenia, bipolar disorder and psychoses who have received cervical smear tests in the last 5 years. In Wiltshire, 70.4% of such mental health patients have received cervical smears. This compares to around 78% in the population as a whole, suggesting there is a gap in care.

As well as negatively impacting patients, lack of integration has a financial cost for the health service. Data from analyses such as the Symphony Project in Somerset indicates that multi-morbidity is also a more important driver of costs in the health and social care system than other factors such as age. The annual cost of poor integration between physical and mental health services is estimated to cost the NHS in England more than £11bn annually.

The Kings Fund makes a number of recommendations for how integration between physical and mental health services can be improved. These include:

- Incorporating mental health into public health programmes
- Promoting health among people with severe mental illnesses
- Improving management of medically unexplained symptoms in primary care
- Strengthening primary care for the physical health needs of people with severe mental illnesses
- Supporting the mental health of people with long-term conditions
- Supporting the mental health and wellbeing of carers
- Supporting mental health in acute hospitals
- Addressing physical health in mental health inpatient facilities
- Providing integrated support for perinatal mental health
- Supporting the mental health needs of people in residential homes

Within Wiltshire, the Mental Health and Wellbeing Partnership, although in its early stages, is bringing these elements together. In addition, joint commissioning is driving progress in integration.

There are still areas where social care and physical and mental health are still very separate due to organisational priorities and obligations, but there are also clear areas where good progress is being made. For example, the recent reorganisation of

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61 *Bringing together physical and mental health. A new frontier for integrated care*. The Kings Fund
the mental health social work teams from two teams to three to match the CCG/AWP areas is helping integration in the long term through better communication (within the organisations and with customers/patients) and better use of resources.

There is limited quantitative data around the inequalities in access to mental health care in Wiltshire. Qualitative data from stakeholders suggests that these inequalities do however exist. Evaluating and then minimising such inequalities should be a focus for future work.

**Inequalities in outcomes**

The inequalities in outcomes for those with mental health conditions are stark. There is extensive evidence that people with severe mental illness such as schizophrenia die between 15 and 25 years earlier than the average for the general population.

As the table illustrates, as well as a range of health outcome inequalities, there are also a range of social inequalities experienced by those with mental health issues such as reduced employment opportunities and access to stable and appropriate accommodation.
Overall, this section has illustrated that the mental health arena is filled with health inequalities that occur at many levels. There are inequalities in risk factors, inequalities in access to services, and inequalities in outcomes both in terms of health and social measures.

**Fig 48 Table to show inequalities in a range of outcomes for those with mental health conditions.**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Wilts</th>
<th>Region England</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stable and appropriate accommodation: % of adults in contact with mental health services aged 16-65 (Persons)</td>
<td>2014/15</td>
<td>-</td>
<td>51.3%</td>
<td>59.7%</td>
</tr>
<tr>
<td>Stable and appropriate accommodation: % of adults in contact with mental health services aged 16-65 (Male)</td>
<td>2014/15</td>
<td>-</td>
<td>52.5%</td>
<td>58.4%</td>
</tr>
<tr>
<td>Stable and appropriate accommodation: % of adults in contact with mental health services aged 16-65 (Female)</td>
<td>2014/15</td>
<td>-</td>
<td>49.9%</td>
<td>61.3%</td>
</tr>
<tr>
<td>Satisfaction with social care protection: % of service users</td>
<td>2015/16</td>
<td>-</td>
<td>85.3%</td>
<td>69.4%</td>
</tr>
<tr>
<td>Employment of people with mental illness or learning disability: % of those with a mental illness or learning disability</td>
<td>2016 Q1</td>
<td>-</td>
<td>41.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate: percentage point difference</td>
<td>2014/15</td>
<td>-</td>
<td>68.6%</td>
<td>77.5%</td>
</tr>
<tr>
<td>Smoking in people with SMI: % of people with SMI aged 16+</td>
<td>2014/15</td>
<td>1.058</td>
<td>40.1%</td>
<td>27.2%</td>
</tr>
<tr>
<td>Suicide: age-standardised rate per 100,000 population (3 year average) (Persons)</td>
<td>2013 - 15</td>
<td>116</td>
<td>10.1%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Suicide: age-standardised rate per 100,000 population (3 year average) (Male)</td>
<td>2013 - 15</td>
<td>76</td>
<td>15.8%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Suicide: age-standardised rate per 100,000 population (3 year average) (Female)</td>
<td>2013 - 15</td>
<td>40</td>
<td>4.7%</td>
<td></td>
</tr>
<tr>
<td>Excess under 75 mortality rate in adults with serious mental illness: ratio of observed to expected mortalities</td>
<td>2014/15</td>
<td>432.0</td>
<td>164.6%</td>
<td>570.4</td>
</tr>
</tbody>
</table>

Source: [https://fingertips.phe.org.uk/profile-group/mental-health/profile/MH-JSNA/data#page/1/gid/1938132924/pat/6/pat/E12000009/ati/102/are/E06000054](https://fingertips.phe.org.uk/profile-group/mental-health/profile/MH-JSNA/data#page/1/gid/1938132924/pat/6/pat/E12000009/ati/102/are/E06000054)

**Recommendations arising from this section**

- Support AWP as it transitions to smoke free services
  - Ensure they have the expertise and access to support and medications etc. they need
- Continue to support the drug and alcohol services to strengthen the dual diagnosis offering. Use data monitoring and evaluation of the service to drive improvement
- Work to reduce inequalities arising from barriers to access particularly around geography, travel and hours of opening
- Continue to drive towards greater integration of physical and mental health and social care services and look for innovative solutions.
- Continue to work toward absolute parity of esteem for mental health
Section E: Prevalence of mental health problems in Wiltshire

Key points
- The main source of prevalence data used is from the Adult Psychiatric Morbidity Survey 2014 whose results were published in September 2016. This allows national estimates of prevalence split by age and sex to be applied to the Wiltshire population to provide local prevalence estimates.

CMD
- There are an estimated 67,000 people in Wiltshire experiencing a common mental disorder.
- The prevalence seeking rates from CMDs are growing faster in women than men.
- Treatment seeking habits are changing with 37% of cases receiving treatment compared to 23% seven years ago. This increase in treatment is seen across the number of prescriptions, GP consultations, community care appointments and IAPT.
- Applying the 37% treatment rate to Wiltshire we would expect around 25,000 people to be receiving treatment for a CMD.

PTSD
- Within Wiltshire, based on national prevalence rates, we can expect around 15,000 people to be experiencing PTSD.
- Adjusting for the military and veteran population this number may be even higher. This population is believed to be largely undiagnosed currently.
- Many of those with PTSD have other co-existing mental health issues making them complex cases requiring more specialist treatment.

Eating Disorders
- There are an estimated 6,000 people in Wiltshire with eating disorders of whom the majority are younger women. Prevalence rates are thought to be growing.
- It is estimated 8/10 people nationally with eating disorders currently receive no treatment representing a large underserved population.

Psychotic Disorders
- Nationally the rates of psychotic disorders are thought to be stable at around 0.5%, translating to around 2,100 cases in Wiltshire.
- The incidence rates suggest we would expect to see ~243 new cases in Wiltshire per year.
- This figure based on national prevalence, may slightly overestimate the local prevalence due to Wiltshire’s lower than average BME population.

Personality Disorders
- There are an estimated 22,000 people in Wiltshire with a personality disorder.
- According to national data around two thirds will not be receiving treatment although around 10-15% will have requested treatment. Again, this represents an under served population.

Bipolar Disorder
- There are an estimated 7,700 people in Wiltshire living with bipolar disorder.
- This is a lifelong condition that can have significant impact on a person.

Suicide and Self-harm
- The reported prevalence of self-harm is rising particularly amongst young women; a quarter of 16-24 year old women report self-harming. Overall, there are estimated to be around 29,000 cases of self-harm in Wiltshire a year. Most go unreported.
- There is also a slight increase in the rate of reported suicidal thoughts and attempts.
The prevalence of an issue provides a measure of how widespread a disorder is in the population and is usually given in terms of the proportion of the population affected.

In this section two main data sources will be used. The main data sources used are:
- Public Health England (PHE) Fingertips tool for mental health,
- Adult Psychiatric Morbidity Survey applied to local population figures

The Public Health England Mental Health Fingertips data tool pulls together information from a number of sources to provide nationally comparable data. It collates and analyses a wide range of publically available data on prevalence, risk, prevention early intervention, assessment treatment outcomes and service costs. Each indicator comes with a detailed description of its methodology of calculation and more information can be found at http://fingertips.phe.org.uk/profile-group/mental-health

The Adult Psychiatric Morbidity Survey (APMS) series provides data on the prevalence of both treated and untreated psychiatric disorder in the English adult population (aged 16 and over). The most recent survey was conducted in 2014 and the results published in autumn 2016.

In some cases the different sources provide substantial variations in estimated prevalence.

**Common Mental Disorders including anxiety, depression phobias, obsessive compulsive disorder and panic disorder**

Common Mental Disorders (CMDs) range in severity from mild to severe and are often associated with physical and social problems. They can result in physical impairment and problems with social and occupational functioning, and are a significant source of distress to individuals and those around them. Both anxiety and depression often remain undiagnosed and sometimes individuals do not seek or receive treatment. If left untreated, CMDs are more likely to lead to long term physical, social and occupational disability and premature mortality. CMDs are relapsing conditions that can recur many years after an earlier episode, because the stressors that cause them endure, and because people with CMD do not always adhere to or seek treatment.

CMDs are generally considered to include different types of depression and anxiety; including phobias, obsessive compulsive disorder, and panic disorder.

When common mental health conditions occur in the perinatal period they are still classed as common mental health conditions but may require specialist services that consider both the mother and the potential impact on the child.
**Adult Psychiatric Morbidity Survey Data on CMD**

The Adult Psychiatric Morbidity Survey (APMS) 2014 showed that nationally 17.0% of the adult population (20.7% of women and 13.2% of men) have a common mental health problem.

Using prevalence from the APMS 2014 survey this suggests approximately 67,000 adults in Wiltshire have a CMD.

Figure 49 shows a breakdown of this number by type of CMD and gender. These numbers are extrapolated from the national APMS 2014 survey results to the Wiltshire population broken down into gender and age group sub bands to reflect the different prevalence of CMD between genders and over the life course.

**Figure 49 showing prevalence and estimated numbers experiencing CMDs in Wiltshire**

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>Estimated No. Adults (Aged 16+ as per survey)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevalence (%)</td>
<td>Est Number</td>
<td>Prevalence (%)</td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td>4.9</td>
<td>9,475</td>
<td>6.8</td>
</tr>
<tr>
<td>Depressive episode</td>
<td>2.9</td>
<td>5,608</td>
<td>3.7</td>
</tr>
<tr>
<td>All phobias</td>
<td>1.8</td>
<td>3,781</td>
<td>3.0</td>
</tr>
<tr>
<td>Obsessive Compulsive disorder</td>
<td>1.1</td>
<td>2,127</td>
<td>1.5</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>0.3</td>
<td>580</td>
<td>0.8</td>
</tr>
<tr>
<td>Mixed anxiety and depression</td>
<td>5.8</td>
<td>11,216</td>
<td>9.6</td>
</tr>
<tr>
<td><strong>Any CMD</strong></td>
<td><strong>13.2</strong></td>
<td><strong>25,525</strong></td>
<td><strong>20.7</strong></td>
</tr>
</tbody>
</table>

Data source: APMS 2014 prevalence estimates applied to Wiltshire population figures

NB some people have more than one CMD and so will be double counted in totals.
Fig 50 Chart to show distribution by sex of cases of common mental health disorders in Wiltshire

Source: APMS 2014 Prevalence data applied to Wiltshire population figures

Fig 51 Chart to show distribution by age of cases of common mental health disorders in Wiltshire

Source: APMS 2014 Prevalence data applied to Wiltshire population figures

Full breakdowns of estimates by age band, sex and disorder can be found at Copy of APMS Prevalence of mental disorders Tables v2 (3).xlsx

Overall, women are approximately 1.5 times more likely than men to experience common mental health problems. For the youngest age band (16-24) women are 3 times as likely to experience common mental health disorders. Compared to the
2007 survey, rates in men have stayed approximately stable while those for women have increased.

In terms of treatment rates the proportion of people with CMD using mental health treatment was found to have increased. Around one person in four aged 16–74 with CMD symptoms was receiving some kind of mental health treatment in 2000 (23.1%) and 2007 by 2014 this had increased to more than one in three (37.3%). For Wiltshire, if national trends are followed this suggest that services should be seeing around 25,000 people with CMD.

The increase in treatment since 2007 was mainly driven by a steep rise in the use of psychotropic medication. However, there has also been an increase in the proportion of people with severe CMD symptoms in receipt of psychological therapy. The use of primary and community care for a mental health reason has also increased over time. People have become more likely to discuss their mental health with a GP. Service contact was highest in people with depression, phobia and OCD.

**Public Health England Mental Health Fingertips data on CMD**

The Public Health England Mental Health Fingertips data tool pulls together information from a number of sources to provide nationally comparable data. Unlike the APMS, PHE Fingertips data includes PTSD and Eating Disorders in common mental health disorders. While the data is given in the table below for completion, these latter disorders will be discussed in more detail in their specific sections.

The PHE fingertips data also includes estimates of 2021 future prevalence.
### Diagram 52 to show estimated prevalence of common mental health disorders

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Wiltsire Count</th>
<th>Value</th>
<th>Region England Count</th>
<th>Value</th>
<th>England Count</th>
<th>Value</th>
<th>Lowest Range</th>
<th>Highest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed anxiety and depressive disorder: estimated % of population aged 16-74</td>
<td>2012</td>
<td>27,290</td>
<td>7.95%</td>
<td>9.46%</td>
<td>8.92%</td>
<td>5.27%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generalised anxiety disorder: estimated % of population aged 16-74</td>
<td>2012</td>
<td>12,391</td>
<td>3.6%</td>
<td>4.2%</td>
<td>4.5%</td>
<td>2.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive episode: estimated % of population aged 16-74</td>
<td>2012</td>
<td>3,796</td>
<td>1.11%</td>
<td>1.30%</td>
<td>2.48%</td>
<td>1.11%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All phobias: estimated % of population aged 16-74</td>
<td>2012</td>
<td>5,436</td>
<td>1.58%</td>
<td>1.86%</td>
<td>1.77%</td>
<td>0.96%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obsessive compulsive disorder: estimated % of population aged 16-74</td>
<td>2012</td>
<td>2,380</td>
<td>0.69%</td>
<td>0.63%</td>
<td>1.10%</td>
<td>0.53%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panic disorder: estimated % of population aged 16-74</td>
<td>2012</td>
<td>1,776</td>
<td>0.52%</td>
<td>0.61%</td>
<td>0.65%</td>
<td>0.12%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated prevalence of eating disorders: % of population aged 16+</td>
<td>2012</td>
<td>23,054</td>
<td>6.7%</td>
<td>6.6%</td>
<td>6.7%</td>
<td>5.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated prevalence of post-traumatic stress disorder (PTSD): % of population aged 16+</td>
<td>2012</td>
<td>10,593</td>
<td>3.1%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>2.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression and anxiety among social care users: % of social care users</td>
<td>2013/14</td>
<td>-</td>
<td>57.8%</td>
<td>53.3%</td>
<td>52.8%</td>
<td>36.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-reported well-being: % of people with a low satisfaction score</td>
<td>2015/16</td>
<td>-</td>
<td>3.4%</td>
<td>3.7%</td>
<td>4.6%</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-reported well-being: % of people with a low well-being score</td>
<td>2015/16</td>
<td>-</td>
<td>3.5%</td>
<td>3.3%</td>
<td>3.6%</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-reported well-being: % of people with a high happiness score</td>
<td>2015/16</td>
<td>-</td>
<td>6.9%</td>
<td>8.4%</td>
<td>8.8%</td>
<td>4.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-reported well-being: % of people with a high anxiety score</td>
<td>2015/16</td>
<td>-</td>
<td>18.0%</td>
<td>18.5%</td>
<td>19.4%</td>
<td>11.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future prevalence of mixed anxiety and depressive disorder: estimated % of population aged 16-74</td>
<td>2021</td>
<td>27,312</td>
<td>7.79%</td>
<td>9.35%</td>
<td>9.26%</td>
<td>5.25%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future prevalence of generalised anxiety disorder: estimated % of population aged 16-74</td>
<td>2021</td>
<td>12,480</td>
<td>3.6%</td>
<td>4.1%</td>
<td>4.7%</td>
<td>2.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future prevalence of depressive episode: estimated % of population aged 16-74</td>
<td>2021</td>
<td>3,816</td>
<td>1.09%</td>
<td>1.29%</td>
<td>2.62%</td>
<td>1.09%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future prevalence of all phobias: estimated % of population aged 16-74</td>
<td>2021</td>
<td>5,372</td>
<td>1.53%</td>
<td>1.82%</td>
<td>1.85%</td>
<td>0.95%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future prevalence of obsessive compulsive disorder: estimated % of population aged 16-74</td>
<td>2021</td>
<td>2,359</td>
<td>0.67%</td>
<td>0.62%</td>
<td>1.14%</td>
<td>0.51%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future prevalence of panic disorder: estimated % of population aged 16-74</td>
<td>2021</td>
<td>1,810</td>
<td>0.52%</td>
<td>0.62%</td>
<td>0.70%</td>
<td>0.12%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: PHE Mental Health Fingertips data from [https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#page/1/gid/8000026/pat/6/par/E12000009/ati/102/are/E06000054](https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#page/1/gid/8000026/pat/6/par/E12000009/ati/102/are/E06000054)
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**Adult Mental Health and Emotional Wellbeing:**

**Health Needs Assessment for Wiltshire**

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Source: PHE Mental Health Fingertips data from https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#page/1/gid/8000026/pat/46/par/E39000034/ati/19/are/E38000206

Note: Coloured boxes following indicator description indicate data quality. Red=significant concerns, orange=some concerns, green=robust

The PHE Fingertips data allows Wiltshire to be compared to the regional and national averages. The data suggests that Wiltshire generally has lower than national average prevalence for CMD.

It is hard to compare the data from the APMS and PHE Fingertips due to different measures being used. For example, on first look, the estimated prevalence for CMDs from the Fingertips tool appears lower than the overall estimate from the APMS (45,069 vs. 66,975). Part of this difference may be because the APMS data includes 16-18 year olds and those age 75+ while the PHE data does not. In Wiltshire the aged 75+ group is estimated to contain around 4,000 people with CMDs accounting for about 20% of the difference. It may also be that the national prevalence rates in the APMS data over estimate the prevalence of CMD in Wiltshire due to differences in ethnic mix nationally and locally.

**Post-Traumatic Stress Disorder**

During their lifetime many people will experience traumatic events, for example, road traffic accidents, assaults or natural disasters. During and immediately after such trauma, they will commonly feel distressed, experiencing (for example) symptoms of insomnia and anxiety. These symptoms usually dissipate with time. Although this is the usual response, symptoms may sometimes persist, and some individuals go on to develop posttraumatic stress disorder (PTSD). This can be a severe and disabling condition, characterised by flashbacks, nightmares, avoidance, numbing and hypervigilance. PTSD is often comorbid with other mental health disorders, including depression and substance misuse.

---

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Wiltshire</th>
<th>Sub-region</th>
<th>England</th>
<th>England</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated prevalence of common mental health disorders: % of population aged 16+</td>
<td>2014/15</td>
<td>45,069</td>
<td>13.1%</td>
<td>13.9%</td>
<td>15.6%</td>
<td>10.3%</td>
</tr>
<tr>
<td>Depression recorded prevalence (QOF): % of practice register aged 18+</td>
<td>2015/16</td>
<td>28,854</td>
<td>7.5%</td>
<td>7.9%</td>
<td>8.3%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Depression recorded incidence (QOF): % of practice register aged 16+</td>
<td>2015/16</td>
<td>4,561</td>
<td>1.2%</td>
<td>1.3%</td>
<td>1.4%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Long-term mental health problems (GP Patient Survey): % of respondents (aged 18+)</td>
<td>2015/16</td>
<td>269</td>
<td>4.2%</td>
<td>4.1%</td>
<td>5.2%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Depression and anxiety prevalence (GP Patient Survey): % of respondents (aged 18+)</td>
<td>2015/16</td>
<td>711</td>
<td>10.6%</td>
<td>10.3%</td>
<td>12.7%</td>
<td>7.8%</td>
</tr>
</tbody>
</table>

---

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Adult Psychiatric Morbidity Survey Data on PTSD

The APMS 2014 survey included PTSD for the first time in 2014. It gathered data on prevalence of having experienced a traumatic event (a prerequisite to experiencing PTSD) and an estimate of prevalence for those who screened PTSD positive. It also gathered information on the prevalence of some PTSD symptoms.

The APMS results, extrapolated to Wiltshire, are given below

**Figure 53 Bar chart to show estimated numbers of people with symptoms associated with PTSD**

![Bar chart to show estimated numbers of people with symptoms associated with PTSD](chart.png)

**Source: APMS 2014 Prevalence data applied to Wiltshire population figures**

The APMS survey identified a number of interesting points. Overall around 4.4% of the population screened positive for PTSD. Of those screening positive 1 in 8 had already been diagnosed by a health professional. This suggests a large under diagnosed population. In Wiltshire, this could represent around 15,000 people. In reality, this figure may be even higher given the large veteran population in Wiltshire (see risk factors section).

Among women, the likelihood of screening positive for PTSD was particularly high among 16–24 year olds (12.6%) and then declined sharply with age. In men, the rate remained quite stable between the ages of 16 and 64, only declining in much later life. This suggests that young women may be particularly in need of PTSD services.
The tables below summarise the APMS findings applied to the Wiltshire population.

**Fig 53; tables showing estimated Trauma and PTSD prevalence for Wiltshire**

<table>
<thead>
<tr>
<th>Men</th>
<th>APMS Estimated prevalence (%)</th>
<th>Estimated number of cases for Wiltshire</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PTSD screen positive</td>
<td>Trauma experienced</td>
</tr>
<tr>
<td>16-24</td>
<td>3.6</td>
<td>17.9</td>
</tr>
<tr>
<td>25-34</td>
<td>4.7</td>
<td>28.7</td>
</tr>
<tr>
<td>35-44</td>
<td>4.4</td>
<td>33.7</td>
</tr>
<tr>
<td>45-54</td>
<td>4.2</td>
<td>38.6</td>
</tr>
<tr>
<td>55-64</td>
<td>5.0</td>
<td>35.8</td>
</tr>
<tr>
<td>65-74</td>
<td>1.1</td>
<td>34.8</td>
</tr>
<tr>
<td>75+</td>
<td>0.4</td>
<td>30.6</td>
</tr>
<tr>
<td>All</td>
<td>3.7</td>
<td>31.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Women</th>
<th>PTSD screen positive</th>
<th>Trauma experienced</th>
<th>PTSD screen positive</th>
<th>Trauma experienced</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>12.6</td>
<td>32.8</td>
<td>2,746</td>
<td>7,183</td>
</tr>
<tr>
<td>25-34</td>
<td>6.2</td>
<td>30.5</td>
<td>1,584</td>
<td>7,835</td>
</tr>
<tr>
<td>35-44</td>
<td>4.7</td>
<td>29.4</td>
<td>1,450</td>
<td>9,067</td>
</tr>
<tr>
<td>45-54</td>
<td>4.8</td>
<td>32.1</td>
<td>1,813</td>
<td>12,065</td>
</tr>
<tr>
<td>55-64</td>
<td>2.5</td>
<td>34.1</td>
<td>780</td>
<td>10,508</td>
</tr>
<tr>
<td>65-74</td>
<td>2.0</td>
<td>29.9</td>
<td>573</td>
<td>8,382</td>
</tr>
<tr>
<td>75+</td>
<td>0.8</td>
<td>28.7</td>
<td>200</td>
<td>7,389</td>
</tr>
<tr>
<td>All</td>
<td>5.1</td>
<td>31.2</td>
<td>10,194</td>
<td>62,566</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All adults</th>
<th>PTSD screen positive</th>
<th>Trauma experienced</th>
<th>PTSD screen positive</th>
<th>Trauma experienced</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>8.0</td>
<td>25.2</td>
<td>3,714</td>
<td>11,685</td>
</tr>
<tr>
<td>25-34</td>
<td>5.4</td>
<td>29.6</td>
<td>2,917</td>
<td>15,959</td>
</tr>
<tr>
<td>35-44</td>
<td>4.6</td>
<td>31.5</td>
<td>2,730</td>
<td>18,854</td>
</tr>
<tr>
<td>45-54</td>
<td>4.5</td>
<td>35.3</td>
<td>3,360</td>
<td>26,193</td>
</tr>
<tr>
<td>55-64</td>
<td>3.7</td>
<td>35.0</td>
<td>2,262</td>
<td>21,222</td>
</tr>
<tr>
<td>65-74</td>
<td>1.6</td>
<td>32.3</td>
<td>871</td>
<td>17,516</td>
</tr>
<tr>
<td>75+</td>
<td>0.6</td>
<td>29.5</td>
<td>285</td>
<td>13,251</td>
</tr>
<tr>
<td>All</td>
<td>4.4</td>
<td>31.4</td>
<td>17,350</td>
<td>123,572</td>
</tr>
</tbody>
</table>

Source: APMS 2014 Prevalence data applied to Wiltshire population figures

**Public Health England Mental Health Fingertips data on PTSD**

The Fingertips data estimates the prevalence of PTSD in Wiltshire to be 3.1% suggesting 10,593 people in the county likely to be experiencing PTSD. This is lower than the estimated prevalence based on the APMS findings and, for the reasons discussed previously this is likely to be lower than the actual number.
PTSD often co-exists with other mental health issues such as depression and substance misuse and such cases are often considered complex with potentially complex treatment needs.

**Eating Disorders**

Eating disorders are a group of illnesses defined by the National Institute of Mental Health as being those in which the sufferer experiences a preoccupation with body weight and shape which disturbs their everyday diet and attitude towards food. Unusually, compared with other mental health issues, eating disorders result in both physical and psychological symptoms and can have long term physical side effects including organ failure, with Anorexia Nervosa standing out as the disorder with the highest mortality rate. Eating disorders includes conditions such as Anorexia Nervosa and Bulimia Nervosa as well as lesser known disorders such as binge eating disorder.

**Adult Psychiatric Morbidity Survey Data on Eating Disorders**

The APMS 2014 survey did not include data on eating disorders so data in this section is based on the results from the 2007 survey.

**Fig 54 Table to show estimated prevalence of eating disorders in Wiltshire**

<table>
<thead>
<tr>
<th>Age band</th>
<th>Prevalence (%)</th>
<th>Estimated number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>16-24</td>
<td>1.7</td>
<td>5.4</td>
</tr>
<tr>
<td>25-34</td>
<td>0.7</td>
<td>3.6</td>
</tr>
<tr>
<td>35-44</td>
<td>0.3</td>
<td>2.5</td>
</tr>
<tr>
<td>45-54</td>
<td>0.8</td>
<td>3.1</td>
</tr>
<tr>
<td>55-64</td>
<td>0.1</td>
<td>0.9</td>
</tr>
<tr>
<td>65-74</td>
<td>0.3</td>
<td>0.6</td>
</tr>
<tr>
<td>75+</td>
<td>-</td>
<td>0.1</td>
</tr>
<tr>
<td>All</td>
<td>0.6</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Source: Prevalence data applied to Wiltshire population figures

As can be seen from the table above and the chart below the prevalence of eating disorders is significantly higher for women than men. Most studies suggest that around 10% (lower than in this study) of individuals with eating disorders are male. However, it should be noted that there may be under recording given lack of awareness of eating disorders in men. Locally the public service LGBT network has flagged eating disorders in gay men as an underserved area.

Prevalence is highest in the 16-24 age group 3.5% and then declines after 55. Eating disorders tend to emerge in adolescence with anorexia developing around 16 to 17 and bulimia around 18 to 19. Binge eating disorder emerges slightly later in life around 30 to 40.

62 https://www.b-eat.co.uk/assets/000/000/302/The_costs_of_eating_disorders_Final_original.pdf?1424694814
**Public Health England Mental Health Fingertips data on Eating Disorders**

As can be seen in Figure 62 in the CMD section, the PHE Fingertips tool estimates the population prevalence of eating disorders to be 6.7% suggesting 23,054 people aged 16 plus with an eating disorder.\(^\text{63}\). This is substantially higher than the age adjusted population estimate of 6,304 from the 2007 APMS data and for a population wide prevalence seems very high. While the APMS prevalence may be an underestimate of the true value for prevalence, it also seems likely that the PHE Fingertips data is an overestimate.

Recent studies have found a significant increase in eating disorder rates since 2007 when the above data was collected. If the same 34% increase observed in admission rates over this time period was applied to the 2007 APMS prevalence data then the updated prevalence estimate would be closer to 8,447 people in the county with an eating disorder.

**Discussion of information from other data sources around eating disorders**

The lack of clarity around Wiltshire population prevalence of eating disorders is not a uniquely local issue. It has been acknowledged that understanding of the prevalence and distribution of eating disorders across the population is poor nationally.\(^\text{64}\).

While the precise prevalence may be unclear, the available evidence suggests the problem is growing with increasing numbers of reported cases of eating disorder in the UK. Research using GP data in the UK indicates an increase in the age-

\(^{63}\) [https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#page/1/gid/8000026/pat/6/par/E12000009/ati/102/are/E06000054](https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#page/1/gid/8000026/pat/6/par/E12000009/ati/102/are/E06000054)

\(^{64}\) [https://www.b-eat.co.uk/assets/000/000/302/The_costs_of_eating_disorders_Final_original.pdf?1424694814](https://www.b-eat.co.uk/assets/000/000/302/The_costs_of_eating_disorders_Final_original.pdf?1424694814)
standardised annual incidence of all diagnosed eating disorders (for ages 10-49) from 32.3 to 37.2 per 100,000 between 2000 and 2009. This increase appears to be due to an increase in the unspecified eating disorder category as Anorexia Nervosa and Bulimia numbers remained fairly stable. A time series analysis of data on the total number of cases of eating disorders being diagnosed in England illustrates a similar trend in increasing prevalence over time with a 34% increase in admissions since 2005-06. This is approximately 7% per annum.

Hospital admission data suggest that around half of all cases admitted for treatment are under 20. Some eating disorders can be life-long conditions with recovery rates for anorexia nervosa and bulimia nervosa both fewer than 50%.

In terms of treatment, it is estimated that eight out of ten people with eating disorders currently receive no treatment.

Psychotic Disorder
Psychotic disorders are disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. Despite being relatively uncommon, psychotic illness has been found to result in a high level of service and societal costs. The World Health Organisation (WHO) calculates that the burden and human suffering associated with psychosis at the family level is exceeded only by dementia and quadriplegia. People with a psychotic illness who live in the community have low rates of employment, and when employed are often in poorly paid and less secure jobs.

There are three sources of information on the prevalence of serious mental illness. These are PHE Fingertips Mental Health Data tool, APMS 2014 and the Quality Outcome Framework (QOF).

Adult Psychiatric Morbidity Survey Data on Psychotic Disorder
In the 2014 APMS survey the results from the 2007 and 2014 survey were pooled to increase the number of positive cases for analysis. The prevalence was felt to be broadly stable between the two surveys at less than one adult in a hundred (0.4% in 2007, 0.7% in 2014). No statistical significance was found between differences in rates for men and women and between age groups. There was however a statistical association with ethnic group, with black men having a higher prevalence (3.2%) than other ethnic groups. Wiltshire has a lower than national average proportion of people from black ethnic backgrounds meaning that national prevalence rate when applied to the local population may overestimate the prevalence of psychotic disorders in Wiltshire.

Overall, four-fifths of people identified with psychotic disorder were in receipt of treatment.

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The APMS prevalence estimates when applied to the Wiltshire population give the following results:

**Figure 56 to show estimated number of people in Wiltshire with a psychotic disorder by age group**

![Chart showing estimated number of people in Wiltshire with a Psychotic disorder in the last year](chart)

Source: APMS 2014 Prevalence data applied to Wiltshire population figures

**Figure 57 to show estimated prevalence of psychotic disorders in Wiltshire**

<table>
<thead>
<tr>
<th>Age band</th>
<th>Men</th>
<th>Women</th>
<th>All adults</th>
<th>Men</th>
<th>Women</th>
<th>All adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>0.2</td>
<td>0.5</td>
<td>0.4</td>
<td>49</td>
<td>115</td>
<td>167</td>
</tr>
<tr>
<td>25-34</td>
<td>0.3</td>
<td>0.8</td>
<td>0.6</td>
<td>84</td>
<td>209</td>
<td>300</td>
</tr>
<tr>
<td>35-44</td>
<td>1.0</td>
<td>0.9</td>
<td>1.0</td>
<td>286</td>
<td>291</td>
<td>578</td>
</tr>
<tr>
<td>45-54</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>194</td>
<td>180</td>
<td>374</td>
</tr>
<tr>
<td>55-64</td>
<td>0.7</td>
<td>0.8</td>
<td>0.7</td>
<td>206</td>
<td>236</td>
<td>443</td>
</tr>
<tr>
<td>65-74</td>
<td>0.1</td>
<td>0.3</td>
<td>0.2</td>
<td>33</td>
<td>83</td>
<td>117</td>
</tr>
<tr>
<td>75+</td>
<td>NA</td>
<td>0.2</td>
<td>0.1</td>
<td>NA</td>
<td>48</td>
<td>50</td>
</tr>
<tr>
<td>All</td>
<td>0.5</td>
<td>0.6</td>
<td>0.5</td>
<td>896</td>
<td>1,226</td>
<td>2,125</td>
</tr>
</tbody>
</table>

Source: APMS 2014 Prevalence data applied to Wiltshire population figures

**Public Health England Mental Health Fingertips data on Psychotic Disorders**

PHE Fingertips records data on estimated *incidence* of first episodes of psychosis per 100,000. It estimates that there are 50 new cases per year giving an incidence rate of 16.9 per 100,000 vs and England average of 24.2 per 100,000. The relatively small proportion of BME individuals in Wiltshire may account for some of this difference when compared to the national average.
Personality Disorder

Personality disorders are longstanding, ingrained distortions of personality that interfere with the ability to make and sustain relationships. They are associated with a substantial burden on affected individuals, their families and wider society. Two of the most common types of personality disorder are described below.

Borderline Personality Disorder (BPD) is characterised by high levels of personal and emotional instability, difficulties with sustaining relationships, and high levels of self-harm and suicidal behaviour.

Antisocial personality disorder (ASPD) is characterised by an aggressive and irresponsible pattern of behaviour. It is defined as a pervasive pattern of disregard for and violation of the rights of others in people aged at least 18, which has persisted since the age of 15. Antisocial personality disorder also has a wide impact on society as it is linked with crime and violence.

Adult Psychiatric Morbidity Survey Data on Personality Disorder

The 2014 survey included a general screening tool to identify a core of traits associated with personality disorders. Using this tool 13.7% of people aged 16 and over screened positive for any PD, with similar rates in men and women. While this is not a diagnostic tool it might identify the broader pool of people with core interpersonal dysfunction and a range of adaptive and maladaptive traits. In Wiltshire terms this equates to around 54,000 people.

In the APMS 2014, 3.3% of people aged 18–64 screened positive for ASPD. It was more common in men (4.9%) than women (1.8%). 2.4% of people aged 16–64 screened positive for BPD. Differences between men and women did not reach statistical significance.

The table below shows the APMS identified prevalence rates for antisocial and borderline personality disorders applied to the Wiltshire population.
Fig 59 Table to show estimated numbers of people with personality disorders in Wiltshire by age group

<table>
<thead>
<tr>
<th>Age band</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>2,211</td>
<td>2,134</td>
<td>4,343</td>
</tr>
<tr>
<td>25-34</td>
<td>2,126</td>
<td>1,650</td>
<td>3,771</td>
</tr>
<tr>
<td>35-54</td>
<td>3,417</td>
<td>1,872</td>
<td>5,289</td>
</tr>
<tr>
<td>55-64</td>
<td>1,560</td>
<td>385</td>
<td>1,945</td>
</tr>
<tr>
<td>All</td>
<td>13,025</td>
<td>9,433</td>
<td>22,458</td>
</tr>
</tbody>
</table>

Source: APMS 2014 Prevalence data applied to Wiltshire population figures

Figure 60 bar chart to show estimated number of people with personality disorders in Wiltshire

Watching an estimated number of people in Wiltshire with a personality disorder

Source: APMS 2014 Prevalence data applied to Wiltshire population figures

Nationally, in terms of treatment data, 25.8% of people who screened positive for ASPD, 39.1% of screen positives for BPD, and 27.1% of screen positives for any PD reported receiving psychotropic medication, psychological therapy or both.

16.6% of screen positives for BPD, 9.1% of screen positives for ASPD, and 7.3% of screen positives for any PD had requested some kind of mental health treatment which they had not (yet) received.

Public Health England Mental Health Fingertips data on Personality Disorders
PHE Fingertips data does not include data on personality disorders

Bipolar Disorder

Bipolar disorder, previously known as manic depression, is a common, lifelong, mental health condition. It is characterised by recurring episodes of depression (feelings of low mood and lethargy) and of mania (feelings of elation and overactivity) or hypomania (a milder form of mania). While at one level it is considered to lie on a
spectrum, several subtypes can be identified, diagnoses of which are based on the frequency and pattern of episodes of (hypo) mania and depression.

Bipolar disorder leads to significant psychosocial impairment, such as fewer employment prospects and lower annual income, as well as placing a great burden on health care services. The annual economic costs for bipolar disorder in England were estimated, in 2007, to be £5.2 billion, two thirds of which was attributable to loss of employment.

Bipolar disorder is comorbid with a number of other disorders such as substance misuse, anxiety disorders, personality disorders and attention-deficit/ hyperactivity disorder (ADHD). Furthermore, the risk of suicide among those with bipolar disorder is approximately 20–30 times greater than that in the general population.

Adult Psychiatric Morbidity Survey Data on Bipolar Disorder

Overall, 2.0% of the population screened positive for bipolar disorder with similar rates in men and women. Positive screening for bipolar disorder was more common in younger age-groups. 3.4% of 16–24 year olds screened positive compared with 0.4% of those aged 65–74. None of the participants aged 75 and over screened positive for bipolar disorder. It did not vary by region or ethnic group.

Figure 61 Table to show estimated numbers of people with bipolar in Wiltshire by age group

<table>
<thead>
<tr>
<th>All Adults</th>
<th>Prevalence (%)</th>
<th>Estimated number of Wiltshire Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age band</td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>16-24</td>
<td>3.1</td>
<td>3.7</td>
</tr>
<tr>
<td>25-34</td>
<td>3.1</td>
<td>3.1</td>
</tr>
<tr>
<td>35-44</td>
<td>2.9</td>
<td>1.9</td>
</tr>
<tr>
<td>45-54</td>
<td>2.1</td>
<td>1.2</td>
</tr>
<tr>
<td>55-64</td>
<td>1.6</td>
<td>1.3</td>
</tr>
<tr>
<td>65-74</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>75+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>All</td>
<td>2.1</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Source: APMS 2014 Prevalence data applied to Wiltshire population figures
Fig 62 to show estimated number of cases of bipolar disorder in Wiltshire by age and sex

![Estimated number of cases of bipolar disorder in Wiltshire by age and sex](image)

Source: APMS 2014 Prevalence data applied to Wiltshire population figures

**Suicide and Self Harm**

Suicide is a complex issue. There is no one reason why people take their own lives. It is often as a result of problems building up to the point where the person can see no other way to cope with what they are experiencing.

The strongest predictor of suicide is a previous suicide attempt. The Suicide Prevention Strategy and Action Plan provides more details of other risk factors (clinical, socioeconomic, lifestyle factors, life events, environmental).

**Adult Psychiatric Morbidity Survey Data on Suicide and Self Harm**

The most recent version of the APMS showed some interesting trends in the prevalence of suicide and self-harm.

Nationally, the proportion of the population who reported having self-harmed increased from 2.4% and 3.8% of 16 to 74 year olds in 2000 and 2007, to 6.4% in 2014. This increase is seen in both men and women and across age-groups. Greater awareness of self-harming may be a factor in the increased reporting.

One in four 16 to 24 year old women (25.7%) reported having self-harmed at some point; about twice the rate for men in this age group (9.7%) and women aged 25 to 34 (13.2%). The gap between young men and young women has grown over time. Self-harm in young women mostly took the form of self-cutting. The majority reported that they did not seek professional help afterwards.
In 2014, 5.4% of 16 to 74 year olds reported suicidal thoughts in the past year, a significant increase on the 3.8% reporting this in 2000. For women, the increase occurred between 2000 and 2007; for men it took place later, between 2007 and 2014.

Since 2000 there has been a slight increase in the reporting of suicide attempts, but only among women (0.5% in 2000, 1.0% in 2007). Particular subgroups have experienced more pronounced increases over time. For example, in people aged 55 to 64 both suicidal thoughts (2.1% in 2000; 4.9% in 2014) and suicide attempts (0.1% in 2000; 0.6% in 2014) at least doubled in rate since 2000. This was seen in both men and women.

**Fig 63 Table to show estimated number of all adult cases in Wiltshire of suicidal thoughts, suicide attempts and self harm**

<table>
<thead>
<tr>
<th>All Adults</th>
<th>Prevalence (%)</th>
<th>Estimated Number of Wiltshire cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age bands</td>
<td>Suicidal thoughts</td>
<td>Suicidal attempts</td>
</tr>
<tr>
<td>16-24</td>
<td>26.8</td>
<td>9.0</td>
</tr>
<tr>
<td>25-34</td>
<td>22.6</td>
<td>8.5</td>
</tr>
<tr>
<td>35-44</td>
<td>21.9</td>
<td>8.0</td>
</tr>
<tr>
<td>45-54</td>
<td>23.7</td>
<td>6.8</td>
</tr>
<tr>
<td>55-64</td>
<td>22.7</td>
<td>7.0</td>
</tr>
<tr>
<td>65-74</td>
<td>11.8</td>
<td>3.6</td>
</tr>
<tr>
<td>75+</td>
<td>8.1</td>
<td>1.7</td>
</tr>
<tr>
<td>All</td>
<td>20.6</td>
<td>6.7</td>
</tr>
</tbody>
</table>

Source: APMS 2014 Prevalence data applied to Wiltshire population figures

**Fig 64 Table to show estimated number of cases in Wiltshire of suicidal thoughts, suicide attempts and self harm in women**

<table>
<thead>
<tr>
<th>Women</th>
<th>Prevalence (%)</th>
<th>Estimated Number of Wiltshire cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age bands</td>
<td>Suicidal thoughts</td>
<td>Suicidal attempts</td>
</tr>
<tr>
<td>16-24</td>
<td>34.6</td>
<td>12.7</td>
</tr>
<tr>
<td>25-34</td>
<td>24.1</td>
<td>9.1</td>
</tr>
<tr>
<td>35-44</td>
<td>22.8</td>
<td>9.5</td>
</tr>
<tr>
<td>45-54</td>
<td>26.6</td>
<td>8.2</td>
</tr>
<tr>
<td>55-64</td>
<td>22.9</td>
<td>8.6</td>
</tr>
<tr>
<td>65-74</td>
<td>11.7</td>
<td>3.7</td>
</tr>
<tr>
<td>75+</td>
<td>8.8</td>
<td>2.1</td>
</tr>
<tr>
<td>All</td>
<td>22.4</td>
<td>8.0</td>
</tr>
</tbody>
</table>

Source: APMS 2014 Prevalence data applied to Wiltshire population figures
Fig 65 Table to show estimated number of cases in Wiltshire of suicidal thoughts, suicide attempts and Self harm in men

<table>
<thead>
<tr>
<th>Age bands</th>
<th>Suicidal thoughts</th>
<th>Suicidal attempts</th>
<th>Self-harm</th>
<th>Suicidal thoughts</th>
<th>Suicidal attempts</th>
<th>Self-harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>19.3</td>
<td>5.4</td>
<td>9.7</td>
<td>4,725</td>
<td>1,314</td>
<td>2,367</td>
</tr>
<tr>
<td>25-34</td>
<td>21.1</td>
<td>8.0</td>
<td>10.9</td>
<td>5,944</td>
<td>2,247</td>
<td>3,076</td>
</tr>
<tr>
<td>35-44</td>
<td>21.1</td>
<td>6.5</td>
<td>6.6</td>
<td>6,097</td>
<td>1,886</td>
<td>1,918</td>
</tr>
<tr>
<td>45-54</td>
<td>20.7</td>
<td>5.4</td>
<td>3.3</td>
<td>7,535</td>
<td>1,968</td>
<td>1,186</td>
</tr>
<tr>
<td>55-64</td>
<td>22.5</td>
<td>5.4</td>
<td>3.3</td>
<td>6,743</td>
<td>1,606</td>
<td>983</td>
</tr>
<tr>
<td>65-74</td>
<td>11.9</td>
<td>3.5</td>
<td>2.0</td>
<td>3,124</td>
<td>930</td>
<td>538</td>
</tr>
<tr>
<td>75+</td>
<td>7.1</td>
<td>1.0</td>
<td>-</td>
<td>1,354</td>
<td>193</td>
<td>-</td>
</tr>
<tr>
<td>All</td>
<td>18.7</td>
<td>5.4</td>
<td>5.7</td>
<td>36,163</td>
<td>10,502</td>
<td>10,958</td>
</tr>
</tbody>
</table>

Source: APMS 2014 Prevalence data applied to Wiltshire population figures

The burden of prevalence is not equally distributed between men and women with women making up the majority of cases. The burden of prevalence is also not equally distributed by age. Both these points are illustrated in the charts below.

Fig 66 bar chart to show distribution of cases of self harm, suicidal thoughts and suicide attempts by age for men in Wiltshire

Estimated number of cases of suicide, self harm and suicidal thoughts in Men in Wiltshire by age

Source: APMS 2014 Prevalence data applied to Wiltshire population figures
Fig 67 bar chart to show distribution of cases of self harm, suicidal thoughts and suicide attempts by age for women in Wiltshire

![Estimated number of cases of suicide, self harm and suicidal thoughts in Women in Wiltshire by age](image)

Source: APMS 2014 Prevalence data applied to Wiltshire population figures

Fig 68 Bar chart to show distribution of total cases of suicide attempts, self harm and suicidal thoughts by sex

![Estimated total number of cases of suicide, self harm and suicidal thoughts by sex](image)

Source: APMS 2014 Prevalence data applied to Wiltshire population figures

Public Health England Mental Health Fingertips data on Suicide and Self harm
Between 2013 and 2015, there were 116 deaths in Wiltshire that were given a verdict of suicide. The directly standardised mortality rate for suicide and undetermined injury in Wiltshire was 9.0 per 100,000 and for England was 10.1 per 100,000. In Wiltshire the rate in women was 5.9 and for men was 12.2. per 100,000. This finding of higher standardised rates of deaths from suicide in men is interesting when compared with the APMS prevalence of suicidal thoughts, suicide attempts and self-harm as the gender balance is reversed.
The PHE Fingertips data suggests that crude suicide rates for women in Wiltshire are the highest in the country. Although these rates are based on small numbers, this suggests an area of concern.

**Co-occurring substance misuse and mental health**

The available research literature demonstrates strong links between mental health and smoking, alcohol use and drug use. Smoking is much more common among those with mental health disorders and most users of drug and alcohol services also experience mental health problems\(^{68}\). Drugs and alcohol can both precipitate or exacerbate mental health problems but are also sometimes used as a way of coping with mental health problems.

Despite national awareness of the common occurrence of co-morbidities there is very little good, local level indicator data on levels of co-morbid substance misuse and mental health disorders. At the local level, the issue of “dual diagnosis” is frequently raised as a concern.

---

In the absence of more specific data PHE suggests reviewing overall data around smoking, alcohol use and drug use as well as data around mental health prevalence and services.

**Adult Psychiatric Morbidity Survey Data on Drugs and Alcohol**

**Alcohol dependence:**

In England, alcoholic drinks are widely available and widely consumed by the majority of the adult population. Most people who drink do so without adverse consequences. However, alcohol is responsible for a considerable degree of health and social harm.

There is evidence that heavy drinkers have poorer levels of mental health. Alcohol misuse often co-exists with common mental disorders, such as depression and anxiety, as well as with misuse of other substances. High levels of hazardous and dependent drinking have been recorded in people being treated for serious mental health problems. Alcohol dependence and other problems associated with alcohol misuse are also frequent in homeless people and prisoners, again often in combination with poor mental health.

The APMS 2014 study uses the Alcohol Use Disorders Identification Test (AUDIT), to determine drinking levels. A score of 16 or more is deemed to denote hazardous drinking.

Nationally, for men aged 16 to 64, between a quarter and a third drank at hazardous levels or above. Such drinking was less common in men aged 65 and older. In women, drinking at hazardous levels or above was most common in 16 to 24 year olds (25.6%). In the 25 to 64 year age-groups, between 13% and 15% drank at these levels, while rates in older women were lower.

Overall, levels of harmful and dependent drinking have remained stable. However, this masks divergent trends between age groups. AUDIT scores of 16 or above have become less common in 16 to 24 year olds (6.2% in 2007, 4.2% in 2014), but more common in 55 to 64 year olds (1.4% in 2007, 2.8% in 2014).

When applied to the Wiltshire population the APMS results suggest there are 8,513 men and 3,703 women engaged in harmful drinking practices in Wiltshire. More detail by age and sex is given below.

---

Fig 70 Table to show estimated numbers of people with harmful alcohol use patterns in Wiltshire by age group

<table>
<thead>
<tr>
<th>Age band</th>
<th>Prevalence (%)</th>
<th>Estimated number of Wiltshire Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>16-24</td>
<td>5.2</td>
<td>3.2</td>
</tr>
<tr>
<td>25-34</td>
<td>6.6</td>
<td>2.2</td>
</tr>
<tr>
<td>35-44</td>
<td>6.1</td>
<td>2.4</td>
</tr>
<tr>
<td>45-54</td>
<td>4.1</td>
<td>1.6</td>
</tr>
<tr>
<td>55-64</td>
<td>3.8</td>
<td>1.9</td>
</tr>
<tr>
<td>65-74</td>
<td>1.6</td>
<td>0.7</td>
</tr>
<tr>
<td>75+</td>
<td>0.6</td>
<td>-</td>
</tr>
<tr>
<td>All</td>
<td>4.4</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Source: APMS 2014 Prevalence data applied to Wiltshire population figures

Fig 71 Bar chart to show distribution of harmful alcohol use in Wiltshire by sex and age bands

Nationally, a quarter of adults with probable alcohol dependence (AUDIT 20+) were receiving treatment and services for a mental or emotional problem. They were also more likely than others to use health and community care services. 6.1% of this group were in receipt of medication intended to treat substance misuse and 6.3% were in substance misuse counselling.

At the Wiltshire level this would suggest that we could expect around 1,200 people with probable alcohol dependence to also be receiving treatment for mental or emotional problems. This may be an underestimate of the actual need as it is felt that many who need dual diagnosis treatment are not receiving it due to difficulties in service access.
Drug misuse:
Drug misuse is defined by the World Health Organisation (WHO) as:
“the use of a substance for a purpose not consistent with legal or medical guidelines, for example the non-medical use of prescription medications or the recreational use of illegal drugs”.

Dependence syndrome is defined in the International Classification of Diseases, 10th edition (ICD-10) as:
“a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persistence in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state” (WHO 1992).

Nationally, 35.4% of men and 22.6% of women had taken an illicit drug at least once in their life. For both men and women, those aged between 25 and 34 were most likely to have ever used illicit drugs (52.9% and 35.0% respectively), declining to 3.3% of men and 2.8% of women aged 75 or over. Cannabis is the most commonly used drug followed by ecstasy, cocaine, ketamine and mephedrone.

Nationally, 3.1% of adults showed signs of dependence on drugs. This breaks down to 2.3% who showed signs of dependence on cannabis only and 0.8% with signs of dependence on other drugs (with or without cannabis dependence as well). After increases in the 1990s, the overall rate has remained stable since 2000.

When applied to the Wiltshire population this suggests 12,105 people in the county with some form of drug dependence. How this is estimated to be distributed across the population in terms of age and sex is illustrated below:

**Fig 72 Table to show estimated numbers of people with drug dependence in Wiltshire by age group**

<table>
<thead>
<tr>
<th>All Adults Prevalence (%)</th>
<th>Estimated number of Wiltshire Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age band</td>
<td>Men</td>
</tr>
<tr>
<td>16-24</td>
<td>11.8</td>
</tr>
<tr>
<td>25-34</td>
<td>6.6</td>
</tr>
<tr>
<td>35-44</td>
<td>4.0</td>
</tr>
<tr>
<td>45-54</td>
<td>2.3</td>
</tr>
<tr>
<td>55-64</td>
<td>1.3</td>
</tr>
<tr>
<td>65-74</td>
<td>0.3</td>
</tr>
<tr>
<td>75+</td>
<td>0.3</td>
</tr>
<tr>
<td>All</td>
<td>4.3</td>
</tr>
</tbody>
</table>

Source: APMS 2014 Prevalence data applied to Wiltshire population figures
Half (50.1%) of people with signs of dependence on drugs other than cannabis were in receipt of mental health treatment at the time of the interview. In contrast, those with signs of dependence on cannabis only (12.6%) had similar mental health treatment rates to the rest of the population (11.2%).

Applied to the Wiltshire population, to be in line with national treatment levels this would suggest 2,726 people with drug abuse problems who also receive mental health treatment. Again, this is likely to be an underestimate of actual need for dual diagnosis treatments, as many people do not currently receive services they need because of problems accessing service.

Over a third of adults with current signs of dependence on drugs other than cannabis (36.2%) had received treatment, help or advice specifically because of their drug use at some point, 28.8% had received this in the past six months. This was twice the rate of those with signs only of cannabis-dependence; among whom 14.6% had ever received treatment, help or support specifically because of their drug use, and 5.5% had received this in the past six months.

**Public Health England Mental Health Fingertips data on Drugs and Alcohol**

As discussed previously there is very limited data available on co-occurring substance misuse and mental health issues. The table below illustrates what is available at the local level from the PHE Fingertips site.

This data is clearly not comprehensive. The only drug misuse data is around opiates and, as noted in the APMS data, this is much less common as a drug of abuse than cannabis and so may give a misleadingly low idea of the prevalence of drug misuse locally. In addition, in the APMS survey the prevalence data for crack or cocaine or heroin/methadone misuse would suggest a count of 2,855 individuals in Wiltshire, which is more than double the PHE fingertips data estimate of 1,140.
It is hard to compare the data on hospital admissions for co-occurring alcohol abuse and mental health problems with the more general data from APMS on co-occurrence of both problems at any level of severity which suggests 1,200 individuals in Wiltshire will be affected. (See previous section).

Fig 74 Chart to show prevalence statistics for co-occurring substance misuse and mental health issues

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Wiltshire</th>
<th>Region England</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Recent</td>
<td>Value</td>
<td>Value</td>
</tr>
<tr>
<td>Estimated prevalence of opiate and/or crack cocaine use</td>
<td>2011/12</td>
<td>–</td>
<td>1,140</td>
<td>3.8</td>
</tr>
<tr>
<td>Admission to hospital for mental and behavioural disorders due to alcohol</td>
<td>2014/15</td>
<td>–</td>
<td>170</td>
<td>36</td>
</tr>
<tr>
<td>Smoking prevalence in adults - current smokers (APS)</td>
<td>2015</td>
<td>–</td>
<td>-</td>
<td>14.3%</td>
</tr>
<tr>
<td>Smoking prevalence in adults with serious mental illness (SMI)</td>
<td>2014/15</td>
<td>–</td>
<td>1,058</td>
<td>40.1%</td>
</tr>
</tbody>
</table>

Recommendations arising from this section

**CMD**
- Ensure services are equipped to cope with rising prevalence, and rising use of treatment services including GP time, medication and IAPT.

**PTSD**
- Ensure services are equipped to cope with the large number of cases that may seek treatment as awareness rises. Cases likely to have complex trauma and possible culturally specific needs (e.g. veterans, abuse survivors, asylum seekers).

**Eating disorders**
- Ensure services can cope with rising prevalence and are culturally sensitive to needs of men and LGBT community.

**Psychotic Disorder**
- Ensure early onset psychosis service is reaching all those who need it.

**Personality Disorder**
- Ensure services are equipped to effectively manage the large numbers of those living with personality disorders to minimise impact on the individuals and wider society of unmanaged symptoms.

**Bipolar Disorder**
- Ensure services are equipped to manage the life course and co-morbidity needs of those with bipolar.

**Suicide and Self-harm**
- Ensure services are equipped to manage the large increase in young women self-harming.

**Drug and alcohol abuse**
- Ensure a preventative approach is taken and that mental health services are competent to work with dual diagnosis patients.
Service Use Data

Key points

- The quality and quantity of service use data that is available is suboptimal for comprehensively assessing the gap between need and demand for mental health services in Wiltshire.
  - The data available is often specific to monthly management monitoring or national recording protocols and does not allow a detailed understanding of the broader service flows.
- A number of services e.g. Primary Care Liaison Services (PCLS) appear to show a very high proportion of returned referrals. A greater understanding of this discrepancy is required as it is likely to represent a large gap between provision and demand and it is important to understand at what level this is occurring.
- For those conditions where it is possible to compare expected local prevalence with service use (e.g. eating disorder, new onset psychosis, personality disorder, self-harm) there appear to be very low rates of service use compared to expected prevalence (even compared to national expected treatment rates). Whether these are real differences or issues in data recording and interpretation are unclear.
- The available IAPT data show that treatment outcomes are less good than nationally. However, the data available do not take into account recent service changes.
- Perinatal IAPT services appear to have less good reported outcomes than general IAPT services locally.

This section provides an overview of quantitative demand for services as well as qualitative data on service user, carer and provider views about services.

Comprehensive and informative service use data was hard to access for a number of reasons. This has limited the reach of the needs assessment. Where appropriate available data has been included and its strengths and limitations discussed.

Section A: Quantitative data on service use

Primary Care Liaison and Acute Care Mental Health Liaison

Many people turn to their GP or hospital as their first port of call for medical help be it for physical or mental health issues. Wiltshire mental health services have both primary care and hospital focused mental health liaison teams.

Primary Care Liaison Service
The primary care mental health liaison service is a short-term support service to help people with mental health difficulties to move forward and get on with their lives.
There were a total of 4,755 referrals received in the 2016/17 year. As might be expected for the primary care liaison service, the majority of referrals are received from GPs (94%). Only a very small proportion (1%) self-referred.

Of the referrals made, 90% are returned to the GPs care following initial assessment or screening. Only 2% of referrals are taken on by the trust. The reason for this low rate is not clear from this data and merits further investigation to clarify the issues involved. It is possible that GPs do not understand the referral pathways, there are a high number of inappropriate referrals, or that services are not equipped to take on the care of those in need. Alternatively it is possible that brief advice is given and the patients are returned to GP care following satisfactory resolution of the issue through different services.

Fig 75. Table to show 2016/17 referral rates, source of referral and outcomes for the Primary Care Liaison Service

<table>
<thead>
<tr>
<th>Measure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total referrals</strong></td>
<td>4,755</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td>4,755</td>
</tr>
<tr>
<td><strong>Source of referrals</strong></td>
<td>4,755</td>
</tr>
<tr>
<td>Internal</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>200</td>
</tr>
<tr>
<td>Other health professional</td>
<td>59</td>
</tr>
<tr>
<td>Social care</td>
<td>1</td>
</tr>
<tr>
<td><strong>GP</strong></td>
<td>4,446</td>
</tr>
<tr>
<td><strong>Self</strong></td>
<td>47</td>
</tr>
<tr>
<td><strong>Outcome of referrals</strong></td>
<td>4,755</td>
</tr>
<tr>
<td>Assessed and Returned</td>
<td>1,590</td>
</tr>
<tr>
<td>Screened and Returned</td>
<td>2,660</td>
</tr>
<tr>
<td>Taken on by Trust</td>
<td>84</td>
</tr>
<tr>
<td>Assessed</td>
<td>203</td>
</tr>
<tr>
<td>Awaiting Assessment</td>
<td>218</td>
</tr>
</tbody>
</table>

Source: CCG Data
Mental Health Liaison (MHLS)
The service offers a mental health assessment to all adults attending Accident and Emergency (A&E) departments who have mental health concerns including self-harm. It also assists acute general hospitals to assess and treat people with mental health concerns who have been admitted with an existing medical problem.

Referral data for Wiltshire CCG residents is available for the 2016/17 period.

Fig 76. Table to show 2016/17 referral rates, source of referral and outcomes for the Mental Health Liaison Service (Hospital based)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total referrals</td>
<td>2,839</td>
</tr>
<tr>
<td>All</td>
<td>2,839</td>
</tr>
<tr>
<td><strong>Source of referrals</strong></td>
<td></td>
</tr>
<tr>
<td>Internal</td>
<td>49</td>
</tr>
<tr>
<td>Other</td>
<td>727</td>
</tr>
<tr>
<td>Other health professional</td>
<td>1,914</td>
</tr>
<tr>
<td>Social care</td>
<td>7</td>
</tr>
<tr>
<td>GP</td>
<td>141</td>
</tr>
<tr>
<td>Self</td>
<td>1</td>
</tr>
<tr>
<td><strong>Outcome of referrals</strong></td>
<td></td>
</tr>
<tr>
<td>Assessed and Returned</td>
<td>1,722</td>
</tr>
<tr>
<td>Screened and Returned</td>
<td>537</td>
</tr>
<tr>
<td>Taken on by Trust</td>
<td>509</td>
</tr>
<tr>
<td>Assessed</td>
<td>28</td>
</tr>
<tr>
<td>Awaiting Assessment</td>
<td>43</td>
</tr>
</tbody>
</table>

Source: CCG data

During the 2016/17 period a total of 2,839 referrals were made. The majority (67%) were from hospital doctors. 80% of referrals were returned to the referrer following assessment and/or screening. 18% of referrals were taken on by the trust. As for the primary care liaison service, this data is not able to provide information as to why referrals are returned or taken on.

The table below summarises the demands made on the service split by hospital during 2014/15 (latest available data with demographic splits).
### Figure 77: MHL Activity Summary 14/15

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>SDH</th>
<th>GWH MHL</th>
<th>RUH MHL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Referrals</strong></td>
<td>1067</td>
<td>1678</td>
<td>1660</td>
</tr>
<tr>
<td><strong>Growth in referral totals 13/14 to 14/15</strong></td>
<td>115.1%</td>
<td>11.8%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Area of Residency</strong></td>
<td>Wiltshire 768 (71.1%) Other CCGs 312 (28.9%)</td>
<td>Swindon: 1076 (64.1%) Wiltshire: 391 (23.3%) Other: 211 (12.6%)</td>
<td>Wiltshire: 618 (37%) BANES 697 (42%) Other CCGs 345 (21%)</td>
</tr>
<tr>
<td><strong>Gender: Female</strong></td>
<td>603 (56.4%)</td>
<td>951 (56.7%)</td>
<td>1007 (59.4%)</td>
</tr>
<tr>
<td><strong>Male</strong></td>
<td>463 (43.5%)</td>
<td>727 (43.3%)</td>
<td>690 (40.6%)</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>1 (0.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Age:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-17</td>
<td>4 (0.4%)</td>
<td>5 (0.3%)</td>
<td>0</td>
</tr>
<tr>
<td>18-35</td>
<td>305 (28.6%)</td>
<td>558 (33.3%)</td>
<td>476 (28%)</td>
</tr>
<tr>
<td>36-65</td>
<td>367 (34.4%)</td>
<td>649 (38.7%)</td>
<td>449 (26.5%)</td>
</tr>
<tr>
<td>66+</td>
<td>391 (36.6%)</td>
<td>466 (27.8%)</td>
<td>772 (45.5%)</td>
</tr>
<tr>
<td><strong>Ethnicity:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>927 (86.9%)</td>
<td>1490 (88.8%)</td>
<td>1521 (89.6%)</td>
</tr>
<tr>
<td>Black</td>
<td>5 (0.5%)</td>
<td>8 (0.5%)</td>
<td>12 (0.7%)</td>
</tr>
<tr>
<td>Asian</td>
<td>1 (0.09%)</td>
<td>19 (1.3%)</td>
<td>5 (0.3%)</td>
</tr>
<tr>
<td>Other</td>
<td>134 (12.6%)</td>
<td>16 (1%)</td>
<td>159 (9.4%)</td>
</tr>
<tr>
<td>Not stated</td>
<td></td>
<td>145 (8.6%)</td>
<td></td>
</tr>
<tr>
<td><strong>New Case:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open on another referral</td>
<td>462 (43.6%)</td>
<td>611 (36.4%)</td>
<td>691 (41%)</td>
</tr>
<tr>
<td>Previously open &lt; 6 months ago</td>
<td>279 (26.4%)</td>
<td></td>
<td>381 (22.7%)</td>
</tr>
<tr>
<td>Previously open &gt; 6 months ago</td>
<td>169 (16%)</td>
<td>1067 (63.6%)</td>
<td>313 18.6%</td>
</tr>
<tr>
<td>*Previous referral to AWP</td>
<td>149 (14%)</td>
<td></td>
<td>296 (17.6%)</td>
</tr>
<tr>
<td><strong>Contact received from MHL</strong></td>
<td>Screened and discharged 204 (19.21%) Assessed and discharged 556 (52.2%) Brief Intervention (&lt;6 contacts) 253 (23.71%) Substantial Intervention (&gt;=6 contacts) 53 (4.97%)</td>
<td>Screened and discharged 2903 total patient contacts</td>
<td>Screened and discharged 670 (39.5%) Assessed and discharged 864 (51%) Brief Intervention (&lt;6 contacts) 148 (9%) Substantial Intervention (&gt;=6 contacts) 16 (1%)</td>
</tr>
<tr>
<td><strong>Referral Source:</strong></td>
<td>Not provided</td>
<td>1065 (63.5%)</td>
<td>Not Provided</td>
</tr>
<tr>
<td>A&amp;E Hospital Wards Internal</td>
<td></td>
<td>1 (0.06%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>612 (36.5%)</td>
<td></td>
</tr>
<tr>
<td><strong>Out of Hours Referrals to the Intensive Team</strong></td>
<td>Jan – Feb 2015 referrals received: 35</td>
<td></td>
<td>Total referrals 14/15: 322</td>
</tr>
<tr>
<td>*referrals additional to MHL referral totals</td>
<td>Jan – Feb 2015 referrals received: 68</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: CCG data

When interpreting the above data, it should be noted that because this is hospital gathered data it will include some data on residents from outside Wiltshire. In addition, it may not capture all Wiltshire residents as some may choose to access hospitals outside the county.
Allowing for the above caveats, demographic data appear broadly representative of local populations. The number of Wiltshire residents accessing the service declined very slightly (3.3%) between 2013/14 and 2014/15.

The overall trend is for increasing referrals. In SFT there was a 115% increase in referrals and a 12% increase for referrals in GWH. In both of these settings, the service is seeing a large number of new patients who are not already known to mental health services. It is potentially of concern that this high proportion of service users have not been picked up before the need for hospital admission and referral.

**Community Mental Health Services**

This service offers a community based continuing care service to those who need it.

During the 2015/16 year there were 858 referrals to the service. More detail is provided in the table below.

**Fig 78. Table to show 2016/17 referral rates, source of referral and outcomes for the community mental health teams**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total referrals</td>
<td>858</td>
</tr>
<tr>
<td>All</td>
<td>858</td>
</tr>
<tr>
<td>Source of referrals</td>
<td>858</td>
</tr>
<tr>
<td>Internal</td>
<td>282</td>
</tr>
<tr>
<td>Other</td>
<td>106</td>
</tr>
<tr>
<td>Other health professional</td>
<td>76</td>
</tr>
<tr>
<td>Social care</td>
<td>5</td>
</tr>
<tr>
<td>GP</td>
<td>374</td>
</tr>
<tr>
<td>Self</td>
<td>15</td>
</tr>
<tr>
<td>Outcome of referrals</td>
<td>858</td>
</tr>
<tr>
<td>Assessed and Returned</td>
<td>110</td>
</tr>
<tr>
<td>Screened and Returned</td>
<td>42</td>
</tr>
<tr>
<td>Taken on by Trust</td>
<td>592</td>
</tr>
<tr>
<td>Assessed</td>
<td>90</td>
</tr>
<tr>
<td>Awaiting Assessment</td>
<td>24</td>
</tr>
</tbody>
</table>

Source CCG data

The two most frequent sources of referral are the GP (44%) and other AWP mental health services (33%). 69% of referrals are taken on by the trust with 18% being returned to the referrer following assessment and or screening.

**IAPT Services**

Improved Access to Psychological Therapies (IAPT) services offer a range of support through GP surgeries to anyone with common emotional and mental health difficulties, primarily those associated with anxiety and depression. The Wiltshire IAPT services range from self-help therapies, to psycho-educational courses and one-to-one support.
Summary 2016/17 data on IAPT service use and outcomes in Wiltshire is given in the table below.

**Fig 79 Wiltshire IAPT service use and outcome data**

<table>
<thead>
<tr>
<th>Service measure</th>
<th>Female</th>
<th>Male</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals Received</td>
<td>7,365</td>
<td>3,736</td>
<td>11,101</td>
</tr>
<tr>
<td>Entered Treatment (those seen for treatment for first time within the period)</td>
<td>6,281</td>
<td>3,217</td>
<td>9,498</td>
</tr>
<tr>
<td>Completed Treatment (Those discharged within the period who had been seen at least twice)</td>
<td>2,132</td>
<td>1,062</td>
<td>3,194</td>
</tr>
<tr>
<td>Moved to Recovery (Those who completed treatment in recovery)</td>
<td>796</td>
<td>392</td>
<td>1,188</td>
</tr>
<tr>
<td>Not at Caseness at start of Treatment (those who started and completed treatment in recovery)</td>
<td>304</td>
<td>185</td>
<td>489</td>
</tr>
<tr>
<td>Total Discharges within the period</td>
<td>7,000</td>
<td>3,493</td>
<td>10,493</td>
</tr>
<tr>
<td>Recovery Rate (Target 50%)</td>
<td>43.5%</td>
<td>44.7%</td>
<td>43.9%</td>
</tr>
<tr>
<td>Access Rate (Target 15%)</td>
<td>21.9%</td>
<td>19.6%</td>
<td>21.1%</td>
</tr>
<tr>
<td>Reliable Improvement</td>
<td>55.2%</td>
<td>53.8%</td>
<td>54.7%</td>
</tr>
<tr>
<td>Moved off sick pay (as a % of all who completed treatment)</td>
<td></td>
<td></td>
<td>4.57%</td>
</tr>
<tr>
<td>Moved off sick pay (a % of all who completed treatment in period and were on sick pay at start of treatment)</td>
<td></td>
<td></td>
<td>60.39%</td>
</tr>
</tbody>
</table>

**Waiting Times**

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Weeks or Less (Target 75%)</td>
<td>96.9%</td>
<td>98.2%</td>
<td>97.3%</td>
</tr>
<tr>
<td>18 Weeks or Less (95%)</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>18 Weeks or More (5%)</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Of the total number of referrals two thirds are female and one third are male. This is in line with the nationally observed findings that more women receive treatment for mental health issues than men. There are no significant differences in recorded outcomes between men and women once they have entered the service.

IAPT services are part of a national programme and, as a result, national benchmarking data is available. A snap shot of this is given below.
Review of this data identifies a number of interesting points. Wiltshire IAPT performs better than the national average around access indicators such as the proportion of those estimated to have anxiety and depression who access IAPT and the access rate per 100,000 population. It also performs better in terms of those having waiting times of less than both 6 and 18 weeks.

However, outcome indicators such as completion of treatment, reliable improvement and those finishing treatment are statistically significantly lower than the National averages. Latest monthly data suggest recent improvements in these metrics.
Revival services
IAPT is not configured to work with complex cases. The CCG commissions Revival to provide a counselling service for adult survivors of childhood sexual abuse who would not fit the criteria for IAPT services. However, they are a small service located in the middle band of the county and only cover survivors of sexual abuse. This places challenges around ease of access to this provision for those living in the South/North of the county. In addition, it does not cover those complex cases who do not meet referral criteria for services such as IAPT and have issues other than sexual abuse.

Perinatal Services
The referral data to local perinatal IAPT services for 2015/16 is summarised below. For the year 339 referrals were made. The type of condition for which the referral was made was not recorded in 61% of cases making an analysis of actual vs expected referrals difficult.

Almost 10% of referrals were for men which is encouraging as traditionally this has been an under recognised issue and men were not referred for perinatal mental health support.

Fig 81 Table to show Wiltshire IAPT Perinatal Referrals in 2015/16

<table>
<thead>
<tr>
<th>PERINATAL REFERRALS RECEIVED 2015/16</th>
<th>Female</th>
<th>Male</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Mental Health Problems (Low Severity)</td>
<td>19</td>
<td>2</td>
<td>21</td>
</tr>
<tr>
<td>Common Mental Health Problems (Low Severity with greater needs)</td>
<td>23</td>
<td>3</td>
<td>26</td>
</tr>
<tr>
<td>Non-Psychotic (Moderate Severity)</td>
<td>35</td>
<td>6</td>
<td>41</td>
</tr>
<tr>
<td>Non-Psychotic (Severe)</td>
<td>20</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>Non-Psychotic (Very Severe)</td>
<td>15</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Blank Cluster</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ongoing Recurrent Psychosis (low symptoms)</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Not Clustered</td>
<td>193</td>
<td>15</td>
<td>208</td>
</tr>
<tr>
<td>Grand Total</td>
<td>307</td>
<td>32</td>
<td>339</td>
</tr>
</tbody>
</table>
Fig 82 Table to show Wiltshire Perinatal Referral Outcomes in 2015/16

<table>
<thead>
<tr>
<th>PERINATAL OUTCOMES 2015/16</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals</td>
<td></td>
</tr>
<tr>
<td>Ended in Period</td>
<td>386</td>
</tr>
<tr>
<td>Completed Treatment</td>
<td>151</td>
</tr>
<tr>
<td>Paired Scores</td>
<td>142</td>
</tr>
<tr>
<td>Not at Caseness at start</td>
<td>18</td>
</tr>
<tr>
<td>Moved to Recovery</td>
<td>40</td>
</tr>
<tr>
<td>Reliably Improved</td>
<td>73</td>
</tr>
<tr>
<td>Recovery Rate</td>
<td>30.1%</td>
</tr>
<tr>
<td>Reliable Improvement Rate</td>
<td>48.3%</td>
</tr>
</tbody>
</table>

When compared to the general IAPT service (see previous section) the outcome data for the perinatal IAPT service are less good than for the general service. (perinatal recovery rate 30.1% vs 43.9% for general service). It is not known if this difference is statistically significant but it flags an area of concern.

**Inpatient mother and baby unit**

AWP have a mother and baby unit in Bristol to which Wiltshire residents can be admitted. In 2015/16, three mothers from Wiltshire were admitted for care.

**Baby Steps Programme**

At risk women, and those with less severe mental health problems, can also be referred to the Baby Steps programme to help address perinatal mental health issues. This is a relationship based perinatal education programme for ‘vulnerable’ parents, including those with mild mental health concerns or experiencing social isolation. Currently a large percentage of referrals are for women with mild mental health problems. This programme is currently being evaluated and results will be available in mid 2017.
Early Intervention in Psychosis Service
This service provides a comprehensive multidisciplinary service to help people and their families as early as possible, giving them the best chance of preventing long-term problems. The service is for anyone from the age of 14-65 experiencing symptoms associated with psychosis.

During the 2015/16 year there were 135 referrals to the service. More detail is provided in the table below.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total referrals</td>
<td>135</td>
</tr>
<tr>
<td>All</td>
<td>135</td>
</tr>
<tr>
<td>Source of referrals</td>
<td>135</td>
</tr>
<tr>
<td>Internal</td>
<td>121</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
<tr>
<td>Other health professional</td>
<td>9</td>
</tr>
<tr>
<td>GP</td>
<td>2</td>
</tr>
<tr>
<td>Outcome of referrals</td>
<td>135</td>
</tr>
<tr>
<td>Assessed and Returned</td>
<td>31</td>
</tr>
<tr>
<td>Screened and Returned</td>
<td>6</td>
</tr>
<tr>
<td>Taken on by Trust</td>
<td>90</td>
</tr>
<tr>
<td>Assessed</td>
<td>6</td>
</tr>
<tr>
<td>Awaiting Assessment</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: CCG data

The most frequent source of referral was other AWP mental health services (90%). 67% of referrals are taken on by the trust with 27% being returned to the referrer following assessment and/or screening.

The estimated incidence of new cases of psychosis for Wiltshire is 50 per 100,000 population giving an estimate of 243 per year. This is 1.8 times higher than the referral rate into the service seen in practice. This difference may represent an over estimate of the number of new cases or that people are not being referred into the service when eligible.

Eating Disorders

The eating disorder service is a specialist service commissioned from Oxford Health. Full year data on service demand is available for 2015/16 and is used in this report.

There were a total of 141 referrals within the 2015/16 period and the average time that a patient was cared for by the service was recorded as 102 days. National prevalence data (see section Local Health Needs, Section E) suggest that at any one time around 6,304 people in Wiltshire will be experiencing an eating disorder.
A range of data is available around the nature of the referrals, and this is summarised below.

As illustrated below, the most common reason for referral is for unspecified eating disorders followed by for anorexia nervosa.

**Fig 84: Bar chart to show reason for referral to the Wiltshire Eating Disorder Service**

![Bar chart showing reason for referral](chart.png)

**Figure 85 Pie Chart to Show the Source of Wiltshire referrals to Eating Disorder service**

![Pie chart showing source of referrals](chart.png)

The majority (71%) of Wiltshire referrals to the Eating Disorder service come from the GP with the next largest referrer (7%) being the Child and Adolescent Mental Health Service.
Referrals to the eating disorder service are highest in the late teens early twenties. This is in line with the national picture.

In Wiltshire in 2015/16, 96% of referrals to the eating disorder service were female. Nationally this figure thought to be around 90% female, 10% male. The fact only 4% of local referrals are for men, suggests that locally men may be being under represented at the eating disorder service. Ethnically, of those that had ethnicity recorded 95% were white British. This is broadly in line with the population split.
Personality Disorders
Within Wiltshire, service users with a personality disorder diagnosis are managed within primary care and secondary care. There are currently no tertiary services commissioned locally. However, this is currently being reviewed by the CCG and a business case is being developed.

In 2014/15 there were believed to be around 246 people with personality disorder being supported by the mental health liaison service. In addition there were 83 inpatient admissions for people with personality disorders.

Fig 87: Distribution of patients with personality disorders supported by mental health liaison services for 2014/15

<table>
<thead>
<tr>
<th></th>
<th>SDH Mental Health Liaison</th>
<th>RUH Mental Health Liaison</th>
<th>GWH Mental Health Liaison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approx number of EUPD patients supported:</td>
<td>106</td>
<td>64</td>
<td>76</td>
</tr>
<tr>
<td>Approx number of clinical contacts delivered:</td>
<td>180</td>
<td>131</td>
<td>130</td>
</tr>
</tbody>
</table>

Fig 88: Wiltshire AWP inpatient admissions and lengths of stay for patients with personality disorder

<table>
<thead>
<tr>
<th></th>
<th>2014/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total admissions</td>
<td>83</td>
</tr>
<tr>
<td>Average length of stay for these admissions</td>
<td>47</td>
</tr>
<tr>
<td>Range LOS of admissions</td>
<td>4-189</td>
</tr>
<tr>
<td>Total Bed days from admissions</td>
<td>3890</td>
</tr>
</tbody>
</table>

Individuals with personality disorders often require repeated admissions or multiple community contacts. Between 2011 and 2015, 76 individual Wiltshire residents diagnosed with personality disorder required an inpatient admission on 154 separate occasions. 94 of these readmissions were in relation to just 21 individuals illustrating that for some of these patients multiple admissions are common.

In the community 363 service users with a diagnosed personality disorder accessed community based services on 1,838 occasions from 2012 to 2015.
Suicide and Self Harm

Comprehensive local data around self-harm and suicide is not readily available.

Wiltshire residents are primarily served by three hospitals, RUH (Bath), GWH (Swindon) and SFT (Salisbury). A self-harm register for over 18s exists at RUH, and one for all ages exists at GWH. SFT, despite support from the local public health team did not set a register up and the pump priming funding for this is no longer available. Each hospital is attended by residents of neighbouring areas as well as Wiltshire, and no one hospital captures the majority of Wiltshire residents. Thus no single data source will capture the picture of self-harm in Wiltshire.

For illustrative purposes a snapshot of data from the GWH self-harm register is included. GWH has Swindon and Wiltshire as its main catchment area so while the data cannot be read as being Wiltshire specific it can be used as a proxy for demand on services in that area.

During the period of data collection between April 2014 and March 2015 there were 1,067 presentations to GWH A&E. These visits were made by 776 individuals meaning that 27% of visits were repeat presentations.

In an average week, GWH receives 21 presentations of self-harm. 80% of these are self-poisoning with paracetamol, often in combination with other drugs. 60% (642/1067) of presentations were female and 40% (425/1067) of presentations were male. This is roughly in line with the gender split seen nationally.

Fig 89. Chart showing age distribution of those presenting to GWH with self harm in 2014/15.

Source: AWP Mental Health Partnership data from Self harm Register Analysis 2014/15
This data suggests that presentations by service users in their late teens and early twenties are most common. Those aged 41-45 are the second highest group and incidence generally declined with greater age thereafter.

Looking at the distribution by employment status provides some interesting insights. For those where employment status was ascertained, the majority were in employment with the second highest proportion being in receipt of sickness benefit. The full results are illustrated in the pie chart below.

**Fig 90** Pie chart to show employment status of those attending GWH in 2014/15 with a presentation of self harm.

Co-occurring substance misuse and mental health

PHE fingertips provides some data around service use for those with drug and alcohol problems and concurrent mental health issues.

From the data given below, 59 Wiltshire individuals were recorded as being in concurrent contact with both mental health services and drug misuse services. This represents just 6% of total drug service users and is much lower than the 50% expected from findings of the Adults Psychiatric Morbidity Survey 2014 (see prevalence section).

There were 47 people recorded as being in concurrent contact with mental health services and alcohol misuse services. This represents 7% of those receiving specialist treatment from alcohol misuse services. Similar to the findings above, this proportion is lower than the 25% expected from the AMPS findings.
Acute Inpatient Services

The detailed data available to analyse the use of acute inpatient services is presented in terms of occupied bed days. Thus it does not give an indication of the number of patients seen, nor the number of admissions. In addition, in line with other available data, information is not available by condition but only at the level of disease cluster. The available data is included for completion although it is acknowledged that it is sub optimal in terms of analysis of demand and comparing estimated need against demand.

For the 12 months between March 2016 and Feb 2017 Wiltshire CCG accrued a total of 28,333 occupied bed days. This relates to 489 admissions (but an unknown number of individuals). Of the 28,333 occupied bed days just under 9% occurred out
of locality. Out of locality placements can place significant strain on patients and their families through travel expenses and day to day logistics.

**Fig 92** Pie chart to show proportion of occupied bed days in and out of locality for Wiltshire CCG Mar/Feb 16/17

![Pie chart showing the proportion of occupied bed days in and out of locality for Wiltshire CCG Mar/Feb 16/17](source: CCG data)

The reason for the occupied bed days can be analysed by diagnostic cluster. Ongoing recurrent psychosis is the most frequent reason for admission representing 29% of occupied bed days. Non-psychotic admissions account for 22% of occupied bed days and organic causes for 18%. This is illustrated in the pie chart below.

**Fig 93** Pie chart to show proportion of occupied bed days by diagnostic cluster for Wiltshire CCG Mar/Feb 16/17

![Pie chart showing the proportion of occupied bed days by diagnostic cluster for Wiltshire CCG Mar/Feb 16/17](source: CCG data)
On some occasions, beds remain occupied even though the occupier is fit for discharge. This delayed transfer of care can occur for a number of reasons as illustrated in the pie chart below. The biggest proportion of such delays (46%) arise from cases when the patient is awaiting nursing home placement, 22% arise from patients awaiting residential home placement and 11% from patients who are in need of housing not covered by the NHS or CCA. Only 11% of delays are due to clinical issues such as awaiting assessment completion or further NHS care.

Fig 94 Pie chart to show proportion of delayed transfer of care from mental health inpatient services by cause for Wiltshire CCG Mar/Feb 16/17

Source: CCG data

Recommendations arising from this section

- Services should work closely with commissioners to provide high quality data that allows a full understanding of the nature of local service use. It should be recognised that this data may need to be different from monthly management data currently provided.
- Referral pathways need to be better understood to provide insight into the high rates of refusals seen in some services with a view to clarifying referral pathways.
- IAPT use needs to better understood to address issues around data reporting and why outcomes, particularly in perinatal services are less good than expected.
- Better data is needed to clarify the number and nature of acute inpatient admissions.
Section B: Service users’ and carers’ perspectives

Key points

- Service users and carers generally felt that finding out about local services was relatively easy and cited that they generally used trusted personal networks or health professionals to provide information on services.
- The majority of respondents felt the mental health services they received were helpful but a sizeable number were ambivalent or felt services were unhelpful. The main drivers of positive feelings were around good communications, empathetic staff and services being well organised.
- The majority of respondents felt that mental health services in Wiltshire did not consider their needs holistically. It was felt voluntary services might be better at this than medical services for whom reported experiences were more mixed.
- Only 34% of respondents agreed it was easy to access the services they felt they needed. Waiting times, difficulty accessing services using public transport, and out of hours’ access were frequently cited as barriers to access.
- Two thirds of respondents felt services did not link up well. The effect of poor links and poor communications were described as “literally soul destroying”. A number of carers referred to themselves as “communication managers” and worried for those who did not have such advocates. When communications were good and services linked the experience was commented on very positively.

Service users’ and carers’ perspectives were sought through a short questionnaire and through two focus group events.

The questionnaire was designed to be a simple, short five question survey. It was designed in conjunction with the Wiltshire Service User Network who offered advice on its appropriateness and ease of use with the target population of service users and carers. The survey was offered to all mental health service users and carers who came into contact with the Wiltshire Service User Network between 24 April 2017 and 5 May 2017. HealthWatch also distributed questionnaires in the same period. In all, 65 completed questionnaires were returned.

The five questions used in the questionnaire were:

1. It is hard to find out about services that support mental health
2. It is usually easy to get an appointment with the mental health support services I need
3. The mental health support I receive is helpful
4. Moving between different services is hard
5. The support I receive considers me as a whole person and considers all my needs not just my mental health needs e.g. housing, finance etc.

The focus group events were held in Trowbridge on 24 April 2017 and in Salisbury on 9 May 2017 and were arranged in conjunction with the Wiltshire Service User Network who facilitated links with the carer and mental health service user
community locally, and ensured a wide range of experiences were represented. There were 23 attendees at the Trowbridge event and 31 at the Salisbury event. The sessions were run in a World Café format with 5 discussion topics, each facilitated by a trained facilitator provided by Wiltshire Service User Network.

**Accessing information about mental health services**

**Fig 95 Summary of questionnaire Q1**

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is hard to find out about services that support mental health</td>
<td>18%</td>
<td>36%</td>
<td>21%</td>
<td>25%</td>
<td>0%</td>
</tr>
</tbody>
</table>

54% of respondents agreed or strongly agreed that it is hard to find out about services that support mental health. This suggests there is a need for better targeted information around mental health services.

A number of interesting insights were gained from the focus group discussions and from the questionnaire comments. One of the favoured ways of getting information was via word of mouth from trusted sources. People reported using personal networks or mental health affiliated groups they already belonged to e.g. MIND groups or WSUN. Mental health professionals were also cited as a source of information that was helpful for signposting services. One service user reported a positive experience with the expert patient scheme they had been linked up with in Bristol.

Internet searches were popular with some, but it was noted that often links are out of date, or services that might be advertised are not actually available. This was a source of frustration and “hub pages” where links don’t work or are out of date were deemed to be “worse than useless because [once one link does not work] you can’t trust any of it”.

---

70 http://www.theworldcafe.com/key-concepts-resources/world-cafe-method/
Issues around experience of local mental health services

Fig 96 Summary of questionnaire Q2

The mental health support I receive is helpful

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of respondents</td>
<td>11%</td>
<td>43%</td>
<td>34%</td>
<td>10%</td>
<td>2%</td>
</tr>
</tbody>
</table>

54% of respondents agreed or strongly agreed that the mental health support they receive is helpful. This suggests there is a large proportion of patients who either feel ambivalent towards, or unhelped by the services they receive.

Attendees at the focus groups were asked to discuss what they felt was or negative about the services they currently receive.

Many of the issues that people felt were positive about services were generic in nature and revolved around good communication, the service being well organised, having empathetic staff at all levels of the organisation (not just clinicians) and services that helped make the user feel part of a valued community. One user felt strongly that a “good service” was one that worked with you to achieve the mental health outcome you want.

Conversely issues such as long waiting times, lack of continuity of staff contact due to high staff turnover and poor facilities all made people feel negative about services.

The types of services that people felt they would benefit from but could not find locally included expert patient programmes, local groups where you can drop in and talk to likeminded people, self-management tutor groups and CBT based services. A number of people also mentioned they would like interest based groups that were able to accommodate those with mental health issues.
Issues around whether services take a holistic approach

Fig 97 Summary of questionnaire Q3

41% of respondents agreed or strongly agreed that the support they receive considers them as a whole person and considers all their needs not just their mental health needs e.g. housing, finance etc. 28% disagreed or strongly disagreed. This suggests there is still some way to go with providing holistic services that people recognise as such.

As might be expected from the questionnaire results, opinions expressed in the focus groups were divided and many examples were provided both of when a holistic approach had been taken, as well as when it had not been taken. There was some suggestion that third sector organisations tend to take a holistic view of the person more routinely than medical services. When examples of medical professionals taking a holistic approach were given, the examples tended to focus on a specific individual rather than the services as a whole. In contrast, when discussing voluntary sector examples, people tended to provide organisation level examples such as where the Citizen’s Advice Bureau routinely provides help in a number of areas and were described as “sensitive and often better than the GP”.

The negative examples were mostly around medical services not taking into account other issues, with one respondent commenting that they had “never been asked by any medical professional about my other needs”. Another noted “people [medical staff] either seem able to think about my physical health or about my mental health. They don’t realise I am both of them”. In contrast, no third sector organisations were cited as not providing holistic care.

One respondent stated that “a good GP goes into everything” and this was broadly agreed with as a gold standard. However, one respondent did note that in situations where the mental health issue is very severe it is not appropriate that a medical professional is focussed on anything other than the medical need, as failing to focus on that could have serious implications.
Ease of service access

Fig 98 Summary of questionnaire Q4

It is usually easy to get an appointment with the mental health support services I need

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>3%</td>
</tr>
<tr>
<td>Agree</td>
<td>31%</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>30%</td>
</tr>
<tr>
<td>Disagree</td>
<td>31%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>5%</td>
</tr>
</tbody>
</table>

34% of respondents agreed or strongly agreed that it is usually easy to get an appointment with the mental health support services they need. 35% disagreed or strongly disagreed.

During the discussions, it was noted that “it makes such a difference to see the right service at the right time”. However, the discussions around service accessibility were mainly highlighting how hard service users find it to access services when they feel they need them. The two respondents that reported a positive experience emphasised that this was because they have strong relationships with their GP saying the GP “knows their needs”.

There were a large number of comments around how hard it can be to get a GP appointment. Multiple comments around GP appointments taking two weeks or even a month were noted. One respondent noted “there is often a two week wait for a GP appointment and, because I have to go back to my GP to be referred on, this just prolongs the waiting time”.

There were mixed views about being able to self-refer to services. Some said the option was not available frequently enough as they disliked having to get GP referrals. However, others reported they found it challenging as often they felt they did not know enough to make effective self-referrals e.g. “each time you have to self-refer to IAPT but sometimes you don't know you need to go back there”.

Waiting times for specialist services were raised as feeling excessive with the comment that “being on a waiting list is not receiving a service” but that because you have “been referred” other health professionals treat it as if it is being in the service. People specifically commented that having to wait for referrals to the crisis team felt particularly uncomfortable. It was raised that “if you are bleeding to death you get treatment straight away, with mental health you just get passed around”.

As well as waiting times, service users also raised issues around difficulty getting to appointments with limited public transport available and what was available being perceived as costly. Getting to out of hours appointments was noted as being particularly difficult if the service user did not have access to a car. It was noted by a number of people that “the bus rarely takes me where I need to go and certainly not at the times I need to be there”. One patient reported that they were “offered an appointment at midnight. To get to the appointment it was an hour’s walk there and an hour’s walk back. I was so desperate that I did it”.

How well services link up and the quality of communications

Fig 99 Summary of questionnaire Q5

<table>
<thead>
<tr>
<th>Moving between different services is hard</th>
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</thead>
<tbody>
<tr>
<td>Strongly agree</td>
</tr>
<tr>
<td>22%</td>
</tr>
</tbody>
</table>

67% of respondents agreed or strongly agreed that moving between different services is hard. Only 5% disagreed or strongly disagreed with this.

It was agreed that there were some services that communicate and link up well but that many do not. Service users were particularly appreciative of when the GP and specialist mental health services linked well with examples of positive communications being offered. The police triage service was also praised as an example of where services link well.

Service users’ reported experiences of the impact on them when services do not link and communicate well were very compelling. People described the impact in terms of it being “literally soul destroying” and making them feel “as if they might as well give up [at the time they were having suicidal thoughts]”. Service users were left feeling frustrated, undervalued, threatened and let down, and in some cases “dreading staff changes” because they knew the new people “will not know what’s going on”.

Some carers referred to themselves as “managers of communications” and wondered how those without an advocate coped. A number of services users noted that they felt some services were “hiding behind” data confidentiality issues to avoid communicating with other services.
Recommendations arising from this section

- Continue to seek out and listen to the views of service users and carers
- Continue to find ways to improve equitable access to services that takes into account, geographical spread of services, opening times and ease of access by public transport
- Work with GPs to ensure parity of mental health offering with the physical health offering
- Continue to improve patient centred offering to ensure service users feel they are receiving holistic care
Section C: Professional perspectives on need

Key points

- Providers emphasised the importance to them of services taking a person centred approach tailored to the needs of the user.
- Providers expressed they felt there was a need for more “pre-crisis” services.
- Providers recognised the importance of easy access to services but expressed concern around geographic barriers to some services, and the delays introduced by requiring a primary care referral back into a service if a previously well person was becoming unwell again.
- Providers felt services could be more joined up in terms of data sharing and combating the stigma around mental health as well as in terms of patient care.
- Provider aspirations for services and user aspirations generally overlapped.

Professional perspectives on services and need were gathered during a provider feedback event run on the 1st February 2017. A range of provider and commissioning organisations were invited. A high proportion of attendees came from voluntary sector organisations.

Whole person approach
Providers offered feedback that excellent mental health services would have a “whole person approach” and use a “social model of health not a medical model”. The importance of person centred, personally tailored services that considered practical issues as well as purely medical ones was repeatedly expressed.

More early intervention and prevention services
Providers expressed concern that there was insufficient provision of “early intervention and prevention services” or “pre-crisis services”. They reported

“too many people reach crisis because suitable preventative services either do not exist, or do exist but are under resourced” and that

“people with low levels or early stage mental health problems are denied access to community mental health teams and fall through the gaps”.

Providers felt there was a lack of suitable services unless people were at “crisis point”.

Difficulties in accessing care
Good access to services was deemed essential, but providers identified problems in a number of areas.

Some geographical barriers to service were identified e.g. around services for survivors of abuse which are only currently available in Swindon and Trowbridge resulting in many Wiltshire residents needing to travel long distances.
Referral pathway issues and barriers were identified through comments like

“GP\'s seem not to understand mental health and so some people still find it
difficult to access services” and

“if someone has previously been under the care of secondary services they
should be able to access the services when they are becoming unwell – they
currently have to go back through primary mental health [causing ]delays [in]
accessing the support they need.”

Issues around perceived thresholds preventing people accessing services were
raised repeatedly.

“Thresholds for secondary services [are] very high and people with complex
needs still find it difficult to access the secondary sector”.
“Services are too inflexible [in whom they will take]”

and some felt

“IAPT does not provide services for all” . It was felt they were too selective
about who they will see.

**Joined up services**

The issue of more “joined up” services came up in several forms. Providers felt
services needed to be more joined up not just in terms of patient care but also in
terms of “data sharing” and mutually combatting the stigma surrounding mental
health problems.

**Recommendations arising from this section**

- Work with providers to ensure services that take a whole person approach
- Work with providers to reduce barriers to access
- Work with providers to find innovative ways to reduce stigma around
  mental health, share information effectively and link services better
Evidence Review of what Works

Key points

- There is a wide range of evidence around what works in mental health.
- From a clinical treatment perspective NICE produces guidelines around what treatments are effective clinically.
- There have been some economics studies around investigating what interventions are cost effective and these are due to be updated by PHE within the next 12 months.
- In terms of public health mental health interventions, there is little evidence in the form of randomised controlled trials. Rather the evidence tends to come in the form of policy initiative supported by case study.
- In terms of public health interventions they can be grouped into life course interventions and those that are place based.
- For each type of intervention there tend to be a number of recommended universal interventions and a number of targeted interventions that are aimed at those who are most high risk.

There is a large amount of literature around what works in mental health. In terms of the type of evidence of what works there is little in the way of randomised controlled trials and some of what is regarded as good evidence in this paradigm of public health is policy initiative supported by case study. The following section will review some of the key evidence and initiatives.

Public Health Interventions

The Faculty of Public Health and the Mental Health Foundation have produced a report called “Better Mental health for All”\(^{71}\) that reviews potential public health interventions and approaches to improve mental health at different stages of the life course and in different settings.

This report considers interventions in two categories – “universal” and “targeted”. Universal interventions are those that target the whole population, groups or settings where there is an opportunity to improve mental health such as schools or workplaces. The targeted category can be further subdivided into selective and indicated. Selective interventions are for people in groups, demographics or communities with higher prevalence of mental health problems; targeting individuals or subgroups of the population based on vulnerability and exposure to adversity such as those living with challenges that are known to be corrosive to mental health. Indicated interventions are for people with early detectable signs of mental health stress or distress; targeting people at the highest risk of mental health problems.

\(^{71}\) Better mental health for All: A public health approach to mental health improvement (2016) London: Faculty of Public health and Mental Health Foundation
As discussed above this report considers interventions over the whole life course. While this is an adult needs assessment, the children of today are the adults of tomorrow and it would be unhelpfully blinkered if this report only mentioned adult targeted interventions. Thus the following section will summarise the report’s full findings.

**Life Course Interventions**

**Perinatal Support**

**Universal programmes:**
- This recommends interventions such as universal infant and parenting programmes, promotional interviewing, perinatal pathways that comply with the NICE guidance in the area, and ensuring that area suicide prevention plans have a specific perinatal section.

**Targeted programmes:**
- Recommended target groups include teenage parents, parents who abuse drug and alcohol and those that have specific risk factors know to put them at higher risk of mental health issues.
- It is noted that skilled facilitators will be required if programmes are to be effective given these groups are often hard to engage. Both CBT and person based counselling have been found to be effective if the practitioner can establish a trusting relationship.
- A case finding approach to managing postnatal depression is recommended due to inefficiencies in screening.
- Programmes such as the Family Nurse Partnership Programme, Perinatal mental health training for midwives and Health Visitor champions are also recommended.

**Parenting**

The report acknowledges that there are many different parenting programmes and that when considering what works locally it is important to consider local experience, specific needs as well as national evaluation outcomes.

**Universal Programmes:**
- Families and Schools Together (FAST), which is offered to reception class parents, has been shown to be effective in a series of randomised control trials (RCT) in the US and is being successfully provided in the UK by Save the Children
- The Family Links Nurturing Programme is a programme developed in the third sector which is valued by practitioners and has been shown to enable parents to change in qualitative studies but has failed to show change in an RCT
- Baby Steps is a programme designed to help parents cope with the pressures of a new baby which has been developed by the NSPCC.
- Triple P is a suite of programmes from universal media based through to intensive one-to-one support for families where children have clinical level problems. The evidence on this programme is mixed and depends on delivery.

**Targeted programmes**
- Mellow Parenting is a suite of programmes covering different age groups from Mellow Baby to Mellow Teen.
- Strengthening Families Strengthening Communities is a programme for communities with a high level of minority ethnic families.
- Incredible Years (IY) was developed in the US and has been extensively trialled in targeted settings, including in the UK.
- There are a number of programmes to support children in families where parents have mental health problems although it is noted the majority of focus has been on the perinatal period rather than later childhood.

Evidence backed programmes that support parents, children and parenting in families where a parent has a mental health problem include:
  - The William Beardslee programme, a family-based approach for prevention in children at risk
  - Lets Talk About Children, a manual for a two session discussion with parents who are living with a mental health problem
  - Parenting under Pressure, a promising programme for supporting parenting in families where parents abuse drugs or alcohol

**Children and Young people Interventions**

**Universal approaches:**
- The English Healthy Child Programme (2009) covers five to nineteen year olds and sets out the recommended framework of universal and progressive services for children and young people in order to promote optimal health and wellbeing.
- NICE advises supporting schools to adopt a comprehensive ‘whole school’ approach to promoting the mental wellbeing of children and young people.
- Anti-bullying programmes are a top prevention investment. Evidence based bullying prevention programmes should be present in settings in which children and young people learn, live and spend their leisure time.

**Targeted Approaches:**
Poverty, discrimination, long-term health issues or factors such as living in care, having parents with mental health problems or drug and alcohol abuse all place children at higher risk of mental health problems. The following approaches are recommended:
- The NICE quality standards for looked after children featured the central recommendation that looked after children should have sufficient involvement in decisions to do with their care. It was also emphasised that it was vital these children had access to nurturing relationships that foster attachment.
- Interventions to reduce drop-out and exclusion rates, and to focus on raising the educational standards of the most vulnerable children and young people should be rolled out.
- Develop targeted wellness services towards clusters of children identified as being at high risk of multiple poor behaviours, rather than providing single issue services only.
- The Early Intervention in Psychosis (EIP) model is an effective intervention that should be implemented at a local area level.
- A prevention intervention aimed at children at risk of eating disorders is Cognitive Dissonance Activities. This initiative engages young people in conversation on body image.
- The Increasing Access to Psychological Therapies (IAPT) programme has recently been extended to children, including those aged five and under. An IAPT programme aimed primarily at the practitioners who support parenting is also being planned.

**Adult Interventions and Approaches**

**Universal approaches:**
- Provide mental health literacy training to frontline housing and advice workers to help individuals and families to secure and sustain appropriate accommodation, manage debt and maximise their incomes.
- Use social media and other avenues to disseminate universal public mental health messages such as those promoted in 5 Ways to Wellbeing
- Mindfulness has a rapidly expanding evidence base and is increasingly popular in both people with mental health problems and in general populations.
- Promote body work that both exercises and stills the mind like Yoga and Tai Chi, which are increasingly popular and have a small evidence base to support their effectiveness.
- Promote walking and exercise on prescription schemes, books on prescription schemes, social prescribing and wellbeing pledge programmes in primary care.
- Promote the use of volunteering, such as timebanks, as a way of linking local people who share their time and skills, and enabling them to live well, improve their health and wellbeing, and link them to their community. Timebanking can help lower the number of GP visits by removing the kind of visits that do not require medical attention.
- Arts and culture based activities also have a growing body of evidence around them

**Targeted Approaches:**

It is noted that self-care is a sustainable approach to health service delivery and that it also empowers people to be in charge of their own health care as well as reducing inequalities. Thus where the option for self-care exists it should be favoured over health service delivery approaches.

- Increasing people’s capacity to use psychological treatment methods can prevent the development of mental health problems, particularly if used during periods of transition and pressure, such as redundancy, after birth or after a bereavement. Simple interventions and promoting available services such as cognitive behavioural therapy, have been successful in this way, particularly with those at increased risk of mental health problems, such as those with long term conditions and those who are isolated.
- Provide bereavement counselling and relationship support.
- Support unemployed working age adults into high quality work, ensure those who are unable to work have access to a reasonable standard of resources and are supported to lead fulfilling lives, moving towards employment as appropriate.
• Increase mental health literacy, especially for people with limited financial and social resources, including older people, people with long term health conditions, refugees, people from Black and Minority Ethnic communities and people living with disabilities. Low mental health literacy limits opportunities for vulnerable groups to be actively involved in decisions about their health and increases delays in help-seeking and access to appropriate treatment.
• People living with serious mental health problems will benefit from regular general physical health assessments and from signposting to information and support that addresses diet, alcohol consumption, exercise, drug misuse and sleep.
• Other important interventions include public health intervention that might otherwise be overlooked such as access to smoking cessation, free dental and optical examinations, and flu vaccinations
• Services, facilities and resources should be inspected to ensure they are accessible.
• Ensure service navigators are available to people with complex needs and advocate for them to have peer experience and be skilled in negotiating the access barriers experienced by minority groups.
• Develop trauma informed care, particularly for those who have witnessed or experienced violence, abuse and/or severe neglect either in childhood or in adulthood.

Later Life Interventions and Approaches

Universal approaches:
• The Campaign to End Loneliness provides adult social care, clinical commissioning groups and public health teams with guidance on developing strategies to address loneliness amongst older people in their local populations. Their Loneliness Framework set out interventions across the healthcare system and the wider community.
• Community approaches to reduce isolation in older people that have been found to be effective include:
  o Befriending and mentoring
  o Social group schemes which incorporate self-help support and peer involvement are effective ways to reduce social isolation, such as the ‘Standing Together’ peer support service delivered by the Mental Health Foundation

Targeted Approaches:
• Implement the NHS Five Year Forward View vision for identifying and supporting carers with a focus on carers aged eighty five and over. Health and social care agencies should work together on this.
• Reminiscence therapy for older people has a range of therapeutic and preventative effects, including reduction in symptoms of depression and improved feelings of self-esteem.
• NICE have produced public health guidance on mental wellbeing and older people. They recommend a range of activities including support sessions to assist with daily routines and self-care, community based physical activity
programmes, walking schemes and training for practitioners. These have all been informed by occupational therapists.

**Place based interventions**

A public health approach to creating mentally healthy places requires targeting outwards from the home and institutional settings where people live, to education and working settings, to the community, then the physical environment, and finally to the overarching socio-economic conditions. It also requires committed and proactive engagement with community members. NICE published updated guidelines on the community engagement to improve health and wellbeing and reduce health inequalities in 2016. A key to this approach is to ensure all frontline staff can act as mental health ambassadors and to do this training and resource development will be required.

**Home**

Many of the interventions listed above as family interventions could also be considered home interventions. The approaches that follow are targeted to those at risk of or recovering from a mental health problem.

**Targeted Approaches:**

- **Psychologically Informed Environment (PIE)** is a promising approach, which centres services’ physical and social environments on service users’ emotional and psychological needs. PIEs have been piloted in housing, homelessness, social care and criminal justice settings in England.
- Provide mental health literacy training to frontline housing and advice workers to make contact count in helping individuals and families to secure and sustain appropriate accommodation, manage debt and maximise their incomes.
- Develop partnership working with a broad range of stakeholders to co-produce an integrated housing, health and social care pathway.
- Work in partnership with government departments, public bodies and other agencies to provide specialist housing support for vulnerable people with mental health problems.
- Advocate for the use of NHS land to make more supported housing available for vulnerable people with mental health problems.

**Educational settings**

The evidence base for school based interventions is perhaps the most extensive of the locality based approaches. Long-term benefits include improved academic performance with a positive benefit on future prospects.

- Implement preschool programmes for children who are at risk in order to promote school readiness, and communication, social and emotional skills.
- The ‘whole school’ approach to prevention and promotion has been shown to be effective at building resilience in young people. This comprises of systematic changes (for example changes to ethos, anti-bullying policies and programmes to support teacher wellbeing), universal interventions for all pupils (for example curriculum based social education), and outreach programmes for parents and the wider community. Whole school approaches are best combined with targeted support (providing timely school-based input for those with risk factors such as behavioural problems).
Whole college and university based approaches within future education, informed by the work of the English Healthy Universities Network and the World Health Organization’s Health Promoting Universities Programme should be implemented.

- Ensure there is leadership for and commitment to supporting mental health within educational settings by providing training and support for teachers and head teachers in relation to mental health literacy, including protecting and improving their own mental health
- Highly effective parenting support programmes like FAST, mentioned above, can also be run through schools.

**Workplace settings**

Effective workplace interventions should address the physical, environmental and psychosocial factors influencing mental health including workload, job control, role clarity and bullying, using a whole workplace approach. This integrated approach combines universal, selective and indicated preventative strategies, and pulls together core business missions, human resources (HR) strategy and corporate social responsibility programmes.

**Universal approaches:**

- Work in partnership with local businesses leaders and employers to embed a whole workplace approach to protect and improve mental health at the individual, collective and organisational level, supporting them to:
  - Adopt the PHE Healthy Workplace Charter
  - Embed mental health in all organisational policies and procedures
  - Deliver line management training to create mentally healthy environments, as detailed in NICE guidance
- Share and use the British Heart Foundation advice on how employers can promote healthy eating using interventions to inform and educate, provide a supportive environment and actively promote healthy choices.

**Targeted Approaches:**

- Support workplaces to provide stress management support for employees experiencing distress.
- Increase access to talking therapies for those who are experiencing common mental health problems.
- Support local employers to engage with evidence based supported employment programmes such as Individual Placement and Support (IPS) and Access to Work in order to enable people to join the workforce.
- Use the recommendations made by CIPD around managing actual or potential problems due to alcohol or substance misuse to support employers.

**Built environment and neighbourhood**

- Public Health England published a briefing on community centred approaches which can inform their inclusion in local public service planning and delivery.
- The English Mental Health Task Force Report proposed the development of mentally healthy communities including through the use of social movement approaches. The Mental Health Foundation have created a ‘Whole Community’ approach that aims to embed mental health improvement action within all settings, systems and policies where there are opportunities to make every contact count. In applying a wider approach to measuring change, this
can address the social determinants and inequalities alongside measures of mental health problems and wellbeing.

- Create and protect green spaces within neighbourhoods in order to generate better physical and mental health outcomes for individuals and communities.

The Economic Perspective.

The previous section focused on public health interventions and approaches that have been shown to be effective in improving mental health and wellbeing when evaluated using public health indicators. However, in a time of increasing financial pressure it is also important to consider the economic evidence around interventions to ensure best value for money.

An economic evaluation was undertaken by London School of Economics and Political Sciences on behalf of the Department of Health in 2011 that modelled different mental health interventions and considered their return on investment potential. Public Health England has commissioned an updated version of the report that is due to be published summer 2017.

The table below gives a summary of the report’s findings. In each of the interventions reviewed the exact conditions under which the intervention was applied are critical for interpreting the results.

For a full picture it is essential that the report findings are reviewed in their entirety. For example the summary table only looks at return on investment. In some contexts considering cost effectiveness in terms of cost per Quality Adjusted Life Year (Cost per QALY) maybe be a preferred benchmark. For example, while early intervention for depression in diabetes has a return on investment of 0.33 per £1.00 invested the study estimated that the incremental cost per Quality-Adjusted Life Year (QALY) gained, which over two years was £3,614. This is highly cost-effective in an English context.

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Knapp M, McDaid D, Parsonage M; Mental Health Promotion and Prevention: The Economic Case; Department of Health, January 2011

72
Table 13: Total returns on investment (all years): economic pay-offs per £1 expenditure a

<table>
<thead>
<tr>
<th>Description</th>
<th>NHS</th>
<th>Other public sector</th>
<th>Non-public sector</th>
<th>Total</th>
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<tr>
<td>Early identification and intervention as soon as mental disorder arises</td>
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<td>Early intervention for conduct disorder</td>
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<td>Befriending for older adults</td>
<td>0.44</td>
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Notes:

a Returns on investment calculated as gross economic pay-offs divided by expenditure on the intervention. Depending on the availability of data, these returns may be calculated over different time periods for different interventions; see Section 2 and Tables 14–16 for details. Returns and expenditures discounted back to present values, expressed in 2009/10 prices.

b For e-learning of GPs plus CBT for all people with somatoform conditions (including sub-threshold cases as well as those with full somatoform disorders).

Source: [http://eprints.lse.ac.uk/32311/1/Knapp_et_al__MHPP_The_Economic_Case.pdf](http://eprints.lse.ac.uk/32311/1/Knapp_et_al__MHPP_The_Economic_Case.pdf)
The National Institute for Health and Care Excellence Perspective

NICE have issued a large array of guidelines for best practice in the mental health and wellbeing arena. Some of these are more clinically focused and other guidelines are aimed at local authorities and commissioners.

The guidance covers the areas of Wellbeing, hot topics in mental health such as smoking, transition between services and user experience, Depression, Anxiety, Panic disorder, PTSD, Eating disorders, OCD, Personality disorders, Psychosis, Bipolar disorder, Multi-morbidity, Alcohol, Drug misuse and Self harm.

Other Public Body Policies, Strategies and Best Practice Perspectives

A large number of other reviews of best practice also exist in the public domain a number of which are summarised below.


This strategy focuses on six shared objectives:
1. More people will have good mental health.
2. More people with mental health problems will recover.
3. More people with mental health problems will have good physical health.
4. More people will have a positive experience of care and support.
5. Fewer people will suffer avoidable harm.
6. Fewer people will experience stigma and discrimination.

The objectives are based on 3 guiding principles.
1. Freedom
2. Fairness
3. Responsibility

The strategy aims to bring about significant change in people’s lives. Bringing the changes, for everyone, across the country and in the most effective way, will mean that:
1. Mental health has ‘parity of esteem’ with physical health within the health and care system.
2. People with mental health problems, their families and carers, are involved in all aspects of service design and delivery.
3. Public services improve equality and tackle inequality.
4. More people have access to evidence-based treatments.
5. The new public health system includes mental health from day one.
6. Public services intervene early.
7. Public services work together around people’s needs and aspirations.
8. Health services tackle smoking, obesity and co-morbidity for people with mental health problems.
9. People with mental health problems have a better experience of employment.
10. We tackle the stigma and discrimination faced by people with mental health problems.

DH Analysis of the Impact on Equality (AIE) of the strategy.

This document explains and analyses the impact of Equality on six shared objectives identified in the Strategy. The Equality Act 2010 covers nine protected characteristics, and there is a public sector duty to advance equality and reduce inequality for people with these protected characteristics.

There are three aspects to reduce mental health inequality:
1. tackling the inequalities that lead to poor mental health;
2. tackling the inequalities that result from poor mental health – such as lower employment rates, and poorer housing, education and physical health; and
3. tackling the inequalities in service provision – in access, experience and outcomes.

Department of Health “No Health Without Mental Health: Implementation framework”.

The national policy integrates mental health and physical health and suggests that there should be a collaborative programme of action to achieve the ambition that mental health is on a par with physical health:

1. Local planning and priority setting should reflect the mental health needs of the population. Mental health and wellbeing is integral to the work of CCGs, health and wellbeing boards and other local organisations.
2. To translate the vision into reality, people with mental health, their families and carers should be fully involved in planning, priority setting and delivery of services.
3. Services actively promote equality and are accessible, acceptable, and culturally appropriate to all the communities. Public Bodies meet their obligations under the Equality Act 2010. People including children, young person, older people, and people from ethnic minority should have access to Psychological Therapies.
4. All people receive evidence-based mental health promotion. Schools and colleges promote good mental health for all children and young people, alongside targeted support for those at risk of mental health problems.
5. The Public Health Outcomes Framework (PHOF) includes mental health measures. Local public health services deliver clear plans for mental health.
6. All organisations should recognise the value of promoting good mental health.
7. Public services should recognise and identify people at risk of mental health problems and take appropriate, timely action, including using innovative service models. Early recognition and intervention will enable stopping serious consequences from occurring.

8. Public health campaigns should include people’ mental health as well physical health. Services tackle and support people with dual diagnosis and substance misuse to achieve better outcomes and reduce cost.

9. Services working together support people with mental health problems to maintain, or to return to employment.

10. Frontline workers, across the full range of services, are to be trained to understand better about mental health, the principles of recovery and be able to tackle any stigma related to mental health.

No health without public mental health: The case for action, Royal College of Psychiatrists, 2010
http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf

This report describes the key points and features that should be part of a public mental health strategy:

1. There is no public health without public mental health. Investment is needed to promote public mental health. This will enhance population well-being and resilience against illness, promote recovery, and reduce stigma and the prevalence of mental illness.

2. The Royal College of Psychiatrists strongly supports the findings of the Marmot Strategic Review of Health Inequalities in England post 2010. It recognises that inequality is a key determinant of illness, which then leads to even further inequality. Government policy and actions should effectively address inequalities to promote population mental health, prevent mental ill health and promote recovery.

3. Physical health is inextricably linked to mental health. Poor mental health is associated with other priority public health conditions such as obesity, alcohol misuse and smoking, and with diseases such as cancer, cardiovascular disease and diabetes. Poor physical health also increases the risk of mental illness.

4. Interventions which apply across the life course need to be provided. Since the majority of mental illnesses have childhood antecedents, childhood interventions which protect health and well-being and promote resilience to adversity should be implemented. If mental health problems occur there should be early and appropriate intervention. Strategies to promote parental mental health and effectively treat parental mental illness are important since parental mental health has a direct influence on child mental health.

5. Older people also require targeted approaches to promote mental health and prevent mental disorder, including dementia. Action is needed to promote awareness of the importance of mental health and well-being in older age as well as ways to safeguard it. Ageist attitudes need to be challenged and values promoted that recognise the contributions older people make to communities, valuing unpaid, voluntary work as we do economic productivity.

6. An effective public health strategy requires both universal interventions, applied to the entire population, and interventions targeted at those people who are less likely to benefit from universal approaches and are at higher risk, including the
most socially excluded groups. Such groups include children in care or subject to bullying and abuse, people of low socioeconomic status, those who are unemployed or homeless, those with addictions or intellectual disability, and other groups subject to discrimination, stigma or social exclusion. Health promotion interventions are particularly important for those recovering from mental illness or addiction problems. Those with poor mental health as well as poor physical health require effective targeted health promotion interventions.

7. The prevention of alcohol-related problems and other addictions is an important component of promoting population health and well-being. The College supports the development of a minimum alcohol pricing policy and a cross-government, evidence-based addictions policy.

8. Smoking is the largest single cause of preventable death and health inequality. It occurs at much higher rates in those with mental illness, with almost half of total tobacco consumption and smoking-related deaths occurring in those with mental disorder. Therefore, mental health needs to be mainstreamed within smoking prevention and cessation programmes.

9. A suicide prevention strategy should remain a government priority and should include strategies to address and reduce the incidence of self-harm.

10. Collaborative working is required across all government departments in view of the cross-government benefits of public mental health interventions across a range of portfolios, such as education, housing, employment, crime, social cohesion, culture, sports, environment and local government. Actions to combat stigma related to mental illness should be included in these strategies.

11. Doctors can be important leaders in facilitating local and national implementation of public mental health strategies. Many psychiatrists already adopt a public mental health approach in their work and influence national and local strategy. Psychiatrists should be supported in assessing the needs of their local population for health promotion.

12. Psychiatrists should be engaged in the commissioning process and inform commissioners of the expected prevalence of specific disorders to anticipate levels of service provision and unmet need, and to help prioritise resource allocation. Support and training are required to facilitate this.

13. Commissioners should take into account the effects of mental health and mental illness across the life course as well as the economic benefits of protecting and promoting mental health and well-being.

14. Commissioners should consider the existing arrangements and adequacy of services for comorbid disorders and unexplained medical symptoms where cost-effective interventions could be provided.

_Closing the Gap: Priorities for essential change in mental health, Department of Health, February 2014 (V2)_


This document aims to bridge the gap between the governments’ long-term ambition (as stated in No Health Without Mental Health) and shorter-term action. It seeks to show how changes in local service planning and delivery will make a difference, in the next two or three years, to the lives of people with mental health problems.
It sets out 25 areas where people can expect to see, and experience, the fastest changes. These are the priorities for action: issues that current programmes are beginning to address and where the strategy is coming to life.

The 25 areas are:
1. Commissioning high-quality mental health services with an emphasis on recovery in all areas, reflecting local need
2. Leading an information revolution around mental health and wellbeing
3. Establishing clear waiting time limits for mental health services
4. Tackling inequalities around access to mental health services
5. Over 900,000 people benefitting from psychological therapies every year
6. Improving 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. Giving adults the right to make choices about the mental health care they receive
9. Radically reducing 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. Using 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. Identifying poor quality services sooner and taking action to improve care and where necessary protect patients
12. Supporting carers better and being more closely involved in decisions about mental health service provision
13. Integrating mental health care and physical health care better at every level
14. Changing the way frontline health services respond to self-harm
15. Ensuring that no-one experiencing a mental health crisis is turned away from services
16. Offering better support to new mothers to minimise the risks and impacts of postnatal depression
17. Supporting schools to identify mental health problems sooner
18. Ending the cliff-edge of lost support as children and young people with mental health needs reach the age of 18
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. Introducing a national liaison and diversion service so that the mental health needs of offenders will be identified sooner and appropriate support provided
22. Offering anyone with a mental health problem who is a victim of crime enhanced support
23. Supporting employers to help more people with mental health problems to remain in or move into work
24. Developing 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
   1. Stamping out discrimination around mental health
A dual diagnosis in one or both parents or caregivers has significant impacts on children living with them—the “hidden harms” of substance misuse. In June 2011, the Advisory Council on the Misuse of Drugs (AMCD) published an enquiry “Hidden Harm”, which sets out 48 recommendations and 6 key messages.


The Triangle of Care is a therapeutic alliance between service user, staff member and carer that promotes safety, supports recovery and sustains wellbeing.

The key elements to achieving a Triangle of Care

The essence of this guide is to clearly identify the six key elements (standards) required to achieve better collaboration and partnership with carers in the service user and carer’s journey through mental health services. For each element we suggest good practice examples and resources that may be helpful. The six key standards state that:

1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
2. Staff are ‘carer aware’ and trained in carer engagement strategies.
3. Policy and practice protocols re: confidentiality and sharing information are in place.
4. Defined post(s) responsible for carers are in place.
5. A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
6. A range of carer support services is available.

In addition to the above, there also needs to be regular assessing and auditing to ensure these six key standards of carer engagement exist and remain in place. A self-assessment audit tool for carer engagement is included in the report.

Guidance for commissioners of older people’s mental health services, Joint Commissioning Panel for Mental Health, 2013


The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) is a new collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists, which brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities.

The guidance provides key recommendations to commissioners:

1. Older people’s mental health services in particular benefit from an integrated approach with social care services. Most patients in older age mental health services have complex social needs. Commissioners should
ensure service providers across agencies work together if they are to meet people’s needs and aspirations effectively. A whole system approach that draws together the expertise of health and social care agencies and those in the voluntary sector will deliver a comprehensive, balanced range of services, which places as much emphasis on services that promote independence as on care services.

2. **Older people’s mental health services need to work closely with primary care and community services.** Models that include primary care ‘in-reach’ or joint working with community physical health care services, provide more co-ordinated care and should be the norm.

3. **Services must be commissioned on the basis of need and not age alone.** Older people’s mental health services should not be subsumed into a broader ‘adult mental health’ or ‘ageless service’. The needs of older people with functional mental illness (for example depression) and/or organic disease such as dementia and their associated physical and social issues are often distinct from younger people.

4. **Older people’s mental health services must address the needs of people with functional illnesses such as depression and psychosis as well as dementia.** The majority of the mental illness experienced by older people is not dementia and there is significant crossover between dementia and functional illnesses such as depression and psychosis.

5. **Older people often have a combination of mental and physical health problems.** Commissioners and service providers need to seek and exploit opportunities for joint working and service delivery that can address both physical and mental health needs. Older people with long-term health conditions make up the greater proportion of this care group. Having more than one long-term condition greatly increases the risk of depression. Planning and delivering an integrated service to manage service delivery to this group through joint working protocols will be the best and most cost-effective way to manage care.

6. **Older people’s mental health services must be multidisciplinary.** Medical doctors are important because of the complex physical and treatment issues common in older people, but given the complex needs of this group, integrated input from nurses, psychologists, physiotherapists, occupational therapists and speech and language therapists is necessary.

7. **Older people with mental health needs should have access to community crisis or home treatment services.** With extended hours of working and intensive crisis management, home treatment workers help to reduce the need for admission, facilitate early discharge and reduce transfer to residential care.

8. **Older people with mental health needs respond well to psychological input.** Evidence shows that response rates amongst older people are as good as those of younger adults. The spectrum of psychological service provision at all tiers needs to reflect this.

9. **Older people should have dedicated liaison services in acute hospitals.** Over 60% of older people in acute hospital wards have a serious mental disorder which is often unrecognised and delays rehabilitation and discharge. Commissioners must ensure appropriate specialist liaison services are in place with relevant discharge care plans and support from secondary care mental health teams.
Recommendations arising from this section

- Use evidence base to inform interventions and build evaluation into all programmes to help grow that evidence bases
- Embed positive mental health approaches into work done in non-traditional health setting such as schools, with housing staff and other council departments
- Consider interventions such as “campaign to end loneliness” and promoting volunteering to improve mental health in older people
Support Currently Offered

Key points

- There are a wide range of commissioned, voluntary and community services available in Wiltshire to support those with mental health or emotional wellbeing needs.
- There are identified gaps in services for those with personality disorders, and anecdotal gaps in inpatient care places more generally.
- There is a concern that as funding pressures mount, some voluntary and community based services will cease to be able to continue operating leaving more gaps in service provision.
- Appendix 2 provides a list of services as currently delivered.

Service Mapping

The purpose of this section of the needs assessment is to identify the services available to meet the mental health needs of the population as identified throughout this document. This, together with the data relating to demand on services and the prevalence information will help to identify any current or future gaps in provision.

Adult Mental Health Services in Wiltshire are currently delivered through an operational delivery model with four distinct tiers. These services are available for adults age 18 plus but transition from Child and Adolescent Mental Health Services (CAMHS) can take place prior to age 18 as determined by professionals working with the young person according to need.

This tiered system was first introduced across the country in the 1990’s and defined the system in terms of the services that provide the care. This can sometimes mean that people have to fit the services, rather than the services fitting the changing needs of the individual. The tiers model can unintentionally create barriers between services, embedding service divisions lead to fragmentation of care and can, in turn lead to people falling into gaps between tiers and experiencing problems with transitions between different services.

The Five Year Forward View for Mental Health (published in February 2016) and Future in Mind (children’s emotional wellbeing and mental health) signal a fresh mindset in taking decisive steps to break down barriers in the ways services are provided and how care is delivered. They advocate a move away from a tiered approach towards models which create a seamless pathway of care and support, and which address the need for the diversity of circumstances and issues with which people approach mental health services. These future models of care should support people’s mental health alongside their other needs including physical health, employment, housing and social care as well as

- Increasing access to the right care at the right time
- Driving down variations in the quality of care on offer
• Improving outcomes

By 2021 there will be a greater emphasis on prevention, self-management, choice, peer support and partnership with other sectors. This will inevitably move service models away from the current tiered structure of support to a more on providing the right kind of support at the right time.

In Wiltshire, the Mental Health and Wellbeing Strategy, CCG Business Plan, the Transformation Plan for Children and Young People’s emotional wellbeing and mental health are all moving us towards a whole systems approach to services and processes. This, in turn, will facilitate a more holistic approach to commissioning and structuring services to meet the needs of the population of Wiltshire.

For the purposes of this report we have detailed the services (Appendix 2) provided according to the tier of the system they currently operate in as that is how the majority of our services are currently structured and categorised. This is illustrated in the diagram below.

When considering this pyramid, it is important to remember that much of the self-care and informal community care illustrated in the bottom two levels of the diagram is provided by Voluntary and Community Sector (VCS) organisations. This is significant because these organisations may need additional support to understand how they can welcome people who are experiencing or recovering from mental ill health.
Fig 101 Diagram to illustrate the domains of mental health services

Description of each service

As outlined in the overview above, the information about services in Appendix 2 has been grouped by Tiers as that is how the majority of our services are currently structured and categorised. This section predominantly covers commissioned services. We have also attempted to capture information about voluntary and community sector (VCS) services in however it is acknowledged that a full mapping exercise has not been conducted for this needs assessment. This is something that could be considered for the future.

Shaping Services for the future

The information contained in this needs assessment will help commissioners to understand the needs of the population and how current services meet that need. It will assist in developing services for the future that meet NICE guidelines and are in line with the ethos of the Five Year Forward View.

The relationship between the local authority, NHS and the health and social care market is changing, with joint commissioners taking on the role of facilitating and developing the health and social care market, as well as directly commissioning services.
Following the publication of this needs assessment, the next step for commissioners will be to use the information to develop a Market Position Statement for mental health services Wiltshire. A Market Position Statement (MPS) is a tool to enable service providers to see how the joint commissioners intend to facilitate and shape the market over the coming years, based on information about anticipated volume and demand, knowledge about the aspirations of people who will require support, and national legislation and guidance.

The MPS will inform the market about our joint intentions for services that support people with a mental health condition, in line with our overall vision and the aim of the Joint Mental Health and Wellbeing Strategy:

\[ \textit{To create environments and communities that will keep people well across their lifetime, achieving and sustaining good mental health and wellbeing for all.} \]

The MPS is a starting point for further consultation and partnership working to enable the market to develop appropriately over the coming years, both to meet the challenges of budget pressures and for providers to deliver more choice and control for individuals.

Information about non-commissioned and other community based services can be found in Appendix 2. It should be noted that the information in the Appendix is limited to those things the project team was informed of during engagement with professionals undertaken for this needs assessment. It is acknowledged that this is not a comprehensive list and we have recommended below that a full mapping exercise be undertaken to further inform this. Information about activities in communities can also be found on the Your Care Your Support health and social care portal [Your Care Your Support health and wellbeing pages](#).

**Current gaps in service provision**

The CCG has highlighted a current gap in service provision for people with Personality Disorder.

Anecdotal evidence suggests that there may be some gaps in in-patient services.

It has also been highlighted during the engagement process that there is potential that some of the 'services' delivered by VCS organisations could reduce or cease within the near future due to reductions in funding and availability of donations. There is a risk that, should this happen, further gaps not identified in this report will emerge and our ability to meet the needs of some people with mental ill health will be compromised.
Recommendations arising from this section

- Consideration should be given to undertaking a full mapping exercise to establish what is available in community areas across the county: This could build on mapping being undertaken for a current pilot virtual ‘Wellbeing College’ for West Wiltshire which may, in time, extend to cover the whole county.

- Consideration should be given to how VCS organisations and community groups (and possibly some of our own community based services) can be supported to enable them to welcome people experiencing or recovering from mental ill health. This would help to ensure that people who are being encouraged to manage their own recovery and/or wellbeing have equality of access to activities that are life promoting as the rest of the population.

- The CCG and Wiltshire Council Joint Commissioning team should produce a Market Position Statement with input from Public Health to help shape future services.
  - It should be considered as part of this whether there would be benefit in undertaking a full Systems Thinking Review which will help to understand current pathways and develop new ones (taking into account best practice and NICE guidance).
Conclusions and Recommendations

Collated Recommendations

Local demographics

- All service planning needs to be future proofed to ensure it fits the changing needs of Wiltshire’s evolving demographics. In particular service planning needs to ensure it is prepared for
  - An aging population and their associated carers
  - Increasing military numbers
  - A small but growing BME population
  - A predominantly rural population with pockets of urban deprivation
- Planning and provision of services should ensure inequalities in access to services for such groups are assessed
- Given the pivotal role of GPs in routine access to mental health services, access routes for those who are not GP registered should be considered

Protective factors

- Use evidence based research around protective and risk factors to inform all mental health and wellbeing prevention interventions
- Consider interventions to ensure carers feel supported and connected
- Work with local areas to reduce loneliness in highest risk area
- Build on the recent momentum to further increase and consolidate physical activity levels in the county. Consider targeted interventions to ensure those who will benefit most are increasing their physical activity
- Work with local communities to develop an inclusive approach to the use of green spaces
- Work with the unemployed, particularly 16/17 year olds, and ensure that the support they receive includes a focus on resilience and mental wellbeing
## Risk Factors

- Use evidence based research around protective and risk factors to inform all mental health and wellbeing prevention interventions.
- Plan services to be culturally competent to work within the context of Wiltshire’s current ethnic mix and its projected changes.
  - This will include issues such as language services (Polish), coping with the specific needs of refugees etc.
- The area of perinatal mental health is complex involving many agencies. Ensure leadership is clear and that there are clear pathways to facilitate early identification of those at risk and a robust evaluation of services and pathways.
- Points of transition be they moving from children’s services to adult services or leaving care continue to be a source of frustration. There needs to be an unrelenting focus on getting this right.
  - Work with care leaver task and finish group to ensure mental health support is written into the Care Leavers Covenant.
- Mental health services need to be culturally competent and flexible enough to appropriately accommodate those with learning difficulties.
  - Ensure mental health teams work towards the “Transforming Care” recommendations and can provide a tailored service for people with learning disabilities.
- Mental health services need to be able to cater to the needs of older people and where appropriate, specialist old age services should be provided. Preventative interventions to reduce the prevalence of poor mental health in old age will be important given the context of the aging local population.
- There is currently a limited understanding of the mental health needs of the local LGBT community and more research could be undertaken to ensure current mental health services are culturally competent and address the community’s needs.
  - Peer support groups and good service signposting have been raised as areas of immediate need.
- The military (and ex-military) makes up a sizeable proportion of Wilshire’s population. Effective multiagency working including third sector groups will be required to provide effective services and support. Alcohol misuse and trauma related issues should be an area of focus.
- The number of carers is likely to continue to grow. Effective support to protect mental and emotional wellbeing is necessary.
  - Service sign posting, peer support groups and adequate social contact have been raised as areas of immediate need.
- Many of the most vulnerable have multiple complex needs including dual diagnosis and social issues as well as mental health issues. Mental health services need to be equipped to deal confidently with such cases.
- Mental health services need to continue to strengthen links with the police, domestic abuse and housing services so that frontline staff are equipped get people the mental health support they need.
Health inequalities

- Support AWP as it transitions to smoke free services
  - Ensure they have the expertise and access to support and medications etc they need
- Continue to support the drug and alcohol services to strengthen the dual diagnosis offering. Use data monitoring and evaluation of the service to drive improvement
- Work to reduce inequalities arising from barriers to access particularly around geography, travel and hours of opening
- Continue to drive towards greater integration of physical and mental health and social care services and look for innovative solutions.
- Continue to work toward absolute parity of esteem for mental health

Prevalence of Mental health problems

<table>
<thead>
<tr>
<th>Condition</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMD</td>
<td>Ensure services are equipped to cope with rising prevalence, and rising use of treatment services including GP time, medication and IAPT</td>
</tr>
<tr>
<td>PTSD</td>
<td>Ensure services are equipped to cope with the large number of cases that may seek treatment as awareness rises. Cases likely to have complex trauma and possible culturally specific needs (eg veterans, abuse survivors, asylum seekers)</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>Ensure services can cope with rising prevalence and are culturally sensitive to needs of men and LGBT community</td>
</tr>
<tr>
<td>Psychotic Disorder</td>
<td>Ensure early onset psychosis service is reaching all those who need it</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>Ensure services are equipped to effectively manage the large numbers of those living with personality disorders to minimise impact on the individuals and wider society of unmanaged symptoms</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>Ensure services are equipped to manage the life course and co-morbidity needs of those with bipolar</td>
</tr>
<tr>
<td>Suicide and Self-harm</td>
<td>Ensure services are equipped to manage the large increase in young women self-harming.</td>
</tr>
<tr>
<td>Drug and alcohol abuse</td>
<td>Ensure a preventative approach is taken and that mental health services are competent to work with dual diagnosis patients</td>
</tr>
</tbody>
</table>
Service Use Data

- Services should work closely with commissioners to provide high quality data that allows a full understanding of the nature of local service use. It should be recognised that this data may need to be different from monthly management data currently provided.
- Referral pathways need to be better understood to provide insight into the high rates of refusals seen in some services with a view to clarifying referral pathways.
- IAPT use needs to better understood to address issues around data reporting and why outcomes, particularly in perinatal services are less good than expected.
- Better data is needed to clarify the number and nature of acute inpatient admissions.

Service user and carer perspectives

- Continue to seek out and listen to the views of service users and carers.
- Continue to find ways to improve equitable access to services that takes into account, geographical spread of services, opening times and ease of access by public transport.
- Work with GPs to ensure parity of mental health offering with the physical health offering.
- Continue to improve patient centred offering to ensure service users feel they are receiving holistic care.

Provider perspectives

- Work with providers to ensure services that take a whole person approach.
- Work with providers to reduce barriers to access.
- Work with providers to find innovative ways to reduce stigma around mental health, share information effectively and link services better.

Evidence Review of What Works

- Use evidence base to inform interventions and build evaluation into all programmes to help grow that evidence bases.
- Embed positive mental health approaches into work done in non-traditional health setting such as schools, with housing staff and other council departments.
- Consider interventions such as “campaign to end loneliness” and promoting volunteering to improve mental health in older people.
Support Currently Offered

- Consideration should be given to undertaking a full mapping exercise to establish what is available in community areas across the county: This could build on mapping being undertaken for a current pilot virtual ‘Wellbeing College’ for West Wiltshire which may, in time, extend to cover the whole county.
- Consideration should be given to how VCS organisations and community groups (and possibly some of our own community based services) can be supported to enable them to welcome people experiencing or recovering from mental ill health. This would help to ensure that people who are being encouraged to manage their own recovery and/or wellbeing have equality of access to activities that are life promoting as the rest of the population.
- The CCG and Wiltshire Council Joint Commissioning team should produce a Market Position Statement with input from Public Health to help shape future services.
  - It should be considered as part of this whether there would be benefit in undertaking a full Systems Thinking Review which will help to understand current pathways and develop new ones (taking into account best practice and NICE guidance).
Appendices

Appendix 1

Appendix 1 lists all NICE guidelines and advice issued in the last 10 year (Search Criteria Jan 2007 to Jan 2017)

<table>
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<tr>
<th>Wellbeing</th>
<th>Reference</th>
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<th>Last updated</th>
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<tr>
<td>Mental wellbeing and independence for older people</td>
<td>QS137</td>
<td>December 2016</td>
<td>December 2016</td>
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<tr>
<td>Early years: promoting health and wellbeing in under 5s</td>
<td>QS128</td>
<td>August 2016</td>
<td>August 2016</td>
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<td>Community engagement: improving health and wellbeing and reducing health inequalities</td>
<td>NG44</td>
<td>March 2016</td>
<td>March 2016</td>
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<td>Older people: independence and mental wellbeing</td>
<td>NG32</td>
<td>December 2015</td>
<td>December 2015</td>
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<td>Mental wellbeing of older people in care homes</td>
<td>QS50</td>
<td>December 2013</td>
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<td>Social and emotional wellbeing for children and young people</td>
<td>LGB12</td>
<td>September 2013</td>
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<td>Dementia: independence and wellbeing</td>
<td>QS30</td>
<td>April 2013</td>
<td>April 2013</td>
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<td>Social and emotional wellbeing: early years</td>
<td>PH40</td>
<td>October 2012</td>
<td>October 2012</td>
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<td>Mental wellbeing at work</td>
<td>PH22</td>
<td>November 2009</td>
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<td>Topic</td>
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<tr>
<td>Social and emotional wellbeing in secondary education</td>
<td>PH20</td>
<td>September 2009</td>
<td>September 2009</td>
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<td>Mental wellbeing in over 65s: occupational therapy and physical activity interventions</td>
<td>PH16</td>
<td>October 2008</td>
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<tr>
<td>Social and emotional wellbeing in primary education</td>
<td>PH12</td>
<td>March 2008</td>
<td>March 2008</td>
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<tr>
<td><strong>Mental Health</strong></td>
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<tr>
<td>Learning disabilities: identifying and managing mental health problems</td>
<td>QS142</td>
<td>January 2017</td>
<td>January 2017</td>
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<tr>
<td>Mental health problems in people with learning disabilities: prevention, assessment and management</td>
<td>NG54</td>
<td>September 2016</td>
<td>September 2016</td>
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<td>Transition between inpatient mental health settings and community or care home settings</td>
<td>NG53</td>
<td>August 2016</td>
<td>August 2016</td>
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<tr>
<td>Antenatal and postnatal mental health</td>
<td>QS115</td>
<td>February 2016</td>
<td>February 2016</td>
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<tr>
<td>Smoking: acute, maternity and mental health services</td>
<td>PH48</td>
<td>November 2013</td>
<td>November 2013</td>
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<tr>
<td>Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services</td>
<td>CG136</td>
<td>December 2011</td>
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### Service user experience in adult mental health services

Reference: QS14  
Published: December 2011  
Last updated: December 2011

### Common mental health problems: identification and pathways to care

Reference: CG123  
Published: May 2011  
Last updated: May 2011

### Depression

**Depression in children and young people**

Reference: QS48  
Published: September 2013  
Last updated: September 2013

**Depression in adults: recognition and management**

Reference: CG90  
Published: October 2009  
Last updated: April 2016

**Computerised cognitive behaviour therapy for depression and anxiety**

Reference: TA97  
Published: February 2006  
Last updated: May 2013

**Depression in children and young people: identification and management**

Reference: CG28  
Published: September 2005  
Last updated: March 2015

**Depression in adults with a chronic physical health problem: recognition and management**

Reference: CG91  
Published: October 2009  
Last updated: October 2009

### Anxiety

**Anxiety disorders**

Reference: QS53  
Published: February 2014  
Last updated: February 2014

**Social anxiety disorder: recognition, assessment and treatment**

Reference: CG159  
Published: May 2013  
Last updated: May 2013

**Generalised anxiety disorder: quetiapine**

Reference: ESUOM12  
Published: May 2013  
Last updated: May 2013

**Computerised cognitive behaviour therapy for depression and anxiety**

Reference: TA97  
Published: February 2006  
Last updated: May 2013

### Panic disorder

**Generalised anxiety disorder and panic disorder in adults: management**

Reference: CG113  
Published: January 2011  
Last updated: January 2011
### Post traumatic stress disorder
Clinical guideline is outside search parameters - 2005

### Eating Disorders
Clinical guideline is outside search parameters - 2004

### OCD
Clinical guideline is outside search parameters - 2005

### Personality disorder

<table>
<thead>
<tr>
<th>Name</th>
<th>Reference</th>
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<tbody>
<tr>
<td>Personality disorders: borderline and antisocial</td>
<td>QS88</td>
<td>June 2015</td>
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<tr>
<td>Antisocial personality disorder: prevention and management</td>
<td>CG77</td>
<td>January 2009</td>
<td>March 2013</td>
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### Psychosis

<table>
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<tr>
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<th>Reference</th>
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<tbody>
<tr>
<td>Bipolar disorder, psychosis and schizophrenia in children and young people</td>
<td>QS102</td>
<td>October 2015</td>
<td>October 2015</td>
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<tr>
<td>Psychosis and schizophrenia in adults</td>
<td>QS80</td>
<td>February 2015</td>
<td>February 2015</td>
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<tr>
<td>Psychosis and schizophrenia in adults: prevention and management</td>
<td>CG178</td>
<td>February 2014</td>
<td>March 2014</td>
</tr>
<tr>
<td>Psychosis and schizophrenia in children and young people: recognition and management</td>
<td>CG155</td>
<td>January 2013</td>
<td>October 2016</td>
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<tr>
<td>Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings</td>
<td>CG120</td>
<td>March 2011</td>
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### Bipolar Disorder

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<th>Name</th>
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<td>Bipolar disorder, psychosis and</td>
<td>QS102</td>
<td>October</td>
<td></td>
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<tr>
<td>Reference</td>
<td>Published</td>
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<td>QS95</td>
<td>July 2015</td>
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<tr>
<td>CG185</td>
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<td>February 2016</td>
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<td>TA292</td>
<td>July 2013</td>
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<td>TA286</td>
<td>May 2013</td>
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<td>NG56</td>
<td>September 2016</td>
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<td>QS83</td>
<td>March 2015</td>
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<td>LGB6</td>
<td>October 2012</td>
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<tr>
<td>QS11</td>
<td>August 2011</td>
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<td>CG115</td>
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<td>February 2011</td>
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<tr>
<td>CG100</td>
<td>June 2010</td>
<td>June 2010</td>
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### Alcohol-use disorders: prevention
- **Reference:** PH24
- **Published:** June 2010
- **Last updated:** June 2010

### Alcohol: school-based interventions
- **Reference:** PH7
- **Published:** November 2007
- **Last updated:** November 2007

### Drug misuse

#### Tackling drug use
- **Reference:** LGB18
- **Published:** May 2014
- **Last updated:** May 2014

#### Drug use disorders in adults
- **Reference:** QS23
- **Published:** November 2012
- **Last updated:** November 2012

#### Drug misuse in over 16s: psychosocial interventions
- **Reference:** CG51
- **Published:** July 2007
- **Last updated:** July 2007

#### Drug misuse in over 16s: opioid detoxification
- **Reference:** CG52
- **Published:** July 2007
- **Last updated:** July 2007

### Self Harm

#### Self-harm in over 8s: long-term management
- **Reference:** CG133
- **Published:** November 2011
- **Last updated:** November 2011
Appendix 2

Information about current service provision by Tier of delivery in which they operate

As outlined in the support currently offered chapter, the information about services in this Appendix has been grouped by Tiers since that is how the majority of our services are currently structured and categorised. This section predominantly covers commissioned services and we have also attempted to capture some of the VCS provision.

Current Tier 1 Services:

**General practice (GP)** is the cornerstone of primary care and a key point of contact throughout the life-course for people experiencing mental ill health. They will assess, liaise as required with the primary care liaison service (and CAMHS), prescribe medication, signpost or refer on to other services and monitor progress, particularly if there are safeguarding concerns.

**Community Groups:** A wide range of wellbeing related groups run in communities across Wiltshire. These include Men’s Sheds, art groups, theatre and performance group, walking groups, sports and activity clubs, ‘Feel Better with a Book’ shared reading groups and a whole raft of hobby related societies. People can access these groups on an individual basis but it should be noted that it is sometimes difficult for people experiencing or recovering from mental ill health to make the first step towards joining in with such community based activities. It should also be noted that these groups will have been established based on what local communities and individuals within them are most interested in and, therefore, community based interventions may not be consistently available in all areas.
Current Tier 1 spanning over to Tier 2

<table>
<thead>
<tr>
<th>Early Years:</th>
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<tr>
<td><strong>Baby Steps</strong> is a targeted perinatal education programme for disadvantaged families including those suffering from mild mental health problems in pregnancy (both parents) – delivered from 6 sites around Wiltshire.</td>
</tr>
<tr>
<td><strong>Family Nurse Partnerships (FNP)</strong> is a preventative programme for vulnerable, first-time mothers aged nineteen and under at the time of conception and offers intensive and structured home visits delivered by specially trained Family Nurses working from early pregnancy until the child reaches two years of age. The programme uses in-depth methods to work with young parents on attachment, relationships and psychological preparation for parenthood.</td>
</tr>
<tr>
<td><strong>Children’s Centre’s</strong> are open access and their core purpose is to improve outcomes for young children and their families as well as reducing inequalities. Parental and infant mental health can be supported through a variety of things like baby massage, 1:1 parenting support, Stay and play sessions and Evidence Based Parenting Programmes.</td>
</tr>
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<table>
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<tr>
<th>Public Health funded programmes</th>
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<tbody>
<tr>
<td><strong>Health Trainers:</strong> Health trainers work on a one to one basis to support behaviour change and improve health. They concentrate on behaviours associated with ill health including unhealthy eating often linked to obesity, stop or reduce smoking, sensible drinking, increasing physical activity. They also give support with emotional wellbeing; building confidence and motivation to change and boosting self-esteem, they also signpost and support clients to access other services and activities where appropriate.</td>
</tr>
<tr>
<td><strong>Arts on Prescription:</strong> NHS patients with a range of long term health conditions (including depression) are referred by their health professional (e.g. GP, District Nurse, Community Mental Health team) for a course of 8 weeks of creative sessions with a professional artist. It should be noted that public health funding for this scheme has now ceased although ‘move on’ groups are in place in many of the pilot practices and our trailblazer practice in Whiteparish has continued to fund this scheme out of its own core funding.</td>
</tr>
</tbody>
</table>
Current Tier 2 Services:

**Early Years:**

**Maternal mental health** is supported by adult services including Primary Care Liaison Service (PCLS), hospital mental health liaison, and IAPT. Perinatal mental health champions have been identified within each of the 3 PCLS locality teams.

**Primary Care Liaison Service:** Access into specialist MH services. Referrals must be from a GP and clients will be triaged and fully assessed if required. They will then be signposted to an appropriate service, admitted or returned their GP.

**Wiltshire IAPT:** Provide a range of therapies available for anyone over the age of 16 who is registered with a GP practice in Wiltshire. These include Psychoeducational courses to help people manage stress, anxiety and depression and Mindfulness courses, IAPT also provide one to one therapy at step 2, with cognitive behavioral therapy (CBT) based guided self-help, and step 3 where a range of evidence based high intensity therapies are provided, predominantly CBT.

**Control Room Triage (previously Street Triage): service is collocated in the police control room.** The Control Room Triage service provides advice/guidance to police when dealing with MH incidents and when considering whether to detain an individual using section 136.

**Non-commissioned services**

**Counselling:** Wiltshire Mind currently provide 1:1 counselling on a self-referral basis for which they make a small charge; they receive regular referrals from GP practices and via services such as IAPT. Additionally there are some counselling interventions in IAPT and other providers e.g. Relate and Cruse provide specialist counselling.
Current Tier 3 Services:

<table>
<thead>
<tr>
<th>Specialist Mental Health Services (Provider AWP) Community Mental Health Teams (funded by the CCG)</th>
</tr>
</thead>
</table>

**Community Mental Health Teams:** Assessment treatment or monitoring for people with severe or enduring mental illness. Aim to complete treatment and discharge back to primary care.

**Intensive Team:** Intensive community support for people in MH crisis. Referral is via GP, PCLS, self-referral CMHT or from inpatient care.

**Early Interventions for Psychosis:** provides a community based service for those aged between 14-65 experiencing their first onset of psychosis or requiring support during their first three years of psychosis. The EIP service provides a range of NICE compliant interventions which includes CBT for Psychosis, Family interventions, physical health assessments, wellbeing support, carer and family education and support, and education and employment support.

**Mental Health Liaison services:** Mental Health Liaison services (MHLS) are located in each of the main three Acute Hospital providers for Wiltshire’s population: Royal United Hospital (RUH), Great Western Hospital (GWH) and Salisbury District Hospital (SDH). MHL provide a service within the emergency departments as well as the hospital wards; primarily to support General Staff in providing appropriate care to those with mental distress; aged 18+. Their focus is assessment, advice and support for people in acute hospital with severe and enduring or problematic mental health problems, either with a mental health condition or with a dementia. This usually involves a rapid assessment, advice and support for the care team involved in the individuals care, and for the individual to continue to have their care provided where they are. This service can act as a ‘gateway’ into the specialist mental health services, or to offer suitable methods of care (with support) in situ. The liaison service also provides significant in-put to the acute hospital care pathway for people who have self-harmed. The services also provide a range of support, education and training to the acute hospital workforce.

**Community Eating Disorder Service:** provides evidence-based therapeutic interventions to those aged 18+ with a diagnosed eating disorder.

Maternal mental health is supported by adult mental health services provided by AWP

**Recovery Based Services (various providers)**

**Jointly Funded (CCG and Council)**

**Advocacy** - IMCA, IMHA, Generic and Care Act advocacy provision (provided by Rethink)

**Recovery & Social Inclusion** (provided by Richmond Fellowship)

Peer Support Service - support network around the County as and when need arises using people with a lived experience
Bridge Building Service - supporting people to access and maintain contact with the mainstream community and its resources and facilities
Outreach - Supports people who aspire to paid employment or meaningful occupation e.g. volunteering and to formulate their ambitions and regain and expand their skills

**Individual Placement Support:** Intensive model of individualised support including rapid job search followed by placement in paid employment and time-unlimited in-work support for both the employee and the employer. Employment Support Staff are based with and work as integral members of the three mental health clinical teams (CMHTs) in Wiltshire (provided by Richmond Fellowship)

**Funded by Wiltshire Council (adult social care)**

**NHS Complaints Advocacy:** Independent advocacy service to support people who wish to make a complaint about services commissioned and/or provided by the NHS (provided by SEAP)

**Community Housing Support Service:** Homelessness prevention floating support service which aims to reduce the incidence of tenancy breakdown and/or individuals losing their homes. Person centred, preventative and recovery focused service for adults over 18 years old with functional mental health issues (provided by Richmond Fellowship).

Intensive Support Service (Rowan House) - 24-hour short term (maximum 2 years) accommodation-based housing-related support service for 10 adults with functional mental health issues (provided by Rethink)

**Supported Housing** - Preventative, community based services focused on independent living as an alternative to acute services and residential care (various providers)

**Funded by the CCG**

**Soundwell:** (music therapy): Community based group and one to one music therapy for individuals aged 18+

**Revival:** community based therapy/counselling for adult (aged 18+) survivors of childhood sexual abuse

**Funded by Public Health**

**Environment/Wildlife Wellbeing Project:** A nature based recovery programme supporting adults facing mental health problems on referral from a GP or health professional. The emphasis has been on early intervention (prevention) and supporting recovery from mental health issues

**Mental Health Debt and Benefit Advice Project:** Provides debt and benefit advice to people in touch with mental health services on a referral basis.
Current Tier 4 Services:
Inpatient Service are provided at Green Lane in Devizes and Fountain Way in Salisbury. In addition to this the CCG commission beds in other units as necessary. There are various options for support upon discharge which are decided based upon an individual needs.
Summary of Non-Commissioned and Other ‘Services’

<table>
<thead>
<tr>
<th>Name of service</th>
<th>Commissioning Organisation (if appropriate)</th>
<th>Scope</th>
</tr>
</thead>
</table>
| Wiltshire Mind (various services and groups provided) | N/A                                         | Counselling service and various groups  
6 peer support groups (Melksham, Trowbridge, Malmesbury, Devizes, Chippenham and Salisbury)  
2 carer groups (for carers of those with MH issues)  
Mens’ group  
Counselling 1-1  
Polish Counselling  
Mental Health Awareness Training |
| SPLITZ                              | To be confirmed                             | Works with people who are victims of domestic violence and with the perpetrators |
| Turning Point                       | Public Health                                | Support or treatment for people with addictions to drugs and alcohol |
| Veterans Service (AWP)              | NHS England                                  | Treat Veterans suffering from PTSD (Post Traumatic Stress Disorder) Depression and Anxiety. |
| Combat Stress                       | N/A                                         | Charity providing support for wounded, injured and sick veterans and their families |
| Help for Heroes                     | N/A                                         | Charity drop-in centre for those who are homeless, sofa surfing or who have complex issues that might affect their ability to acquire and / or sustain a tenancy |
| Doorway - Chippenham                | To be confirmed                             | Day Service for people age 16+ with mental Health Issues;  
Short Break Service for children 8-18 years with disabilities;  
Evening Social Club for people with Special Needs Activities such as Keep Fit; Arts and Crafts; Computer Skills; Yoga; Cookery |
<p>| Elizabeth House - Salisbury         | To be confirmed                             | Web-based virtual meeting place to discuss anything to related to mental health. Members provide mutual peer support. |
| Calne MH Forum                      | To be confirmed                             |                                                                      |</p>
<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Provider Source</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>WSUN (Wiltshire Service User Network)</td>
<td>CCG and Wiltshire Council</td>
<td>Peer support groups</td>
</tr>
<tr>
<td>Carers Support</td>
<td>Wiltshire Council</td>
<td>Support for MH carers and people with a general caring role. Carers Assessments and Carers Alert cards</td>
</tr>
<tr>
<td>Age UK - Befriending service</td>
<td>N/A</td>
<td>Offer support and friendship to make a difference to the lives of isolated older people in their own homes. We match service users with volunteer visitors and callers who have similar interests and are likely to form a good friendship.</td>
</tr>
<tr>
<td>Amesbury Mental Health Group</td>
<td>To be confirmed</td>
<td>Grassroots peer support</td>
</tr>
<tr>
<td>MH support – Wiltshire Council Tennants</td>
<td>Paid for via rent</td>
<td>Service available to Wiltshire council tenants – South Wilts</td>
</tr>
<tr>
<td>MH First Aid - WSUN</td>
<td>N/A</td>
<td>Mental Health first aid training courses for professionals, organisations and individuals</td>
</tr>
<tr>
<td>Relate</td>
<td>N/A</td>
<td>Wide range of counselling and therapy including: Relationship Counselling, Children and Young People's Counselling, Sex Therapy, Family Counselling, Training &amp; Education, Separated Parents Information Programme, Counselling for carers</td>
</tr>
<tr>
<td>Cruse</td>
<td>N/A</td>
<td>Bereavement counselling</td>
</tr>
</tbody>
</table>
Acknowledgements

We would like to thank and acknowledge the contributions made by

Wiltshire Council Public Health Team
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