

**MENTAL HEALTH NEEDS ASSESSMENT**

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# JOINT MENTAL HEALTH NEEDS ASSESSMENT

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# JOINT MENTAL HEALTH NEEDS ASSESSMENT

## 1 EXECUTIVE SUMMARY

- 1.1 Mental health is central to all health and wellbeing. It is defined as the ability to cope with life's problems and make the most of life's opportunities. It is about feeling good and functioning well, both as individuals and collectively. It can positively affect almost every aspect of a person's life; their lifestyle health behaviours through to education, employment, family and relationships. There is no health without mental health.
- 1.2 Mental health problems remain common and expensive. They place a heavy burden on individuals, families, friends and the community at large. No other health condition matches mental ill health in the combined extent of prevalence, persistence and breadth of impact. It is important for health improvement and health service planning that we understand more about the influences and interventions that will reduce the burden of disease and ensure more people have good mental health.
- 1.3 This Joint Mental Health Needs Assessment (MHNA) of known information was undertaken in 2011; it provides a local focus and where possible provides a comparison with the national picture. It recognises the wide ranging positive action already underway, whilst providing a stimulus for future work.
- 1.4 The purpose of this needs assessment was to review and understand key issues related to mental health and demand for services. It aims to assist commissioners to identify priorities and develop appropriate mental health services determined by the needs of current and potential service users. It will also help inform the future Joint Mental Health Strategy.

## 2 SIGNIFICANT FINDINGS

- 2.1 Based on national estimates of one in six, 70,000 people potentially have a mental health problem in Somerset.
- 2.2 Services are struggling with current capacity:
- there are potentially 60,000 people with unmet need
  - not everyone will want/need services
  - services may need to focus on promoting wellbeing to develop emotional resilience rather than treatment
- 2.3 Somerset Partnership NHS Foundation Trust provides services to over 13,000 people.
- 2.4 Around 1,000 people are admitted into psychiatric hospitals annually, with 410 being detained under the 1983 Mental Health Act.

- 2.5 Over 4,000 people had a new diagnosis of depression by their GP in 2009/2010.
- 2.6 Community Rightsteps provide services to over 6,000 people. The resource is overstretched and demand is predicted to grow.
- 2.7 Over 40 voluntary agencies exist within Somerset, who work exclusively or regularly with people with mental health problems. Between them they had over 20,000 unique contacts in 2010. Many are under threat of closure and this will have an impact on primary care mental health services.
- 2.8 NHS Somerset spends 7% of its overall budget on specialist mental health services.
- 2.9 9% of the mental health budget is spent on 15 people.
- 2.10 0.02% of the mental health budget is spent on mental health promotion.
- 2.11 Self-harming has increased nationally and is higher in the south west than other regions. In Somerset, there were 171.2 admissions for self-harm per 100,000 people; more women than men were admitted with the peak age group 15-29.
- 2.12 Taking into account urban and rural area variation, Quality Outcomes Framework (QOF) data still shows significant variation between practices for mental health prevalence, both in terms of existing levels and new cases. The cause of this variation is unclear.
- 2.13 There is evidence that mental health problems are more prevalent in areas of higher social and economic deprivation, both nationally and in Somerset.
- 2.14 Census data from 2001 shows that in Somerset, there were 50,000 carers, ranging from 15,000 in South Somerset to 3,000 in West Somerset. 9,500 provided more than 50 hours of care a week. Somerset Partnership NHS Foundation Trust try to systematically review the needs of carers and have been commended for their work with carers.
- 2.15 50% of women in contact with mental health services have experienced abuse or violence in their lives.
- 2.16 There is a projected 63% increase in the number of older people over 65 in Somerset over the next 20 years. This is likely to put pressure on dementia services.
- 2.17 At present there is no primary care provision for children and adolescents in Somerset. However, Primary Care Trusts (PCTs) are now required to provide "Talking Therapies" (TT) to those already engaged in secondary care from 2011/12. There is a clear need for primary care mental health services for children and young people.

- 2.18 There is a gap in data specifically linking Medically Unexplained Symptoms (MUS) to mental health issues at a local level.
- 2.19 Mental health and dementia prevalence at practice level show a clear gradient with high levels in most deprived areas. There is also evidence at south west regional level of a relationship with alcohol-related admissions and in Somerset between substance abuse amongst young people and the most deprived wards.
- 2.20 The percentage of older people using TT in Somerset is only half the estimated need from national figures. More information is required on the specific needs of older people and primary care mental health services.
- 2.21 Stays in Somerset psychiatric acute hospitals are longer than for acute physical conditions but half are less than a month.
- 2.22 There are a number of key gaps in local data identified, particularly at primary care level and in advocacy services. There is little data regarding specific vulnerable groups and on mental health and wellbeing rather than mental illness.
- 2.23 Results from the *2009 Somerset Lifestyle Survey* suggest a higher proportion of people (17.5%) indicating psychological distress than nationally.

### **3 AREAS FOR FURTHER WORK**

- 3.1 More information is needed on:
  - 3.1.1 The equality and diversity breakdown of clients, particularly in advocacy services.
  - 3.1.2 Medically Unexplained Symptoms in Somerset.
  - 3.1.3 How mental health is addressed for people with long-term conditions.
  - 3.1.4 Inpatient services for people with personality disorders.
  - 3.1.5 The service needs of young mothers and mothers-to-be who have severe mental health issues.
  - 3.1.6 The Acute Care Pathway Review suggested that there should be an alternative to inpatient stays for people with severe personality disorder; this could take the form of “crisis housing”.
  - 3.1.7 The size and nature of mental health problems of people with different protected characteristics.
  - 3.1.8 Whether and how carers in general access mental health services and in particular, the needs of young carers.

- 3.1.9 Emergency and Assessment services for people with learning disability (LD) and a mental health diagnosis.
- 3.2 There is much evidence to suggest that early intervention is a cost-saving approach to mental health and has multiple health outcomes. Strategies need to be developed that adopt the *No Health Without Mental Health* life course approach which includes starting well, developing well, living well, working well and ageing well.
- 3.3 Developing primary care children and young people's services - further work is required to identify what is needed and how it should be delivered, taking into account the *No Health Without Mental Health* evidence for early intervention and commitment to increase health visitor numbers. There also needs to be a smoother transition between children and young people's services and adult services in secondary care.
- 3.4 Exploring appropriate services in line with the increasingly elderly population's mental health needs.
- 3.5 To work with GP practices to develop a more consistent approach to identifying and recording mental illness prevalence such as depression.
- 3.6 The dual diagnosis protocol for substance misuse and mental health services needs re-defining.
- 3.7 Services to address mild to moderate eating disorders.
- 3.8 The care pathway between primary and secondary care services needs to be developed to ensure people are seen as soon as possible at an appropriate level for their needs.
- 3.9 Defining mental health outcomes and performance indicators across all sectors and levels of interventions – for instance, community, primary to secondary care.
- 3.10 A more joined-up approach is needed across different departments in NHS Somerset and Somerset local authorities in terms of funding streams for third sector organisations involved in mental health and wellbeing.

## **4 RECOMMENDATIONS**

- 4.1 To form a Joint Strategic Commissioning Partnership for Mental Health which will include health, local authority, voluntary sector and service user participation. This group should develop a local strategic action plan which will:
  - 4.1.1 Improve the health and wellbeing of the population as a whole.



- 4.1.2 Improve outcomes for people with mental health problems through high quality services, accessible to all, which are both more flexible and responsive to the needs of both service users and their carers.
- 4.1.3 The development of a local commissioning strategy to ensure fair, high quality, integrated services which focuses on the priorities identified within this needs assessment.
- 4.1.4 To ensure that services for people with mental health problems are highlighted as a priority in the development of both the Clinical Commissioning Board and the Health and Wellbeing Board.
- 4.1.5 To adopt the recommendations of the *Audit of Physical Health Checks for People with Severe Mental Illness*.
- 4.1.6 Agree and monitor mental health determinants within Somerset and set improved trajectories.
- 4.1.7 To undertake a mental health needs assessment once every three years or in line with the commissioning cycle.



## 5 INTRODUCTION

- 5.1 It is now widely recognised that there is no health without mental health. Improving mental health goes hand in hand with improving physical health. This link is made very clear in the government's recent mental health strategy *No Health Without Mental Health*. It is also apparent that any work around mental health needs to be conducted in the "joint" environment: NHS services need to compliment social care services and vice versa in order to create seamless care pathways for our population.
- 5.2 Mental health disorders are the single largest cost to the NHS, representing 12% of the overall expenditure. One in four people will have a mental health disorder at some stage during their lives.
- 5.3 The aim of this MHNA is to understand key issues and demands for services by reviewing the data available. This will provide evidence to help plan services and reduce inequalities.
- 5.4 This report outlines the approach taken and provides details of the findings through a series of helpful questions which highlight the range, scale and complexity of the issues to be considered.

## 6 THE NATIONAL PICTURE

- 6.1 The Coalition Government published a new mental health strategy *No Health Without Mental Health* in February 2011, which has a holistic approach and places greater emphasis on the links between physical and mental health. It sets out six objectives, developed cross-government and with partner agencies. The six shared objectives are as follows:
- more people will have good mental health
  - more people with mental health problems will recover
  - more people with mental health problems will have good physical health
  - more people will have a positive experience of care and support
  - fewer people will suffer avoidable harm
  - fewer people will experience stigma and depression
- 6.2 It also places an emphasis on Government departments to address mental health via its other work on early years interventions, drugs, employment, homelessness, veterans and offenders. It also recognises the impact of social issues on the likelihood of developing mental health problems.
- 6.3 In July 2010, a Government White Paper *Healthy Lives, Healthy People: Our Strategy for Public Health in England* was published, which set out a new framework for the delivery of healthcare, including;
- GP commissioning consortia being responsible for defining and purchasing local health services

- the abolishment of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) with the introduction of a National Commissioning Board (NCB), GP commissioning consortia and a Public Health England (PHE)
- a reconfiguration of the public health function, with existing responsibilities split between PHE and locally accountable public health teams under the auspices of local authorities
- the focus on outcome indicators rather than process targets

6.4 The proposals need Government approval and may change during the consultation process, but there are likely to be significant changes to the structures which deliver health services locally. What will become more important, however, is the need for a clear understanding of local health issues to inform the new structures and ensure that the needs of local people are central to the delivery of health promotion, protection and care. The White Paper *Healthy Lives, Healthy People: Our Strategy for Public Health in England* has frequent references to the importance of good mental health in empowering communities and talks of “taking a coherent approach to different stages of life and key transitions instead of tackling individual risk factors in isolation” with mental health being “a key element”.

### **Assessing mental health needs in Somerset**

6.5 In Somerset, promoting mental health is addressed as an integral part of the public health agenda, together with services provided at primary, secondary and tertiary levels. A full MHNA was completed in 1996 and has not been updated since, although mental health has been included in both the Joint Strategic Needs Assessment (JSNA) and in annual reports. In 2007, a comprehensive needs assessment of CAMHS at Tiers 3 and 4 was produced. A needs assessment for emotional health and wellbeing at Tiers 1 and 2 was also commissioned in 2008. The services commissioned in Somerset are at, or have exceeded, full capacity and include:

6.5.1 Somerset Partnership NHS Foundation Trust, which provides secondary care mental health services for people of all ages. Their Community Mental Health Teams also provide the assessment and care management function on behalf of Somerset County Council (SCC) for people who have experienced a mental health problem.

6.5.2 Somerset Community Mental Health, which provides an Improving Access to Psychological Therapies (IAPT) and Emotional Health and Wellbeing service for people aged 18 and over in conjunction with Turning Point, MIND and Somerset Racial Equality Council (SREC). This service is known as Community Rightsteps.

6.5.3 Somerset County Council presently spends £9.1 million on mental health provision. It commissions a range of services including care at home, nursing care, residential care, day care, specialist care for those with

Learning Disabilities (LD) and employment services from a wide range of independent and third sector providers as well as from Somerset Partnership NHS Foundation Trust. This includes jointly commissioned CAMHS from Somerset Partnership NHS Foundation Trust with NHS Somerset.

6.5.4 There are also many voluntary and community sector agencies providing support, advice and practical help for people with mental health issues.

6.6 A new MHNA for Somerset will be required to inform joint mental health promotion and service development over the coming years between NHS services, the local authority and GP consortia. Although this is a time of change in the NHS, mental health is widely recognised to be a key issue and ensuring consistent and appropriate services which meet both felt and expressed need is very important.

### **Definitions**

6.7 Mental health is central to all health and wellbeing. There are many different definitions of mental health and these are influenced by individual experiences and expectations, as well as cultural and religious beliefs. Mental health can be defined as “a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.” (WHO, 2005).

6.8 Mental health is more than the absence of mental illness. Mental wellbeing influences how we think and feel about ourselves and others and how we interpret events. It affects our capacity to learn, to communicate and to form and sustain relationships. It also influences our ability to cope with change, transition and life events. Mental health and wellbeing can positively affect almost every aspect of a person’s life: education, employment, family and relationships. It can help people achieve their potential, realise their ambitions, work productively and contribute to their community and society.

6.9 Mental health and wellbeing have been found to be associated with:

- improved educational attainment and outcomes, greater productivity and remaining in employment, improved cognitive ability and quality of life and improved sense of social connectedness
- reduced mortality, criminal behaviour, risk-taking behaviour (smoking) and sickness absence. Reduced used of health and social care services
- increased resilience – greater ability to deal with life’s problems and a reduced risk of developing mental illness or completing suicide

## **The Approach**

6.10 The purpose of a Joint Mental Health Needs Assessment (JMHNA) is to understand the mental health and wellbeing needs of those who live, work and visit Somerset and how this can be improved. This document provides up-to-date information to help describe the future mental health and wellbeing needs of the local population and help inform commissioning of services.

6.11 Recommended best practice for assessing need in local areas is to use a health needs assessment approach. This is a recognised methodology which addresses eight key questions:

- what is the problem?
- what is the size and nature of the problem?
- what are the current services?
- what are the views of patients, professionals and other stakeholders?
- what does best practice say about the most appropriate and cost-effective solutions?
- what are the resource implications?
- what are the recommendations and the plan for implementation?
- is assessing need likely to lead to appropriate change?

6.12 The needs assessment will be a three stage process:

- an initial data analysis exercise to identify issues across Somerset, based on secondary data sources together with an overview of current services
- consultation with stakeholder and community groups to understand reasons behind the findings from the data, what potential gaps are and what is currently being done locally to address them
- to consider the need to focus on one or two key areas in more depth if this was seen to be beneficial in setting priorities

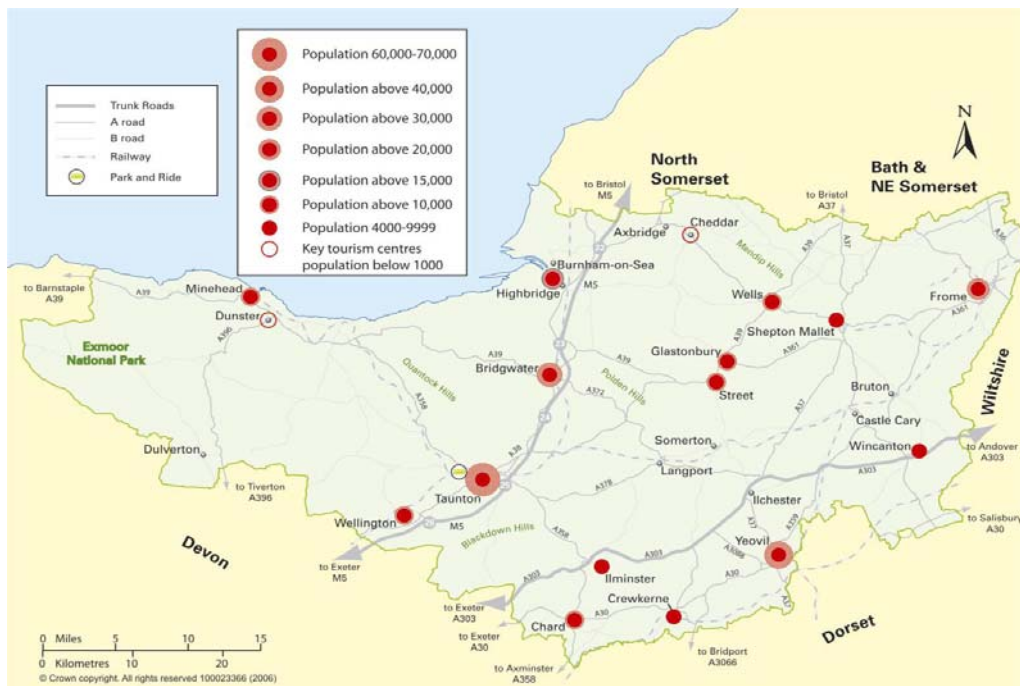
6.13 The initial data analysis exercise has been structured around a number of key questions informed by both understanding the local picture and the national priorities identified in *Talking Therapies – A Four-year Plan of Action*.

## **7 A BRIEF PROFILE OF SOMERSET**

7.1 For a detailed profile of Somerset, the Joint Strategic Needs Assessment (JSNA) published in 2008, gives a comprehensive overview of the county and its issues. Additional data is available in Appendix A.

- 7.2 The population of Somerset in 2010 was 530,200, a third of whom live in the urban areas of Taunton, Yeovil, Bridgwater and Frome.
- 7.3 28% are aged under 25 and 21% over 65 (over 65s range from 19% in Mendip to 30% in West Somerset).
- 7.4 In general, men tend to form the majority of the younger population and women the older.
- 7.5 In 2010, 17,076 people were aged over 85, two thirds of whom were female.
- 7.6 Around 2,390 migrants (adult overseas nationals entering the UK and being allocated a National Insurance Number) registered in Somerset in 2009. The highest percentage of migrants were from Poland (33%), followed by Romania (9%) and Bulgaria (7%). The Polish language is now the second most common first language (after English) of Somerset school children, followed by Portuguese.

**Figure 1**



- 7.7 The population in Somerset grew by 12.93% between 1991 and 2008, well above the national growth rate of 6.77% and slightly above the regional growth rate of 11.11%.
- 7.8 Projections into the future suggest a 12% increase in the overall population of Somerset by 2025 and a 53% increase in the 65 and over age group, compared to a 2008 baseline.
- 7.9 Average life expectancy in Somerset is 81.01 years, which is higher than the national average (79.68 years).

- 7.10 There are fourteen Lower Super Output Areas (LSOAs) in Somerset, which are ranked amongst the 20% most deprived in the country according to the 2010 Indices of Multiple Deprivation (IMD). Together they contain just over 22,000 people - 4% of the total population of Somerset.
- 7.11 There are 207,400 jobs in Somerset (2006). Businesses are smaller than the national average, with 85% of workplaces having 10 or fewer employees and there are relatively few major employers, with only 95 workplaces having over 200 employees.
- 7.12 The employment sectors of manufacturing and distribution, hotels and catering are over-represented in Somerset, compared with national and regional averages. Over one sixth of employees in Somerset work in the manufacturing of a wide range of foods from fruit juice to helicopters. Somerset has an established and regionally competitive advantage in food and drink, aerospace, advanced engineering and tourism.
- 7.13 Tourism is an important element of the economy of the south west and in Somerset is of particular importance in West Somerset and parts of Sedgemoor. An estimated 19,000 actual jobs (2006) are directly and indirectly supported by tourism expenditure, with day and staying visitors spending around £602 million in 2003.
- 7.14 Key issues around access to healthcare identified by the JSNA are:
- 7.14.1 28% of rural residents have either a minimum 30 minute travel time to their nearest GP or no service at all by public transport, compared with only 1% of urban residents.
- 7.14.2 43% of residents have either over an hours' travel time to their nearest community hospital or no service at all by public transport.
- 7.14.3 Around one in five residents have either a 30 minute minimum travel time to their nearest supermarket or no service at all by public transport.

## **8 WHAT IS THE PROBLEM?**

- 8.1 According to *No Health Without Mental Health*, one in six adults will have a mental health problem at any one time and for half of these it will last longer than a year. One in 100 have a serious mental health problem. Half of adults with mental health problems have developed them by age 14.
- 8.2 Mental ill health contributes up to 22.8% of the total burden of ill health and is the single largest cause of disability in the UK<sup>1</sup>, compared to 15.9% for cancer and 16.2% for cardiovascular disease. The wider economic costs of mental illness in England have been estimated at £105.2 billion each year. This includes direct costs of services, lost productivity at work and reduced quality of life. By condition, estimates are:

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<sup>1</sup> WHO (2008) The Global Burden of Disease 2004 update available at [www.who.int/healthinfo/global\\_burden\\_disease](http://www.who.int/healthinfo/global_burden_disease)



- depression - £7.5 billion
- anxiety - £8.9 billion
- schizophrenia - £6.7 billion
- dementia - £17 billion
- MUS - £18 billion

8.3 Gathering information at a local level depends on the availability of good quality consistent data which measures, both directly and indirectly, levels and impacts of mental illness and where possible, wellbeing. This chapter provides available data and information to help understand what the problems around mental health are in Somerset, but begins by briefly considering some of the data limitations.

### **What is the quality and availability of data on mental health?**

8.4 Data about service users is available and of reasonable quality in Somerset, particularly at secondary care level. For general hospital admissions, quality of data depends on the accuracy of coding. There are a number of key gaps identified, particularly at primary care and in advocacy services, amongst specific vulnerable groups and on mental health and wellbeing rather than mental illness. Sometimes data only provides a snapshot in time rather than information on trends or local variation.

8.5 The data could be improved to provide further evidence of the impact of investment and ability to achieve the six shared objectives of the *No Health Without Mental Health* strategy.

8.6 There is a need to develop ways to assess mental health needs data on positive mental health indicators, which is not robust on a local or national level.

8.7 Information about people who access NHS mental health services is available from a number of different sources:

- workload information is available from the Mental Health Minimum Dataset (MHMD) which is collected nationally
- hospital admissions data is available locally, giving details about any hospital admission anywhere in the country for people resident in Somerset or those registered with a Somerset GP
- QOF data is available by GP practice for a small number of mental health indicators
- Community Rightsteps performance reports, which provide insight into those using primary services to which they have been referred by their GP and via the IAPT national dataset

8.8 In addition to NHS services, there are a whole range of voluntary and community services which support people with mental health needs either directly (for example, MIND) or indirectly (for example, by providing opportunities for engaging with nature or returning to employment). Data is available about the organisations themselves but also to varying degrees about their clients.

8.9 The main gaps in data at a local level are:

- population-based positive mental health and wellbeing indicators
- practice level information about the number of people with low level mental health problems, who are not subsequently diagnosed as having a formal mental illness
- information on those with physical illnesses who may have mental illness as a result, although there is some information in the QOF data
- specific information about vulnerable groups, particularly those making up a small proportion of the population such as black and ethnic minority groups, people coming to the county from abroad to live or work, gay, lesbian and transsexual people, carers and people with disabilities
- Census data which is available for some of the determinants of mental health is now 10 years out of date
- information on people who do not recognise that they have a mental illness, are not aware of the help available or believe that their problems are not associated with a mental illness or their wellbeing
- people with a dual diagnosis who do not match service criteria for mental health support agencies

## WHAT IS THE SIZE AND NATURE OF THE PROBLEM?

- based on national estimates of one in six, 70,000 people in Somerset could be suffering from a common mental health problem at any one time. 80% of these will not be receiving treatment; Improving Access to Psychological Therapies (IAPT) services are currently expected to support 15% of those in need, but are not currently meeting this requirement
- self-harming has increased nationally and is higher in the south west than other regions. In Somerset there were 171.2 admissions for self-harm per 100,000 people; more women than men were admitted, with the peak age group 15-29
- the *2009 Somerset Lifestyle Survey* estimates 17.5% of people have a possible psychiatric disorder
- in 2009/10, 13,000 people used services provided by Somerset Partnership NHS Foundation Trust with around 1,000 being admitted to hospital. 410 were formally detained under the 1983 Mental Health Act
- stays in hospital are longer than for physical conditions but half are less than a month
- in 2009/10 there were 4,293 new diagnoses of depression in primary care, according to QOF data
- mental illness affects a lot of people in Somerset, particularly anxiety and depression, with a significant minority accessing treatment services
- there is some evidence that people do not seek help for mental health issues because of fear of being stigmatized
- the size and nature of mental health problems of people with different protected characteristics needs further investigation

9.1 The *2007 Adult Psychiatric Morbidity Survey* found that while one in six people in England suffers from a common mental health problem at any one time, only a quarter are accessing any form of treatment. In Somerset, based on an adult population of 421,485 (2010 population estimates), this equates to approximately 70,000 people. The rate of common mental disorders, typically depression and anxiety, has risen by a fifth amongst middle-aged women since 1993, with an 80% increase in self-harm among women aged between 16-24 since 2000. Nationally, people living in households with the lowest level of income are more likely to have a common mental health disorder than those in high income households.

80% of people with a common mental health disorder are not receiving treatment, although 38% had spoken to their GP in the last year and some may not wish to seek help, primarily through fear of the associated stigma.

- 9.2 In the south west, 10.8% of men met the criteria for a common mental disorder (which includes depressive and anxiety disorders) compared to 12.5% nationally. For women, 19.2% of women met the criteria compared to 19.7% nationally.
- 9.3 For men, the south west has the second highest level of generalised anxiety disorders compared to other regions (4.3% compared to 3.4% overall) and the third highest level of panic disorders. The proportion of women who had self-harmed was highest in the south west compared to other regions.
- 9.4 Latest figures from the Department of Health (DH) show that in the south west, £199.49 is invested in mental health services per head of weighted working-age population<sup>2</sup>. This is the second highest in the country after NHS London. Spending on CAMHS from the Children's Services Mapping Tool was budgeted to be £3,234,000 for Somerset<sup>3</sup>. In Somerset overall, £56m is spent on mental health which is approximately 7% of the total budget of NHS Somerset. This is less than the England average, which is approximately 11%, although this may also include overheads.
- 9.5 The *2009 Somerset Lifestyle Survey* included a question asking people whether they had a mental health problem and also questions from the GHQ-12. This is a validated tool which contains 12 questions about general level of happiness, depression, anxiety and sleep disturbance over the past four weeks. A score of four or above is considered "high" and is used as a threshold to identify respondents with possible psychiatric disorders based on these questions. The survey found that 53% of those who stated that they had a mental health problem had scored four or more on the GHQ-12, compared to only 16% who stated that they did not have a problem. This suggests that people's perception of their own mental health is quite good, although there is a minority of people who have levels from the GHQ-12 which may indicate an issue but who do not consider themselves to have a mental health problem.
- 9.6 In 2009/10, 13,611 people used adult and elderly NHS secondary mental health services provided by Somerset Partnership NHS Foundation Trust, an increase of 11.2% on 2008/09<sup>4</sup>. Of these, 1,060 (7.9%) were admitted to hospital for at least one day and 11,713 had contact via outpatients, community services or a Care Programme Approach (CPA) review. The number of cases has been fairly consistent over the last seven years overall, with a slight increase in those not admitted. Rates of access for NHS Somerset were 2,743 per 100,000 population, which compares to 2,713 per 100,000 for all commissioners across the country.

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<sup>2</sup> The 2009/10 National Survey of Investment in Mental Health Services (DH)

<sup>3</sup> <http://www.childrensmapping.org.uk/>

<sup>4</sup> <http://www.mhmdsonline.ic.nhs.uk/statistics>

- 9.7 Data is also available from the MHMD on the average length of stay per record<sup>5</sup> for people who spent time as inpatients during the year in Somerset Partnership NHS Foundation Trust hospitals. 50% are less than one month, with only 2% longer than one year in 2009/10. This is comparable to national statistics and has been fairly consistent over the last two years. For comparison, local data for general acute admissions, using just elective and non-elective inpatients (excluding day cases, regular day cases and regular inpatients) shows 97.5% of stays were less than 30 days.
- 9.8 In 2009/10, 410 people spent at least one day formally<sup>6</sup> detained in hospital under the 1983 Mental Health Act. This compares to 435 in 2008/09 and 424 in 2007/08. This means 38.2% were formally rather than informally detained compared to 39.4% nationally.
- 9.9 In the UK, the Care Programme Approach (CPA<sup>7</sup>) is used for the care and treatment of mentally ill people in the community. This has four aspects:
- assessment
  - a care plan
  - a key worker
  - regular reviews
- 9.10 The MHMD shows that in 2009/10 2,485 people were on CPA under Somerset Partnership NHS Foundation Trust (18.3% of all mental health service users). This is a decrease compared to the previous year, although prior to 2009/10 CPA was categorised into standard and enhanced, for those with more complex mental health needs. In 2008/09 1,118 people were on enhanced CPA and 2,105 on standard. Of those on the CPA and receiving secondary mental health services in 2009/10, 753 were in settled<sup>8</sup> accommodation and 114 in non-settled<sup>8</sup>. However, there was no data recorded for over 600 people. Somerset Partnership NHS Foundation Trust report that 88% of their clients live in settled accommodation (December 2010 data).
- 9.11 The QOF collects data at a general practice level, for which GPs receive specific payments. This includes two indicators which relate to how depression is managed at the practice:
- the percentage of people on the diabetes register and/or the coronary heart disease (CHD) register for whom case finding for depression has been undertaken on one occasion during the previous 15 months, using two standard screening questions

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<sup>5</sup> Calculated as total number of bed days divided by number of admissions in the current year for each record within year only

<sup>6</sup> Each person is counted only once and in one category with "formal" ranked before "informal" so if a person spent time as a formally detained patient and time as an informal patient, they are counted once only in the "formal" category

<sup>7</sup> DH guidance in spring 2008 stated that from October 2008 only those people considered most at risk or who required a higher level of care co-ordination should be on CPA

<sup>8</sup> "Settled" refers to secure, medium to long-term accommodation where the occupier or head of household has a security of tenure/residence in their usual accommodation in the medium to long-term. "Non-settled" refers to accommodation which is precarious, or where the person has no or low security of tenure/residence in their usual accommodation and so may be required to leave at very short notice.

- for patients with a new diagnosis of depression, the percentage who have had an assessment of severity at the outset of treatment, using an assessment tool validated for use in primary care

9.12 Figures for Somerset are 89.9% and 93.6% respectively. Data is also collected on the incidence of depression (for instance, the number of new cases). In 2009/10 there were 4,293 new diagnoses of depression. This is a decrease of 2.8% compared to 2008/09, but an increase of 10.7% on 2007/08.

9.13 The IAPT service is expected to provide treatment to 15% of the expected prevalence of those with anxiety and depression. The local service is not yet at this level.

9.14 According to the *Somerset Dementia Strategy*, it is estimated that there are currently 7,640 people with dementia, 145 of whom are aged under 65. The focus of the *Somerset Dementia Strategy* is to:

- raise awareness and understanding of dementia within the general public
- ensure that there is early diagnosis, support and intervention for people with dementia and their carers
- provide a higher quality of care to enable people to live well with dementia

**How does mental health prevalence in Somerset compare nationally and to other parts of the south west?**

- results from the *2009 Somerset Lifestyle Survey* suggest a higher proportion of people indicating psychological distress than nationally
- for users of services at secondary and primary care levels, Somerset is similar to other counties with similar characteristics
- levels of alcohol-related admissions are lower in Somerset than other parts of the south west

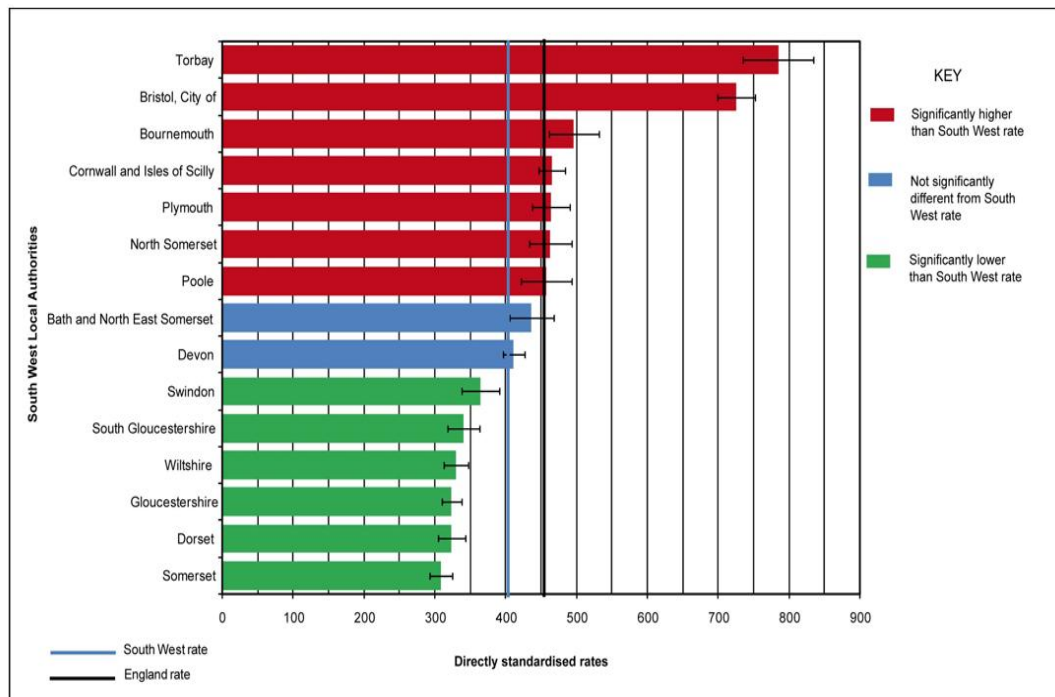
9.15 Somerset is generally a healthy place to live, with life expectancy above the national average. 76.2% of people in the Place Survey in Somerset in 2008 described their health as good or very good, compared to 75.8% nationally. However, there is some evidence that this does not translate to good mental health. In the GHQ-12 questions in the *2009 Somerset Lifestyle Survey*, a score of four or more is used as a threshold to identify informants with high levels of psychological distress. 17.5% of people in Somerset scored four or more, compared to 12.5% across England when the same tool was used in the *Health Survey for England*. Higher levels of

depression are associated with old age and all the factors that age brings: frailty, lack of energy, loss of senses, social isolation, loss of ability to totally self-care. The higher than average age of the population may account for the higher levels of psychological distress.

9.16 The QOF gathers a range of information from general practices, including clinical registers from which prevalence data can be estimated. In Somerset, standardised mental health prevalence was 6.6 per 1,000 population in 2009/10. In 2009/10, 0.7% of all people registered with a GP were on a register for people with schizophrenia, bipolar disorder or other psychoses (3,558 out of 536,811 people). This is similar to Devon, Dorset, Shropshire and Herefordshire and ranges from 1.7% at Victoria Gate Surgery in Taunton (60/3,508) to 0.1% at Westlake Surgery (Dr Smith) at West Coker (2/1,612).

9.17 Recent work by the South West Public Health Observatory (SWPHO) looked at directly standardised rates of alcohol-specific admissions per 100,000 population, which are defined as “admissions wholly attributable to the use of alcohol.” Somerset has a significantly lower level than the overall south west rate. Mental and behavioural disorders due to the use of alcohol were the leading cause of alcohol-specific hospital admissions, causing 63% of all alcohol-specific admissions, followed by alcoholic liver disease (18%) and ethanol poisoning (13%) across the south west.

**Figure 2**



9.18

QOF data is also available for other indicators which give more insight into how practices respond to people with mental health issues, both in terms of reviews and case finding. However, sometimes patients are on a register although they do not have the relevant condition; this may be because they are taking, for example, lithium therapy, but not for any of the conditions listed or because of historic coding rules. The denominators will exclude “exceptions”:

- Frome Medical Centre, which is the largest practice in Somerset, has the highest number at 200 patients on the register of people with schizophrenia, bipolar disorder or another psychoses at general practice, but excluding Frome, the average register size per practice is 45
- the percentage of patients on the psychoses register who have had a review in the preceding 15 months is 94.3% across Somerset, ranging from 88.4% at Burnham Medical Centre to 100% in 20 practices
- 88.5% of patients on the psychoses register across Somerset have a documented comprehensive care plan, ranging from 50% at Cannington Health Centre (seven out of 14 patients) in 2009/10 to 100% at 15 different practices

**Table 1**

Mental Health Register Size	Number of practices
0-19	19
20-39	19
40-59	14
60-79	11
80-99	10
100-119	2
120+	1

**Where are the highest levels of known mental health problems in Somerset?**

- there is variation at both district and practice level in Somerset
- indicators of anxiety and depression suggest higher levels in Sedgemoor, but more generally in urban areas such as Taunton, Bridgwater and Glastonbury
- West Somerset, despite being the most rural part of Somerset, scores highest for people feeling well connected and not isolated



- practice data shows highest levels of dementia in Taunton Deane (particularly Wellington practices, which cover a large number of care homes) and learning disability highest in West Somerset
- QOF data shows significant variation between practices for mental health prevalence, both in terms of existing levels and new cases. Practices in West Coker have very high levels of new and existing cases of depression
- practices where GPs have a special interest in mental health may appear to have a higher prevalence because they are more likely to diagnose and Read Code patients correctly

9.19 The true level of mental health problems within an area is unknown. However, recorded data gives some idea of known mental health problems. Using this to explore variation may not reflect genuine fluctuations in actual problems but may vary due to:

- patients' willingness to present
- GPs ability/willingness to diagnose
- the ease/accessibility of access to primary or secondary care

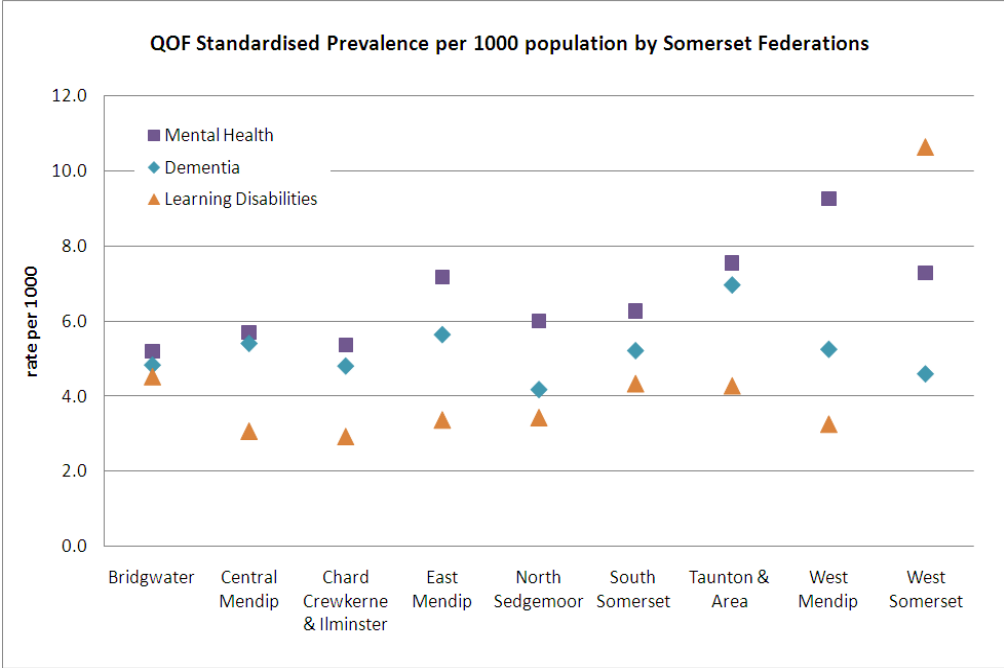
9.20 In 2008, the Mental Health Observatory carried out some work to estimate the prevalence of common mental health problems in order to inform likely demand for psychological therapy services. It used data from the *2000 Psychiatric Morbidity Survey*, together with 2005 population data and regression techniques and as such is somewhat out of date. Information was available at both upper and lower tier local authority levels. This found that:

- anxiety and depression had the highest prevalence rates
- rates for all types of disorder were highest in Taunton Deane, although there was little difference at district authority level
- areas with the highest predicted rates of common, mild to moderate mental health conditions were Glastonbury, Bridgwater, Chard, Taunton and Alcombe West

9.21 In the GHQ-12 used in the *2009 Somerset Lifestyle Survey*, a score of four or more is used as a threshold to identify respondents with high levels of psychological distress. Sedgemoor had the highest proportion of those scoring four or more at 19.6%. Taunton had the lowest proportion, scoring 15.7%. Despite West Somerset being the most geographically isolated area, the proportion of "very connected" was the highest and the proportion of "very isolated" the lower.

- 9.22 Higher scores tended to be in more urban areas, particularly around parts of Glastonbury, Street, Bridgwater, Taunton, Yeovil and Frome. When the scores are translated, mental health index scores are highest around urban areas but with more emphasis around Minehead, Wells and parts of central Somerset.
  
- 9.23 There were 773 deaths with dementia as the underlying cause for people over 65 in Somerset, between 2005 and 2010. Rates were highest in Taunton Deane (following age and sex standardisation) and lowest in West Somerset for both dementia as a main cause (176.1 per 100,000 and 39.1 per 100,000 population respectively) and contributory factor (337.8 per 100,000 and 112.5 per 100,000 population respectively).
  
- 9.24 From QOF data at practice level, mental health prevalence ranged from 20.2 per 1,000 population at NHS Yeovil Health Centre (although this is based on very small numbers) and 17.2 at Victoria Gate Surgery in Taunton to 1.2 per 1,000 population at Westlake Surgery, West Coker. West Mendip has a significantly higher level than other federations, at 9.3 per 1,000 population. West Mendip covers the Glastonbury, Street and Wells area.
  
- 9.25 The Yeovil Health Centre is a drop-in centre; people do not need to be registered at the practice to make an appointment. The high prevalence of mental health issues at the Yeovil Health Centre could be because people feel more comfortable discussing their concerns in an anonymous environment.

**Figure 3**



- 9.26 Dementia prevalence was 5.4 per 1,000 population for Somerset, with the highest levels in Taunton and Wellington. Wellington Medical Centre is split into two practices, which have the first and fourth highest prevalence across

Somerset. Across Somerset in 2009/10, 2,892 people were on the dementia register. For LD, prevalence is highest in West Somerset, which may be due to the specialist further education college in Minehead and this is reflected in the practice with the highest level (20.3 people per 1,000 population) compared to a Somerset-wide average of 4.2 per 1,000.

**Table 2**

<b>6 practices with highest prevalence levels per 1,000 population</b>						
	<b>Mental Health</b>		<b>Dementia</b>		<b>Learning Disabilities</b>	
1	NHS Yeovil Health Centre	20.2	Wellington Medical Centre	13.6	Harley House Surgery, Minehead	20.3
2	Victoria Gate Surgery, Taunton	17.2	Lyngford Park Surgery, Taunton	10.8	Victoria Surgery, Taunton	15.6
3	Lyngford Park Surgery, Taunton	14.6	Crown Medical Centre, Taunton	10.6	Penn Hill Surgery, Yeovil	15.5
4	Glastonbury Health Centre	14.2	Warwick House Medical Centre, Taunton	10.5	Exmoor Medical Centre	13.3
5	Wells City Practice	13.8	Wellington Medical Centre	9.1	Lyngford Park Surgery, Taunton	11.0
6	Harley House Surgery, Minehead	11.9	Westlake Surgery, West Coker	9.0	The Surgery, Dunster	10.1
	<i>Somerset</i>	6.6	<i>Somerset</i>	5.4	<i>Somerset</i>	4.2

9.27 Somerset Partnership NHS Foundation Trust provide Memory Assessment Services (MAS) which provide information, advice and support for people in the early stages of dementia.

9.28 There were 1,162 referrals to the MAS by practices from 1 May 2010 to 25 January 2011 with 1,244 assessed and 1,086 new cases. The highest number were at Burnham Medical Centre (118) followed by Highbridge, Taunton Road and Cheddar Medical Centres. Interestingly, referrals from Wellington and Lyngford Park surgeries were very low despite high prevalence of dementia based on QOF data.

9.29 According to QOF data, in 2009/10 there were 4,293 new diagnoses of depression – 0.8% of all those registered with a GP. By practice there is considerable variation. The number of new cases in 2009/10 were highest at:

- NHS Yeovil Health Centre (5% 11/219)
- Westlake Surgery (Smith), West Coker (1.9%, 31/1,612)
- Westlake Surgery (Cox/Cotton), West Coker (1.8%, 39/2,186)
- East Quay Medical Centre, Bridgwater (1.7%, 227/13,715)
- St James Medical Centre, Taunton (1.7%, 195/11,816)

- 9.30 The number of new cases in 2009/10 were lowest at:
- Church Street Surgery, Martock (0.1%, 11/11,019)
  - Burnham Medical Centre, Burnham-on-Sea (0.1%, 8/15,030)
- 9.31 However, whether the differences are significant depends on the number of cases at each.
- 9.32 The number of patients who have a history of depression coded at any time (not just new cases) is 10.4% for Somerset as a whole. This ranges from 26.8% at Westlake Surgery (Dr Smith) in West Coker to 2.6% at the Quantock Medical Centre in Bridgwater in 2009/10.
- 9.33 Both surgeries in West Coker have a significantly higher prevalence of depression than the rest of Somerset, or across England, and it is interesting to note that one of the GP partners has a special interest in psychiatry.

**Is there a clear relationship between deprivation and prevalence of mental health or service use?**

- there is evidence that mental health problems are higher in areas of higher deprivation
- there are clear areas of deprivation in Somerset, which is in general an affluent area
- both mental health and dementia prevalence at practice level show a clear gradient with high levels in most deprived areas. There is also evidence at south west regional level of a relationship with alcohol-related admissions and in Somerset between substance misuse amongst young people and the most deprived wards

- 9.34 The national strategy *No Health Without Mental Health* noted that people with mental health problems were more likely to live in areas of high social deprivation. There is also evidence that mental health problems are linked with poor diets, less exercise, heavy smoking and drug and alcohol misuse. The socio-economic deprivation of a practice locality has been shown to be a predictor of the prevalence and persistence of depressive symptoms amongst patients<sup>9</sup>.
- 9.35 In Somerset, deprivation is concentrated in pockets across the county. Ten of the fourteen LSOAs are located within one of the three largest towns in Somerset: Taunton, Yeovil and Bridgwater and three are in the single ward of Bridgwater Sydenham. In these areas<sup>10</sup>:

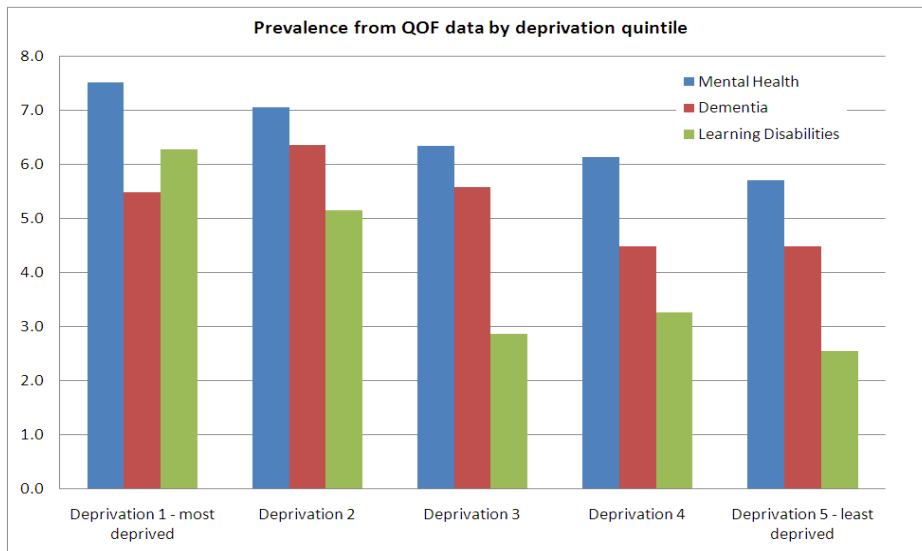
<sup>9</sup> Influence of socio-economic deprivation on the prevalence and outcome of depression in primary care. The Hampshire Depression Project k. Ostler, c. Thompson, a.-l. K. Kinmoth, C. Peveler, I. Stevens, A. Stevens, British Journal of Psychiatry 2001: 178

<sup>10</sup> Community Profile: Priority Areas (uses IMD 2007) Somerset Intelligence Network www.sine.org.uk

- one in three are lone parents, compared to one in five across Somerset
- 67% are satisfied with where they live, compared to 86% across Somerset
- almost one in four are claiming out of work benefits, compared to one in 10 across Somerset
- 39% feel very or fairly safe outdoors after dark, compared to 59% across Somerset
- in May 2009, 9.3% were claiming incapacity benefit, compared to 3.9% across Somerset

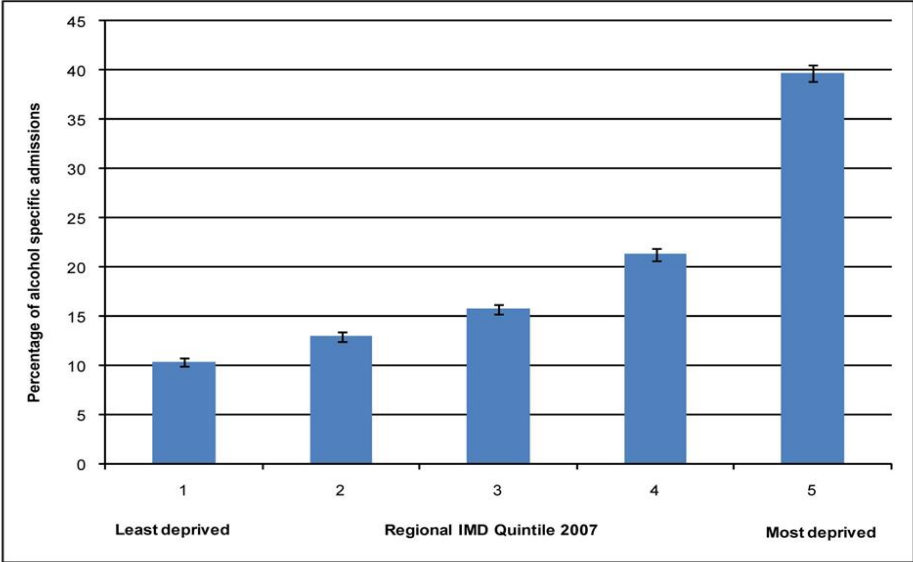
9.36 There appears to be a relationship between deprivation (as measured by the IMD and accumulated across practices) and prevalence of mental health and dementia in Somerset, although the data for dementia (and LD) may be skewed by where there are care homes. There are higher levels of prevalence across all three in the most deprived areas and an apparent gradient. There is much debate as to the direction of this relationship; for instance, whether people living in more deprived areas are more vulnerable to mental health issues or whether people with mental health issues end up living in more deprived areas. This pattern is consistent with other health inequalities assessment surveys.

**Figure 4**



9.37 There is also evidence (at south west region level and within Somerset) of a link between deprivation and alcohol-specific hospital admissions. Peak levels for both men and women were age 40-44. For 2008/09, the rate of admission in the most deprived area was almost twice that of the least deprived area.

**Figure 5**



9.38 Areas within Somerset which are experiencing the highest levels of multiple deprivation, based on a methodology for scoring used in the *Somerset Young People’s Substance Misuse Needs Assessment*, including social exclusion amongst young people, are:

- Taunton Deane 009E – Taunton Halcon (North)
- Sedgemoor 008C – Bridgwater Sydenham (Central)
- Taunton Deane 009D – Taunton Halcon (West)
- South Somerset 013C – Yeovil West (Freedom Avenue area)
- Sedgemoor 005C – Highbridge (West)

9.39 These five areas also contain the highest concentration of young people experiencing one or more risk factors for substance misuse. This finding suggests that there is a correlation between areas of socio-economic depression and areas where young people most at risk of substance misuse are likely to be concentrated.

9.40 It is recognised that there is a three-fold risk of mental health problems in children if they live in families with lower income levels. The number of children in Somerset living in relative poverty is 14.2% which is below the national average of 20.9%. Below is a breakdown by district of the percentage of children in families receiving means-tested benefits and low income from 2008 data:

Somerset 15,335 children	(14.2%)
Mendip 3,120	(13.5%)
Sedgemoor 3,830	(16.0%)
South Somerset 4,120	(12.6%)
Taunton Deane 3,105	(13.8%)
West Somerset 1,155	(19.5%)

**Who is most vulnerable to mental health issues and does this vary by age or gender?**

- vulnerability depends on the mental illness and is strongly associated with social determinants such as socio-economic conditions, deprivation and social isolation. These determinants can both contribute to the development of mental health problems and result from them
- there is both national and local evidence that women are more vulnerable to depression and depressive disorders. Men are more likely to suffer from ASPDs and psychotic illnesses. Somerset Partnership NHS Foundation Trust hospital admissions show interesting variation by gender; for example, men are more vulnerable to dementia in other diseases such as Parkinson's and developmental diseases
- the *2009 Somerset Lifestyle Survey* results suggest that older people feel more connected and less socially isolated than under 25s
- some groups of young people are known to be more vulnerable to poor mental health, including those with parental mental health illness, who are looked after or have other social issues. There is some evidence of a relationship between substance abuse and mental illness in young people
- women are more vulnerable to eating disorders and being a victim of domestic violence. They also experience post-natal depression.

9.41 Mental illnesses affect men and women differently. Some disorders are more common in women and some express themselves with different symptoms. Scientists are only now beginning to tease apart the contributions of various biological and psychosocial factors to mental health and mental illness in both men and women. In addition, researchers are currently studying the special problems of treatment for serious mental illness during pregnancy and the postpartum period.

9.42 It is generally known that depression is twice as common in women, lifetime prevalence rate of alcohol dependence is more than twice as high in men and men are more than three times as likely to be diagnosed with an anti-social personality disorder (ASPD). There are no marked gender

differences in the diagnosis rate of serious psychological disorders, such as schizophrenia and bipolar disorder<sup>11</sup>.

9.43 The mental disorders affecting women include the following:

- anxiety disorders, including Obsessive Compulsive Disorder (OCD), panic, Post Traumatic Stress Disorder (PTSD), social phobia and generalised anxiety disorders
- Attention Deficit Hyperactivity Disorder (ADHD, ADD)
- bipolar disorder
- borderline personality disorder
- depression
- postpartum depression
- eating disorders
- schizophrenia

9.44 The *2009 Somerset Lifestyle Survey* found that:

- the proportion of those reporting “any isolation” was 42%. Males and females reported similar levels of “any isolation”, but there was a suggestion that more females experienced more intense isolation
- there was a decrease in perceived social isolation with age. Those aged over 55 reported being very connected – more than twice as often as those aged less than 25
- there was a high correlation with people who reported a mental health problem, as would be expected. However, 16% of people who reported no mental health problem scored high on the scale, suggesting that people are perhaps not recognising the signs and symptoms of mental stressors

9.45 Data by gender shows 56% of bed days in 2009/10 were for females and 44% for males for Somerset Partnership NHS Foundation Trust. Further analysis of types of admission for Somerset Partnership NHS Foundation Trust showed some significant variation:

- there are approximately 2.5 male admissions for schizophrenia and acute psychotic illness for every one female admission
- men have higher admission for “dementia in other diseases” than women – this is particularly linked to dementia in Parkinson’s disease although the number of admissions is small
- for “pervasive developmental disorders” such as autism, there were 33 male admissions over five years, compared to only three for females

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<sup>11</sup> [http://www.who.int/mental\\_health/prevention/genderwomen/en/](http://www.who.int/mental_health/prevention/genderwomen/en/)



- severe depression, recurrent depression and depressive episodes are all more common for women than men
- admissions for women for “emotionally unstable personality disorders” are 3.5 times higher than for men
- out of 35 admissions for anorexia nervosa, 29 were female

9.46 For domestic abuse and sexual violence:

- from February 2010 to 2011, Avon and Somerset Police figures showed that 425 high-risk cases of domestic violence were referred to a Multi-agency Risk Assessment Conference across Somerset. This involved 572 children. 25.5% of the cases were repeats
- in 2009-2010 there were 5,655 domestic violence incidences reported to the police and 324 sexual offense crimes
- the wards with the highest number of incidence of domestic abuse being reported to the police were; Taunton Halcon, Bridgwater Victoria and Yeovil Central
- the wards with the highest incidence of reporting sexual violence to the police were; Yeovil Central, Bridgwater Victoria and Bridgwater Hamp
- 56% of women experiencing domestic violence will be diagnosed with a psychiatric disorder (Danielson et al, 1998)
- more than 50% of women in contact with mental health services have experienced abuse and/or violence (Naz, 2003: DH, 2002; Jordan et al, 2004)
- up to 44% of abused women have tried suicide as a means to escape violence (Humphreys, 2003)

9.47 In 2007 a review of needs for Tier 3 and 4 children’s specialist services was undertaken, which identified particular groups who were more vulnerable to mental health problems than others, including:

- looked after children
- children with LD
- children with special educational needs
- young offenders
- children with a physical illness
- homeless children

9.48 The *Somerset Young People's Substance Misuse Needs Assessment* found that:

- one group at particularly high risk of substance misuse were those who had behavioural conduct disorders and/or mental health problems
- the PROMISE mentoring and advocacy programme had a caseload of 130 clients across Somerset in July 2009. Of these, information was collected on risk factors and 43 cited “mental health – parent” as a risk factor and 34 “mental health”, suggesting family mental health problems have a significant influence on young people. 32 clients had substance misuse problems, with 13 and 11 citing their own, or a parent's mental health, as a risk factor
- 12% of referrals to specialist substance misuse services were from mental health as the referring agency in Somerset, compared to only 3% across the south west, although this only equated to 11 people

9.49 Somerset & Wessex Eating Disorders Association<sup>12</sup> (SWEDA) estimates that around 5,000 people in the county of Somerset will have a clinical eating disorder, with a further 5,000 having an eating disorder which has a significant impact on their life and health. This includes women of all ages, the majority being between 14-35 years of age. Around 10% of sufferers are male. Eating disorders impact on the families and friends of sufferers so the estimated figure for need in Somerset could be in the region of 50,000. There is currently no specific service commissioned in Somerset for mild to moderate eating disorders.

9.50 It is recognised that when someone is cold they are two and half times more likely to become depressed. The Somerset fuel poverty figures for 2008 show a significant number of wards where there is a need to spend more than 10% of income on fuel. The three wards with the highest percentage of people spending over 10% are Exmoor, Old Cleeve and Brompton, which are three wards with a high proportion of retired and older people living within them.

**What is known about access to physical health checks for people with severe mental health problems?**

- in March 2011, the *Audit of Physical Health Checks for People with Severe Mental Illness (SMI) Report* was produced. The audit revealed the need for improvement in the content of physical health checks and follow ups for people with SMI to ensure reduced risk of physical ill health

<sup>12</sup> <http://www.swedauk.org/disorders/disorders.htm>

- 9.51 The *Audit of Physical Health Checks for People with Severe Mental Illness (SMI) Report* showed the following key findings.
- 9.52 2,701 patient records were audited.
- 9.53 75% of patients had received an annual health review within the previous 18 months, but there was no record of an annual health review at all for 18% of patients.
- 9.54 55% of the audit sample were recorded as “current smokers”. This figure is in line with national data. Smoking prevalence in the general population in Somerset is currently 18.3%. Recorded compliance with giving smoking advice to current smokers is poor, with only 41% receiving advice in the last 18 months and 45% with no record of ever having been given advice. This is a marked contrast with patients in long-term condition comparator categories, where more than 95% had received advice in the last 18 months.
- 9.55 4% of patients have a blood pressure recording which is moderately to severely raised, compared to 1% of patients with a diagnosis of Transient Ischaemic Attack (TIA)/stroke, CHD or diabetes. The patients with SMI are much less likely to have had a blood pressure check at all or in the last 18 months (88% v 99% and 69% v 87% respectively).
- 9.56 Only 43% of patients with SMI, a Body Mass Index (BMI) over 29.9 or relevant co-morbidities had received a cholesterol check within the last 18 months. 38% of such patients had never had a cholesterol check. In comparator patient groups, 80% had received a cholesterol check within the last 18 months.
- 9.57 Only 29% of patients with SMI had received a blood glucose check in the last 18 months to check for the development of diabetes. 50% had never had such a check, according to records, including 318 obese patients.
- 9.58 There does appear to be good access to cervical screening for eligible women with SMI and there is no evidence of health inequality in relation to the general population. However, access to breast screening appears to be lower than that in the general population, although this may be explained (in whole or in part) by the high proportion (24%) of patients with No Documented Evidence (NDE) of a breast screen, compared to just 6% for cervical screening.

**What is the need and current provision for older people’s primary care mental health services?**

- there is evidence older people are under-represented in their use of IAPT services
- more information is needed on specific needs of older people and primary care mental health services

9.59 During July 2010 to February 2011, 6% of all adults entering IAPT treatments in Somerset were aged 65 and over. People aged 65 and over made up 26% of the Somerset adult population as of January 2011. The *Adult Psychiatric Survey* assesses national prevalence of depression amongst 65-74 year olds at 10.6% and amongst all adults as 6%. Therefore, locally the expected rate of over 65s in IAPT services, given the profile of the population and the community prevalence of anxiety and depression disorders, would be 12%. This is consistent with national findings that older people are significantly under-represented in the profile of IAPT users.

9.60 A 2008 report by Age Concern found that older people visit their GP practice more often than younger people and most consider their GP to be the most important person in their healthcare. People aged 65 and over visit their GP, on average, seven times a year. This compares with an average of four visits a year by younger adults. In any two week period, more than one in five older people visit their GP. One in seven people had some difficulty accessing an appointment. Somerset has a high proportion of older residents, which is likely to increase significantly over time and therefore place added pressure on primary care services.

9.61 Somerset spend on dementia prescribing is mid-way, compared to other PCTs at around £450 per 1,000 population, but with slightly higher levels of Rivastigmine and lower levels of Donepezil, compared to similar spending areas. Both Donepezil and Galantamine are used to treat mild to moderate dementia in Alzheimer's disease. Rivastigmine can also be used to treat mild to moderate dementia associated with Parkinson's disease.

#### **What is known about the mental health of veterans and service personnel in Somerset?**

- there are a number of large military units in Somerset and many veterans will choose to retire in the area that they were last based
- combat operations have increased significantly in the last 10 years
- most veterans who seek help for mental health issues will not do so for 14 years after they leave the service
- little is known about specific issues in Somerset, although Combat Stress provide support locally

9.62 The Government announced in March 2011 that it is to fund a new £200,000 pilot, offering a helpline to armed forces personnel affected by mental health issues. The helpline will be run by mental health charity Rethink, in association with veterans' support group Combat Stress and will support ex-service personnel and their families. The helpline will enable them to discuss their issues and access help in their locality. Most veterans

who do seek help with mental health issues will not do so for 14 years after they leave the services.

- 9.63 Nationally during the three-month period July to September 2010, 942 new episodes of care for mental disorders were identified within UK armed forces personnel, representing a rate of 4.7 per 1,000 strength. This is the same rate seen in the previous quarter of April to June 2010.
- 9.64 Neurotic disorders were the most common initial assessment for patients with a mental disorder:
- rates for Army and RAF personnel were significantly higher than for Royal Navy and Royal Marines personnel
  - rates for “other” ranks were significantly higher than for officers
  - rates for females were significantly higher than for males
- 9.65 In Somerset, it is difficult to obtain specific data on mental health amongst service personnel. There are substantial military communities across the county where many of the personnel will have been involved in close quarters military combat over the last 10 years. RNAS Yeovilton, located close to Yeovil, has approximately 3,500 naval personnel and there are several Royal Marine bases near Taunton.
- 9.66 Combat Stress is a charity working nationally and across the south west to support veterans. Locally they have a team of three: one welfare officer, one Community Psychiatric Nurse and one Mental Health Social Worker (these two are part-time outreach workers). Combat Stress estimate that they have 38 ongoing cases in Somerset.
- 9.67 Somerset Partnership NHS Foundation Trust have a contract with the DH to provide mental health beds for service personnel.
- 9.68 The Ministry of Defence (MoD) and DH across the UK provided set-up funding for six regional community mental health service pilots<sup>13</sup> for armed forces veterans, which were evaluated in 2010. This identified successful and less successful features of services to support veterans, which included:
- services should provide both assessment and treatment with no long delays or additional waiting lists at each stage
  - services should be staffed by people who have experience of working with veterans (or are a veteran themselves) and have a knowledge of the culture within the forces
  - group work with other veterans is seen as a positive source of support

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<sup>13</sup> The University of Sheffield An Evaluation of Six Community Mental Health Pilots for Veterans of the Armed Forces (A Report for the Ministry of Defence CTLBC-405) December 2010

- services should accept self-referrals rather than other health professionals acting as gatekeepers
- services should not be dependent on the expertise/drive of one person

### **Are carers particularly vulnerable to mental illness?**

- from the 2001 Census, there were 50,000 carers in Somerset and there is national evidence that carers are more vulnerable to mental illness and particularly neuroses, such as anxiety and depression
- more information is needed on whether and how carers access mental health services and also about the burden on young carers

9.69 A survey of the mental health of carers, commissioned by the Office of National Statistics (ONS) in 2002, found that female carers were 23% more likely to have neurotic symptoms than women in general, although there was no such difference for men. Factors which increased the risk of mental health problems for carers included:

- being divorced, separated or co-habiting
- living in an urban area
- having the cared-for person living in the same house

9.70 13% of all carers had consulted a GP about being anxious or depressed or about a mental, nervous or emotional problem in the last year.

9.71 Data is generally collected as part of the Census and so is currently 10 years out of date. In 2001, there were 5.2 million carers in England and Wales, including over one million providing more than 50 hours a week. In Somerset, there were 50,000 carers at the 2001 Census, ranging from 15,000 in South Somerset to 3,000 in West Somerset. 9,500 provided more than 50 hours of care a week. Somerset Partnership NHS Foundation Trust have been commended for their work with carers and try to systematically review the needs of carers. The Somerset Carers' Network provides support, information and training for carers.

9.72 Data from the National Audit Social Care Intelligence Service 2011 reveals only 18% of carers, of service users aged 18-64 with mental health problems, receive a carer-specific service compared to 28% of carers in general.

### **What are the issues around prisoner mental health?**

- the 2003 mental health needs assessment for Shepton Mallet prison identified high levels of mental disorders amongst the prison population. This is being updated in 2011
- there is scope to look further at the mental health needs of ex-offenders as they leave prison, as little is known about this area

9.73 In Somerset in 2003, a MHNA was carried out in Shepton Mallet prison, using the Psychiatric Diagnostic Screening questionnaire, which was adapted for use in the prison. A total of 159 out of 180 prisoners replied.

9.74 The findings of the assessment were:

- 62% of prisoners produced a score which indicated the presence of one or more possible mental disorders
- 58% indicated neurotic disorders, 35% indicated PTSD, 9% indicated suicidal intent and 11% indicated psychosis
- 48% suggested a history of alcohol dependence and 35% drug dependence, prior to imprisonment

### **What is known about mental health in relation to the perinatal and postnatal period?**

- national evidence suggests up to one in seven women will suffer a depressive illness either pre-or-post-natal. In Somerset there were 5,654 live births in 2009
- there are known risk factors for perinatal and postnatal depression
- a survey in Somerset found health visitors were generally good at identifying mental health issues and referring onwards appropriately, but there is still scope for improvement
- there is a gap in data at primary care level
- little is known about the impact of domestic violence on mental health at the perinatal and postnatal period in Somerset
- the *Maternal Mental Health Strategy* needs to be rewritten, taking into account the intention of a further 4,200 health visitor posts pledged by national Government to have a stronger focus on maternal and infant mental health

- 9.75 For every 1,000 live births, 100-150 women will suffer a depressive illness and one or two women will go on to develop a puerperal psychosis (O'Hara and Swain, 1996). Perinatal depression affects around 15% of women who give birth to live babies in the UK. Failure to treat either disorder may result in a prolonged and significantly adverse effect on the relationship between the mother and other family members and on the child's psychological, social and educational development (Grace et al 2003). It is also associated with increased risk of serious mental illness and increased risk of suicide in the perinatal period. Indeed, 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<sup>14</sup>.
- 9.76 Women at higher risk include those who:
- have had a previous history of depression (especially postnatal depression)
  - had psychological problems during pregnancy
  - lack social support or someone to confide in
  - have marital problems
  - have had a recent negative life event (for example, bereavement)
  - lost their own mother when young
  - are ambivalent about the pregnancy
- 9.77 Each year an average of three women are cared for in specialist Mother and Baby Units (MBU). There have been cases where there is a clear need to provide this type of treatment but places are not available close to home or at all. This has been recognised in the south west and there are plans to form a new MBU in the Cornwall area which will relieve pressure on the units closest to Somerset. In the past some women have had to be separated from their babies, families and friends and home location in order to meet their personal need. It is well documented that this early detachment between mother and child disrupts or can completely destroy the normal bonding process and causes generational mental health issues.
- 9.78 During 2010, both acute hospitals in Somerset conducted an audit of midwife notes. Yeovil District Hospital NHS Foundation Trust results indicated that 87% of women had a mental health assessment (including the Whooley questions<sup>15</sup>) undertaken at some time during their care. The audit at Taunton and Somerset NHS Foundation Trust indicated that 96% of their sample had been asked the Whooley questions during their care.

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<sup>14</sup> National Perinatal Mental Health Project Report

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_124880.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124880.pdf)

<sup>15</sup> (1) During the past month, have you often been bothered by feeling down, hopeless or depressed? (2) During the past month, have you often been bothered by having little interest or pleasure in doing things? A third question should be considered if the woman answers "yes" to either of the above. (3) Do you feel you need or want help with this? (National Institute for Clinical Excellence, Antenatal and postnatal mental health: clinical guideline CG54. London: HMSO, 2007)



- 9.79 These are encouraging results; however, both organisations felt there were other areas of work which would benefit the expectant mothers and have developed action plans to take these forward. 75% of mothers in the sample were asked the Whooley questions at the first contact with a health visitor. The review suggested that health visitors were generally good at identifying mental health issues and referring onwards appropriately; however, as with the midwife units they also felt there had to be improvement. This area will be covered in more depth through the *Maternal Health Strategy* which will follow this needs assessment.
- 9.80 The South West Strategic Health Authority published a *Maternal Mental Health Strategy* on 31 January 2011, which directs a number of changes to the way in which services are currently delivered. These need to be implemented via a *Somerset Maternal Mental Health Strategy*.

**What do projected demographic changes mean for mental health service demand?**

- there is variation between districts in terms of projected numbers of people with common mental disorders
- in Somerset there is predicted to be a 63% increase in the over 65 population between 2010 and 2030. This will have a significant impact on the demand for services for older people, particularly at primary care level
- it is estimated that demand for dementia services will increase by 9% over the next 10 years in Somerset

- 9.81 There are two national systems which predict demand based on population projections and prevalence from the *National Adult Psychiatric Morbidity Survey*. One is for 18-64 year olds and for Somerset shows:
- the number of people with common mental health disorders is projected to remain fairly constant across Somerset over the next 20 years
  - this disguises significant variation between district council areas
  - Mendip and South Somerset are projected to remain fairly constant for common mental disorders, personality disorders and psychotic disorders
  - there are slight increases in Sedgemoor and Taunton Deane, particularly for ASPD (4.3% and 2.3%) projected across the next 20 years

- in West Somerset, the numbers of people with common mental disorders, personality disorders and psychotic disorders are projected to decrease by an average of 9% by 2030. However, the impact of the new Hinkley Point development is unknown, which may impact both Sedgemoor and West Somerset in terms of numbers of construction staff and the impact on local residents over the next 10 years

**Table 3**

Area	Psychiatric Morbidity (lifestyle)				PANSI estimate 18-64 (thousands) 2010	PANSI estimate 18-64 2010 as % of Somerset value
	GHQ12 score 4+	Number of people aged 16-74 in mid 2010	Estimated number 16-74 2010 (thousands)	Estimated number 16-74 2010 as % of Somerset value		
Mendip	19%	78725	14.6	22%	10.4	21%
Sedgemoor	20%	82296	16.1	24%	10.8	22%
South Somerset	17%	115408	19.5	29%	15.0	30%
Taunton Deane	16%	78117	12.3	18%	10.4	21%
West Somerset	16%	25335	4.1	6%	3.1	6%
Somerset	18%	379880	66.6	100%	49.7	100%

- 9.82 Population projections suggest that there may be a reduced demand for adult services in West Somerset over the next 20 years, or that services may need to be maintained at current levels if there is currently a deficit. These figures do not take into account changes in the determinants of mental health such as rising unemployment, increasing rural isolation, environmental change or the ongoing need for services which promote wellbeing and keeping well.
- 9.83 Data is also available specifically for over 65s. In Somerset, there is predicted to be a 63% increase in the over 65 population between 2010 and 2030. For mental health, increases in different conditions are clearly influenced by the predicted increase in population numbers. The projections suggest:
- a 62% increase in depression amongst over 65s in Somerset from 9,807 to 15,913 compared to 54% in the south west. The highest increase is in Mendip
  - all areas showed the greatest percentage increase in over 85s, although the highest actual numbers are in the 65-69 age group
  - for severe depression, the predicted increase is higher at 69% in Somerset, although it affects a small proportion of the population (3,129 in 2010, forecast to increase to 4,691 in 2030). This compares to a 60% increase in the south west and a 55% increase across England

9.84 Modelling has been completed for dementia services around numbers requiring specialist treatment, although this has some caveats. It is estimated that overall demand will increase from 9,315 per year at present to 10,144 a year in 10 years time (an increase of 9%).

**Is there a clear relationship between alcohol and drug use and prevalence of mental health issues or service use?**

- there is evidence that people with drug and alcohol problems may have mental health issues and also that people with mental health issues may abuse alcohol and drugs
- there is also concern that a dual diagnosis may prohibit access to services, particularly community services such as IAPT
- admission to hospital for substance misuse is often related to mental and behavioural disorders related to alcohol
- dual diagnosis protocol for substance misuse and mental health service needs redefining

9.85 The *Adult Psychiatric Morbidity Survey* measures both hazardous and harmful drinking (using the Alcohol Use Disorders Identification Test) and alcohol dependence (using the Severity of Alcohol Dependence questionnaire). Nationally, 24% of adults engaged in hazardous drinking, with 3.8% drinking to a level which would be considered harmful. Alcohol dependency was 5.9%, peaking for men aged 25-34 and in women aged between 16-24. 14% of alcohol-dependent adults were receiving treatment for a mental or emotional problem.

9.86 The prevalence of drug use in the last year was 9.2%, with the highest levels amongst young people aged 16-24 and those living in low income households. Drug dependency was 3.4%, with 2.5% dependent on cannabis. 14% of those dependent on cannabis only and 36% dependent on other drugs were receiving treatment for mental health problems. In the south west, the percentage of men using amphetamines was higher than in any other region and the percentage of females using ecstasy was over double the national average, although the actual numbers are small.

9.87 From the *Somerset Adult Alcohol Needs Assessment 2009*, the total number of admissions to hospital where substance misuse was a main or subsidiary reason for admission was 15,692 over the period April 2002 to March 2008. Of these, 2,315 had substance abuse as the main reason for admission. Within this group, the most common reason for admission over the whole period was mental and behavioural disorders due to use of alcohol, which accounted for 39% or 903 people. In 2010, 67 under 18s were admitted to hospital as emergency psychiatric inpatients with a substance misuse-related diagnosis.

9.88 Drug and alcohol services are provided by Turning Point. At July 2009, 313 people were being treated for alcohol abuse and the most common age group was between 30-44. Based on figures in the *National Alcohol Strategy*, the total estimated dependent-drinker population within Somerset is 12,426 people (9,546 males and 2,880 females). The *Adult Alcohol Needs Assessment 2009* found:

- Sedgemoor is significantly under-represented in the Turning Point client population, with only 12.5% of alcohol clients living in Sedgemoor, compared with 21.5% of the general Somerset 16-plus population
- Taunton Deane seems to have the greatest “need” where alcohol is the only or main substance, whereas Mendip and South Somerset have the greatest “need” when clients misuse both alcohol and drugs
- South Somerset has the greatest over-representation compared to other districts, particularly where alcohol is a secondary substance

9.89 The IAPT service mainly uses cognitive behavioural therapy (CBT). As with most therapies, CBT relies heavily on the individual being able to actively participate in their therapy; this is often not possible if the individual is under the influence of drugs or alcohol, or on prescribed drugs which dull emotions.

**What is known about the link between mental health and employment status?**

- evidence suggests only one in five people using secondary mental health services were known to be employed in 2009/10
- there is little local evidence on the impact common mental disorders may have on employment in Somerset
- the public sector is the main employer in the south west but there are proposals for some local authorities to cut jobs by up to 30%
- mental health is a significant issue in the south west for sickness absence

9.90 Stress, depression and anxiety are estimated to be the cause of more working days lost than any other work-related illness, estimated to affect one in six British workers each year. With the economic downturn, there is evidence of increased levels of sickness absence, particularly mental health and stress issues as a result of job insecurity. People are also more likely to engage in unhealthy behaviours if they are stressed at work. There is also an economic cost of working-age ill health, estimated by the Black

Report<sup>16</sup> to cost the country £100 billion a year. NOMIS<sup>17</sup> shows that of people aged 16-64 in Somerset known to have “depression, learning problems, mental problems and nervous disorders” in 2010/11, 28% were employed, 15% unemployed and 57% economically inactive.

9.91 Table 4 gives the employment status for people receiving services compared to neighbouring providers (“other” includes education and training) based on data in the MHMD. Despite a large proportion of people with no data recorded, the figures highlight the small proportion of people in employment. Based on figures from the National Indicator Set for social care and mental health, 9.5% of adults with mental health problems aged 18-69 in contact with secondary mental health services were known to be in paid employment at the time of their assessment or latest review. In Somerset employment figures for secondary care clients over the second quarter of 2011/2012 was 14%.

9.92 Employment is a key part of the *National Mental Health Strategy* in achieving recovery and enhancing quality of life for people with mental illness. This includes a “New Responsibility Deal” with industry, non-governmental and other organisations looking at ways that people can remain in, and return to, work following illness. Somerset Partnership NHS Foundation Trust record that 23% of their clients are “employed” (April 2010 figures).

**Table 4**

Mental Health Provider	% Employed	% Unemployed	% Other	% Default	% No data
Somerset Partnership NHS Foundation Trust	8.6	43.1	3.7	4.1	40.5
Dorset Healthcare University NHS Foundation Trust	10.7	44.9	27.7	13.0	3.7
Devon Partnership NHS Trust	9.6	54.8	12.6	2.5	20.5
Avon & Wiltshire Mental Health Partnership NHS Trust	10.4	42.4	21.4	-	26.0

9.93 The Somerset Partnership NHS Foundation Trust Employment Support Service has “Centre of Excellence” status. The team supports service users to access open employment on a full or part-time basis in the local job market. The service has adopted the Individual Placement and Support model, the key principles of which are:

- a clear focus on competitive employment
- active job search

<sup>16</sup> “Working for a Healthier Tomorrow”, Dame Carol Black, DH 2008

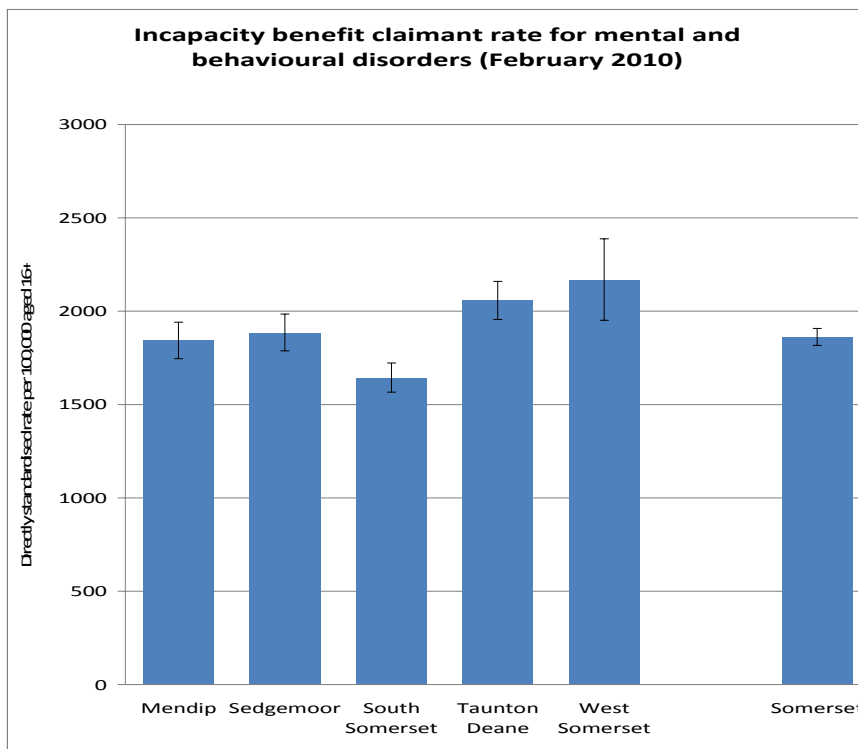
<sup>17</sup> <http://www.nomisweb.co.uk/>

- integration with mental health care (countywide Community Mental Health Teams)
- responsiveness to user preferences
- continuous and comprehensive assessment
- time-limited support

9.94 The service works closely with partner organisations, such as JobCentre Plus, Westcountry Training and Consultancy Services, Adult Learning and Leisure and employers in the county, to actively promote the interests of service users who have experienced mental health difficulties and who wish to work.

9.95 There are different sources of data for young people who are not in education, employment or training (NEET). Quarterly statistics are produced by the Department for Education, based on information from Connexions. The latest figures for 2009 show that 4.4% of 16-19 year olds in Somerset are NEET. This compares to 5.6% across the south west, ranging from 3.6% in Torbay to 8.2% in Swindon. Figure 6 shows levels of incapacity benefit claimant by area, standardised by working age population.

**Figure 6**



9.96 Data from Community Rightsteps on the employment status of clients referred to them after 1 July 2010 shows that out of 4,847 people, 2,403 (42%) were in full or part-time employment, 858 (18%) were officially unemployed and 1,206 (25%) had no employment status recorded. The remainder were students, retired or a full-time homemaker/carer.

## Are people with Medically Unexplained Symptoms (MUS) in Somerset vulnerable to mental health problems?

- much of the evidence around MUS is at a national level, although applying national rates locally suggests it potentially accounts for over 600,000 prescriptions and 8,000 A&E attendances
- there is a gap in data specifically linking MUS to mental health issues at a local level

9.97 The issues relating to effectively treating people with MUS are complex and need to be carefully considered. However, it is now clear that the cost of inappropriate use of limited health resources is so significant that action needs to be taken to address them.

9.98 People with physical symptoms which are caused by psychological distress present commonly to the NHS. Analysis of 2008/09 figures shows that they account for as many as one in five new consultations in primary care, 7% of all prescriptions, 25% of outpatient care, 8% of inpatient bed days and 5% of A&E attendances. It is estimated that this work costs the NHS £3 billion per year (based on 2008/09 prices)<sup>18</sup>. In Somerset this would equate to 8,675 A&E attendances and 35,423 inpatient bed days, excluding those who do not stay overnight.

**Table 5**

	Somerset 2009/10	Number that may be due to medically unexplained symptoms
1. Primary Care consultations	<i>Practices set up their consultations differently and can choose depending on patient need so no overall consistent figures</i>	
2. Prescription Item (not actual prescriptions - A single prescription with two items on it would therefore be counted as two items on ePACT)	9,027,333	631,913
3. Outpatient appointments	685,793	171,448
4. Inpatient bed days (Counting people who don't stay overnight as spell length = 1 i.e. each "day" is counted even if they don't stay overnight)	580,620	46,450
4. Inpatient bed days (Counting people who don't stay overnight as spell length = 0 i.e. if they don't stay overnight they are not counted)	442,791	35,423
5. A&E attendances	173,504	8,675

<sup>18</sup> Bermingham S, Cohen A, Hague J and Parsonage M (In press) The cost of somatisation among the working-age population in England for the year 2008/09. Mental Health in Family Medicine

9.99 For people of all ages with MUS, contacts with GPs may be at least 50% greater than in the general population and they may also have 33% more secondary care consultations. However, correctly identifying such symptoms remains a challenge and the programme will take a considered approach to this area of work.

9.100 TT services have also been shown to improve outcomes for people with long-term conditions and mental health issues and for those with MUS. Integrating access to TT into the care pathways of those who suffer with these conditions will improve outcomes and potentially secure long-term cost savings by reducing the heavy use of NHS resources by people with these conditions, particularly in an acute inpatient setting.

**Are people with long-term conditions in Somerset vulnerable to mental health problems?**

- people with long-term conditions are three to four times more likely to experience anxiety and depression than the rest of the population
- because of the predicted increases in the numbers of older people in Somerset over the next 20 years, the numbers of those with long-term conditions is also likely to increase substantially
- there is also an issue with people who have SMI and whether their physical health is being adequately addressed

9.101 People with long-term physical health conditions (LTC) such as diabetes, cardiovascular disease (CVD) or chronic obstructive pulmonary disease (COPD) often have co-morbid mental health conditions. They are rarely referred for psychological interventions, despite good evidence that the management of such mental health problems can reduce their need for GP appointments, hospital stays and outpatient procedures. Also, people of all ages who have these conditions are between three and four times more likely to experience depression and anxiety disorders than the rest of the population. Recent estimates suggest, for example, that approximately 430,000 people who have depression alongside their diabetes are receiving sub-optimal care and account for a significant number of GP and outpatient consultations, A&E attendances and bed days.

9.102 Mental health problems are much more common in those with physical illnesses. Compared with the general population, people with diabetes, hypertension and coronary artery disease are twice as likely to suffer from mental health problems and those with COPD, cerebrovascular disease and other chronic conditions are three times more likely. People with two or more LTCs are seven times more likely to have depression.

9.103 Untreated depression leads to worse health outcomes and increased healthcare spending amongst those with LTCs:



- co-morbid depression is associated with a 50-75% increase in health spending amongst diabetes patients
- those with cardiac problems are three times more likely to die of these causes if they also suffer from depression than if they do not
- research has shown that people with heart disease are more likely to suffer from depression and when they do they are at greater risk of more heart disease events

9.104 The number of people over 65 in Somerset with an LTC is predicted to increase by 68% to 81,788 from 2010 to 2030, although this is based on the 2001 Census. The number of people over 85 with an LTC is likely to increase by 100% nationally over the next 20 years and 116% in Somerset. Increases are projected to be highest in Mendip (125%) and South Somerset (120%) and lowest in West Somerset (100%). The impact of this on mental health service between 2010 and 2030 is forecast to be:

- a 62% increase in the number of over 65s predicted to have depression in Somerset
- a 68% increase in Mendip compared to a 54% increase in West Somerset of demand for mental health services
- a 69% increase in the number of over 65s predicted to have severe depression in Somerset
- a doubling of the number of people in Somerset with dementia

9.105 NHS Somerset has recently undertaken a joint clinical audit project to assess access to annual health checks and screening in primary care for people with SMI. There is a well established link between SMI and increased mortality and morbidity from a wide range of physical illnesses including CHD, cancers, diabetes and respiratory problems. In Somerset it was found that:

- a review of physical health occurs in the majority (75%) of people over 18 years of age in Somerset in whom a diagnosis of SMI was last recorded less than eight years ago. However, 18% of cases have no record of any annual health check and a further 7% had no check undertaken within the last 18 months
- patients with SMI have a very high smoking prevalence compared to the general population or people with other LTCs but are much less likely to have been given advice in the last 18 months than other high-risk patients (41% compared to 95%) or at all (45% compared to 99%)
- patients with SMI are less likely to have blood pressure checks, blood glucose or cholesterol checks or have their BMI recorded than the general population

- it is important that health services do not over-focus on mental health issues to the detriment of good physical health for people with SMI
- 9.106 The Bridgwater Bay Health Federation (comprising 11 GP practices) is leading a Somerset pilot in Enhanced Care Co-ordination (ECC), one of the Quality Innovation Productivity Prevention (QIPP) workstreams for LTC. The Bridgwater GP Enhanced Care Hub (ECH) works with any health or social care professional to support delivery and co-ordinate services/communications for patients with LTC.
- 9.107 Key aims of the project are to improve patient outcomes and reduce avoidable emergency hospital admissions. Somerset Partnership NHS Foundation Trust is very supportive of this work and has made mental health staff resources available to the multi-disciplinary ECC team. This, together with the involvement of other partner agencies such as social care and private sector domiciliary care, provides insight into the full picture of a patient's situation, facilitating identification of both reactive and proactive actions which may improve outcomes.
- 9.108 Also co-located with the ECH are the Complex Care Team (CCT): a GP and two experienced nurses (all part-time) who are working in partnership with local care homes to support staff in developing advanced care plans for residents and building confidence about when it is not appropriate or necessary to dial 999. Reducing avoidable admissions for people with dementia is particularly desirable as their condition makes such an event particularly traumatic. A local community enabling service in Bridgwater, which links to ECH, provides low level support to individuals on a variety of issues which may affect their sense of health and wellbeing – for example, isolation or bereavement. Supporting people to use public buses or settle them into an evening class or group are just a couple of simple examples which can significantly improve mental health.

**What is the need and provision for child and adolescent primary care mental health services?**

- both Targeted Mental Health in Schools Programme (TaMHS) and Child and Adolescent Mental Health Services (CAMHS) are well established in Somerset, although funding runs out for TaMHS in 2011/12
- the new *No Health Without Mental Health* strategy recommends IAPT services being available to under 18s
- lack of provision is evident where signs and symptoms are mild to moderate
- frontline staff and parents are anxious about finding support to help and advice when a child or adolescent has needs beyond their experience

- there is no primary care provision for children and adolescents in Somerset; however PCTs are required to provide “Talking Therapies” to those already engaged in secondary care from 2011/12. There is a clear need for primary care mental health services

9.109 The Targeted Mental Health in Schools programme (TaMHS) target work in and close to schools for children and young people at risk and/or experiencing mental health problems. The aims of the programme are to:

- improve mental health outcomes for children and young people through interventions delivered through schools
- test “effective” models of early intervention work within school-based settings, which have a clear impact on improving mental health outcomes for children and young people at risk of and experiencing mental health problems
- integrated effective early intervention models as part of wider local authority and PCT systems of assessment, referral and intervention work within targeted support services and specialist CAMHS
- understand what are the factors promoting the successful implementation of the effective models at a strategic and operational level so that these lessons can be further rolled out
- understand the barriers (structural, cultural, financial and professional) to the successful implementation of effective models of work in schools at strategic and operational levels

9.110 In Somerset, TaMHS is well embedded and shows some real progress with specific individuals.

9.111 In 2007, a needs assessment for Tier 3 and 4 CAMHS services in Somerset took place. This found that:

- one in 95 children and young people receive specialist mental health services
- demand for Tier 2, 3 and 4 services was estimated to be 11,300 per year with estimates of 4,500 children and young people not receiving the specialist CAMHS interventions they need. One in 10 children and young people aged five to 15 (11,347) are estimated to have a diagnosable mental health disorder which would benefit from specialist mental health services
- referrals to CAMHS was mainly via GPs and health visitors

- there was a need for an equity audit as some evidence suggested a geographical bias in people accessing some services

9.112 In 2010, Young Voices carried out a consultation event with young people about CAMHS services and this included their experiences of mental health services and wellbeing. This found that:

- young people, in general, wanted to have early intervention preventative services available to them at schools, colleges, GP surgeries and where they were readily available, they were really valued
- teachers, college lecturers and other workers had a role to play in terms of the positive promotion of mental health and emotional wellbeing, as well as the level of universal CAMHS. Services should challenge stigma and be available in schools, colleges, GP surgeries and other places where children and young people go
- services should be young-person centred, where people listen to their comments and concerns and are responsive to their needs (for instance, services are prepared to change)

9.113 The DH are aware of the need for primary care mental health services for children and adolescents across the country; currently, services are provided for those who meet secondary care criteria through the NHS. Some services are provided by the county council via schools and private therapy is also available. As of 2011/12, PCTs will be required to provide TT services for this age group if they meet the secondary care mental health criteria.

#### **What is the evidence on people with personality disorders in Somerset?**

- 1,391 people were predicted to have a borderline personality disorder and 1,065 an Anti-Social Personality Disorder (ASPD) in Somerset in 2010, applying rates from the *Adult Morbidity Survey*
- there were over 500 actual hospital admissions for specific personality disorders in Somerset between 2005 and 2009. 21% were female, between the ages of 25 and 34 and the highest numbers came from the Taunton Deane area

9.114 Personality disorders are long-standing, ingrained distortions of personality which interfere with the ability to make and sustain relationships. ASPD and Borderline Personality Disorder (BPD) are two types with particular public and mental health policy relevance.

9.115 ASPD is characterised by disregard for, and violation of, the rights of others and accounts for a disproportionately large proportion of crime and violence

committed. Nationally, it was present in 0.3% of adults aged 18 or over (0.6% of men and 0.1% of women). BPD is characterised by high levels of personal and emotional instability associated with significant impairment. The overall prevalence of BPD was 0.4% of adults aged 16 or over (0.3% of men, 0.6% of women).

9.116 National data suggests 3.4% of 16-19 year olds have a personality disorder.

9.117 Data is available on projections for numbers of people with personality disorders in Somerset for 2010, based on predicted population and the proportions in the *2007 Adult Morbidity Survey*. For Somerset in 2010:

- 1,391 people were predicted to have BPD and 1,065 ASPD
- this ranges from 88 in West Somerset to 419 in South Somerset for BPD and 66 to 324 for ASPD

9.118 Hospital admissions data shows:

- there were 525 admissions to hospital between 2005 and 2009 for specific personality disorders (F60)
- 281 (54%) were for emotionally unstable personality disorders (“tendency to act impulsively and without consideration of the consequences”) and 106 for unspecified personality disorders
- 234 out of 525 admissions were from Taunton Deane and 22 from West Somerset. Despite forecasts of numbers of people with personality disorder in general being highest for South Somerset, actual numbers are much lower than from Taunton Deane residents
- crisis admission by a duty doctor is more common than emergency or planned admission
- 60% are admitted from home and a further 23% from a general NHS hospital
- 21% were female, aged 25-34; however, for Taunton Deane the highest admissions came from males aged 35-44

## What are the challenges for those with severe mental health disorders alongside depression or anxiety disorders?

- more information is needed on this at a local level
- according to prevalence data, Somerset is not meeting the mental health demand
- 9% of the total NHS Somerset mental health budget is spent on 15 people with very high needs
- Somerset Partnership NHS Foundation Trust currently provides a well regarded psychological therapy service and staff training programme for secondary care patients

- 9.119 Mental health conditions affect one in six people in the population at any one time; with 420,000 in Somerset's adult population, 70,000 will have a mental health condition. Somerset Partnership NHS Foundation Trust are on average providing services for 2,600 people at any one time; these are low demand, high cost services. Somerset has approximately 15 people in secure services every year; these are very low demand, very high cost services.
- 9.120 The Rightsteps Service sees approximately 6,500 people per year who have mild to moderate mental health conditions; this is a high demand with a relatively low individual cost service.
- 9.121 This means the unmet need that is not provided for by the NHS in Somerset is approximately 60,000 people at any one time. To put this in context, people in this group are likely to have low to moderate mental health conditions. Some may not wish to seek help, some will require socialisation and community help that will not be labelled as "mental health care", some will be seeking help from private sources or from one of the numerous charitable organisations in Somerset. Some will be waiting to see Community Rightsteps and some will be cared for solely by their GP and some will have unmet need.
- 9.122 The divide in treatment costs and the demand for the services means that 9% of the total NHS Somerset mental health budget is spent on 15 people with very high needs.
- 9.123 The *Commissioning Talking Therapies for 2011/12* paper explains that TT should be provided for those with severe and enduring mental health illness within the next three years. In this context, south west commissioners understand this to include those with personality disorder, bipolar disorder and psychosis. Somerset Partnership NHS Foundation Trust currently provides a psychological therapy service and staff training programme to cover this area which is well regarded and is likely to be used as a model for other PCTs.

9.124 For people with SMI, National Institute for Clinical Excellence (NICE) guidelines cite possible net savings of £1,000 per person with schizophrenia treated with CBT, based on the first 18 months after initial treatment. This analysis only includes direct service costs and does not consider further savings to health and social care, to welfare through increased productivity and to criminal justice through reduced offending.

## 10 WHAT ARE CURRENT SERVICES?

- Somerset Partnership NHS Foundation Trust is the main provider of secondary care services for people of all ages who have acute and enduring mental health needs
- In August 2011, Somerset Partnership Trust acquired Somerset Community Health which delivers the talking therapies service known as Community Rightsteps
- Somerset County Council is a key partner in the delivery of mental health services. Any development of services needs to be conducted in a joint environment. NHS services need to compliment social care services and vice versa in order to create seamless care pathways
- Voluntary sector provision is typically provided by small organisations with budgets of under £50,000. 62% cover the whole of Somerset. 67% of organisations' funds come from statutory agencies such as the county council, NHS and district councils.
- Complaints and issues raised through NHS Somerset PALS and staff surveys indicate that some GPs and clients have had problems accessing appropriate mental health services in Somerset.

10.1 Given the nature of mental health, services which might be of assistance are far ranging, covering mental specialist services through to local volunteering opportunities, information and advice centres, adult learning and sporting clubs. It remains a challenge to capture all the possible services that people may find helpful when addressing mental health issues.

### **Statutory services**

10.2 Somerset Partnership NHS Foundation Trust provides secondary care services for people of all ages who have acute and enduring mental health needs. This includes secondary inpatient services, male low secure inpatient services and community-based services: these services require working in partnership with other statutory services and the voluntary sector. The lead responsibility for the support of people with LD rests with the local authority, but Somerset Partnership NHS Foundation Trust provides some specialist healthcare for this group. This includes:

- psychiatry
- speech and language therapy
- physiotherapy
- psychology
- occupational therapy
- specialist community LD nursing

10.3 These services are provided in community settings, including family homes and social services day and residential facilities.

**Table 6**

Type and location of in-patient beds

Location	Name	Service type	Beds
Taunton	Rydon Ward	Adult Acute	22 *
	Holford Ward	PICU/low secure	11
	Pyrland Ward	Older adult acute	36
Bridgwater	Broadway Park Young People's Unit	Tier 4 CAMHS (challenging behaviour/also some eating disorders)	12 (6 contracted to other commissioners)
	Ash Ward	Male Low Secure	12
	Willow Ward	Mixed Sex rehab	10
Yeovil	Rowan Ward	Adult acute	22
	Magnolia Ward	Older adult acute	22
Wells	Cedar Ward	Older adult	12
	Beech Ward	Adult Acute	12
TOTAL			185

10.4 There are a variety of community-based services which aim to keep patients in the home or residential setting and only intervene when necessary or help to plan admissions if they are needed. Avoiding emergency admissions reduces the cost of the services significantly. The following community-based services are also provided:

- rapid intervention team
- health action planning team
- clinical psychology and psychological therapies service
- psychological therapy service
- crisis resolution and home treatment teams
- eating disorders team
- assertive outreach team
- forensic team
- placement support team
- Aspergers Syndrome team
- psychiatric liaison team
- employment support service
- Somerset team for early psychosis (STEP)



- 10.5 STEP is a specialist service designated for young adults (14-35) experiencing, or at high risk of developing, their first episode of psychosis. The aim of the service is to reduce the duration of untreated psychosis, minimise the risk of relapse and improve the prospect of recovery. A recent external review commissioned by NHS Somerset of the acute mental health pathway in Somerset revealed that the care provided by Somerset Partnership NHS Foundation Trust is good, with some areas being exceptional. However, a recent report also pointed to some team cohesion issues in some wards, which could lead to a poorer quality of care for patients.
- 10.6 Somerset Community Health have been providing IAPT, now rebranded as the Talking Therapies Service and Emotional Health and Wellbeing Service, in conjunction with Turning Point, Mind and SREC. The service is aimed at people aged 18 and over and now falls under the responsibilities of Somerset Partnership since Somerset Community Health was acquired over the summer 2011. The service currently specifically caters for people with:
- depression
  - anxiety
  - phobias
  - stress
  - relationship problems
  - difficult life events
  - self-image and identity issues
  - unresolved bereavement or loss
  - issues of abuse
  - coping with traumatic events
  - obsessive compulsive disorder
- 10.7 The national IAPT model requires commissioners to expand the service to cater for young people and those with MUS, LTCs, people in prison, service personnel and veterans. In addition, it will require employment support coordinators, provision for “dual diagnosis” clients and more detailed work with women and their families in the perinatal and postnatal periods. The service struggles to meet demand and has a long waiting list, which causes anguish to those on the list. The service is divided into four areas, which operate slightly differently with different waiting times in each area: this is not an equitable service. The service has been reviewed and systems are in place to address the issues.
- 10.8 Somerset County Council commissions Somerset Partnership Trust to:
- 10.8.1 Deliver services which help people back to, or maintain people, in work when they have a need for secondary mental health services.
- 10.8.2 Deliver Support Time Recovery Workers and the social care component of the multi-agency Community Teams.

## Voluntary Services

10.9 There are a wide range of voluntary services involved in mental health in Somerset.

10.10 In March 2011, the Public Health Directorate at NHS Somerset carried out a survey to identify and profile the main voluntary and third sector organisations whose focus is to promote mental health and/or address mental illness. The survey found that:

- over 40 voluntary and third sector organisations filled in the service profile
- combining face to face and telephone contacts, approximately 22,350 unique client contacts (10,000 face to face and 12,250 telephone) were recorded over 12 months across 34 organisations
- the three most common services provided were advice and information, helplines and signposting services and counselling and support services
- the average number of different services offered by one organisation was five
- more people (53%) hear about the services through referral than word of mouth (35%) or publicity (10%)
- the most common access criteria set by services was that someone had to have a general emotional, mental health or support need (30%). 30% of services supported service users with specific conditions and 15% supported those who were currently accessing a statutory service
- criteria for accessing services was split between being open to anyone with a general emotional, mental health or support need and set up for specific client groups such as veterans, farmers or conditions such as an eating disorder. 15% required someone to be accessing a statutory agency
- 75% of those who answered the question said that service users do not need a referral to access the service. Of the 25% who said a referral was needed, a third required referral from community mental health teams, suggesting that many of these services which require referral are supporting those service users with severe and enduring mental health problems
- 62% cover the whole of the county of Somerset. South Somerset had a slightly higher number of organisations serving the district than other parts of Somerset

- a third of services operate during office hours (Monday-Friday, 9am-5pm) with 18% additionally offering limited weekend and evening services
- of the 43% who offered time-limited services, the most popular option was six-10 sessions
- 67% had disabled access into their buildings
- engaging with service users was evident, with 86% using service user feedback forms and over 50% maintaining a user forum and service users on working groups. 33% also had service users on their governing body
- organisations were most likely to have seven full-time staff. The most common answer was one full-time member of staff. There was a wide variety of answers from one to 60 full-time staff
- the majority of volunteers (53%) work occasionally, with only 0.13% volunteering full-time
- 30% of the organisations are working to budgets of under £50,000 and two organisations are working with over £3 million. 67% of the organisations' funds come from statutory agencies, such as the local authority, district councils and the NHS

10.11 The picture is quite mixed. Clearly the majority of voluntary and third sector mental health organisations are small and scattered. They are committed but acknowledge they work too much in isolation from each other. It would appear they are more well known to other service providers than to the public at large and are heavily reliant on statutory funding, which is influencing the type and style of services and support being offered. The majority felt they had a positive relationship with the local statutory agencies. Stigma around mental health was voiced and remains a challenge in looking at promoting services and encouraging early intervention.

10.12 Gaps in provision were apparent for known target audiences such as:

- ex-offenders
- parents with young children suffering from mental health problems
- support for adolescents
- support around employment retention
- problems with drug and alcohol below the threshold for specialist services
- community-based support for victims of domestic abuse
- sexual violence and depression in older people

- 10.13 Appendix 2 provides further details of the organisations and their service profiles.
- 10.14 30 of the main voluntary and third sector organisations attended a workshop to explore working together to promote mental health. The workshop identified a number of key priorities to help improve the difference services made for people with mental health problems and sector sustainability. The main priorities were to:
- set up a Mental Health Forum – a forum to represent voluntary and third sector organisations
  - develop a Mental Health Forum website – online directory and current development updates
  - train and elect representatives from the Forum to be on decision-making bodies
  - write a Community Mental Health Development Plan for the Forum to deliver
  - set up a Funding Forum – collaborative bids and shared fundraising to the public
  - focus on building the capacity of the sector. Share facilities, skills and training across organisations – for example, skills bank, room sharing, supervision for managers, common induction training
  - develop common code of practice and common assessment form
  - gain funding to develop the “Hide the Wiring” project – to join up services better for people needing help and support. Stop “signposting” and deliver a better joined-up service
  - joint initiatives for World Mental Health Day

**Table 7**

<b>Answer Options from Survey of Voluntary Sector Organisations</b>	<b>Response Percent</b>	<b>Response Count</b>
Advice and information service	76.3%	29
Advocacy service	23.7%	9
Alcohol and addiction services	10.5%	4
Carer services	21.1%	8
Citizens Advice Bureau	5.3%	2
Counselling and support services	39.5%	15
Domestic abuse and sexual violence support	13.2%	5

<b>Answer Options from Survey of Voluntary Sector Organisations</b>	<b>Response Percent</b>	<b>Response Count</b>
Eating disorders	7.9%	3
Emergency support and counselling	15.8%	6
Fundraising help and advice	10.5%	4
Healthy living and health promotion	31.6%	12
Helplines and signposting services	39.5%	15
Housing, homeless and tenancy support	23.7%	9
Money advice services	21.1%	8
Older people's services	26.3%	10
Training services	28.9%	11
Transport services	5.3%	2
Self-help groups	34.2%	13
Venue hire	18.4%	7
Volunteer centres and volunteer services	21.1%	8
Young person's services	31.6%	12
Other (please specify)		17
	<b><i>answered question</i></b>	<b>38</b>
	<b><i>skipped question</i></b>	<b>6</b>

### **Are services in the right place to meet known need?**

- 10.15 Evidence from local surveys and national reviews indicate that the main issues concerning services being able meet need are not so much about being in the “right place” but that the following issues are considered:
- when a person needs a service is it easy to find and access?
  - improving links between services so that it feels like one continuous service and not haphazard. There is a need to invest and find ways to make it easier for the public and other service providers to refer into the sector at any point and feel confident that the person who has needs will be dealt with in a timely, effective and efficient way
  - investment in affordable transport solutions – acknowledging mental health needs within criteria for use of patient and community transport services
  - a common code of conduct so that services are more personalised and safe
- 10.16 Complaints and issues raised through NHS Somerset Patient Advice and Liaison Service (PALS) indicate that some GPs and clients have had problems accessing mental health services in Somerset. There were two key themes:

- waiting times for the Community Rightsteps IAPT service is too long
- Step 3 to 4 clients are sometimes rejected from primary care services and referred to secondary care and then also rejected from secondary care. These are not inappropriate referrals, more that the interface between the two services is not functioning correctly. It could also indicate that there could be a gap in the commissioning of specialist services which fits in between Step 3 and 4 services

10.17 One way to assess whether services are meeting need is via consultation with the general public (potential service users), current service users and staff. The next stage of the MHNA will be to engage patients, professionals and other stakeholders. Appendix 3 summarises existing relevant information held by NHS Somerset which explores views from patients and staff about mental health services in Somerset. This highlighted:

- community support for people with alcohol, self-harm, personality disorders, autism, long-standing mental health disorders or eating disorders was not always clear, as Rightsteps staff sometimes felt uncomfortable dealing with these cases
- there is a gap in services for young people aged 16-18
- concern over the impact of economic cuts both on individuals (due to job loss or job insecurity) and reduced services to support people

## 11. Concluding remarks

11.1 This document updates the 1996 Mental Health Needs Assessment. It provides a wealth of useful information and highlights a range of further issues that require exploring.

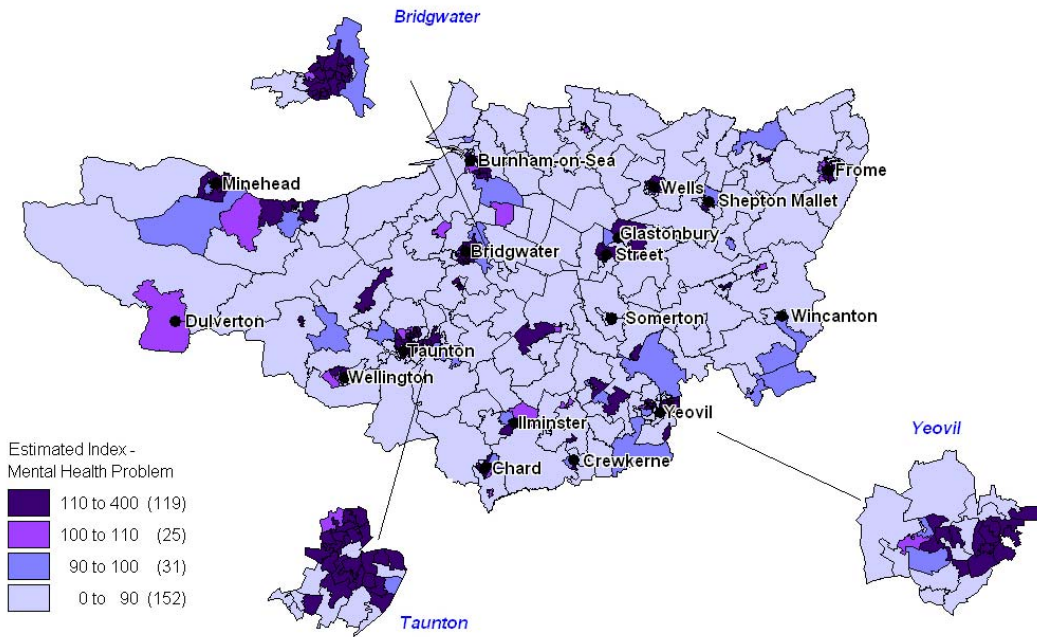
The Executive Summary collects the recommendations made throughout the document along with suggestions for further work.

From the data gathered it is clear that mental health both influences and is influenced by a wide range of factors, many beyond individual control. For example, social deprivation and health inequalities are shown to be factors in influencing mental health. The report also suggests that different population characteristics need to be considered further when trying to develop accessible services. Establishing better ways to monitor wellbeing has emerged together with the fact that there was significant variation between practices for mental health prevalence. The primary care needs of children with mental health problems needs attention as does the growing reality that the number of older people living in Somerset is increasing year on year to a 67% increase in the next 20 years.

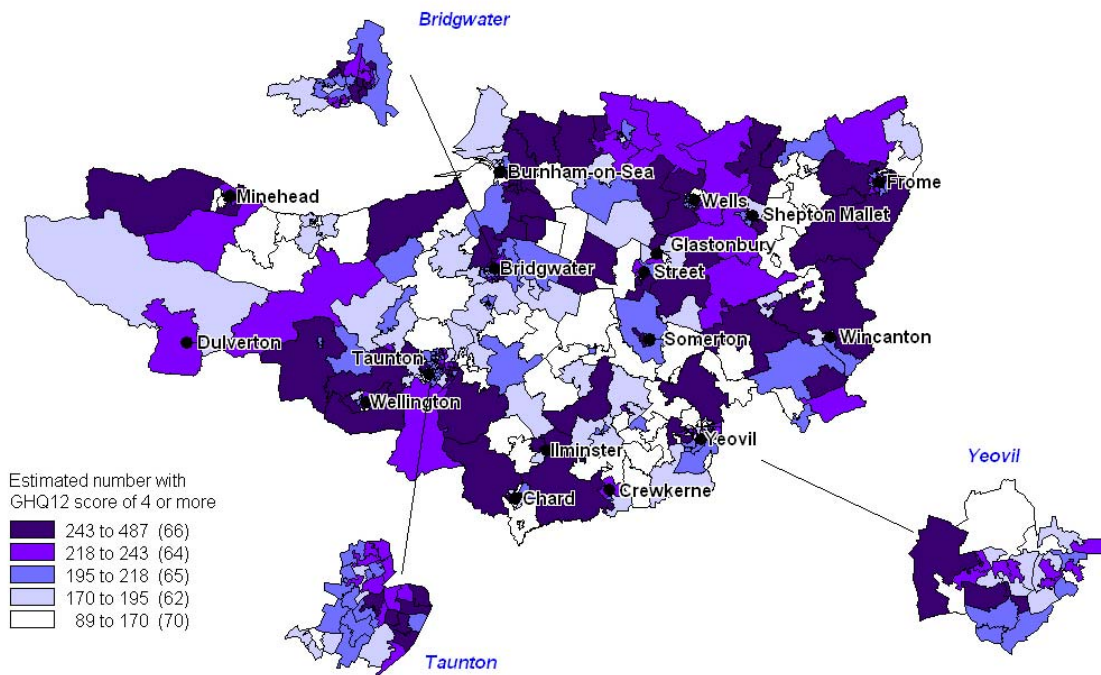
This report shows that mental health problems remain common and demand for services is rising; they place a heavy burden on individuals, families, friends and the community at large. No other health condition matches mental ill health in the combined extent of prevalence, persistence and breadth of impact. It is important for health improvement and health service planning that we understand more about the influences and interventions that will reduce the burden of disease and ensure more people have good mental health.

MAPS

ESTIMATED INDEX FOR PEOPLE AGED 16-74 COMPARED TO SOMERSET AS A WHOLE  
AT LOWER SUPER OUTPUT AREA LEVEL  
100 = SOMERSET AVERAGE

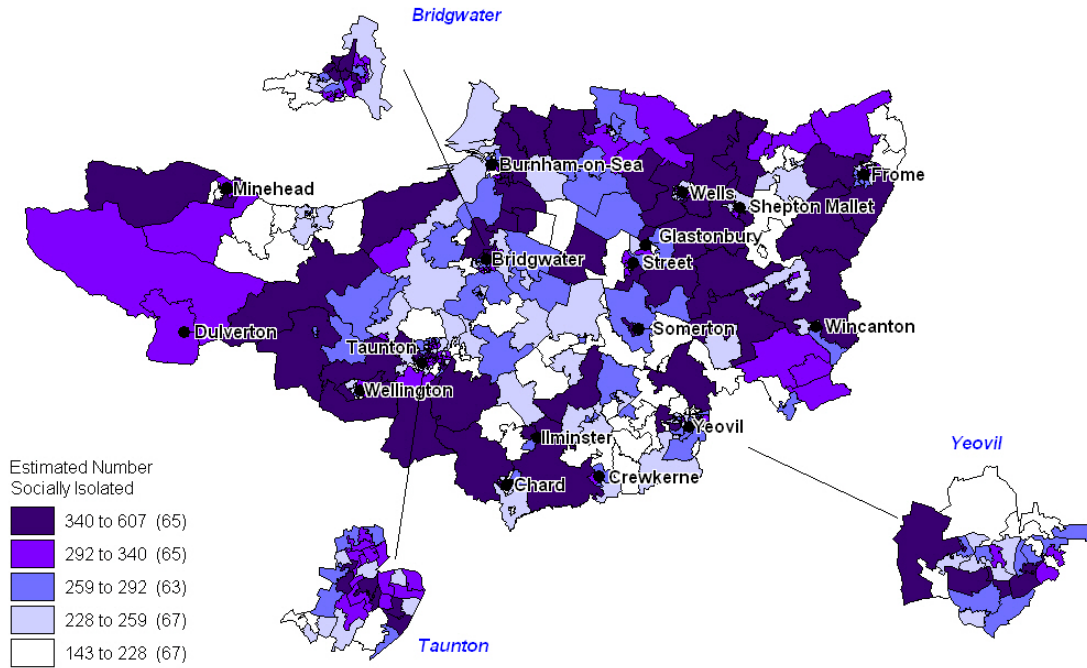


ESTIMATED NUMBER OF PEOPLE AGED 16-74  
AT LOWER SUPER OUTPUT AREA LEVEL

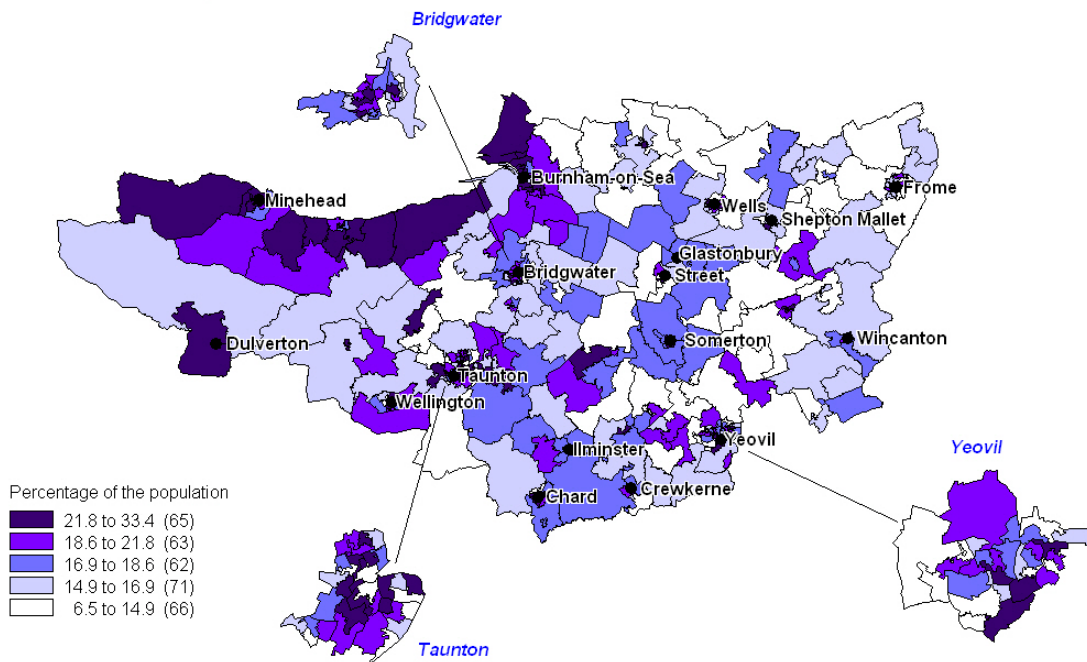




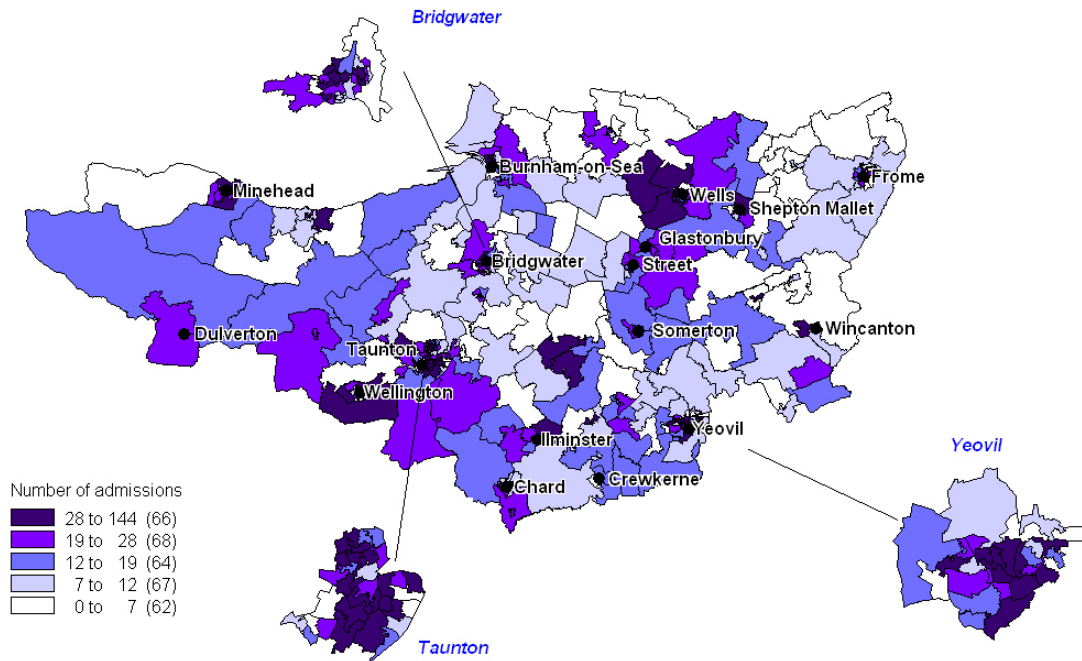
**ESTIMATED NUMBER OF PEOPLE AGED 16-74  
AT LOWER SUPER OUTPUT AREA LEVEL**



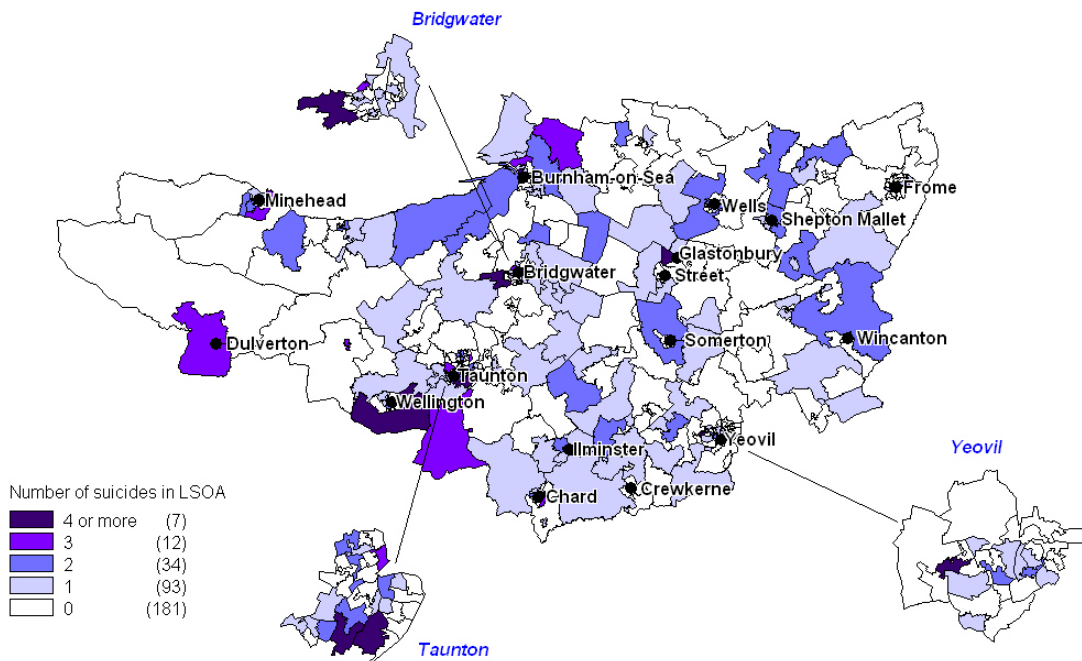
**PERCENTAGE OF THE POPULATION WITH A LIMITING LONG TERM ILLNESS  
BY LOWER SUPER OUTPUT AREA  
NATIONAL CENSUS, 2001**



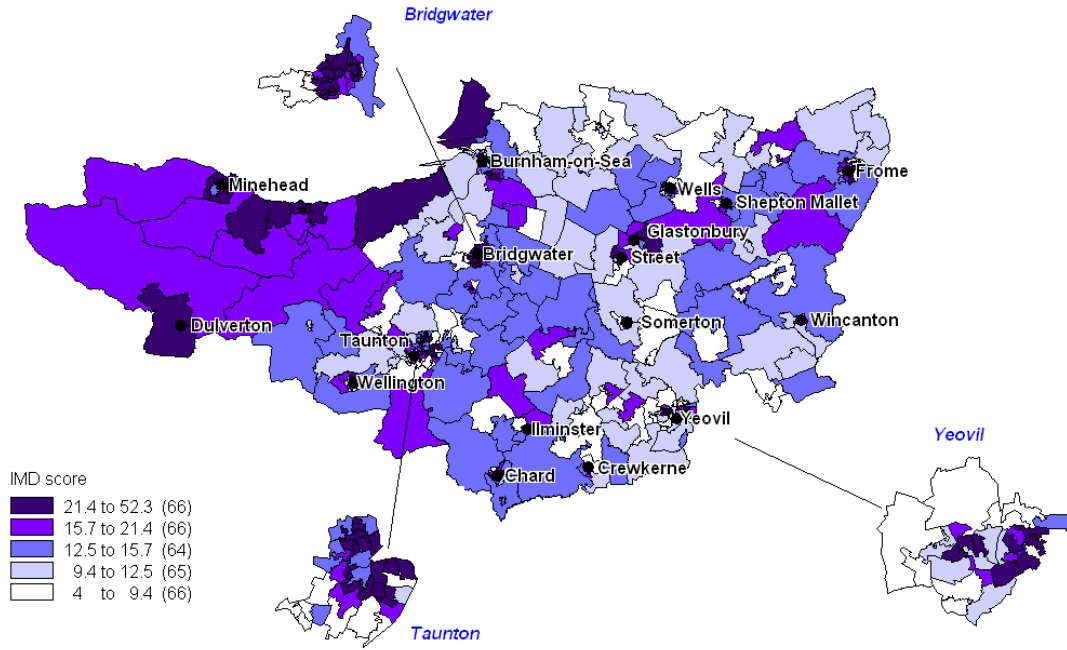
NUMBER OF HOSPITAL ADMISSIONS FOR MENTAL AND BEHAVIOUR DISORDERS (ICD10 = F\*)  
 BETWEEN APRIL 2005 AND MARCH 2010  
 AT LOWER SUPER OUTPUT AREA LEVEL



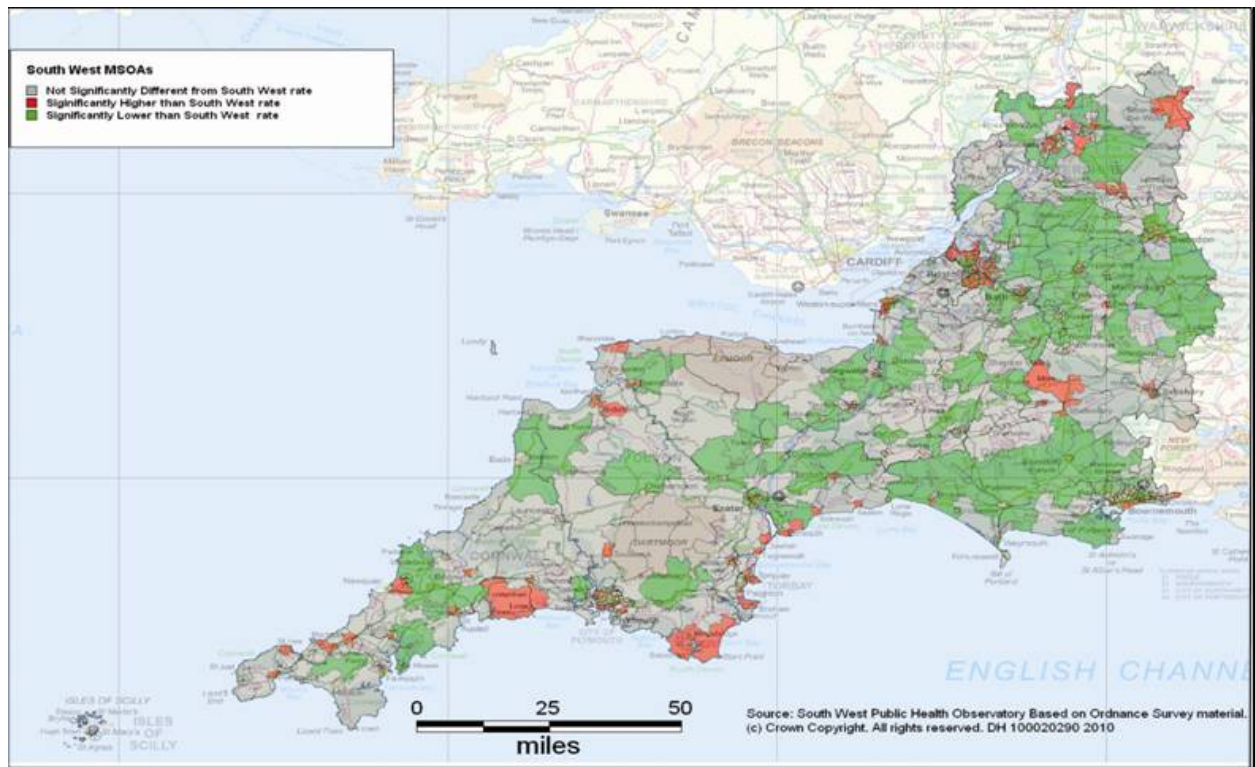
NUMBER OF SUICIDES OR DEATHS FROM INJURIES WITH UNDETERMINED INTENT  
 BY LOWER SUPER OUTPUT AREA  
 APRIL 2005 TO MARCH 2010



INDEX OF MULTIPLE DEPRIVATION  
AT LOWER SUPER OUTPUT AREA LEVEL



Alcohol attributable admissions by Middle Super Output Area



In addition, the Partnership Trust provides crisis intervention and assertive outreach services plus a range of day activities across the county.

**Young people's community teams** in Taunton, Bridgwater, Yeovil and Wells.



**Somerset Partnership**

Adult and Older People's Community Mental Health Teams.

Adult and Older People's Community Mental Health Teams.

**Wyvern Court** – 14 bed specialist rehabilitation unit, plus 4 bed intensive treatment facility.

**Beech Ward** – adult (18-64 inpatient assessment and treatment (12 beds).

**Cedar Ward** – inpatient assessment and treatment for older people (65+) (12 beds).

Adult and Older People's Community Mental Health Teams.

Generic Community Mental Health Team (Minehead).

**Orchard Lodge** – Tier 4 regional specialist inpatient unit for adolescents (12 beds).

**Holford Ward** – psychiatric intensive care unit (10 beds).

**Rydon Ward** – adult (18-64) inpatient assessment and treatment (32 beds).

**Pyrland Ward** – inpatient assessment and treatment for older people (65+) (38 beds).

Adult and Older People's Community Mental Health Teams.

Minehead  
Burnham on Sea  
Bridgwater

Taunton

Yeovil

Chard

**Magnolia Ward** – inpatient assessment and treatment for older people (65+) (24 beds).

**Rowan Ward** – adult inpatient unit providing assessment and treatment (18-64) (26 beds).

Adult and Older People's Community Mental Health Teams.

Adult and Older People's Community Mental Health Teams.

Adult and Older People's Community Mental Health Teams.

Wells  
Frome



## PROPOSED PUBLIC HEALTH INDICATOR OUTCOMES

The new Public Health White Paper includes a list of proposed outcome indicators to measure the success of the public health strategy, but also the development of a healthy and happy society.

Domain 2: tackling the wider determinants of ill-health: tackling factors which affect health and wellbeing proposes 21 indicators, listed below:

**Table 8<sup>19</sup>**

1. Children in poverty
2. School readiness: foundation stage profile attainment for children starting Key Stage 1
3. Housing overcrowding rates
4. Rates of adolescents not in education, employment or training at 16 and 18 years of age
5. Truancy rate
6. First time entrants to the youth justice system
7. Proportion of people with mental illness <i>and or disability</i> in settled accommodation
8. Proportion of people with mental illness <i>and or disability</i> in employment
9. Proportion of people in long-term unemployment
10. Employment of people with long-term conditions
11. Incidents of domestic abuse
12. Statutory homeless households
13. Fuel poverty
14. Access and utilisation of green space
15. Killed and seriously injured casualties on England's roads
16. The percentage of the population affected by environmental, neighbour, and neighbourhood noise
17. Older people's perception of community safety**
18. Rates of violent crime, including sexual violence
19. Reduction in proven reoffending
20. Social connectedness
21. Cycling participation

<sup>19</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_123113.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_123113.pdf)



## ECONOMIC CASE FOR MENTAL HEALTH INTERVENTIONS

The DH has recently published *The Economic Case for Improving Efficiency and Quality in Mental Health*<sup>20</sup>. This highlighted the economic benefits of intervening in the following areas:

### Early identification and intervention as soon as mental health problems emerge:

- parenting interventions are effective for families of children with conduct disorder
- extending early interventions for people with psychosis from 15-35 year olds as at present to the whole population
- early detection of psychosis can prevent later psychotic illness
- screening and brief interventions in primary care for alcohol misuse
- early diagnosis and treatment of depression at work

### The promotion of positive mental health and prevention of mental health problems in childhood and adolescence:

- health visitor interventions to reduce postnatal depression
- prevention of conduct disorder through social and emotional learning programmes
- school-based interventions to prevent violence and reduce bullying

### The promotion of positive mental health and prevention of mental health problems in adults:

- time banks and community navigators
- work-based mental health promotion
- suicide prevention

### Addressing the social determinants and consequences of mental health problems:

- debt advice
- befriending older people
- reducing stigma and discrimination
- targeted employment support for those recovering from mental health problems
- housing support services, including warm housing

In addition, a recent report by the Personal Social Services Research Unit at the London School of Economics and Political Science on *Mental Health Promotion and Mental Illness Prevention: The Economic Case*<sup>21</sup> highlighted total returns on investment (all years) with economic pay-offs per £1 expenditure for a range of interventions.

<sup>20</sup> [http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicatoinspolicyandguidance/DH\\_123739](http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicatoinspolicyandguidance/DH_123739)

<sup>21</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/dh\\_digitalassets/documents/digitalassets/dh\\_126089.pdf](http://www.dh.gov.uk/prod_consum_dh/dh_digitalassets/documents/digitalassets/dh_126089.pdf)





VOLUNTARY SECTOR SERVICES

Name of Organisation	Website?	Newsletter?	Referral needed?	Time-limited services?	Geographical area covered by your service?	Opening times?	Main income source	Services offered	Criteria
2bu Somerset	Yes	No	Yes	No	countywide	group runs Weds eve, individual appts by arrangement	statutory	Advice and information service, self help groups, young person's services	That they are lesbian, gay, bisexual or questioning their sexuality. Although not a transgender group trans young people can also access our support
Age UK Somerset	Yes	Yes	No	No	countywide	office hours	no response	Advice and information service, advocacy, healthy living, helplines and signposting, money advice, older people's services	Anyone in later life - over the age of 50.
Alzheimer's Society	No, but part of a national website	Yes	No	Yes	countywide	office hours	statutory	Advice and information service, carer service, older people services	Services for people affected by dementia.
Barnardo's Mandala Project	No, but part of a national website	No	Yes	No	countywide	office hours	no response	Advice and information service, counselling, domestic abuse and sexual violence, young person's services, bereavement support	Mandala is a specialist therapeutic service supporting any child aged 5-18 who has experienced trauma.

Name of Organisation	Website?	Newsletter?	Referral needed?	Time-limited services?	Geographical area covered by your service?	Opening times?	Main income source	Services offered	Criteria
Chard Intentional Peer Support Group	No	No	Yes	No	South Somerset	various office opening, groups 2 days a week	other	Advice and information, self help groups, sign posting	Recommended by other organisations through our referral system. To join the peer group they need to be an adult with mental health issues and be recommended via the local mental health team. To join our new project W.A.T.CH they would be a vulnerable adult, socially isolated, needing to engage with our group to gain confidence, communication skills etc
Combat Stress	Yes	Yes	No	No	countywide	24 seven	no response	Assessment and treatment of ex-servicemen/women	Must have served for one day in one of the Armed Forces of this country or in the Merchant Navy.
Compass Disability Services	Yes	Yes	No	No	countywide	office hours	statutory	Consultation and engagement services, Independent Living support services, training and venue hire.	Disabled people/all impairments, Carers
Elim Connect Centre	Yes	Yes	No	Yes	Mendip	office hours + limited w/end hours, eves by arrangement	government	Housing, emergency support, postal and C/o address, counselling, venue hire, older and younger people's service, alcohol	We are open to everyone and no-one is turned away. We open 7 days a week

Name of Organisation	Website?	Newsletter?	Referral needed?	Time-limited services?	Geographical area covered by your service?	Opening times?	Main income source	Services offered	Criteria
								support, advocacy, advice and information	
Farm Crisis Network (Somerset)	No, but part of a national website	No	No	No	countywide	Our national Helpline is available from 7am until 11pm every day of the year. I am available on my mobile at any time.	statutory	Advice and information service, counselling and support, emergency support and counselling	They must be farmers or working in the agricultural industry
Flourish Homes - Care & Support	Yes	Yes	No	Yes	Mendip	office hours, Care services - 24 hours	no response	Advice and information service, carer service, counselling, healthy living, signposting, housing, homeless and tenancy support, money advice, older people's services	Need to have an agreed care or support need.
Futures at Knightstone	Yes	Yes	Yes	Yes	South Somerset	office hours +OOH if necessary	statutory	Housing, homeless and tenancy support	We will consider individuals that have Care Coordination from the Community Mental Health Teams that have a med-low support need
Job Centre Plus - Health and Disability advisors	No, but part of a national website	No	No	Yes	countywide	office hours	statutory	Advice and Information	Health and work related issue

Name of Organisation	Website?	Newsletter?	Referral needed?	Time-limited services?	Geographical area covered by your service?	Opening times?	Main income source	Services offered	Criteria
Mind in Sedgemoor	Yes	Yes	Yes	Yes	Sedgemoor	10-2 pm Tue - Sat 6-10 pm Wed & Sat	statutory	User led activity groups Social Enterprise (Food for the Mind) - allotment -> making soup-> soup mornings-> cafe. help & support, emergency care, self help helplines, venue hire, training	They need a care co-ordinator from the Somerset Partnership
Mind in Taunton West Somerset	Yes	Yes	No	Yes	Mendip	office hours, other times by arrangement	no response	help and support, advice, training, self help,	Mostly open access for persons with mental distress seeking help or information.
Mindline Somerset-Part of Mind TWS	Yes	Yes	No	Yes	countywide	Weds, Fri, Sat, Sun 8pm-midnight	no response	Helpline and signposting	The service is open access to anyone in the community, it is targeted at the county of Somerset, but we accept calls from anywhere
Novas Scarman Group	Yes	Yes	Yes	No	countywide	mon to fri 9 to 8pm	statutory	Housing, homeless and tenancy support	Housing support need
RETHINK	No, but part of a national website	Part of a national newsletter	Yes	Yes	countywide	Varies according to service - up to 24/7	legacies	Housing, homeless and tenancy support, self help advice, older and young people's services	People affected by mental illness, dementia and asperser's type conditions.
Samaritans Yeovil Branch	No, but part of a national website	No	No	No	South Somerset	24 seven	other	Helpline and signposting	Anyone in any kind of distress may contact Samaritans

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Shelter Somerset	No, but part of a national website	Part of a national newsletter	No	No	no response	Monday - Friday 0900 - 5.30 through the telephones Monday, Wednesday and Friday 0930 - 1.. Drop in to our office	statutory	housing, homeless ad tenancy support, advocacy, money advice, training	At Shelter Somerset must be eligible under the Legal Help Scheme for Housing, Debt or Welfare Benefit Advice.
Somerset Active Living	yes	yes	no	no	countywide	various, some courses run over seven days, some once a month	government	Social inclusion, physical activities, taster sessions on a range of activities, volunteering opportunities, healthy eating, health checks, falls information/ prevention, informal support networks, meals and support for vulnerable frailer people, LD work placements, intergenerational activity. memory cafe's and singing for the brain groups. Carers Support groups.	We have open access to anyone, although some activities are aimed at people aged 50 plus

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Somerset Advice Network	Yes	Yes	No	No	countywide	no response	statutory	Advice and information service	In need of information and advice
Somerset and Wessex Eating Disorders Association	Yes	No	No	Yes	countywide	office hours	statutory	Eating disorder counselling and support	They have a psychologically based difficulty with their relationship with food
Somerset Area Cruse Bereavement Care	No, but part of a national website	Yes	No	No	countywide	office - 9.30am-2-30pm, client appointments vary	no response	Advice and information service, bereavement services, counselling, training, young person's services	The only criteria is that they have been bereaved by the death of a person.
Somerset Care and Repair	Yes	No		No	countywide	office hours	no response	Core function is as a Home Improvement Agency, helping vulnerable people to stay in their own homes and be secure (home safety, building works, stair lifts, handy person, decorating, gardening, energy advice). Additional services include HomeShare scheme, supported gardening project)	Elderly, disabled, vulnerable.

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Somerset Community Rightsteps	No, but part of a national website	No	Yes	Yes	countywide	Office hours	no response	Advocacy, counselling and support, helplines and signposting	Adults with mild to mental health problems; anxiety and depression
Somerset County Council	Yes	Yes	No	Yes	countywide	Office hours	no response	advocacy, advice and support, older and younger people's services, money advice, emergency, training, carers, healthy living, training, transport, self help, volunteering services	Depends on the service, FACS eligibility for Adult Social Care services
Somerset LINK	Yes	Yes	No	No	countywide	Various	government	Involvement and public interest, advice and information	They must reside in Somerset or use publicly funded health or social services in Somerset.
Somerset Partnership Carers service	Yes	Yes	No	No	countywide	office hours +OOH if necessary	statutory	carers services	The person the carer is caring for is registered with Somerset partnership
Somerset Racial Equality Council	Yes	Yes	No	No	countywide	no response	no response	advice and information, advocacy, helplines and signposting, self help	1. Harassment or discrimination on the ground of race. 2. Difficulty with access to mental health services, particularly if the difficulty is because of your racial background.



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Somerset Skills and Learning	Yes	Yes	No	No	countywide	various, day and evening	other	We are primarily an education provider and therefore our engagement would be through offering learning opportunities for those who are ready to engage in social activity. Often this is through discreet provision to organisations such as MIND. We have also enabled many groups, with a mental well being focus to engage service users in discreet and relevant learning opportunities through NLDC (Neighbourhood Learning with Deprived Communities) funding.	None, our service provides many opportunities for service users to engage with us, through discreet provision, as previously explained, or through one of our many local courses. We often find shorter courses and workshops will suit service users, however this is a personal choice. We offer fee concessions on certain benefits and offer many courses that have a proven beneficial benefit to those suffering mental ill health i.e. Arts and Crafts, relaxation and exercise classes are just a few.

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South Somerset CAB	No, but part of a national website	Part of a national newsletter	No	No	South Somerset	phone: Mon-Fri 10am-4pm, Drop in: Mon -Fri (not Thurs) 10am-4pm	statutory	CAB, money advice, advice and information	We offer our general advice service to all members of the South Somerset community. We also offer: specialist welfare benefit and debt advice to those entitled to legal aid specialist money advice to all members of South Somerset community specialist welfare benefit advice to cancer patients, their carers and relatives, funded by Macmillan.
South Somerset Mind	Yes	No		Yes	Mendip, Sedgemoor, South Som	office hours	trust funds	advice and information, advocacy, self help, training, venue hire, signposting	Anyone experiencing emotional distress is welcome to contact the
South and Wessex Eating Disorders Association	Yes	Not known	Not known	Not known	countywide	Not known	Some via Somerset Partnership	support for anorexia & bulimia nervosa, compulsive eating & binge eating disorder & related eating disorders	Not known
South West Foundation	Yes	No	No	Yes	countywide	office hours	no response	We support small voluntary and community groups in the south west by providing small grants, undertaking research and delivering training,	Small community voluntary organisations

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								and putting on events.	
Stonham	No, but part of a national website	Part of a national newsletter	Yes	Yes	no response	no response	statutory	Advice and information service, housing, homeless and tenancy support	Age 18 to 65 years old. Male & Female Accepted Medium to Low Support needs
Stonham	No, but part of a national website	No	Yes	Yes	no response	no response	no response	Young person's services, housing, homelessness and tenancy support, healthy living, alcohol and addiction services, domestic violence, signposting and helplines	18 to 65 for the project at Richmond Road Clients with mental health and having support with the mental health services in taunton. 16 to 65 for the project at Priory Avenue clients who are single homeless and have been referred from another agency
Taunton & District Citizens Advice Bureau	Yes	Yes	No	No	Taunton Deane	office hours + Wed until 6.30pm Sat 10-12 noon	statutory	Advice and information service, CAB, money advice, training including financial capability training to frontline workers and end users	Free, confidential and impartial to everyone

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Taunton Samaritans	No, but part of a national website	Yes	No	Yes	Sedgemoor, Taunton Deane, West Somerset	9am-9pm daily or 24/7 via phone, email, text	other	Samaritans provides confidential non-judgemental emotional support, 24 hours a day for people who are experiencing feelings of distress or despair, including those which could lead to suicide. We offer our service by telephone, email, letter, SMS and face to face in most of our branches. Samaritans is available to anyone in the UK and Ireland. If you live outside of the UK and Ireland, visit <a href="http://www.befrienders.org">www.befrienders.org</a> to find your nearest helpline.	Our service is available 24 hours a day for any person suffering emotional distress. Callers do not necessarily need to be suicidal
THE ACORN PROJECT	No	No	No	No	countywide	Wed 1pm to 4pm	no response	Advice and information, signposting	

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The Albemarle Centre	Yes	Yes	No	No	Taunton Deane	8.00a.m. until 10.00p.m. Monday to Friday	no response	Our main charitable aims are to provide activities and support to all disadvantaged groups within the community, ranging from social clubs, craft etc activities, music and drama, Day Care, Lunch Club, Supported Housing, Community Access Scheme, access to a counselling service, Childcare	Ages range from 18 - 80, and anyone is welcome at the Albemarle Centre
Turning Point	No, but part of a national website	No	No	Yes	countywide	office hours +one eve until 8pm	statutory	Turning Point has 2 community substance misuse services in Somerset; Turning Point Somerset and Somerset Community Access programme. These services provide a ranges of county-wide services, including; advice & info, signposting, needle exchange, community	Substance Misuse services: 18 years + and Somerset residents with drug and/or alcohol dependence

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								<p>detoxification, counselling, group work, specialist prescribing, Shared Care (in GP surgeries), hospital alcohol liaison, Arrest Referral, BBV services, Carers Assessments, Family support, access to in-patient detoxification &amp; residential rehabilitation. We also offer Aftercare services (employment support, support re volunteering, education and meaningful activities) Turning Point also provides the low intensity staffing for the Rightsteps (IAPT) service across Somerset</p>	

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ViSTA,	Yes	Yes	No	No	countywide	office hours + limited sat hours	statutory	Training, fundraising, venue hire, self help, signposting, We offer community development and partnership development and intergenerational volunteering We offer personal development planning with individuals and development planning with groups.	Open criteria unless otherwise stated due to a funder's specification
Wincanton Community Venture Ltd	Yes	Yes	No	No	South Somerset	8.00am - 9.30pm	statutory	Advice , counselling, venue hire, domestic violence, health living, training, volunteer services, eating disorders	Resident within 10 miles of Wincanton