Mental Health and Wellbeing

Health Needs Assessment

September 2013

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Foreword

This needs assessment has been produced to support the commissioning of mental health and wellbeing services across the cluster of Devon and Torbay and compliments the Plymouth Mental Health Needs Assessment. This needs assessment also considers the wider wellbeing of the population which supports the local authorities' responsibility for public mental health.

Changes brought in to effect from April 2013 through the health and social care act now place the responsibility for local public health with Devon County Council, Torbay Council and Plymouth City Council. The close working relationship with the NHS continues through the provision of public health support and advice to the two clinical commissioning groups covering the area: Northern, Eastern and Western (NEW) Devon Clinical Commissioning Group and South Devon and Torbay Clinical Commissioning Group.

This needs assessment is one of many local health needs assessments that are either completed, planned or underway which consider different aspects of health and wellbeing in Devon. Completed needs assessments are published on the Devon Health and Wellbeing website www.devonhealthandwellbeing.org.uk. The recommendations in this document should be considered alongside other related needs assessments, the Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment, to ensure a full picture of need.

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Executive Summary

Ensuring good mental health within the population throughout the life course is about more than just the absence of mental disorder, and is a major contributor to wellbeing within the population. Our mental health impacts on all aspects of people's lives and it is therefore the responsibility of not only the individual, but also families, friends, employers and the wider community to enable people to develop and importantly maintain good mental health.

The requirement for a needs assessment around mental health and wellbeing was identified as part of the last public health business plan. Mental health and wellbeing were also identified as areas the Devon Shadow Health and Wellbeing Board were keen to include as initial priority areas whilst developing the Joint Health and Wellbeing Strategy. Therefore this needs assessment will feed in to the Joint Strategic Needs Assessment providing baseline information and identifying more detailed areas for consideration to support commissioning by Clinical Commissioning Groups, Local Authorities and support for service providers.

A working group was established to develop and direct the needs assessment and this group has met on a number of occasions and members have signposted the appropriate people to feed in information in the relevant areas. The invited members of this working group covered the following organisations:- Devon Partnership Trust, Devon County Council, North, East and West Devon Clinical Commissioning Group, South Devon and Torbay Commissioning Group, GPs with a lead for mental health, Child and Adolescent Mental Health Services, Devon Access and Referral Team, UBUNTU Counselling service, LINk Devon and Rethink.

Pressures and challenges to good mental health vary throughout the life course and to reflect this, the report looks, where possible, at needs and activity through four stages of children and young people, young adults, adults and older people. Recommendations are made at the end of each section and then summarised at the end.

The children and young people section includes a great deal of estimated prevalence data for a range of conditions but highlights the need for improved local data to assess the variation between estimated and actual prevalence. Further work has been suggested to better understand the variation and patterns shown in attendance and admissions for self-harm across Devon.

Within young adults a recommendation has been made to look in more detail at the way eating disorders are managed across Devon. The data shows that patients are accessing the Haldon Unit for services but there is no care pathway in place to best manage patient needs from diagnosis. Anecdotal evidence from Child and Adolescent Mental Health Services suggests an increase in younger people presenting with eating disorders and so within this recommendation, further work looking at the pathway throughout the life course is needed.

There is variation across the area in the numbers and proportions accessing services in the adult population, and for many services, showing higher levels of need and service use in the South Devon and Torbay areas. It also highlights the overlap

between mental health and homelessness and substance misuse and should be read alongside the needs assessments around both of these topics and are published on the Devon Health and Wellbeing website.

The older peoples section shows the variation shown in estimated levels of depression across the area and where the greatest use of social care services for people with mental health services takes place. This section sits alongside a separate needs assessment that has been completed around dementia and can also be found on the Devon Health and Wellbeing website.

The final section begins to look at service mapping across the area. This is a basic look at commissioned services as due to capacity it proved complicated to identify other services and to make an assessment to the level of service they provide. A recommendation is made to develop this area of work.

Recommendations have been made from the needs assessment to look at data collection and quality around child and adolescence mental health services, to look in more detail at understanding the patterns seen in activity around self-harm, to consider the wider services for eating disorders, to continue and develop service user engagement, to improve access to prescribing data, to review current suicide prevention strategies, to support the implementation of recommendations from the dementia needs assessment and to look in more detail at the mapping of mental health services.

1. Introduction

Ensuring our population experiences good mental health is important for a wide range of reasons. Good mental health is vital to ensuring good physical health. It is also important for ensuring the development and maintenance of family relationships and friendships, our education, training and ability to fulfil our potential in employment. As it impacts on all aspects of people's lives, it is therefore the responsibility of not only the individual, but also families, friends, employers and the wider community to enable people to develop and importantly maintain good mental health.

There are many ways that mental health can be defined. The World Health Organisation defines mental health as:

> 'Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.'[1]

This clearly defines good mental health as a major area of wellbeing. Although mental health has always been an important priority, the way in which it is now being considered is different. Although the prevention and treatment of people with mental

[1] World Health Organisation. *Mental Health: a state of well-being.* http://www.who.int/features/factfiles/mental_health/en/ (Accessed October 16th 2012)

health disorders are still important, it is acknowledged that promoting good mental health and well being is wider than this and includes ensuring all people, not just those with a defined condition are experiencing positive mental health and are therefore able to fulfil their potential in relation to academic achievements, productivity, and helping towards experiencing good physical health.

As with many areas of health, there are clear inequalities between people of different socio-economic groups, genders, ages, ethnicities as to their mental health. People from different groups of society have different abilities to access support and to engage in communities and this makes some people more susceptible to mental health problems. Recognising the impact of both risk and protective factors relating to the circumstances of peoples lives is imperative when designing health improvement interventions.[2] The latest government have committed to ensuring the wellbeing of the whole population. Improving mental and health and wellbeing is associated with a range of better outcomes for all people. These include improved physical health and therefore life-expectancy, better educational achievement, increased skills, reduced risky health behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation.[3] Addressing these areas for the whole population will make large steps to reducing inequalities experienced in mental health and also in preventing more serious mental health conditions developing.

Why undertake a needs assessment around Mental Health?

As previously acknowledged, after focusing heavily on physical health for many years there is growing recognition of the importance and wide ranging impact of mental health. Mental ill health represents up to 23% of the total burden of ill health in the UK and is the largest single cause of disability.[4]

Economic Context

In secondary care, 11% of the annual health budget is spent on mental health.[5] Nationally more than £2 billion is spent annually on social care for people with mental health problems.[5] With increases in the population, and particularly in the older age groups with increasing life expectancy, it is estimated that the cost of treating mental health problems could double over the next 20 years.[6]

The impact of mental health on peoples wider lives can affect their educational attainment, employment, housing, family relationships and therefore there are wider costs of mental health problems than just health related costs. Costs to the individuals, their families and their communities in lost potential are essentially incalculable. However detailed estimates suggest the overall calculable cost of mental health problems in England to be around £105 billion and around £30 billion

[2] NHS Devon. *Annual Public Health Report 2009/10*. 2010
[3] Department of Health. *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. 2011
[4] Who (2008) *The Global Burden of Disease: 2004 update*, available at: www.who.int/healthinfo/global_burden_disease
[5] Department of Health (2009) *Departmental Report 2009: The Health and Personal Social Services Programmes*, available at: www.official-documents.gov.uk/document/cm75/7593/7593.pdf
[6] Mccrone P, dhanasiri s, Patel A et al. (2008) *Paying the Price: The cost of mental health care in England*. london: king's Fund, 220–226.

of this estimate is work related.[7] This is largely due to sickness absence and reduced productivity. There are also large costs associated with the impact on the criminal justice system and also the housing system and particularly the homelessness services. One of the largest areas of cost is the benefit system. The most common reason for incapacity benefit claims is mental health, with 43% of the 2.6 million people on long-term health-related benefits have a mental or behavioural disorder as their primary condition.[8]

Mental health throughout the life-course

Mental health problems can begin very early in life, often earlier than other causes of disability. There are also connections between mental health problems in childhood and in young adulthood, with one in ten children aged between 5 and 16 years having a mental health problem.[9] Over half of people with a lifetime mental health disorder at the age of 26 will have met the diagnostic criteria first by the age of 14.[10] Mental wellbeing during pregnancy and the antenatal period can have an impact on the wellbeing of the child, so is an important time within the life course. One in ten new mothers experience postnatal depression.[11] During adulthood mental health can impact upon people's ability to maintain employment, housing and secure family relationships. Depression in older people affects up to 25% of the population and up to 40% of those living in care homes.[12] At present dementia affects 1 in 5 of people aged over 80 and with an aging population the burden of this will increase.[3] In 2008, The Government Office for Science produced a report based on the project Mental Capital and Wellbeing: Making the most of ourselves in the 21st Century. The report looks at how our population is changing and how this will impact on our wellbeing and mental health. The report includes a comprehensive diagram of a synthetic view of the mental capital trajectory and factors that may act upon it. This diagram is shown in figure 1.1[13]. It is clear that mental health is an issue throughout the life course and in many different areas of people lives.

National Policy and Context

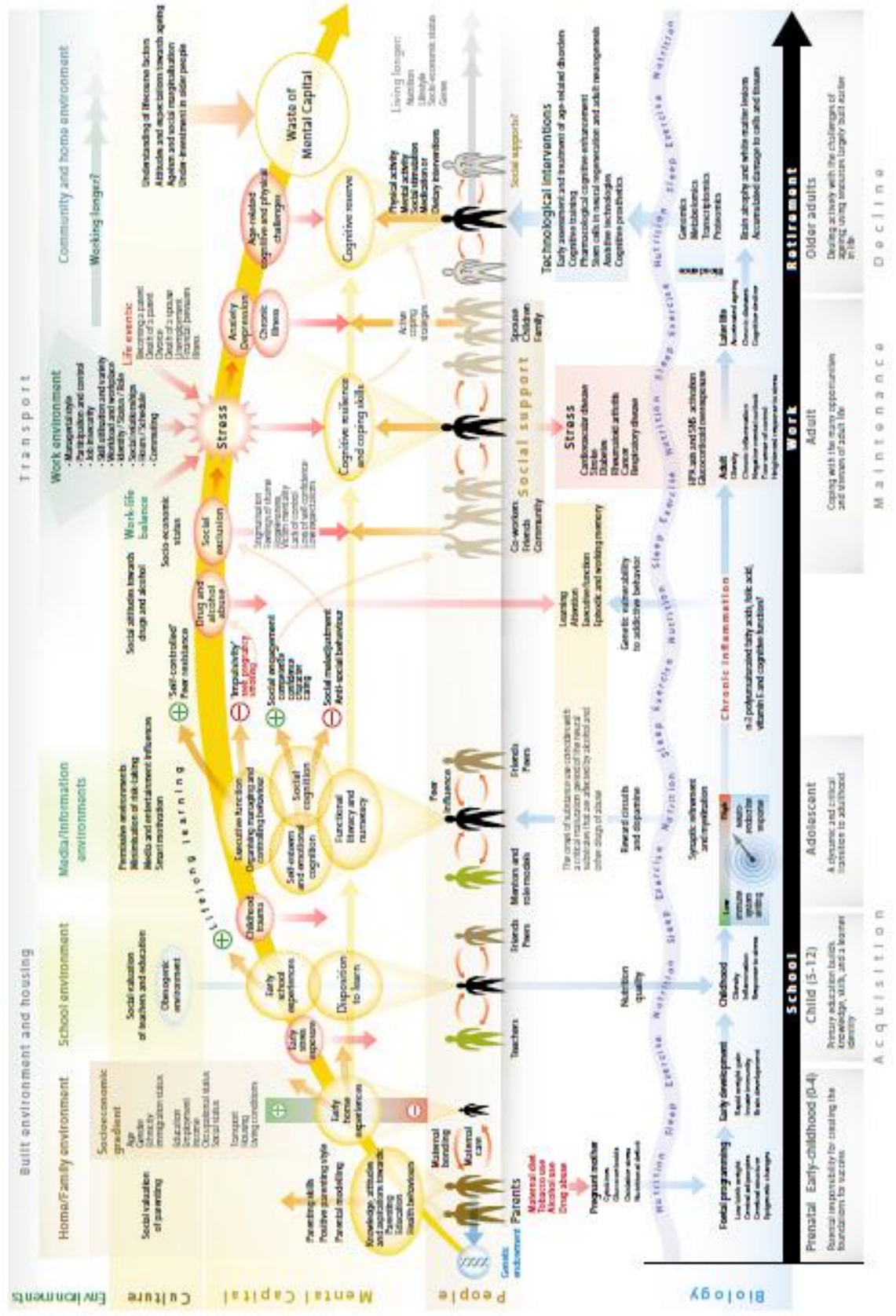
Mental health has been high on the agenda with both the last and current governments. In February 2011 the Department of Health published the national public health strategy 'No Health without Mental Health: A cross government mental health outcomes strategy for people of all ages.' [3] This document identified six outcomes:

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

[7] Centre for Mental Health (2010) *The Economic and Social Costs of Mental Health Problems in 2009/10*, available at: www.centreformentalhealth.org.uk/pdfs/Economic_and_social_ costs_2010.pdf
[8] Department for Work and Pensions (2010) statistical summaries, available at: http://campaigns.dwp.gov.uk/asd/index.php?page=statistical_summaries
[9] Green h, McGinnity A, Meltzer h et al. (2005) *Mental Health of Children and Young People in Great Britain, 2004.* Basingstoke: Palgrave Macmillan.
[10] Kim-Cohen J, Caspi A, Moffitt T , Harrington H, Milne B, Poulton R. *Prior juvenile diagnoses in adults with mental disorder*. Archives of General Psychiatry 2003; 60: 709–717.
[11] Gavin n, Gaynes B, lohr k et al. (2005) *Perinatal depression: a systematic review of prevalence and incidence. Obstetrics and Gynaecology* 106: 1071–1083.
[12] Age Concern. *Improving services and support for older people with mental health problems*. London: Age Concern; 2007.
[13] The Government Office for Science, London (2008) Foresight Mental Capital and Wellbeing Project Final Project report – Executive summary.

3. More people with mental health problems will have good physical health
4. More people will have a good experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

Figure: 1.1 Synthetic view of the mental capital trajectory and factors that may act upon it



Source: Foresight Mental Capital and Wellbeing Project Final Project report

Prior to this publication the Royal College of Physicians identified the importance of public mental health, particularly in the early identification and early intervention at the start of the life-course. It also discusses the uses of universal and targeted approaches to prevention and how these need to be applied to the population. It highlights the importance of dual diagnosis, which is further described in section 5.8, and identifies areas where there are inequalities that need to be addressed. It also emphasises the need for providers to be involved in commissioning of services to ensure need is identified and met, the need for commissioners to consider the effects of mental health and mental illness across the life course and also the wider economic impact of promoting positive mental health and wellbeing.[14]

Local Policy

Mental health promotion and mental health are priorities for a range of organisations locally. Both the Health and Wellbeing Boards in Devon and Torbay recognise the importance of mental health and its impact on quality of life throughout the life course. Consequently the Joint Health and Wellbeing Strategies include mental health, in terms of promoting mental wellbeing and support to people with specific mental health needs, as a priority.

Therefore this needs assessment will contribute to the production of local mental health strategies and inform the priorities set out within Clinical Commissioning Group and Local Authority commissioning plans and integrated health and social care plans.

Methodology and approach

The objective of the Mental Health and Wellbeing Health Needs Assessment is to understand the mental health and wellbeing needs of the Devon population, including high risk groups, and establish whether the content and configuration of existing services meet this demand.

Methodology

To achieve this objective NHS Devon has a short timescale to complete a comprehensive health needs assessment. The figures below set out the principles behind a needs assessment and the stages to be taken as part of a rapid and a comprehensive needs assessment. The main areas which differ are around the establishment of an expert panel and user engagement. An expert panel was assembled with the intention of meeting at the start of the process to establish the direction and baseline of the document and again at draft stage to review and amend before publication. Elements of both rapid and comprehensive needs assessment are being covered.

[14] The Royal College of Psychiatrists. *No Health without Public Mental Health: the case for action.* 2010. http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf (accessed October 16th 2012)

Figure 1.2 Core elements to a needs assessment[15]

The core elements are:

- map need
- examine demand
- map service
- provision
- assess gaps

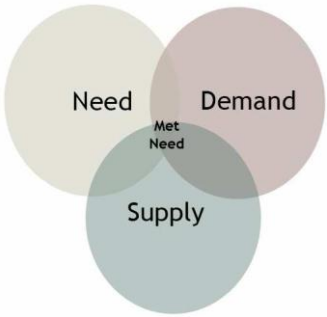
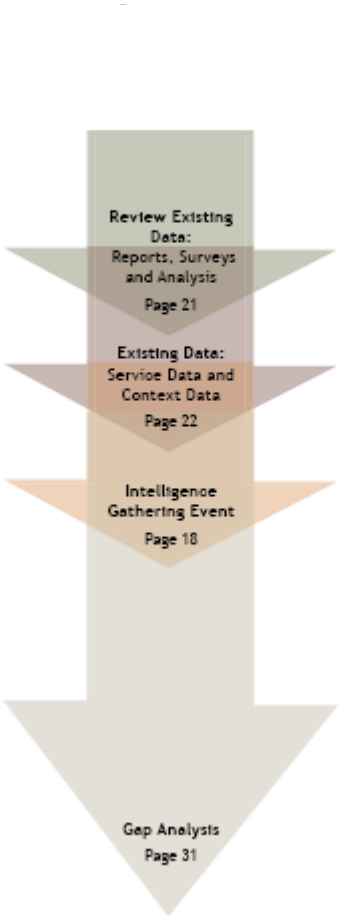
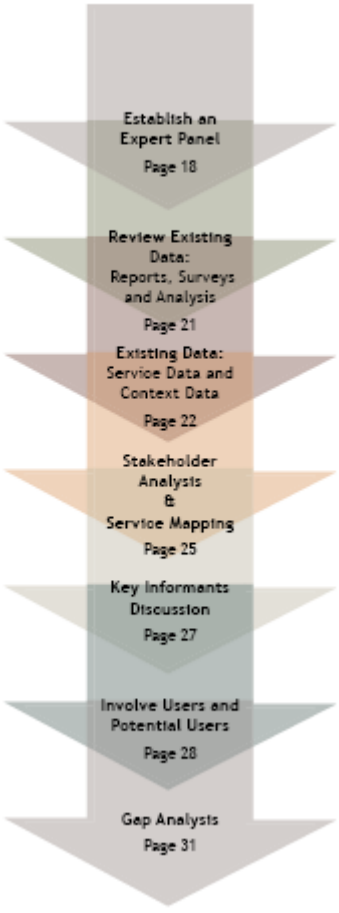


Figure 1.3 Stages in a comprehensive and rapid health needs assessment[14]

Rapid Needs Assessment



Comprehensive Needs Assessment



2. Profile of Happiness, General Wellbeing and Quality of Life

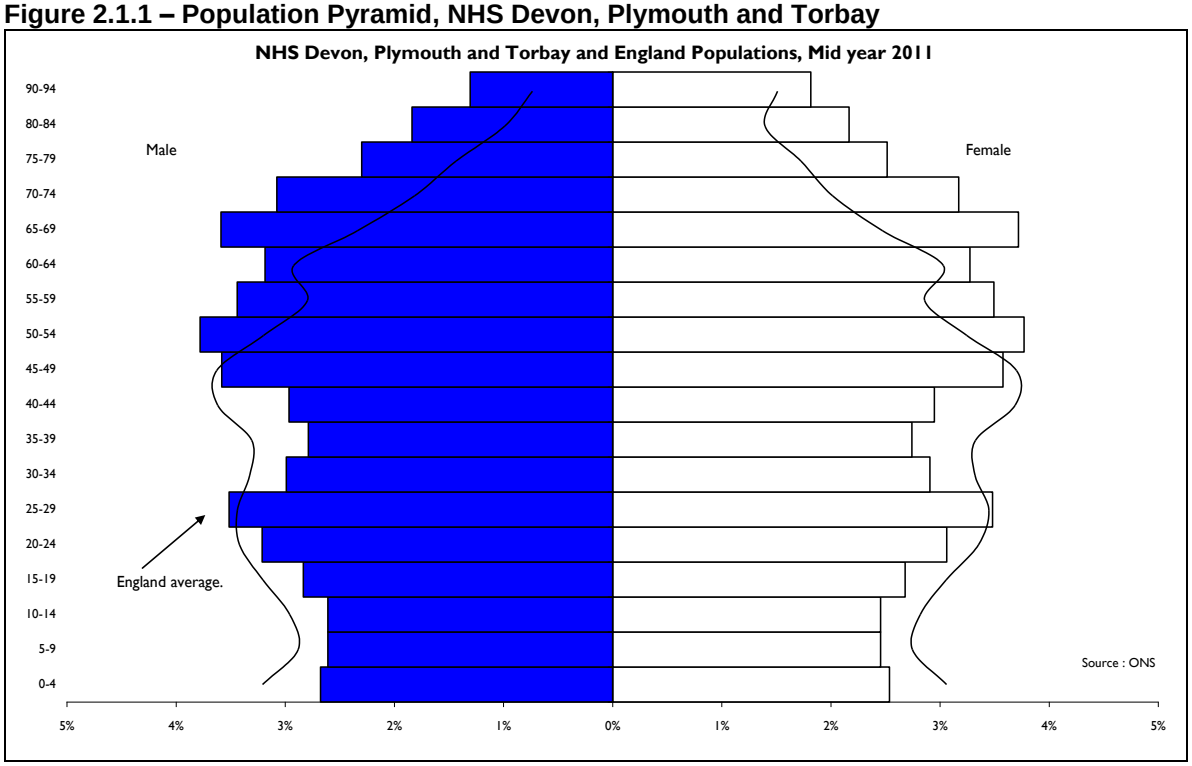
2.1 Population

It is estimated that there are approximately 1,181,700 people living in the cluster of Devon, Plymouth and Torbay. The graph below shows this by age and gender

[15] Design Options, commissioned jointly by the Department of Health's National Support Teams for Sexual Health and Teenage Pregnancy. *Sexual Health Needs Assessments A "How to Guide.* August 2007

compared to the England population. This clearly depicts the older age structure of the Devon, Plymouth and Torbay population. It also shows the higher elderly female population which goes alongside the higher life expectancy for females.

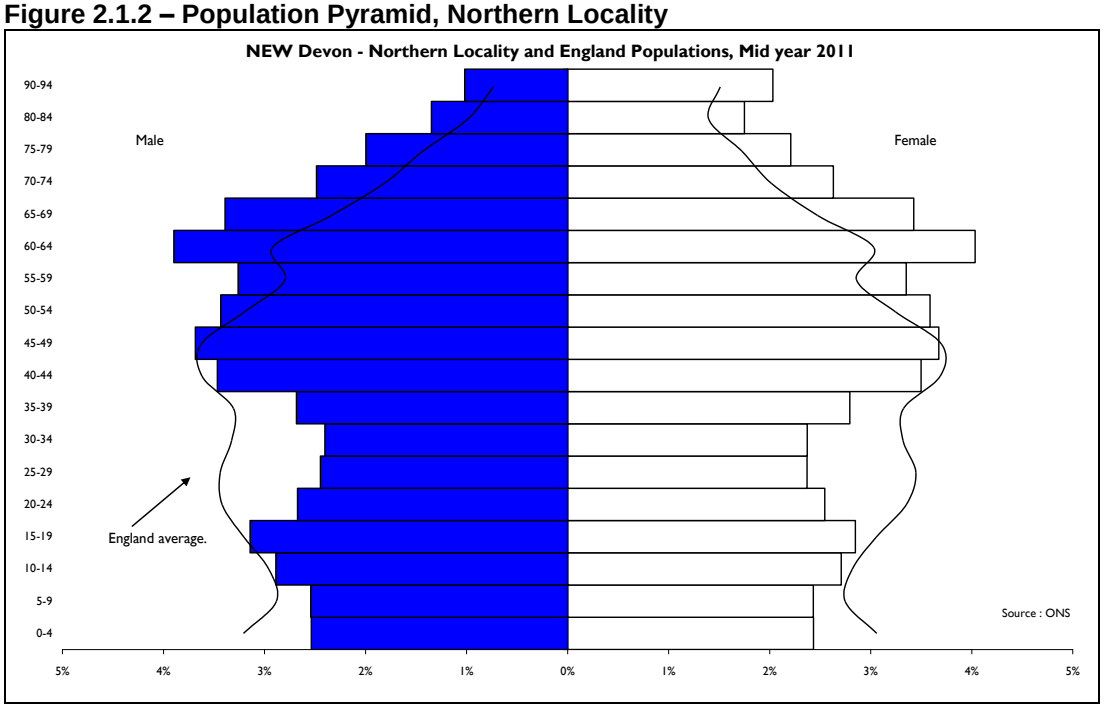
Figure 2.1.1 – Population Pyramid, NHS Devon, Plymouth and Torbay



Source: Patient and Practitioner Services Agency

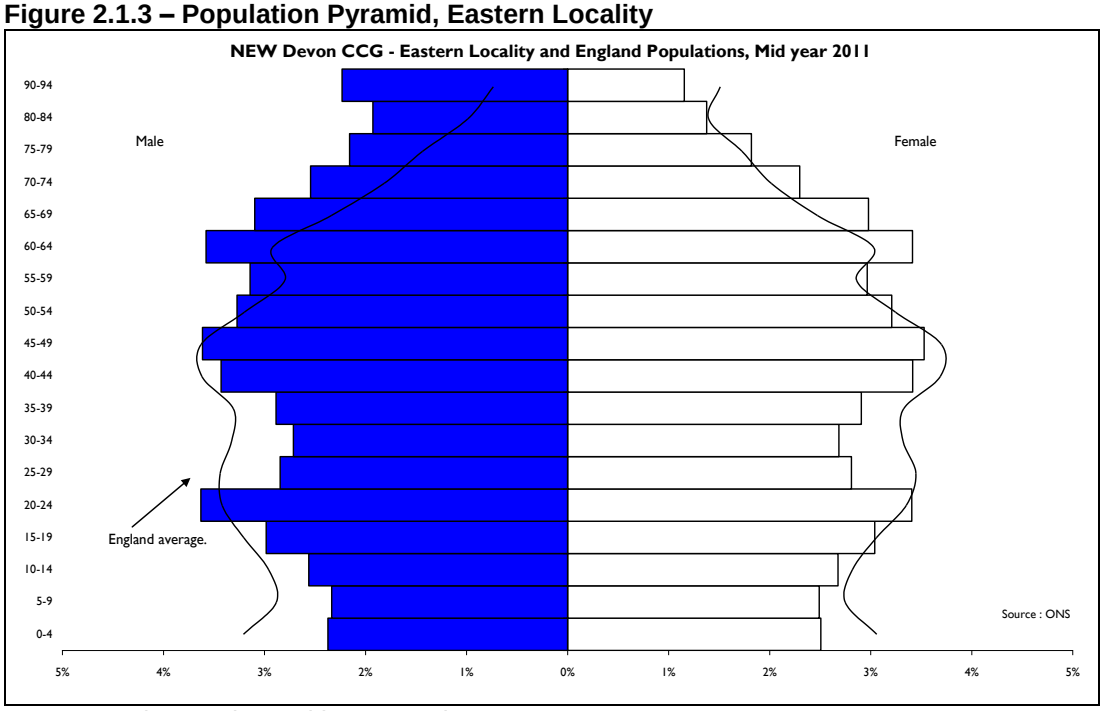
The area is split in to two Clinical Commissioning Groups (CCG). The population of the NEW Devon CCG is just below 894,000 and the population of the South Devon and Torbay CCG is just below 288,000. The NEW Devon CCG is split in to three localities and the South Devon and Torbay CCG in to five localities and the population pyramids of these areas are shown below. The Northern locality has a considerably lower proportion of people aged 20-40 than England, as do Coastal, Paignton and Torquay. The Western and Eastern localities have a higher proportion of people aged 20-24, largely due to the student populations. Other than Newton Abbot and Moor to Sea, all localities have a lower proportion of younger people age under 10. All localities, with the exception of Western have greater proportions of people aged over 55 and particularly aged over 65.

Figure 2.1.2 – Population Pyramid, Northern Locality



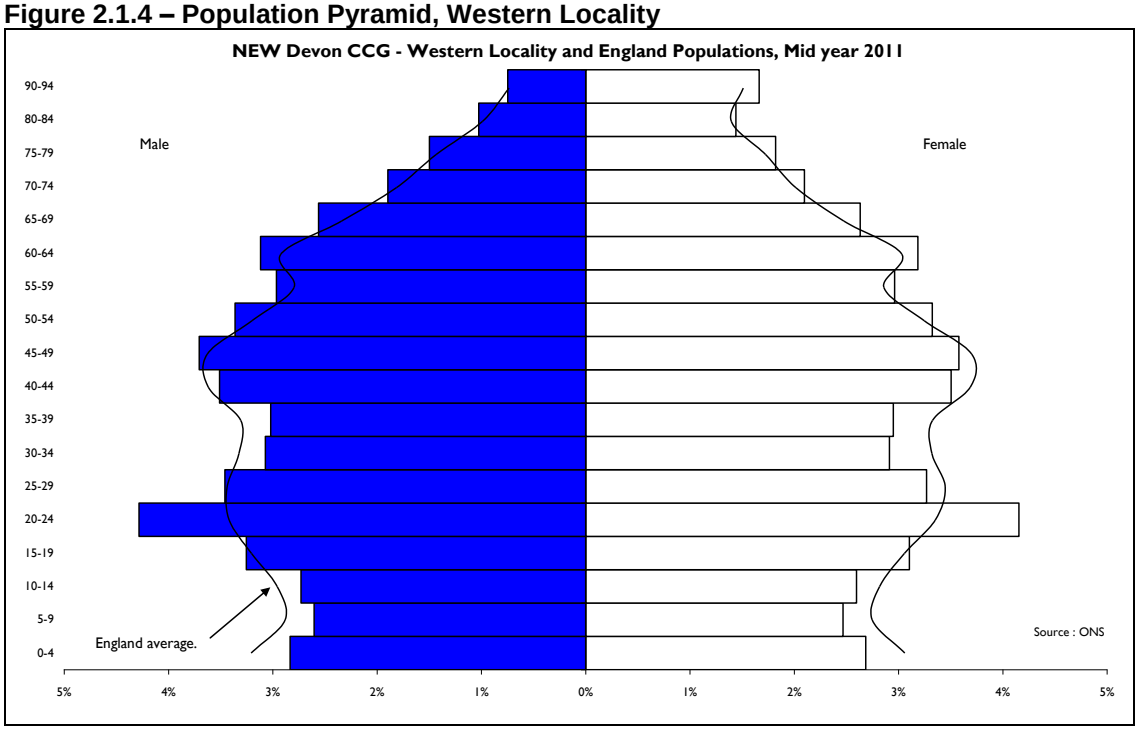
Source: Patient and Practitioner Services Agency

Figure 2.1.3 – Population Pyramid, Eastern Locality



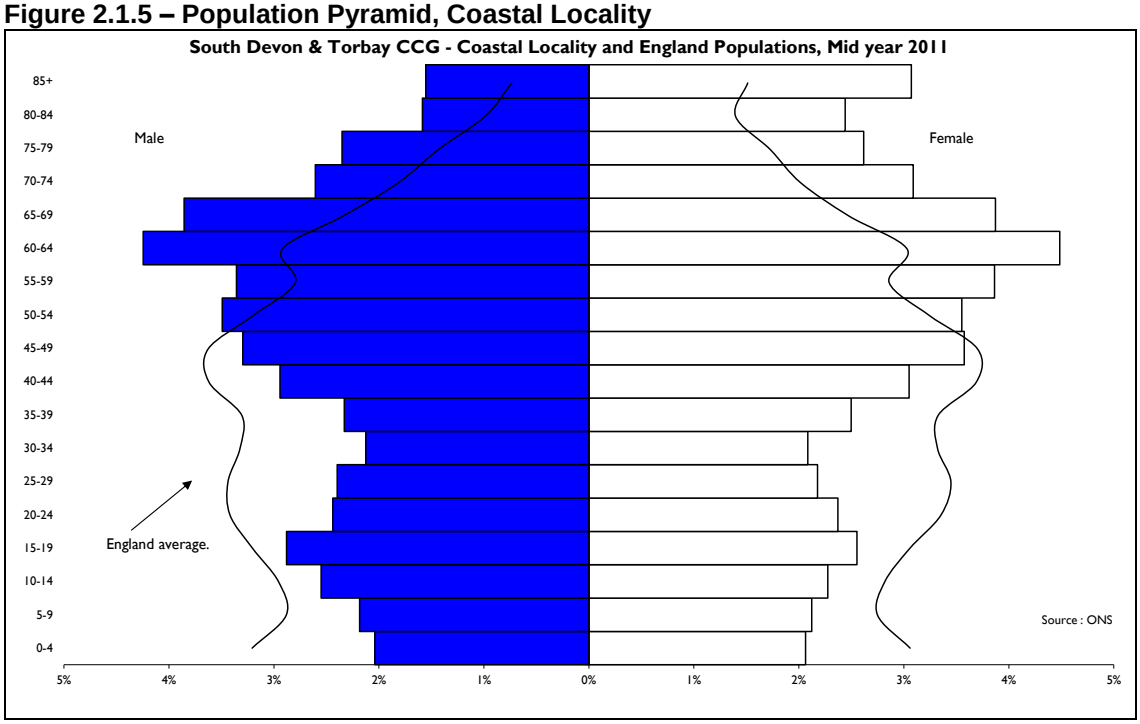
Source: Patient and Practitioner Services Agency

Figure 2.1.4 – Population Pyramid, Western Locality



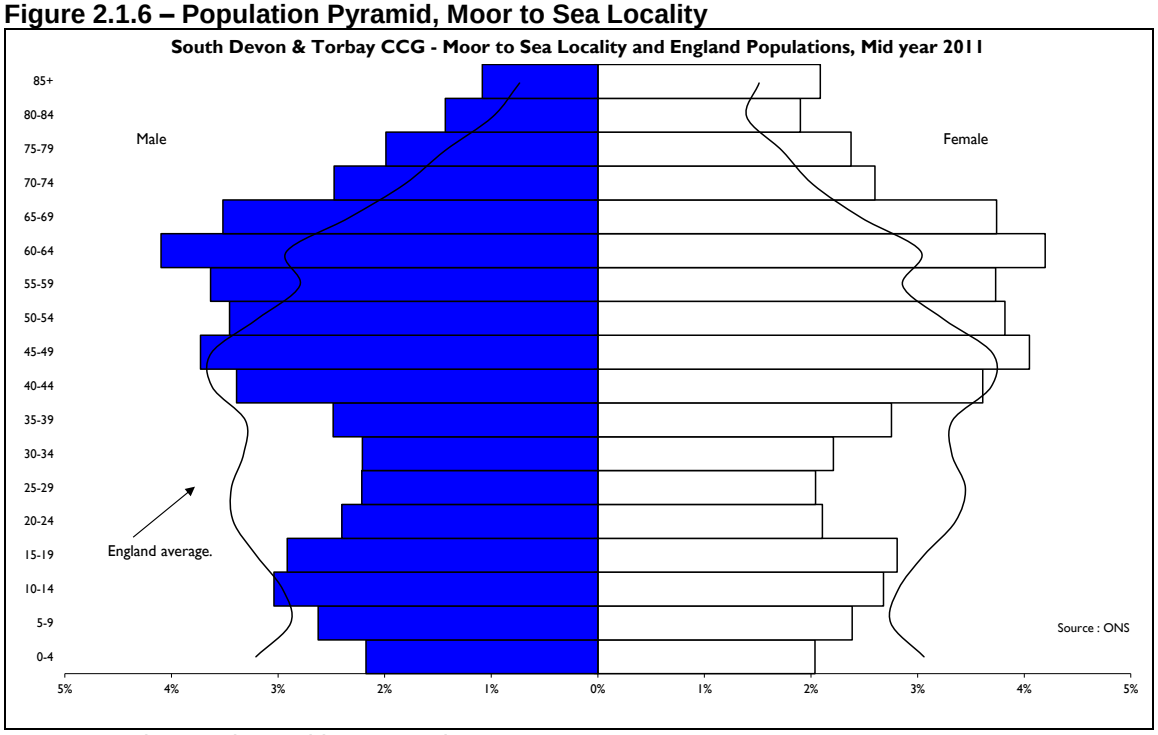
Source: Patient and Practitioner Services Agency

Figure 2.1.5 – Population Pyramid, Coastal Locality



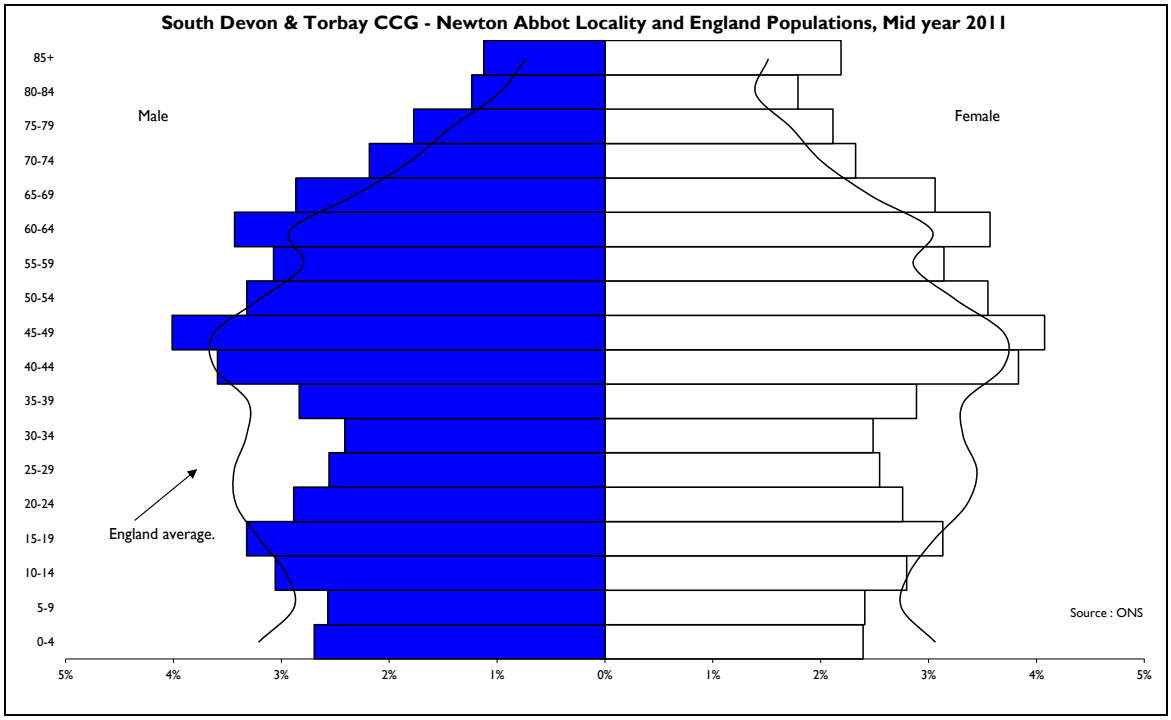
Source: Patient and Practitioner Services Agency

Figure 2.1.6 – Population Pyramid, Moor to Sea Locality



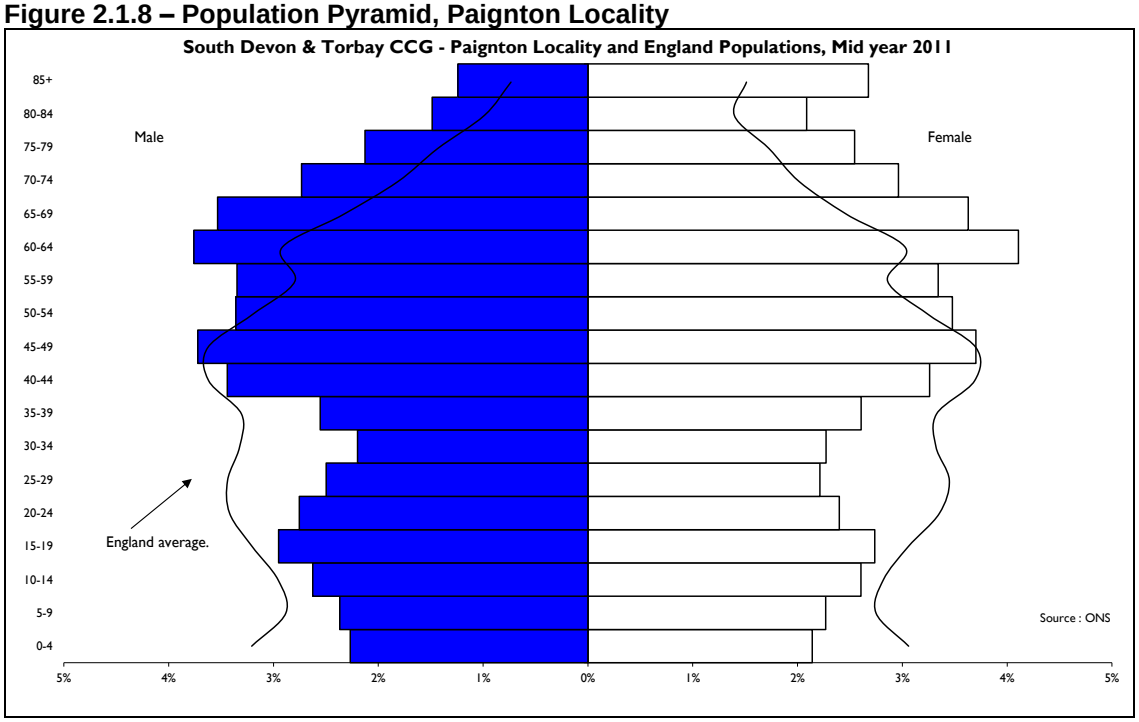
Source: Patient and Practitioner Services Agency

Figure 2.1.7 – Population Pyramid, Newton Abbot Locality



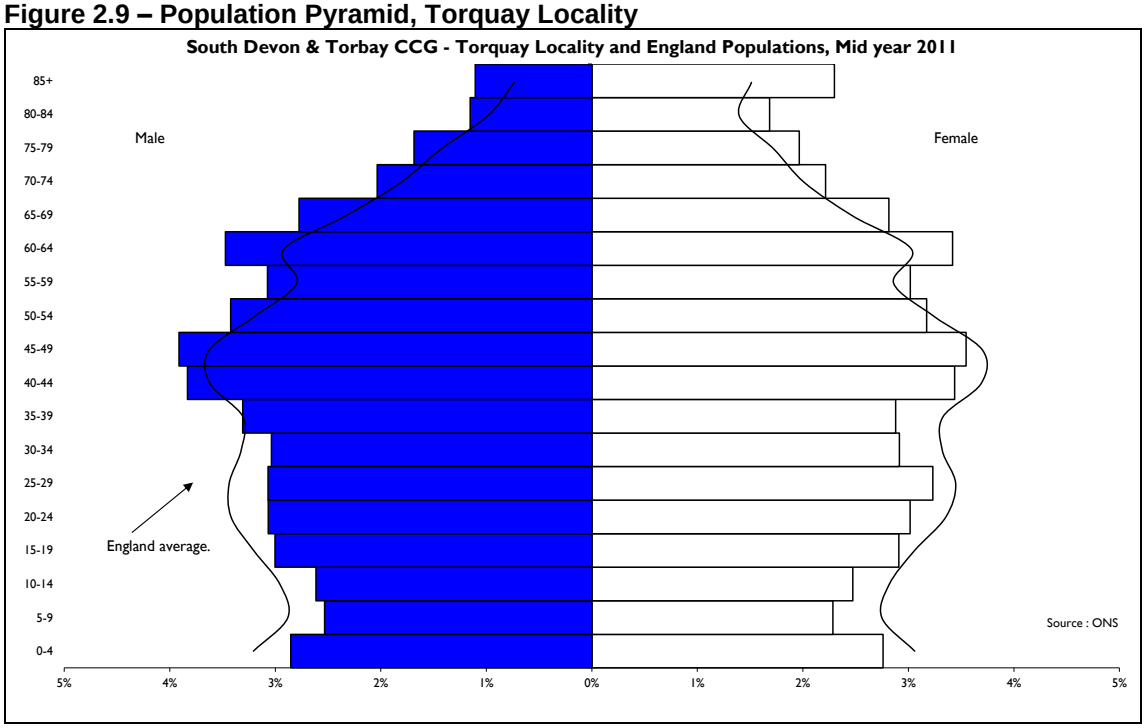
Source: Patient and Practitioner Services Agency

Figure 2.1.8 – Population Pyramid, Paignton Locality



Source: Patient and Practitioner Services Agency

Figure 2.9 – Population Pyramid, Torquay Locality



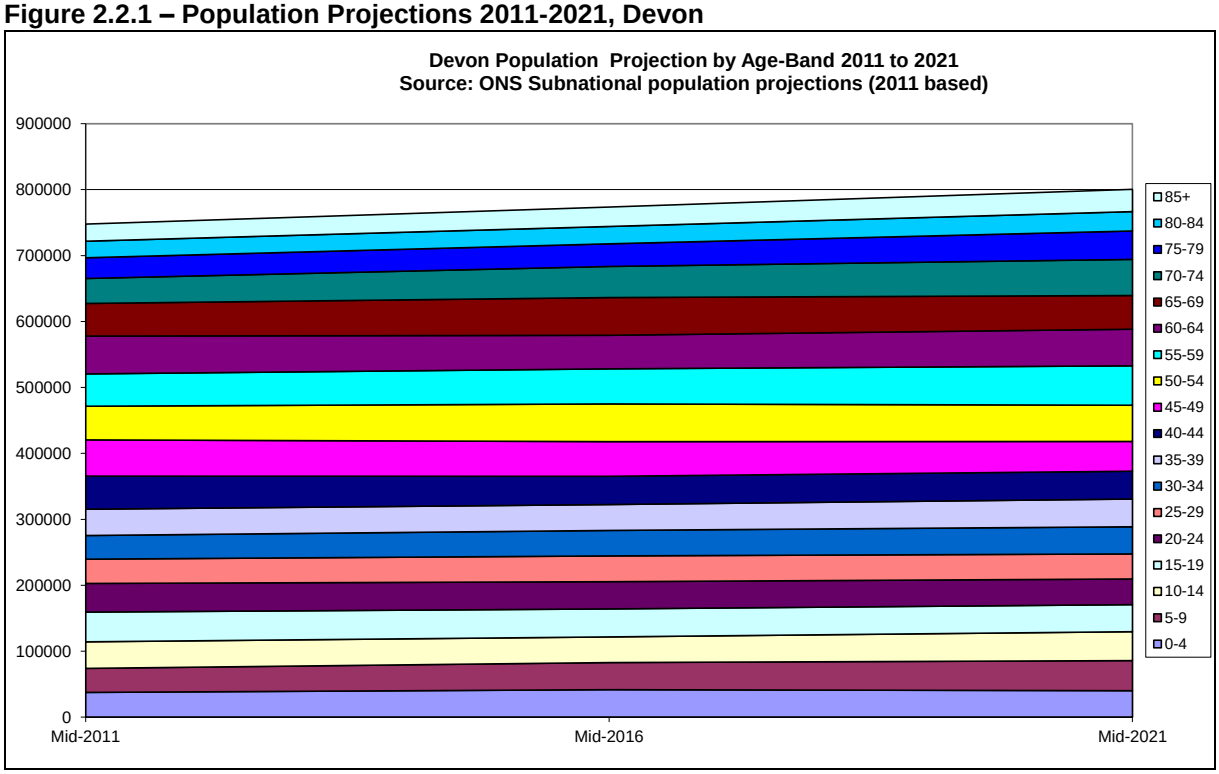
Source: Patient and Practitioner Services Agency

These pyramids reflect that nationally our life expectancy is increasing and as a result the population is aging. The Devon area has a noticeably older population than nationally as it is also a popular area for in-migration at retirement age.

2.2 Population Projections

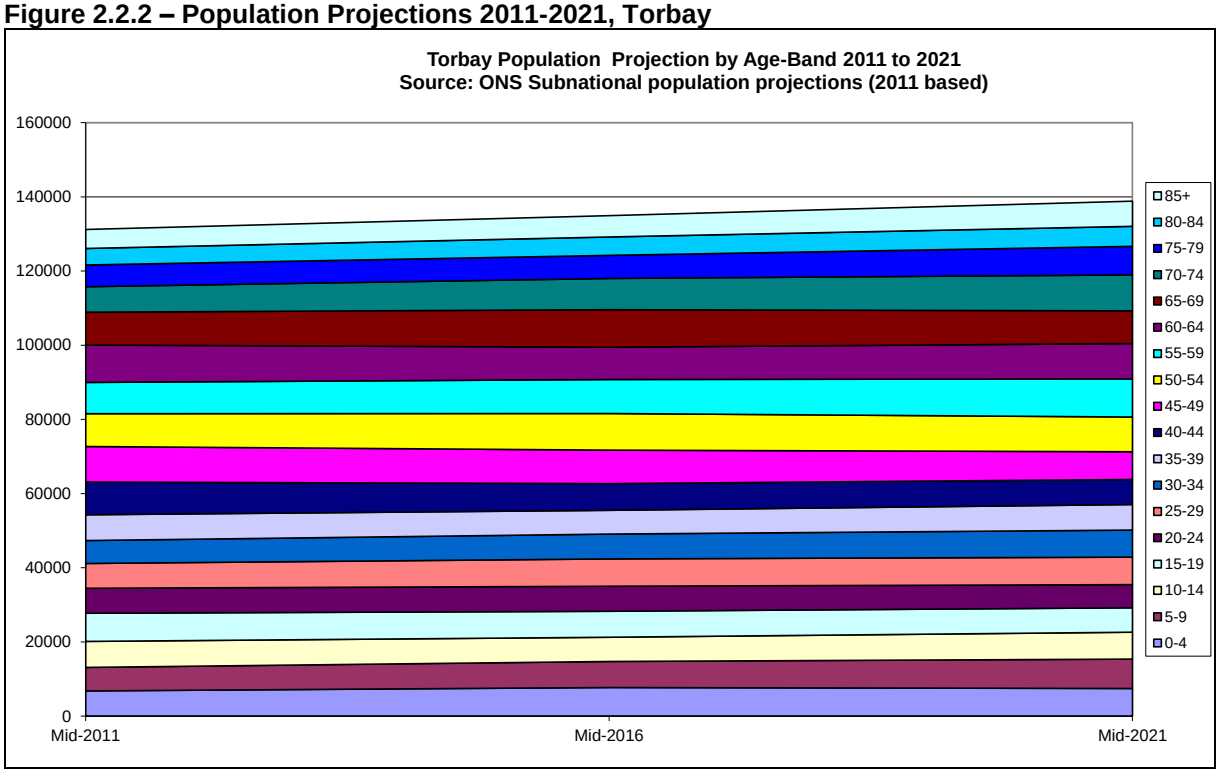
Population projections are not currently available locally or nationally by the Clinical Commissioning Group boundaries. The following graphs show the projected growth for Devon, Plymouth and Torbay Local Authority areas between 2011 and 2021 estimated by the Office of National Statistics based on 2011 Census mid-2011 estimates. Devon and Torbay both show the higher proportions and growth in older age groups, but all three areas show an increase in numbers in the elderly population aged 70 and above. Plymouth also shows slightly higher growth in younger age groups and smaller proportions in the older age groups.

Figure 2.2.1 – Population Projections 2011-2021, Devon



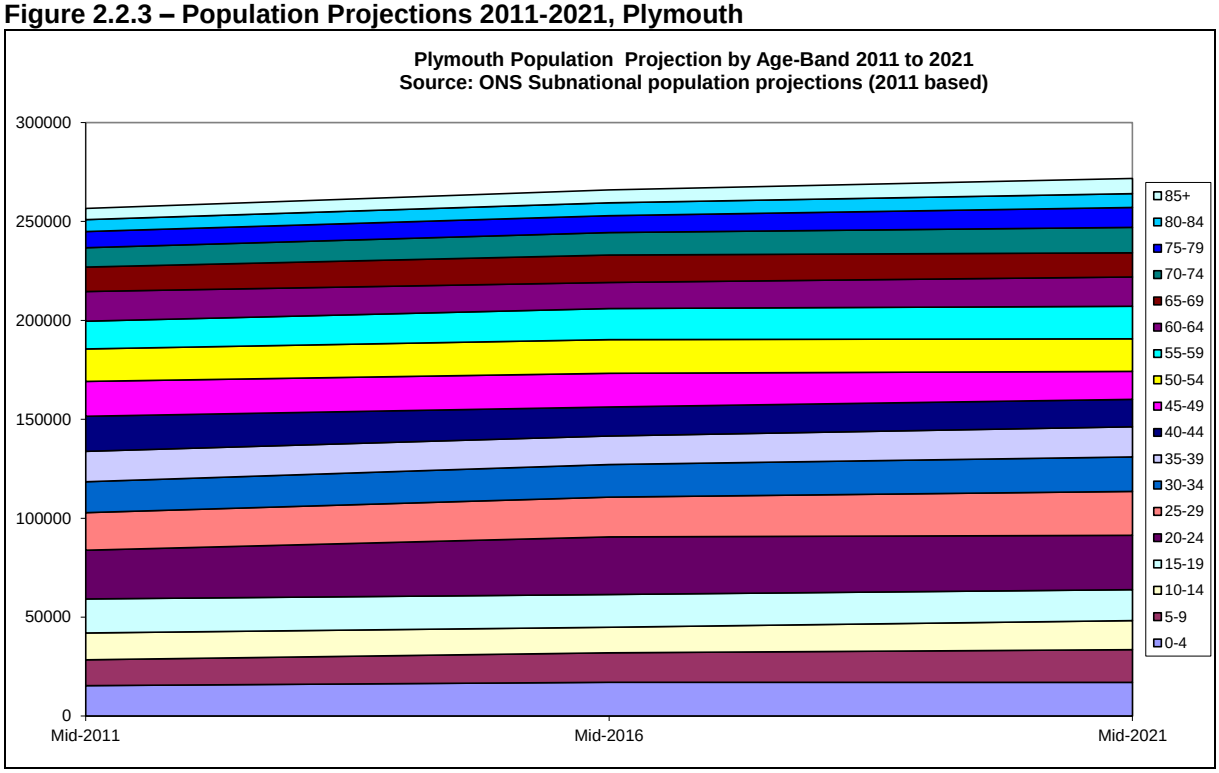
Source: Office of National Statistics subnational population projections (2011 based)

Figure 2.2.2 – Population Projections 2011-2021, Torbay



Source: Office of National Statistics subnational population projections (2011 based)

Figure 2.2.3 – Population Projections 2011-2021, Plymouth



Source: Office of National Statistics subnational population projections (2011 based)

2.3 Ethnicity and migration

Devon and Torbay have relatively small ethnic minority populations compared to the national average. There are likely to be pockets of ethnic minority populations within the larger local authority areas, however Exeter, being more urban and also with the university population possibly having an impact, has the largest ethnic minority

population across Devon. The 2011 Census by Local Authority districts highlights that 2.5% of the Devon population are from non-white ethnic groups, this is also 2.5% in Torbay and slightly higher at 3.9% in Plymouth. The highest proportions of people from non-white ethnic groups were Asian/Asian British in Devon and Plymouth with 1.2% and 1.5% respectively. In Torbay, the highest non-white group was mixed/multiple ethnic groups with 1.1%.

Table 2.3.1: Percentage of population by ethnic group and Devon district, 2011

local authority	White		Mixed/multiple ethnic groups		Asian/Asian British		Black/African/Caribbean/ Black British		Other ethnic group	
	Number	%	Number	%	Number	%	Number	%	Number	%
East Devon	130,347	98.4	904	0.7	930	0.7	146	0.1	130	0.1
Exeter	109,590	93.1	1,938	1.6	4,595	3.9	667	0.6	983	0.8
Mid Devon	76,696	98.6	484	0.6	428	0.6	94	0.1	48	0.1
North Devon	91,742	97.9	785	0.8	835	0.9	158	0.2	147	0.2
South Hams	81,784	98.4	653	0.8	458	0.6	121	0.1	124	0.1
Teignbridge	122,163	98.3	925	0.7	893	0.7	117	0.1	122	0.1
Torridge	63,021	98.7	429	0.7	271	0.4	51	0.1	67	0.1
West Devon	52,730	98.5	402	0.8	300	0.6	59	0.1	62	0.1
Devon	728,073	97.5	6,520	0.9	8,710	1.2	1,413	0.2	1,683	0.2
Torbay	127,699	97.5	1,420	1.1	1,353	1.0	251	0.2	236	0.2
Plymouth	246,509	96.1	3,287	1.3	3,906	1.5	1,678	0.7	1,004	0.4

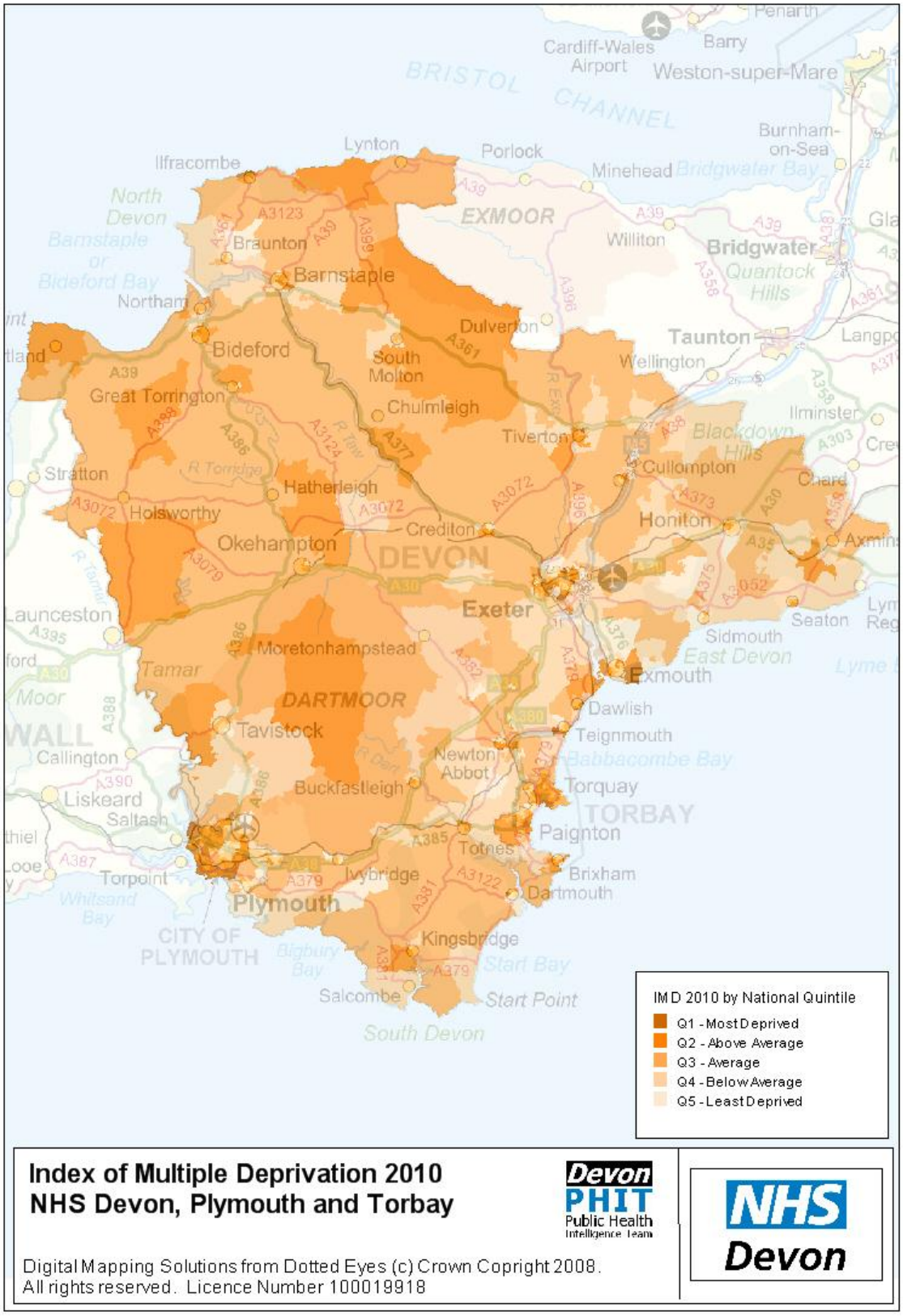
Source: 2011 Census ONS Crown Copyright Reserved [from Nomis on 25 February 2013] Deprivation

2.4 Deprivation

An updated version of the Index of Multiple Deprivation for 2010 was published in March 2011. Figure 2.4.1 shows Index of Multiple Deprivation 2010 figures by Lower Super Output Area (small areas of similar size created by the Office for National Statistics).

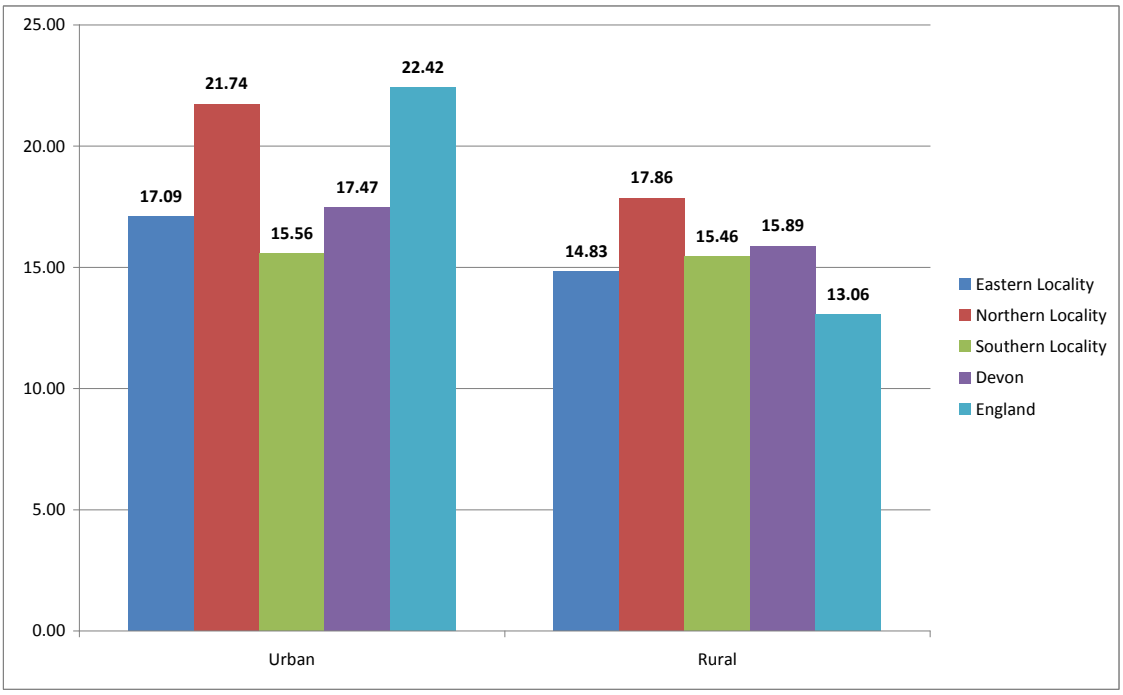
This suggests that just below 12% of the Devon, Plymouth and Torbay population live in the most deprived national quintile (one-fifth). These areas include parts of Exeter, Ilfracombe, Barnstaple, Bideford, Dawlish, Dartmouth, Teignmouth, Newton Abbot, Tiverton, Torquay and Plymouth. 9% of the cluster population were in the least deprived quintile. While overall levels of deprivation across Devon are lower than the national average, there are issues in relation to rural and urban deprivation which seem to affect Devon differently than is experienced elsewhere. With Devon being a largely rural county this is an important difference to be explored. Figure 2.4.2 compares average deprivation scores for urban and rural areas in the three locality areas in Devon. This indicates that within Devon rural areas are generally more deprived than rural areas elsewhere in England, whilst urban areas are generally less deprived than urban areas nationally. Furthermore, while urban areas are usually more deprived than rural areas, the rural areas surrounding a number of towns in Devon are more deprived than the town itself, including Crediton, Great Torrington, Holsworthy, Honiton, Okehampton, South Molton and Tavistock.

Figure 2.4.1: Map of Devon showing Lower Super Output Areas according to Index of Multiple Deprivation, 2010



Source: Indices of Deprivation 2010, Department for Communities and Local Government, Crown Copyright

Figure 2.4.2: Index of Multiple Deprivation, 2010 by Devon locality and rurality



Source: Indices of Deprivation 2010/Urban and Rural Classification 2004, Department for Communities and Local Government, Crown Copyright

2.5 ONS experimental subjective well-being survey results

It is recognised that alongside many measures of society, the environment, employment and economy an important part of the picture of the populations wellbeing is being able to assess the way people feel about their own lives and wellbeing. The Office of National Statistics began collecting an experimental dataset around the population's subjective wellbeing by additional questions added to the constituent surveys of the Integrated Household Survey (IHS) and the Opinions and Lifestyle Survey (OPN) between April 2011 and March 2012.

The four questions which were asked to measure wellbeing were:

- Overall, how satisfied are you with your life nowadays?
- Overall, to what extent do you feel the things you do in your life are worthwhile?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?

All four questions were answered by using a scale from 0 to 10 where 0 is "not at all" and 10 is "completely". The responses from the four questions are not combined in to a single index but are considered separately. The results of the four questions for England, the South West, Devon, Plymouth and Torbay are presented below in tables 2.5.1 to 2.5.4. The tables show the percentage showing lower ratings and higher ratings on the scale and also an average score. The responses from the four questions are not combined in to a single index but are considered separately. The first two questions are designed to measure happiness in people's overall lives, and the second two are designed to measure people's day to day emotions.

Overall in the South West, people felt more satisfied with their lives than in England overall. Plymouth had similar levels of satisfaction as the South West, Devon had slightly higher levels and Torbay slightly lower levels of life satisfaction.

Table 2.5.1 Results of question "How satisfied are you with your life nowadays?"

	Percent in each category on 11 point scale (0-10):		Average rating
	Rated 0-6	Rated 7-10	
England	24.27	75.73	7.40
South West	21.77	78.23	7.52
Devon	20.66	79.34	7.56
Plymouth	21.86	78.14	7.51
Torbay	29.36	70.64	7.17

Source: ONS Wellbeing Survey

A similar pattern of results are seen in the answers to the question around how worthwhile people felt the things they did in their lives were as with overall life satisfaction. Overall in the South West a higher proportion of people felt things they did in their lives were worthwhile. In Plymouth a similar proportion to the South West felt things they did were worthwhile, Devon had a slightly higher proportion. In Torbay rates were slightly lower, however they were still higher than the England average.

Table 2.5.2 Results of question "Overall, to what extent do you feel the things you do in your life are worthwhile?"

	Percent in each category on 11 point scale (0-10):		Average rating
	Rated 0-6	Rated 7-10	
England	20.08	79.92	7.66
South West	18.27	81.73	7.77
Devon	17.13	82.87	7.86
Plymouth	18.96	81.04	7.71
Torbay	19.58	80.42	7.65

Source: ONS Wellbeing Survey

A higher proportion of people in the South West rated their feeling of happiness higher than in England overall. Devon had a higher than average score for happiness than Plymouth and Torbay where the average was lower than in England overall.

Table 2.5.3 Results of question "Overall, how happy did you feel yesterday?"

	Percent in each category on 11 point scale (0-10):		Average rating
	Rated 0-6	Rated 7-10	
England	29.02	70.98	7.28
South West	26.90	73.10	7.38
Devon	24.56	75.44	7.49
Plymouth	29.05	70.95	7.27
Torbay	32.15	67.85	7.08

Source: ONS Wellbeing Survey

The recording for this question would be in reverse, in that a more positive response would show a lower point on the scale, so a lower proportion having experienced anxiety. Again, the South West shows a better overall average score than nationally

at 2.99 compared to 3.15. Devon and Torbay had similar average scores to the South West, where as Plymouth had a higher average score than the South West and nationally and therefore showed higher proportions of people suffering with anxiety.

Table 2.5.4 Results of question "Overall, how anxious did you feel yesterday?"

	Percent in each category on 11 point scale (0-10):		Average rating
	Rated 0-3	Rated 4-10	
England	59.89	40.11	3.15
South West	62.31	37.69	2.99
Devon	63.79	36.21	2.99
Plymouth	57.19	42.81	3.23
Torbay	61.63	38.37	2.98

Source: ONS Wellbeing Survey

2.6 Economy and Employment

There are variations between the economy in Devon, Plymouth and Torbay. In Devon, high levels of economic activity and relatively high employment rates often mask the low productivity and low average wages within the county. Whilst there are some features that are shared with our neighbouring areas, the economy of Devon has its own unique profile, shaped by the people that live here and its historic and cultural heritage. The Devon economy has developed over the centuries to become vibrant, innovative and dynamic. Torbay's economy is dominated by the tourism industry, with many parts of this sector showing decline. An over reliance on this sector has led to high levels of seasonal employment, low-wages and high unemployment compared to the national average. Annual full time pay of Torbay residents has shown an increase from 2010 to 2011 with an increase of 12.7%[16]. The Plymouth economy has changed over time and this change is visible in many new developments across the city, alongside plans for regeneration and improving infrastructure. There is an accelerated approach to growth within the city which although is welcomed, requires a clear and joined up framework. Plymouth's labour market is similar to national trends with unemployment high relative to pre-recession; however rates have not increased as significantly as they have in some other UK cities. Plymouth has a large 18-24 population and a proportionately high number of 18-24 year olds claimants. Long term unemployment is increasing, particularly in the 25-49 age group. Annual full time pay of Plymouth residents has shown an increase from 2010 to 2011 by 1.1% to £23,879. This is however still below the South West and national average annual pay.

Devon and Plymouth both have higher proportions of economically active people aged 16 and above than nationally. Torbay has a similar rate of economic activity as nationally. The breakdown in economic activity by type of employment and gender are shown in table 2.6.1. All geographic areas have relatively high proportions of economically inactive retired populations and Devon and Plymouth also have reasonably high proportions of economically inactive students. All three areas have high proportions of people employed in the service industry, particularly in health, education and public administration. In Torbay and Devon there are also higher

[16] *ONS Annual Survey of Hours & Earnings (ASHE) 2011 via South West Observatory*

proportions employed in the distribution, hotel and restaurant service industry. As would be expected, Devon and Torbay both have higher than national proportions of people employed in the Tourism industry.

Figure 2.6.1 – Economic Activity (October 2011- September 2012)

	Devon		Plymouth		Torbay		South West	Great Britain
	numbers	%	numbers	%	numbers	%	%	%
All people								
Economically active†	372,900	79.4	137,000	78.7	62,200	76.1	78.5	76.7
In employment†	353,200	75	124,100	71.2	57,700	70.4	73.6	70.5
Employees†	279,000	61.4	107,600	62.1	46,400	57.9	62.2	60.5
Self employed†	71,500	13.3	14,300	7.9	10,900	12.1	11.1	9.6
Unemployed§	19,700	5.3	11,100	8.2	4,900	7.9	6.0	7.9
Males								
Economically active†	199,500	85.4	74,300	83.7	32,800	80.6	84.2	83
In employment†	187,600	80.2	65,800	74	30,600	75	78.3	75.9
Employees†	137,600	61.6	55,200	62.5	22,900	57.7	62.9	62
Self employed†	49,000	18.4	9,800	10.5	7,600	17.2	15	13.4
Unemployed§	11,900	6	8,400	11.4	2,200	6.8	6.8	8.4
Females								
Economically active†	173,400	73.5	62,700	73.5	29,400	71.7	72.8	70.5
In employment†	165,700	70	58,300	68.3	27,100	65.9	69	65.2
Employees†	141,400	61.1	52,400	61.6	23,500	58.2	61.4	59.1
Self employed†	22,500	8.3	4,500	5.2	3,400	7.1	7.2	5.7
Unemployed§	7,700	4.5	4,500	7.1	2,300	7.8	5.1	7.4

Source: ONS annual population survey, via Nomis
†numbers are for those aged 16 and over, % are for those aged 16-64
§numbers and % are for those aged 16 and over. % is a proportion of economically active

3. Children and Young People

Children and young people with mental health problems represent some of the country's most vulnerable people. Their mental health and wellbeing is of paramount importance to the future health, wellbeing and prosperity of our society. Emotional and behavioural problems in early life are predictors of poor outcomes in later years. A positive child-parent relationship is particularly important for social and emotional development[17]. The degree of parental and family interaction and how positive or negative it is accounts for as much as 30–40% of the variation in antisocial behaviour among children[18].

We therefore know that the needs of parents and the family environment significantly impact on the mental health, and indeed life chances of the child; therefore, any assessment needs to take account of the whole family's needs. Children, young people and their families have different levels of need and their needs often change over time depending on their circumstances.

[17] Fonagy P, Target M, Cottrell D (2005) What works for whom? A critical review of treatments for children and adolescents. New York: Guilford Press
[18] Patterson GR, DeBaryshe D, Ramsey E (1989) A developmental perspective on antisocial behavior. American Psychiatry 44: (2) 329–35

There are known factors which make children, young people and the families particularly vulnerable. Children at risk may include those who had a low birth weight, have poor child-parent attachment, have poor cognitive, social and emotional skills or have behavioural difficulties. For older children and young people, examples where there may be additional risks include: family problems, transition into adulthood; teenage pregnancy and parenthood, if they are Looked After Children or have special educational needs, those not in education, employment or training or are persistently absent from school, if they are young carers or if they, or someone in their family has substance misuse issues.

The mental health of children and young people is a complex arena, and in order to improve the mental wellbeing of children and their families, both the factors that increase the risk of poor mental health and those that help protect mental wellbeing need to be taken into account. Early interventions, such as activities to raise self-esteem and to improve the child-parent relationship are essential if their mental health needs are to be addressed[19].

3.1 Prevalence

The Child and Maternal Health Observatory (ChiMat) have produced local authority profiles applying published prevalence for various mental health problems affecting children to Local Authority populations to support the development of needs assessments. This data and analysis has been utilised in the following section and provides estimated prevalence of conditions applied to the 2011 population for Devon local authorities.

Pre-school children

There are relatively few data available to enable prevalence on mental health problems in pre-school children to be calculated. The Report of the Children and Young People's Health Outcomes Forum[20] has recommended that a three yearly survey is developed to look at prevalence on mental health problems in children and young people and to build upon previous published studies in 2004. A literature review of four studies looking at 1,021 children aged 2 to 5 years (inclusive), found that the average prevalence rate of any mental health disorder was 19.6%[21]. Based on this prevalence, the table below shows the estimated numbers of 2-5 year olds who have a mental health disorder resident in each local authority.

[19] Barlow J, Parsons J (2009) Group based parent-training programme for improving emotional and behavioural adjustment in 0-3 year old children. Oxford: Wiley and Sons Ltd

[20] Department of Health (2012) Report of the Children and Young People's Health Outcomes Forum. Available at: www.dh.gov.uk/health/files/2012/07/CYP-report.pdf

[21] Egger, H. L. and Angold, A. (2006) Common emotional and behavioral disorders in preschool children: presentation, nosology, and epidemiology. Journal of Child Psychology and Psychiatry, 47 (3-4), 313–37.

Table 3.1.1 Estimated number of pre-school children with a mental health disorder

Local Authority	Estimated number of 2-5 year olds who have a mental health disorder
East Devon	917
Exeter	1004
Mid Devon	698
North Devon	776
South Hams	592
Teignbridge	941
Torridge	498
West Devon	412
Devon	5838
Plymouth	2305
Torbay	1035

Source: Child and maternal health intelligence network, accessed January 2013

School-age children

Prevalence estimates for mental health disorders in children aged 5 to 16 years have been estimated in a report by Green et al[22] (2004). Prevalence rates are based on the ICD-10 Classification of Mental and Behavioural Disorders with strict impairment criteria – the disorder causing distress to the child or having a considerable impact on the child's day to day life. Prevalence varies by age and gender, with boys more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%). Children aged 11 to 16 years olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems. Using these rates, the table below shows the estimated prevalence of mental health disorder by age group and gender. Note that the numbers in the age groups 5-10 years and 11-16 years does not add up to those in the 5-16 year age group, due to the rates being different for each age group.

Table 3.1.2 Estimated number of children with mental health disorders by age group and gender

	Children			Boys			Girls		
	5-10	11-16	5-16	5-10	11-16	5-16	5-10	11-16	5-16
East Devon	571	989	1538	390	554	1826	183	424	1250
Exeter	505	920	1398	351	504	1660	159	412	1136
Mid Devon	403	644	1041	273	363	1236	125	280	846
North Devon	451	745	1185	310	418	1407	144	321	963
South Hams	379	639	1006	253	363	1195	119	276	817
Teignbridge	570	971	1521	392	559	1806	187	412	1236
Torridge	293	488	772	200	277	917	94	210	627
West Devon	256	423	672	175	242	798	82	181	546
Devon	3428	5819	9133	2344	3280	10845	1093	2516	7421
Plymouth	1203	2070	3228	826	1169	3833	390	911	2622
Torbay	594	1003	1578	410	559	1874	188	428	1282

Source: Child and maternal health intelligence network, accessed January 2013

[22] Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2004) Mental health of children and young people in Great Britain, 2004. Office for National Statistics. London, HMSO.

These prevalence figures have been further broken down in to different types of mental health disorders, to conduct disorders, emotional, hyperkinetic and less common disorders[18]. The following tables shows the estimated number of children with conduct, emotional, hyperkinetic and less common disorders, by applying these prevalence rates (the numbers in this table do not add up to the numbers in the previous table because some children have more than one disorder).

Table 3.1.3 Estimated number of children with conduct disorders by age group and gender

	Children		Boys		Girls	
	5-10	11-16	5-10	11-16	5-10	11-16
East Devon	364	568	264	356	100	210
Exeter	321	528	237	324	87	204
Mid Devon	257	370	185	233	69	139
North Devon	287	428	210	269	79	159
South Hams	241	367	171	233	66	137
Teignbridge	363	557	265	360	102	204
Torridge	186	280	135	178	52	104
West Devon	163	243	119	156	45	90
Devon	2182	3341	1586	2109	600	1247
Plymouth	765	1188	559	752	214	451
Torbay	378	576	277	360	103	212

Source: Child and maternal health intelligence network, accessed January 2013

Table 3.1.4 Estimated number of children with emotional disorders by age group and gender

	Children		Boys		Girls	
	5-10	11-16	5-10	11-16	5-10	11-16
East Devon	178	430	84	176	90	251
Exeter	157	400	76	160	78	244
Mid Devon	126	280	59	115	62	166
North Devon	141	324	67	133	71	190
South Hams	118	278	55	115	59	163
Teignbridge	178	422	84	178	92	244
Torridge	91	212	43	88	46	124
West Devon	80	184	38	77	40	107
Devon	1069	2530	506	1042	538	1489
Plymouth	375	900	178	371	191	539
Torbay	185	436	88	178	92	254

Source: Child and maternal health intelligence network, accessed January 2013

Table 3.1.5 Estimated number of children with hyperkinetic disorders by age group and gender

	Children		Boys		Girls	
	5-10	11-16	5-10	11-16	5-10	11-16
East Devon	119	120	103	106	14	16
Exeter	105	112	93	96	12	16
Mid Devon	84	78	72	69	10	11
North Devon	94	91	82	80	11	12
South Hams	79	78	67	69	9	11
Teignbridge	118	118	104	107	15	16
Torridge	61	59	53	53	7	8
West Devon	53	52	46	46	6	7
Devon	713	708	620	626	84	97
Plymouth	250	252	219	223	31	35
Torbay	124	122	109	107	15	17

Source: Child and maternal health intelligence network, accessed January 2013

Table 3.1.6 Less common conditions (Less common disorders include autistic spectrum disorder, tic disorders, eating disorders and mutism)

	Children		Boys		Girls	
	5-10	11-16	5-10	11-16	5-10	11-16
East Devon	96	120	84	70	14	45
Exeter	85	112	76	64	12	44
Mid Devon	68	78	59	46	10	30
North Devon	76	91	67	53	11	34
South Hams	64	78	55	46	9	29
Teignbridge	96	118	84	71	15	44
Torridge	49	59	43	35	7	22
West Devon	43	52	38	31	6	19
Devon	577	708	506	416	84	267
Plymouth	203	252	178	148	31	97
Torbay	100	122	88	71	15	46

Source: Child and maternal health intelligence network, accessed January 2013

A study conducted by Singleton et al[23] has estimated prevalence rates for neurotic disorders in young people aged 16 to 19 (inclusive) living in private households. The tables below show how many 16 to 19 year olds would be expected to have a neurotic disorder if these prevalence rates were applied to the populations of the local authorities.

Table 3.1.7 Estimated number of males aged 16 to 19 with neurotic disorders

	Mixed anxiety and depressive disorder	Generalised anxiety disorder	Depressive episode	All phobias	Obsessive compulsive disorder	Panic disorder	Any neurotic disorder
East Devon	155	49	27	18	27	15	261
Exeter	188	59	33	22	33	18	316
Mid Devon	98	31	17	12	17	10	165
North Devon	118	37	21	14	21	12	200
South Hams	98	31	17	12	17	10	165
Teignbridge	151	47	27	18	27	15	255
Torridge	78	24	14	9	14	8	131
West Devon	65	20	12	8	12	6	110
Devon	951	298	168	113	168	94	1603
Plymouth	375	118	66	44	66	37	633
Torbay	159	50	28	19	28	16	268

Source: Child and maternal health intelligence network, accessed January 2013

Table 3.1.8 Estimated number of females aged 16 to 19 with neurotic disorders

	Mixed anxiety and depressive disorder	Generalised anxiety disorder	Depressive episode	All phobias	Obsessive compulsive disorder	Panic disorder	Any neurotic disorder
East Devon	347	31	76	59	25	17	538
Exeter	476	42	104	81	35	23	737
Mid Devon	218	19	48	37	16	11	338
North Devon	258	23	56	44	19	12	399
South Hams	228	20	50	39	17	11	353
Teignbridge	337	30	73	57	24	16	522
Torridge	169	15	37	29	12	8	261
West Devon	139	12	30	24	10	7	215
Devon	2172	192	474	370	158	105	3363
Plymouth	863	77	188	146	63	42	1336
Torbay	357	32	78	60	26	17	553

Source: Child and maternal health intelligence network, accessed January 2013

[23] Singleton, N., Bumpstead, R., O'Brien, M., Lee, A. and Meltzer, H. (2001) Psychiatric morbidity among adults living in private households, 2000. Office for National Statistics. London. HMSO.

3.2 Autistic Spectrum Disorder (ASD)

A study of children in South East London by Baird et al[24] estimated the prevalence of autism in children aged 9 to 10 years at 38.9 per 10,000 and that of other ASDs at 77.2 per 10,000, making the total prevalence of all ASDs 116.1 per 10,000.

A survey by Baron-Cohen et al (2009) of autism-spectrum conditions using the Special Educational Needs (SEN) register alongside a survey of children in schools aged 5 to 9 years produced prevalence estimates of autism-spectrum conditions of 94 per 10,000 and 99 per 10,000 respectively. The ratio of known to unknown cases is about 3:2. Taken together, a prevalence of 157 per 10,000 has been estimated, including previously undiagnosed cases.

The European Commission[25] highlights the problems associated with establishing prevalence rates for Autistic Spectrum Disorders. These include the absence of long-term studies of psychiatric case registers and inconsistencies of definition over time and between locations.

Table 3.2.1 Estimated number of children with autistic spectrum disorders

	Autism in children aged 9-10 years	Other ASDs in children aged 9-10 years	Total of all ASDs in children aged 9-10 years	Autism-spectrum conditions disorders in children aged 5-9 years
East Devon	10	20	30	94
Exeter	8	17	25	86
Mid Devon	7	14	21	68
North Devon	8	16	23	75
South Hams	7	13	20	63
Teignbridge	10	20	30	94
Torridge	5	10	15	49
West Devon	5	9	13	42
Devon	60	119	177	571
Plymouth	21	41	62	203
Torbay	10	21	31	99

Source: Child and maternal health intelligence network, accessed January 2013

3.3 Estimated need for services at each tier

Estimates of the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4 have been provided by Kurtz[26]. The following table shows these estimates for the population aged 17 and under.

[24] Baird, G., Simonoff, E., Pickles, A., Chandlert, S., Loucas, T., Meldrum, D. and Charman, T. (2006) Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP). Lancet, 368 (9531),210-5.
[25] European Commission (2005) Some elements about the prevalence of Autism Spectrum Disorders (ASD) in the European Union. European Commission Health and Consumer Protection Directorate-General. Luxembourg.
[26] Kurtz, Z. (1996) Treating children well : a guide to using the evidence base in commissioning and managing services for the mental health of children and young people. London. Mental Health Foundation.

Table 3.3.1 Estimated children by CAMHS tier

	Tier 1	Tier 2	Tier 3	Tier 4
East Devon	3,492	1,630	431	17
Exeter	3,471	1,620	428	17
Mid Devon	2,439	1,138	301	12
North Devon	2,769	1,292	342	14
South Hams	2,268	1,058	280	11
Teignbridge	3,489	1,628	430	17
Torridge	1,794	837	221	9
West Devon	1,530	714	189	8
Devon	21,252	9,917	2,622	105
Plymouth	7,872	3,674	971	39
Torbay	3,699	1,726	456	18

Source: Child and maternal health intelligence network, accessed January 2013

3.4 Factors influencing and influenced by mental health

The reasons young people may experience mental health problems are varied and likely to be complex. There are however factors which are known to influence the likelihood of young people experiencing problems. Some of these are identified and discussed below.

Children and young people with learning disabilities

Children with learning disability are more likely to suffer from mental health problems. Estimating numbers of children with a learning disability is difficult and so numbers should be treated with caution. Emerson et al[27] calculated prevalence in children and young people with learning disabilities for different age groups as follows: 5 to 9 years: 0.97%; 10 to 14 years: 2.26%; and 15 to 19 years: 2.67%. Although these numbers should be treated with caution, they have been included to give an indication.

Table 3.4.1 Estimated total number of children with learning disabilities

	Children aged 5-9	Children aged 10-14	Children aged 15-19
East Devon	58	160	195
Exeter	53	120	251
Mid Devon	42	106	123
North Devon	47	120	150
South Hams	39	104	125
Teignbridge	58	158	190
Torridge	30	79	96
West Devon	26	70	80
Devon	253	917	1210
Plymouth	125	307	475
Torbay	61	160	203

Source: Child and maternal health intelligence network, accessed January 2013

[27] Emerson, E. Hatton, C. Robertson, J. Roberts, H. Baines, S. Evison, F. and Glover, G. (2011) People with learning disabilities in England 2011.
Available at:www.improvinghealthandlives.org.uk/publications/1063/People_with_Learning_Disabilities_in_England_2011

The increase in numbers as the age rises reflect the fact that as children get older, more are identified as having a mild learning disability. The Foundation for People with Learning Disabilities[28] estimated an upper limit of 40% prevalence for mental health problems associated with learning disability and higher rates in those with more severe learning disabilities. The table below shows these proportions, estimating how many children with learning disabilities may also have mental health problems.

Table 3.4.2 Estimated total number of children with learning disabilities with mental health problems

	Children aged 5-9	Children aged 10-14	Children aged 15-19
East Devon	23	64	78
Exeter	21	48	100
Mid Devon	17	42	49
North Devon	18	48	60
South Hams	15	42	50
Teignbridge	23	63	76
Torridge	12	32	38
West Devon	10	28	32
Devon	139	367	483
Plymouth	50	123	190
Torbay	24	64	81

Source: Child and maternal health intelligence network, accessed January 2013

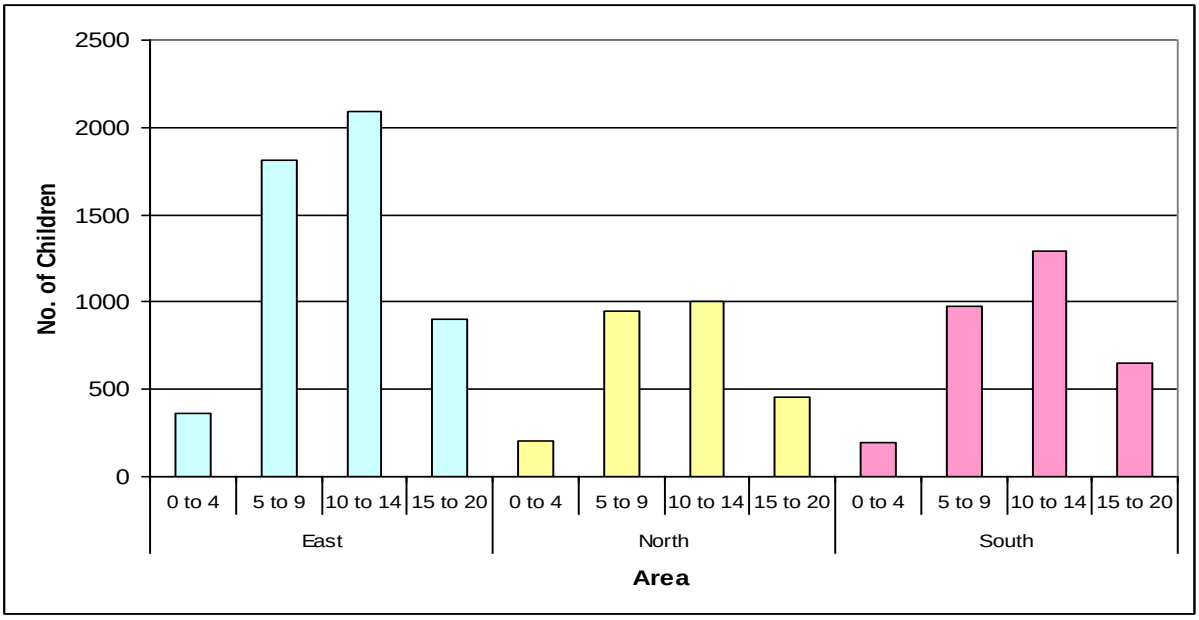
Children with Additional Needs and Special Educational Needs

Devon County Council produces a data book which provides details of children with additional needs within Devon. It gives a snapshot of how many children with additional needs are known about by the council, which services they access and how much these services cost. The latest version of this which is used here was produced in November 2012 and at this point there were 11,172 children with additional needs known and accessing services.

Figure 3.4.1 shows the number of children with additional needs by age and by area. Some children with severe additional needs will be known about from birth, whereas others may become more apparent when children move through primary and then secondary school. The demands caused by a more formal secondary education setting may also lead to more children requiring assistance at School Action Plus Level. As children start to leave school the numbers drop as although educational needs may remain, they move out of the educational system.

[28] Foundation for people with learning disabilities (2002) Count us in. Foundation for people with learning. London.

Figure 3.4.1 - Children with Additional Needs by Area and Age Group



Source: Devon County Council

There are three levels of Special Educational Need; School Action, where a child requires extra or different help within school and the school manage this without external support, School Action Plus, where the school requires advice from external professionals in order to support the child, and Statement of SEN, where the child's needs and the extra help they should get are set out in a document. The needs are grouped in to a number of categories, and although not all are directly related to mental health and wellbeing, the issue of self-esteem and wellbeing is relevant to all pupils with special educational needs.

The number of children known to services with additional needs is shown by the grouping of the need below. It also shows how many of the children have statemented needs. The highest number of additional needs fall in to behavioural, emotional and social difficulties, speech, language and communication needs. There are many smaller categories with have been grouped here in to 'other disabilities/difficulties'. The highest proportions of children with statemented needs were those with Autistic Spectrum Disorders and severe learning disability. Table 3.4.3 shows the rates of different statemented educational needs by local educational area. Devon and Plymouth and Torbay had highest rates of behavioural, emotional and social difficulties.

Table 3.4.3 Devon children with additional needs

Category of need	Total known children	Statemented
Autistic Spectrum Disorder	877	648
Behavioural, Emotional and Social Difficulties	2146	821
Hearing Impairment	218	95
Moderate Learning Disability	1066	316
Physical Disability	633	388
Speech, Language and Communication Needs	2090	822
Severe Learning Disability	283	217
Specific Learning Difficulty	828	117
Other Disabilities/Difficulties	3031	133

Source: Devon County Council

Table 3.4.4 Rates of pupils with statemented special educational needs

	Rate per 1,000 pupils		
Category of need	**Devon**	**Plymouth**	**Torbay**
Autistic spectrum disorder	6.7	10.7	5.1
Specific learning difficulty	12.1	5.9	14.5
Moderate learning difficulty	12.9	11.3	17
Severe learning difficulty	1.1	0.3	0.9
Profound and multiple learning difficulty	x	x	0
Behaviour, emotional and social difficulties	22.9	21.6	29.5
Speech, language and communications needs	20.7	23.5	16.7
Hearing impairment	2.4	2.6	3
Visual impairment	1.5	1.1	2.6
Physical disability	5	3.3	4.4
Other difficulty/disability	4.2	2.3	5.5
Multi-sensory impairment	x	x	x
Total	**89.9**	**82.7**	**99.2**

Source: Source: Child and maternal health intelligence network, accessed June 2013 (x = rates restricted due to low numbers)

Looked-after children

It has been shown that Looked-after children are more likely to experience mental health problems[29] . Among children aged 5 to 17 years who are looked after by local authorities in England, it is estimated that 45% had a mental health disorder, 37% had clinically significant conduct disorders, 12% had emotional disorders, such as anxiety or depression, and 7% were hyperkinetic[30]. These estimates vary depending on the type of setting the looked after child is placed in, with two-thirds of children living in residential care found to have a mental health disorder compared with four in ten of those place with foster-carers or their birth parents.

[29] Ford, T. Vostanis, P. Meltzer, H. and Goodman, R. (2007) Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households. British Journal of Psychiatry.
Available at: bjp.rcpsych.org/content/190/4/319

[30] Meltzer, H. Gatward, R. Corbin, T. Goodman, R. Ford, T. (2003) The mental health of young people looked after by local authorities in England. Office for National Statistics. London. HMSO.

Homelessness and sleeping rough

Many studies have looked at the impact of homelessness and sleeping rough on young people's mental health. Vonstanis, P. (2002)[31] states that homeless adolescents and street youth are likely to present with depression and attempted suicide, alcohol and drug misuse, and are vulnerable to sexually transmitted diseases. Two major studies of this group in London[32] and Edinburgh[33] found significant histories of residential care, family breakdown, poor educational attainment and instability of accommodation. These were also shown to be associated with sexually risky behaviours, substance misuse and comorbid psychiatric disorders, particularly depression.

In a study by Quilgars et al (2011)[34], the estimated number of young people aged 16 to 24 sleeping rough in England in 2008/9 was 3200, giving a rate of 51.3 per 100,000. In a study of 16 to 25 year olds who were sleeping rough in London, Vasiliou (2006)[35] found that 67% had mental health problems. Applying these rates to the populations in Devon provides an estimate of 28 young people with mental health problems who are sleeping rough, 13 in Plymouth and 4 in Torbay.

3.5 Suicide and self-harm

Suicide is a complex issue and one which requires further research in to each case to understand better the specific risk factors associated with it. Looking at suicides in the UK between 1997 and 2003, one study has made the following observations[36]:

- Three times as many young men as young women aged between 15 and 19 committed suicide
- Only 14% of young people who committed suicide were in contact with mental health services in the year prior to their death, compared with 26% in adults.
- Looking at the difference between genders, 20% of young women were in contact with mental health services compared with only 12% of young men

Across Devon, Plymouth and Torbay between 2000 and 2010 there were 25 deaths with an underlying cause of suicide or injury undetermined in young people aged 0-18. These deaths were spread across districts in Devon, apart from North Devon and Mid Devon where there were none. Although year on year these numbers are relatively low, the numbers of years lost associated with deaths in this young age group is extremely high.

[31] Vostanis, P. (2002) Mental health of homeless children and their families. Advances in Psychiatric Treatment 8 (6), 463-9.
[32] Craig, T., Hodson, S., Woodward, S. and Richardson, S. (1996) Off to a bad start: a longitudinal study of homeless young people in London. London: Mental Health Foundation.
[33] Wrate, R. Blair, C. (1999) Homeless adolescents. In Vostanis, P. and Cumella, S. eds. Homeless children: problems and needs . London: Jessica Kingsley. 83 – 96.
[34] Quilgars, D. Fitzpatrick, S. and Pleace, N. (2011) Ending youth homelessness: Possibilities, challenges and practical solutions. Universities of York and Heriot-Watt, for Centrepoint.
[35] Vasiliou, C. (2006) Making the link between mental health and youth homelessness. a pan-London study. London. Mental Health Foundation.
[36] Windfuhr, K., While, D., Hunt, I., Turnbull, P. , Lowe, R., Burns, J., Swinson, N., Shaw, J., Appleby, L., Kapur, N. and the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2008) Suicide in juveniles and adolescents in the United Kingdom. Journal of Child Psychology and Psychiatry, 49 (11),1157–67.

Self Harm – National Evidence

Self-Harm amongst younger people is one of the most direct forms of impairment to health or development. It splits in to two broad categories, self poisoning – including overdoses with medicines or swallowing poisonous substances, and self-injury-such as cutting, burning, and scalding, hanging, shooting and jumping from heights or in front of vehicles. It can often be linked to other mental health conditions or can be a reaction to or seen as a way of coping with distressing events.

Levels of self-harm are higher among young women than young men. The rates of self-harm in young women averaged 302 per 100,000 in 10 to 14 year olds and 1,423 per 100,000 in 15 to 18 year olds. Whereas for young men the rates of self-harm averaged 67 per 100,000 in 10-14 year olds and 466 per 100,000 in 15 to 18 year olds[37]. Self-poisoning was the most common method, involving paracetamol in 58.2 % of episodes[33]

Presentations of self harm, especially those involving alcohol, peaked at night. Repetition of self-harm was frequent (53.3 % had a history of prior self-harm and 17.7 % repeated within a year)[33]. Common characteristics of adolescents who self-harm are similar to the characteristics of those who commit suicide). Young South Asian women in the United Kingdom seem to have a raised risk of self-harm. Intercultural stresses and consequent family conflicts may be relevant factors[33]. As many as 30% of adolescents who self-harm report previous episodes, many of which have not come to medical attention. At least 10% repeat self-harm during the following year, with repeats being especially likely in the first two or three months[33].

The risk of suicide after deliberate self-harm varies between 0.24% and 4.30%. Our knowledge of risk factors is limited and can be used only as an adjunct to careful clinical assessment when making decisions about after care. However, the following factors seem to indicate a risk: being an older teenage boy; violent method of self-harm; multiple previous episodes of self-harm; apathy, hopelessness, and insomnia; substance misuse; and previous admission to a psychiatric hospital[33].

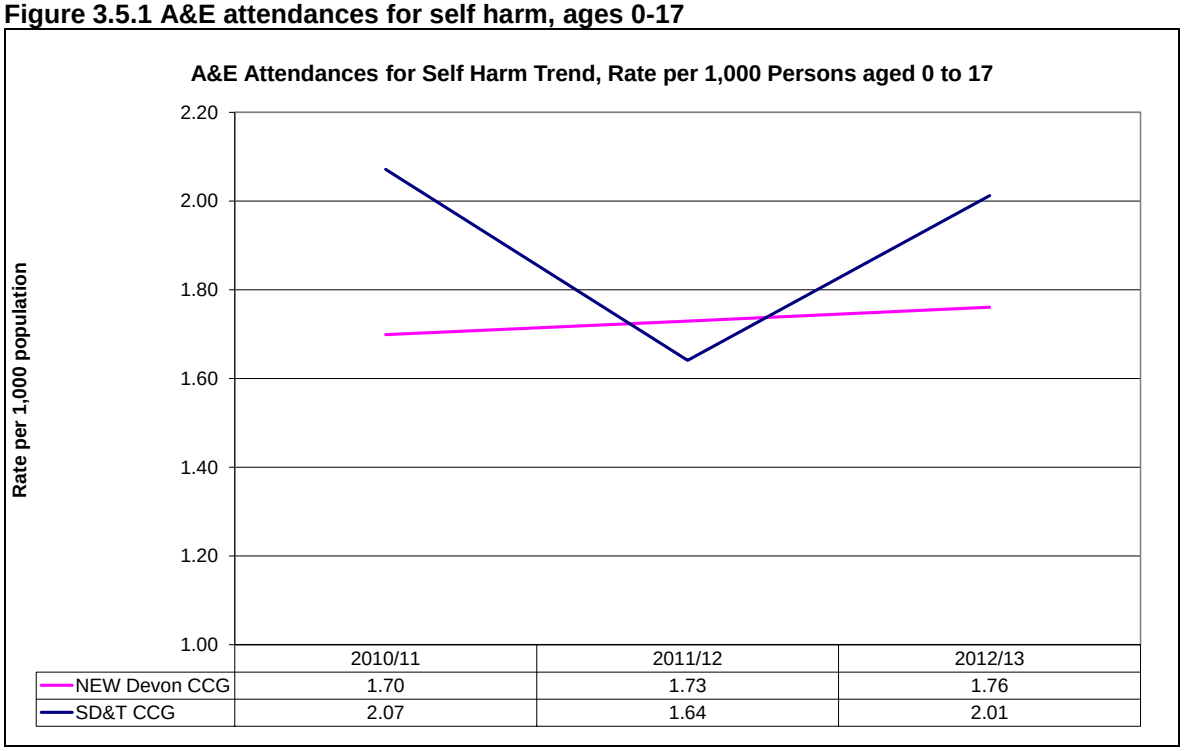
Self-Harm Activity

Not all cases of self-harm would be serious enough to present to health services, and as a result gathering an accurate prevalence of the problem is difficult. Some cases do present to Accident and Emergency and some incidences may require hospital admission so looking at the data related to this below gives a picture of the problem across Devon, Plymouth and Torbay.

Figure 3.5.1 shows the trend in young people attendances at A&E for self-harm from 2010-11 through to 2012-13 for South Devon and Torbay CCG and NEW Devon CCG. This graph shows rates of attendance have remained relatively stable over the past three years in the NEW Devon CCG area. The rates in the South Devon and Torbay CCG show a slightly less stable trend, but the changes in rates are not statistically significant over the years and the confidence intervals are wide.

[37] Hawton, K., Bergen, H., Waters, K., Ness, J., Cooper, J., Steeg, S., and Kapur, N. (2012) Epidemiology and nature of self-harm in children and adolescents: findings from the multicentre study of self-harm in England. European child & adolescent psychiatry, 21 (7), 369-77.

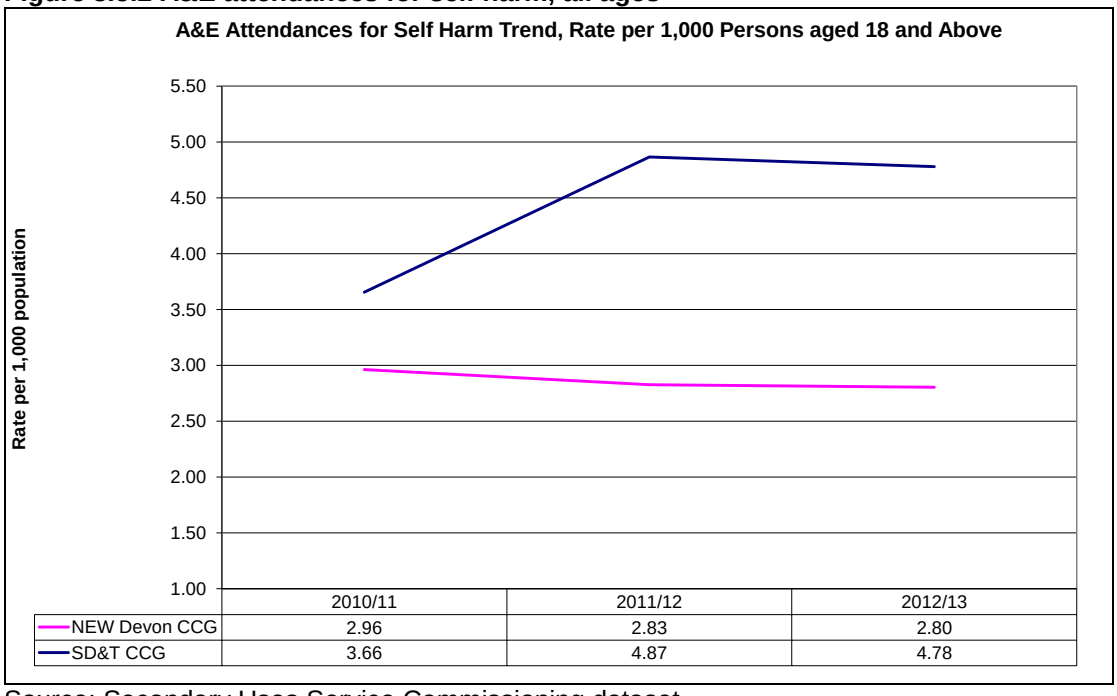
Figure 3.5.1 A&E attendances for self harm, ages 0-17



Source: Secondary Uses Service Commissioning dataset

Although self-harming is a behaviour that often develops in early adolescence, it often continues in to adulthood, as unless the underlying problems are dealt with the pattern is established. It is also something that can develop in other stages of adulthood. The graph below shows the trend in A&E attendances in people aged 18 and above. The rate in the NEW Devon CCG shows a very slight decrease although this is not statistically significant, and South Devon and Torbay CCG shows a statistically significant increase in rate from 2010-11 to 2011-12.

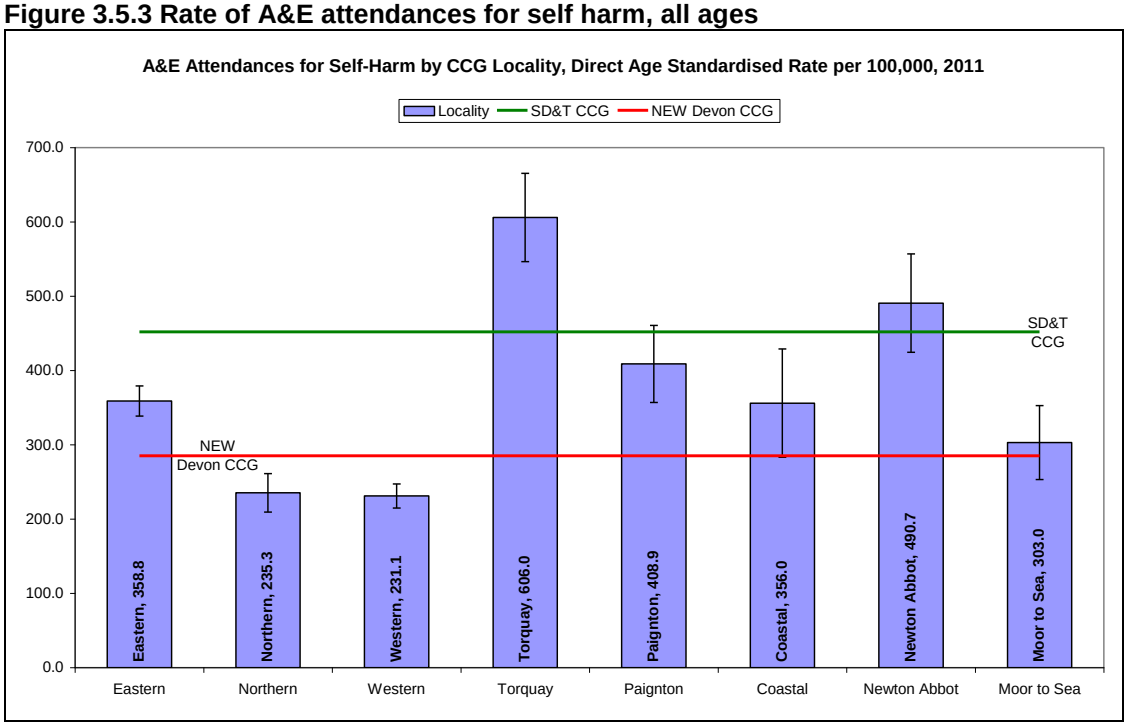
Figure 3.5.2 A&E attendances for self harm, all ages



Source: Secondary Uses Service Commissioning dataset

Figure 3.5.3 below shows the directly age standardised rates of A&E attendances of people of all ages for self-harm by localities within the two CCGs for 2011. This shows that there are significant differences in rates of A&E attendances with the areas, with Eastern locality showing a significantly high rate the NEW Devon CCG and Northern and Western showing significantly lower rates. In South Devon and Torbay CCG, Torquay has a significantly higher rate and Coastal and Moor to Sea have statistically significant lower rates.

Figure 3.5.3 Rate of A&E attendances for self harm, all ages



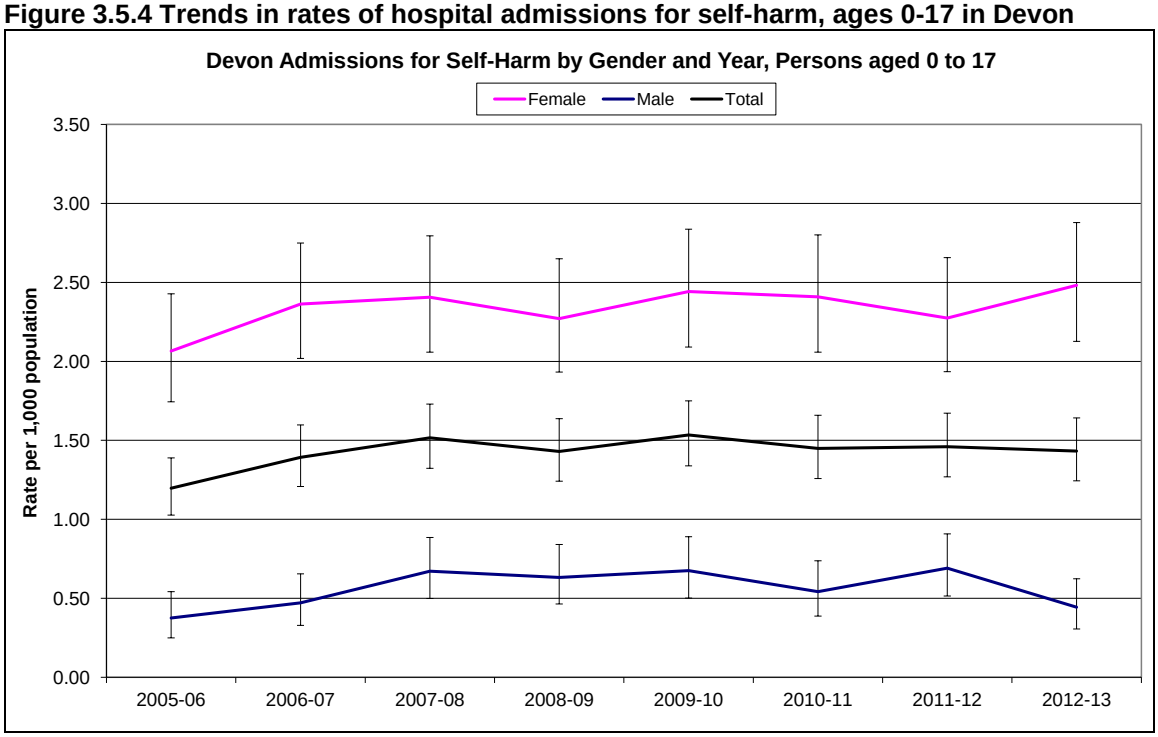
Source: Secondary Uses Service Commissioning dataset

Self harm admissions

Admissions for self harm vary by gender, with females having much higher rates of admissions than males. Figure 3.5.4 shows the trend in admissions for young people in Devon with an overall increasing rate in females and relatively stable rate in males. The overall rate shows a relatively stable trend and although females rates are statistically significantly higher than males, there are no statistically significant differences year on year. In Plymouth and Torbay data was not available back so far but the admission rates in both areas are higher than in Devon. The rates however show a similar pattern by gender with the female rates increasing and the males showing a dip in rates in the latest year.

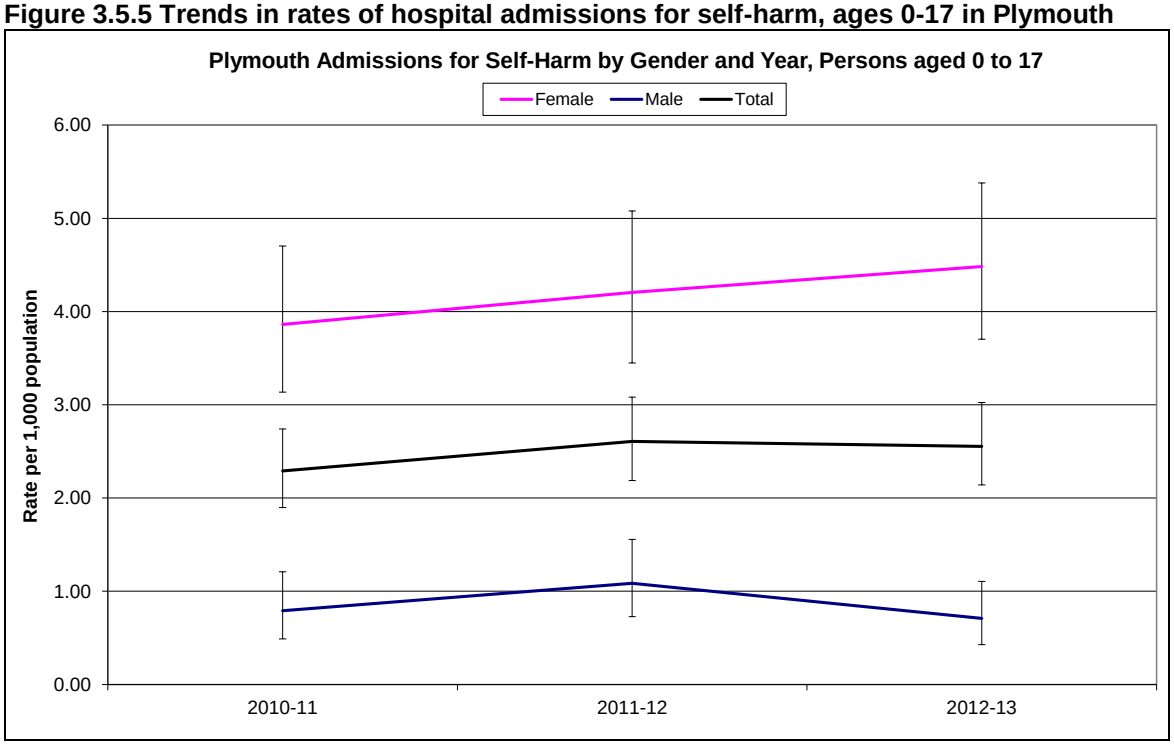
Figure 3.5.5 shows rates of admissions for young people in Plymouth. The data is not available as far back as in Devon, due to a data warehousing issue but is shown for the latest three years available. Admission rates for self harm are higher than Devon overall in Plymouth, but are showing a similar pattern with females having higher rates than males, and female rates increasing overall and make rates decreasing. Torbay rates of admissions for young people show the same pattern with rates in males lower but staying relatively stable and rates showing a greater increase in females.

Figure 3.5.4 Trends in rates of hospital admissions for self-harm, ages 0-17 in Devon



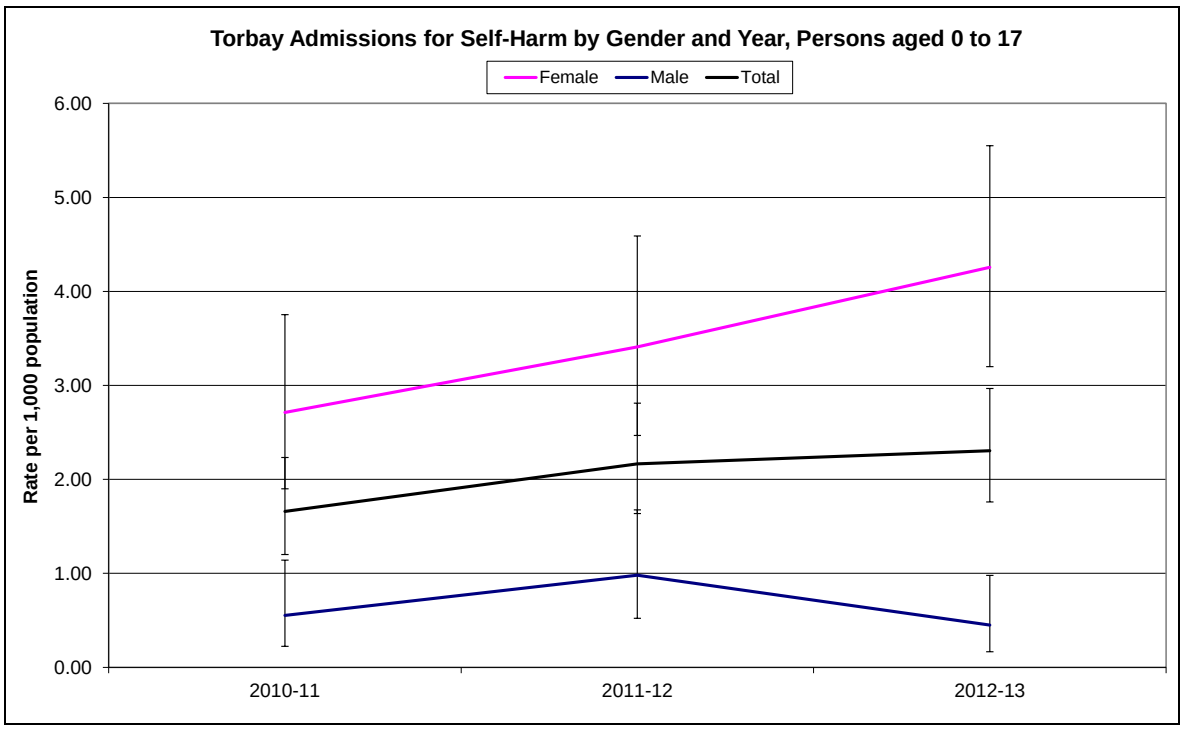
Source: Secondary Uses Service Commissioning dataset

Figure 3.5.5 Trends in rates of hospital admissions for self-harm, ages 0-17 in Plymouth



Source: Secondary Uses Service Commissioning dataset

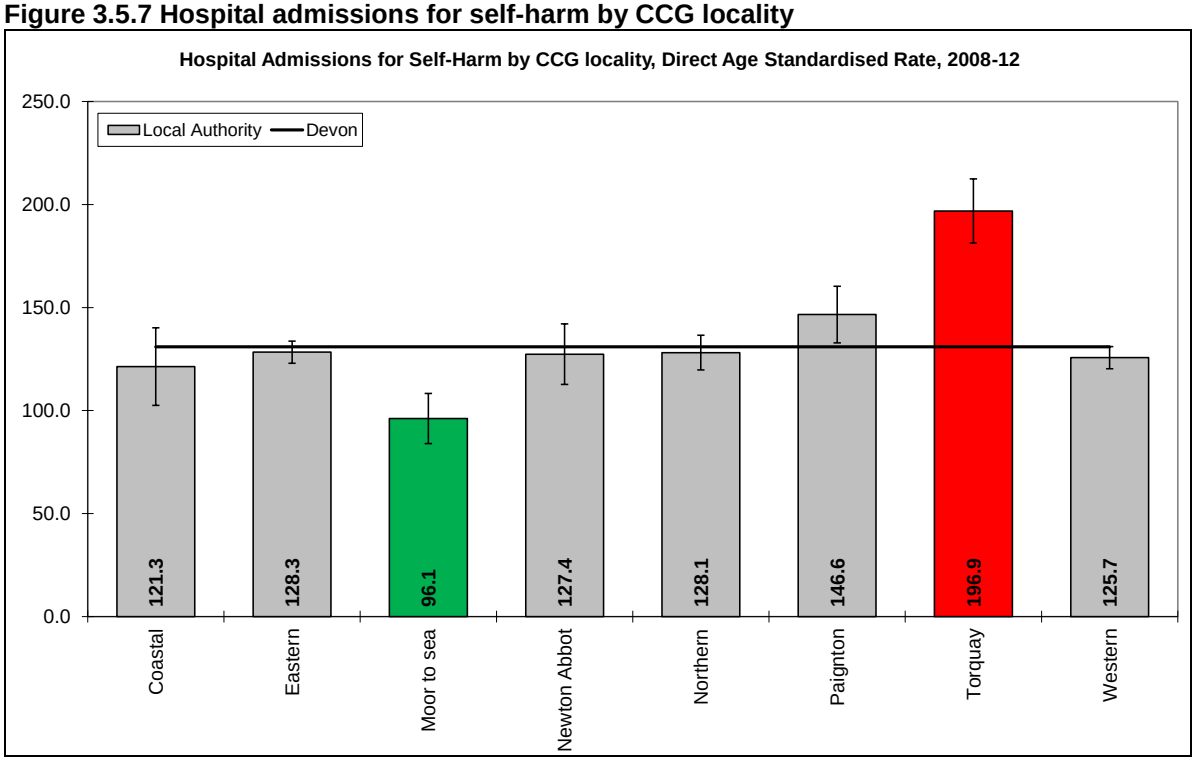
Figure 3.5.6 Trends in rates of hospital admissions for self-harm, ages 0-17 in Torbay



Source: Secondary Uses Service Commissioning dataset

The rate of admissions year on year fluctuate, so to give a more stable picture the following graph looks at rates by CCG localities for the five year period from 2008 to 2012. This shows there are two areas that are statistically significantly different to the cluster wide rate, Torquay has a statistically significant high rate and Moor to sea locality has a statistically significant low rate.

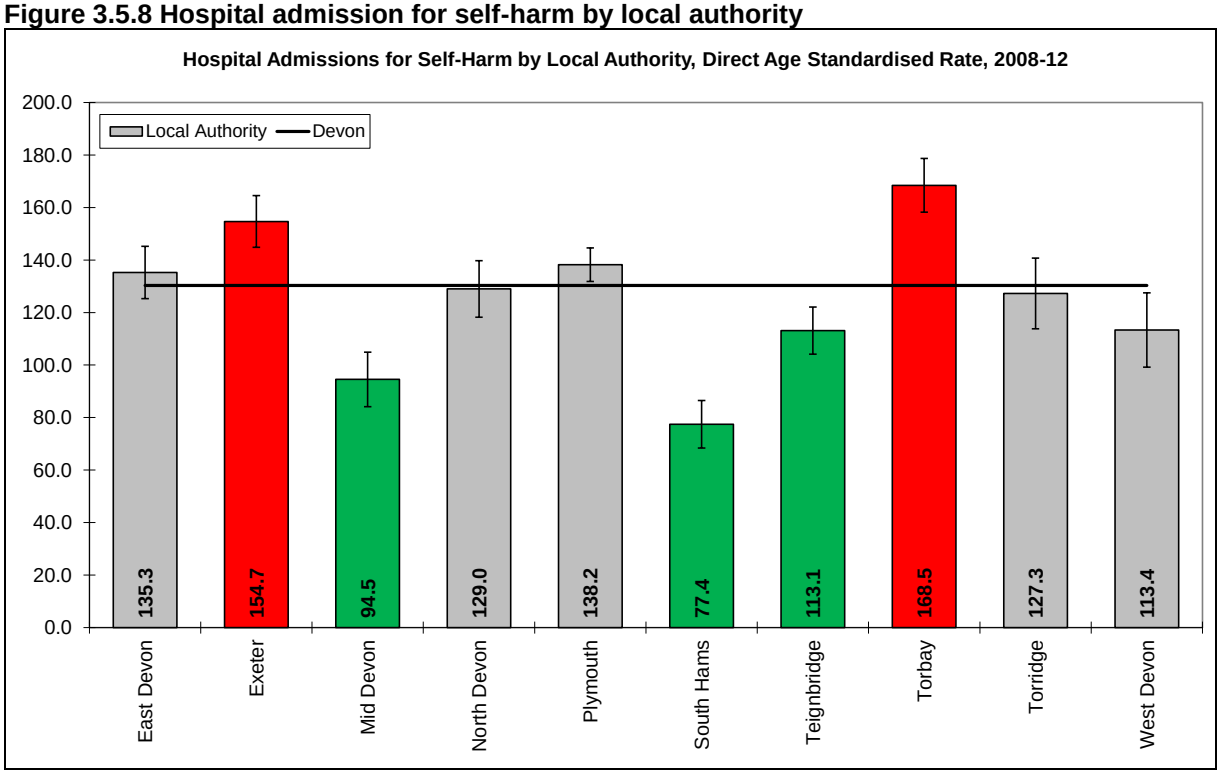
Figure 3.5.7 Hospital admissions for self-harm by CCG locality



Source: Secondary Uses Service Commissioning dataset

A slightly different picture is shown looking at the same information by Local Authority. The graph below shows that the rates are statistically significantly higher in Exeter and also in Torbay. Mid Devon, South Hams and Teignbridge all have statistically significantly lower rates of admissions.

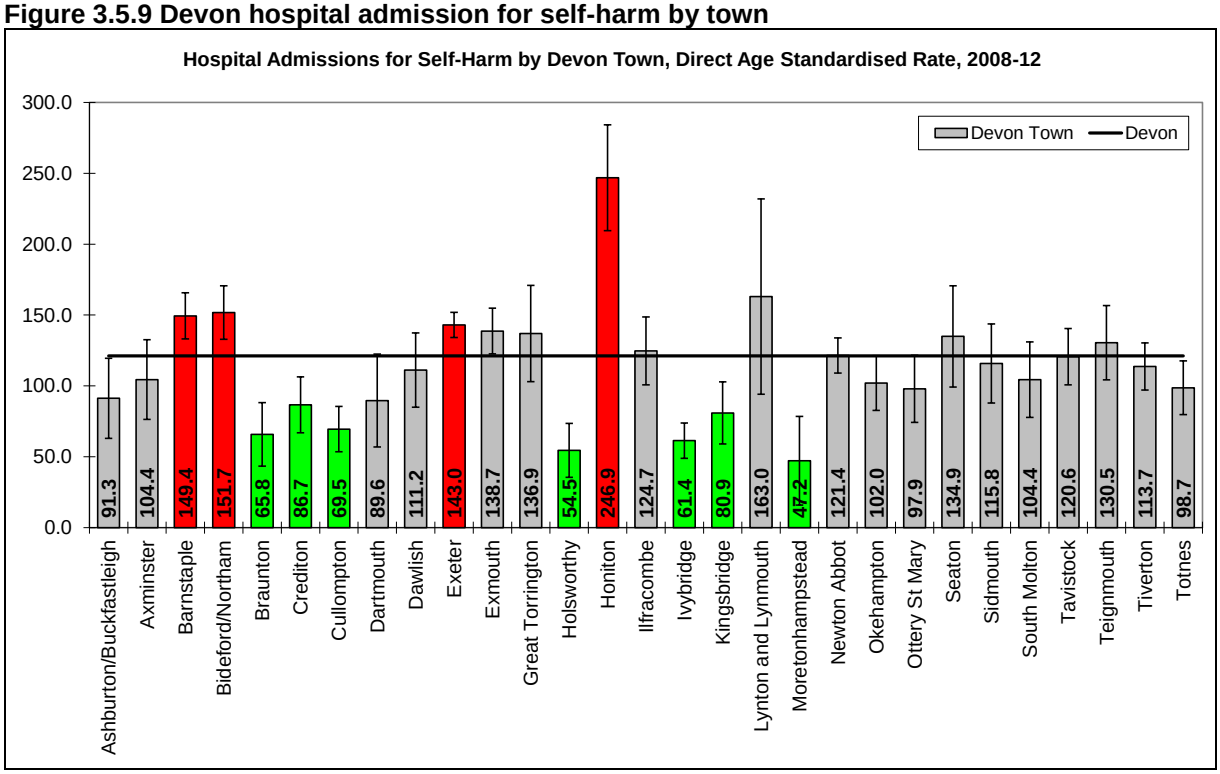
Figure 3.5.8 Hospital admission for self-harm by local authority



Source: Secondary Uses Service Commissioning dataset

Within the local authorities there are further variations by market town. The graph below shows the admissions by town for the same time period, clearly showing statistically significant high rates of admissions in Honiton, Barnstaple, Bideford/Northam and Exeter. Significantly lower rates were seen in Braunton, Crediton, Cullompton, Holsworthy, Ivybridge, Kingsbridge and Moretonhapstead.

Figure 3.5.9 Devon hospital admission for self-harm by town



Source: Secondary Uses Service Commissioning dataset

3.6 Child and Adolescent Mental Health Service Activity

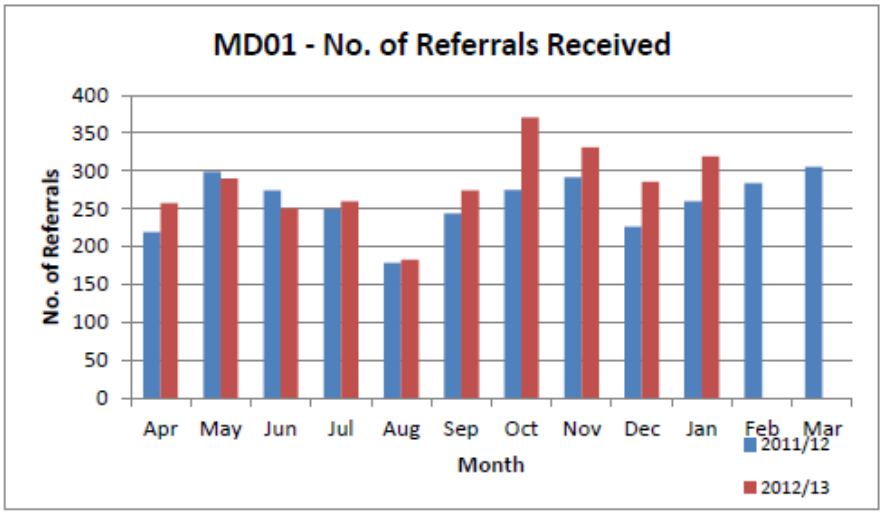
Activity data in CAMHS does not provide robust enough recording to enable prevalence of conditions to be identified locally. The recording of diagnosis is not complete in many cases, and as a result any reporting would not be a true picture of the burden of conditions in the population.

It is recommended that data quality is considered as part of the planned CAMHS service review by the Partnerships Directorate later this year to enable the estimated and actual need to be compared.

Activity in CAMHS is monitored against the contract on a monthly basis and the following information has been taken from this process. As a result, the indicators are not necessarily ones that would be chosen to present but feel that in the absence of anything else it is worth identifying what is available.

Figure 3.6.1 below shows the trend in referrals received by CAMHS, comparing 2011/12 to 2012/13 up to January 2013. This shows higher numbers of referrals in the latest financial year compared to 2011/13, particularly in the later part of the year.

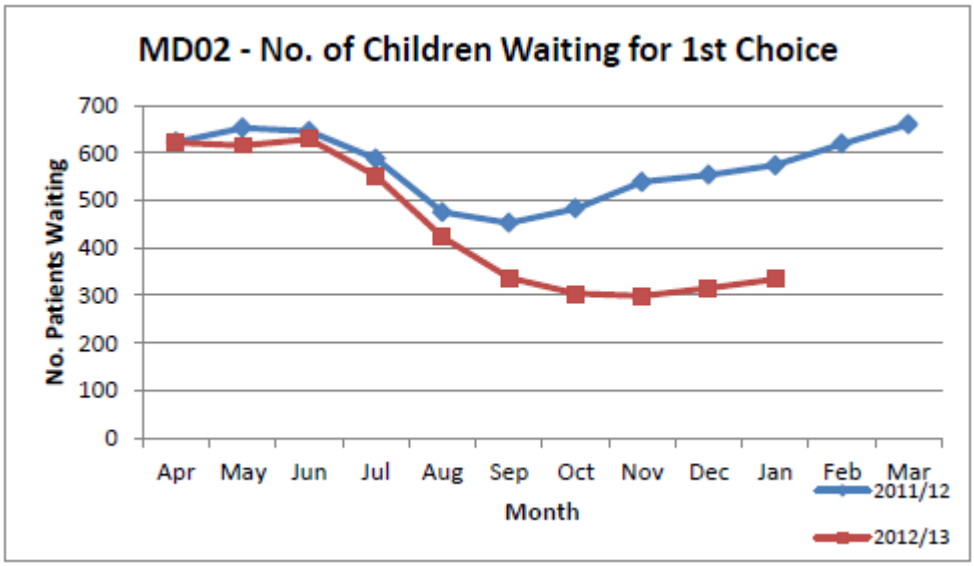
Figure 3.6.1 Trends in referrals to CAMHS in Devon



Source: CAMHS ICS contract monitoring

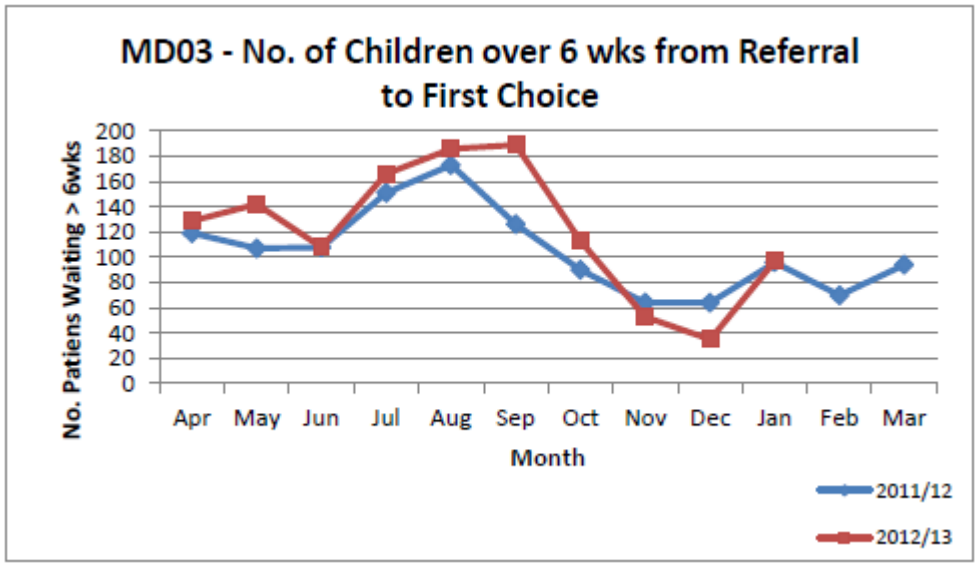
A contract target is set around waiting times from referral to first Choice appointment. Figure 3.6.2 below shows the number of children waiting for their first Choice appointment and figure 3.6.3 shows how many have been waiting 6 weeks or more. In 2012-13, the number of children waiting for first Choice appointments is generally lower than the number in 2011-12. The number of children waiting over 6 weeks for a first Choice appointment in 2012-13 has followed a fluctuating but relatively similar pattern to 2011/12. Figure 3.6.4 shows the same data as a percentage and shows there have been higher proportions of children waiting over 6 weeks in 2012/13 than 2011/12, particularly in the later half of the year.

Figure 3.6.2 Trends in referrals to CAMHS in Devon waiting for first Choice appointment



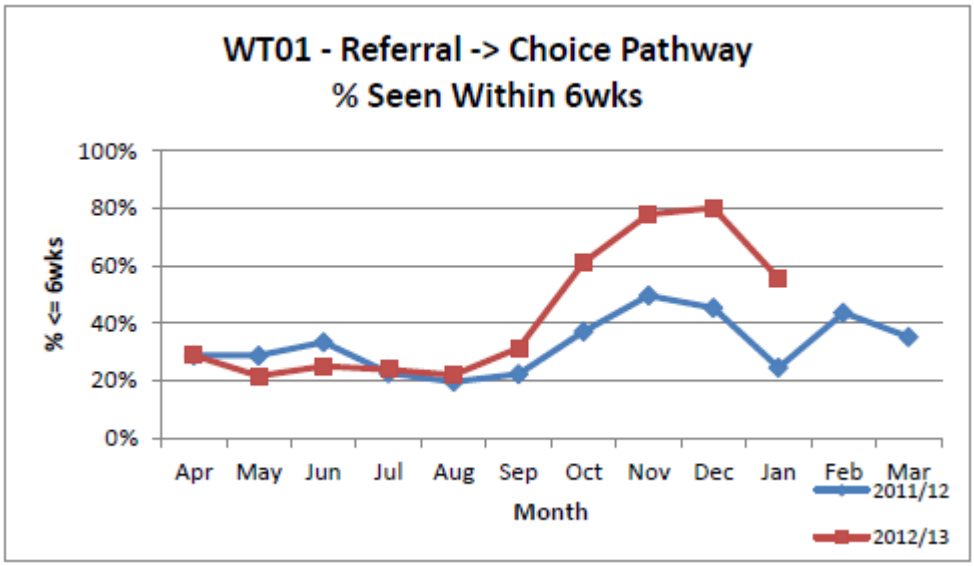
Source: CAMHS ICS contract monitoring

Figure 3.6.3 Trends in referrals to CAMHS in Devon waiting over 6 weeks for first Choice appointment



Source: CAMHS ICS contract monitoring

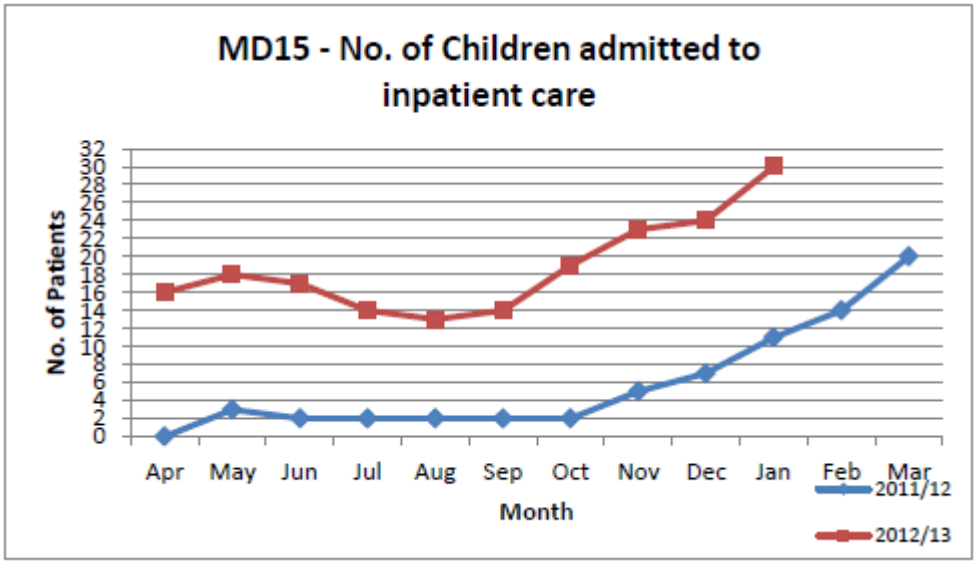
Figure 3.6.4 Trends percentages of referrals to CAMHS in Devon waiting over 6 weeks for first Choice appointment



Source: CAMHS ICS contract monitoring

Figure 3.6.5 shows the number of children receiving services from CAMHS who were admitted to inpatient care. The numbers of inpatient stays were higher in 2012/13 than 2011/12 and the trend was showing increased numbers for later in the year.

Figure 3.6.5 – Number of children known to CAMHSs admitted to inpatient care



Source: CAMHS ICS contract monitoring

3.7 Perinatal Mental Health

Pregnancy and the period after childbirth can bring a range of emotional changes for the mother, her partner and other members of the family. Many mothers find these changes are a positive experience, but some undergo emotional upheaval that can result in mental health problems. The National Institute for Health and Clinical Excellence (NICE) *Guidance for Antenatal and Postnatal Mental Health*[38] recognises that mental health disorders during pregnancy and the postnatal period can have serious consequences for the health and wellbeing of the mother, her baby and other family members. Therefore, this is also a time for preventative perinatal interventions in order to promote strong attachment and positive parenting, thereby reducing mental health problems later for both mother and child.

Mothers in the perinatal period, so during pregnancy, childbirth and the postnatal year, suffering from mental health problems, frequently do not receive the care that they need, even though perinatal mental health has been recognised as a significant public health concern. There is extensive evidence that investment in mental health provision for the perinatal period has a very significant cost–benefit effect in terms of future use of health and social services, by both parents and children. Past policy initiatives[39] [40] [41] have emphasised the need for a perinatal mental health strategy in every locality. NHS Devon published a Perinatal Mental Health Strategy in February 2009.

[38] NICE (2004) *Guideline for antenatal and postnatal mental health. Scope Document*
[39] Department of Health and Department for Education and Skills (2004) *National Service Framework for Children, Young People and Maternity Services*
[40] Department for Education and Skills (2004) *Every Child Matters: Change for Children*
[41] NICE (2007) *Antenatal and Postnatal Mental Health-Clinical management and service guidance*

It is important that services are inclusive and flexible enough to meet the needs of all women and families. Due to its geographical diversity, Devon has specific challenges in ensuring that services are equitable and accessible, as rurality can provide a particular difficulty. Services need to be readily accessible to vulnerable and hard to reach families, those who are socially disadvantaged and those from ethnic minority groups. This may require professionals to practice in outreach settings and to provide consultancy support through the tiered approach to service delivery.

In Devon in any one year, it is estimated that between 750 and 1100 cases of postnatal depression will be diagnosed and between 7 and 14 women will experience puerperal psychosis, in particular teenage mothers. In Plymouth this would equate to between 320 and 500 cases of postnatal depression and between 3 and 6 cases of puerperal psychosis, and in Torbay, 150-225 cases of postnatal depression and between 1 and 3 cases of puerperal psychosis. Although local data is not systematically collected, the general perspective is that the local picture is similar to nationally. However, evidence from work in Exeter from 2001-2004, which focused heavily on perinatal mental health promotion, reported prevalence rates of around 20%. This correlates with national evidence that indicated that although on average postnatal depression rates are between 10-15%, deprived areas may experience higher prevalence of up to 40%. Across Devon, Plymouth and Torbay as shown in figure 2.4.1, there are variations in deprivation so this needs to be taken in to account across the area.

3.8 Recommendations

1 As part of the planned CAMHS service review by the Partnership Directorate later this year, service activity recording and data quality are reviewed with plans for improvement agreed where necessary.

2 Carry out further analysis of self-harm activity data to gain a better understanding of the variation shown to inform future service provision

4. Young Adults

Introduction

The period of changing from being a child to an adult can be challenging for many. It is a period when personalities are further developed and independence is established. For many this can be a transition from school to work, from living with families to living alone and there are many challenges that need to be overcome. For some this can be difficult due to already established mental health difficulties, and for others this can be a time when mental health problems can arise.

4.1 Transition from CAMHS to AMS

Transition between services can be a difficult time for vulnerable young people and therefore it is important to ensure is a well-managed process. The transition can be difficult for a number of reasons, one of which is the age thresholds and severity thresholds for different services and identifying and preparing for transition to ensure

that young people do not get lost in this transition due to their age or severity of condition. Some young people may transition to services other than adult mental health services, which may offer a different type and level of service which may take some adjusting too. Good life-course models of care, communication and planning are needed to ensure continuity of appropriate care is provided.

This section is awaiting local information around transition in Devon from Lyn Davies in Devon's Integrated Children's Services. This will be added once it is provided.

4.2 Manifestation of personality disorders

Personality disorders are increasingly recognised as major mental health issues and the management and diagnosis of these can be complex. Personality disorders develop whilst growing up and mean some aspects of your personality can cause repeated problems in life, particularly in developing and maintaining relationships with friends, family, employers and care services. The International Classification of Mental and Behavioural Disorders (ICD-10) (World Health Organization 1992), defines a personality disorder as: a severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality and nearly always associated with considerable personal and social disruption. The aetiology of personality disorders remains unclear but there is evidence that links these behaviours with dysfunctional early environments that prevent the development of the ability to adapt to situations in regular ways. Factors in childhood that evidence has linked to this are sexual abuse, physical abuse, emotional abuse, neglect, bullying[42]. Within ICD-10 classifications there are nine categories of or personality disorder and ten categories within the DSM-IV. Clinicians find these classifications difficult to use as patients often fall in to more than one category which makes it difficult to use.

Studies estimate that personality disorder in some form affect 4-11% of the UK population. This is particularly evident in prison populations with 60-70% suffering from some form of personality disorder.

Personality disorders are included within this section for young adults as it is not normal for personality disorders to be diagnosed in children and adolescents as the development of personality is still taking place and traits may not continue in to adulthood. Although traits may have been evident earlier and would have had to have been managed, once over 18 and in to young adulthood personality disorders are likely to be diagnosed and therefore learning to cope and manage them in this part of the life course is important.

Treatment and activity

Psychotherapy is the basis of care for personality disorders. People with personality disorders have poor or limited coping skills and psychotherapy aims to improve perceptions of and responses to social and environmental triggers to help reduce the risk associated with this.

[42] A guide to working with offenders with personality disorders, Dept of Health (February 2011)

Devon Partnership Trust Activity data

During the financial year 2012-13 Devon Partnership Trusts Personality Disorder Service had 52 Devon and Torbay patients referred to the service. In March 2013, there were 94 active cases open within the personality disorder service. This may well not be a true reflection of the number of people in Devon and Torbay with a diagnosed personality disorder however, as many patients are seen within the service for a period of time and then discharged until the service is again needed.

4.3 Eating Disorders

People with eating disorders make up a substantial proportion of those seen in mental health services. Previous surveys in Devon and Cornwall suggested 10%, and attempts are being made to use the Devon Partnership Trust RIO information system to identify current representation. The chronic nature of eating disorders and the numerous psychiatric and physical co-morbidities and complications, mean that people who recover often require multi-dimensional care over a period of years. While most people develop an eating disorder during adolescence, the long-term nature of the disorder means that people requiring treatment will span across the transition from adolescence into early adulthood, and can continue well into adulthood, and even older adulthood. Most people who develop an eating disorder are female, but around 10% are male. While many young people are concerned about weight and shape, there is sub-group whom for a number of reasons, including genetic predisposition, psychological influences, and life experiences develop an eating disorder.

Eating disorders comprise a range of syndromes and encompass physical, psychological and social features. The main eating disorders are anorexia nervosa, bulimia nervosa and binge eating disorder and there are also less common atypical eating disorders.

The NICE guidelines around treatment and management of eating disorders have worked to pull together data from a range of studies to identify prevalence of eating disorders in the population. It estimates the prevalence of new cases of anorexia nervosa to be around 19 per 100,000 in the female population and the prevalence of bulimia nervosa to be between 0.5% and 1%[43]. The highest rates were identified to be among young females aged 13-19. Eating disorders also affect men, although numbers are generally lower with the prevalence of anorexia nervosa being 2 per 100,000 males and around 90% of patients diagnoses with bulimia are female. Table 4.3.1 below shows these estimates applied to the local population giving an estimate of new cases expected per year. The government strategy for mental health[2] gives slightly different estimates of prevalence based on the ones in NICE but are for patients overall suffering with eating disorders. They estimate the prevalence of anorexia nervosa to be nearly 1% of females aged between 15 and 30 and the prevalence of bulimia nervosa to be between 1% and 2%. Table 4.3.2 below shows these prevalence figures applied to our local populations in Devon, Plymouth and Torbay. Although locally the prevalence is not known, in Plymouth it is felt a higher prevalence may be evident due to the numbers presenting to the service.

[43] NICE (2004) *Eating Disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders.* NICE Clinical Guideline 9, available at: http://guidance.nice.org.uk/CG9

Table 4.3.1 – Estimated prevalence of new cases of anorexia nervosa and bulimia nervosa applied to local populations

	Anorexia nervosa estimated prevalence		Bulimia nervosa estimated prevalence
	Males	Females	Females
Devon	5	45	1185-2371
Plymouth	2	16	431-863
Torbay	1	8	207-414

Source: [1] NICE (2004) *Eating Disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders* [3] and Patient and Practitioner Services Agency

Table 4.3.2 – Estimated overall prevalence of anorexia nervosa and bulimia nervosa applied to local populations

	Anorexia nervosa estimated prevalence	Bulimia nervosa estimated prevalence
Devon	706	706 - 1412
Plymouth	329	329 - 659
Torbay	122	122 - 245

Source: No Health Without Mental Health: Delivering better mental health outcomes for people of all ages[2] and Patient and Practitioner Services Agency

Community Services in Devon and Torbay

Within Devon Partnership a Consultant Clinical Psychologist is commissioned to work with people with eating disorders. This is the only specialist professional element within community eating disorders. Therefore, community and medical services provide care without the specialist support of psychiatry and dietetics and limited psychotherapy provision. Within the role of the consultant psychologist, training is offered to clinicians across the trust, individual or group consultations are provided on request along with joint reviews/assessments on request. This role also provides 2 sessions of psychotherapy to provide cognitive analytical therapy (CAT) for people with eating disorders. A range of clinicians have been supported from this role including staff from; secondary adult mental health, primary care (particularly GPs), liaison psychiatry, acute general wards, older adults, learning difficulties, ENDAS, forensic, CAMHS, psychological therapies and psychotherapy. Devon Partnership Trust also commissions some therapy from the charity Eating Disorders Support in Plymouth. There is currently no community dietician supporting eating disorders and only a couple of hour's community specialist medical support from a consultant psychiatrist.

There is currently no care pathway for eating disorders in Devon Partnership Trust. People with an eating disorder would be identified through their GP, and GPs have monitoring guidelines. If a patient has bulimia and no other co-morbidity, they may then get referred to the depression and anxiety service for cognitive behavioural therapy for bulimia, or in addition, sent to Eating Disorder Service (EDS) in Plymouth if they are in South Devon. If they have anorexia, they would be referred onto the local mental health teams for assessment. They are then often referred for a care plan, which could include referral to the Haldon Unit, referral to a provider for psychological therapy, further assessment for co-morbidity (personality disorder, addictions, ASD for example), social supports, work support, psychiatric medical

review, and housing as examples. In addition, there is the relationship that people form with their care coordinators over time which is seen as an important part of their recovery process which can go over a period of years.

In Plymouth a care pathway for eating disorders has been developed which is different than in Devon and Torbay. A Severe Eating Disorder Consultation and Assessment Service (SEDCAS) has been developed which aids recovery in people with eating disorders by working together with colleagues in Plymouth Community Healthcare (CIC), Plymouth Hospitals NHS Trust and also Primary Care. This service enhances the delivery of safe and effective interventions appropriate to the individual stage in a person's recovery. A new Eating Disorder Day Service has also been developed and SEDCAS provides a strategic and clinical overview to the service, which enables the continuation of care seamlessly within community services. Work is underway to develop a care pathway for children and adolescents in Plymouth. This will include making SEDCAS ageless to try to reduce the concerns and problems that arise when patients transition between services.

About 20% of people will develop Severe and Enduring Eating Disorders (SEEDs) which will require considerable care and support from general medical services, specialist services, secondary mental health services, community care home initiatives, and palliative care. Some individuals may enter the mental health services through admission in the general acute ward, either for the effects of severe starvation, or in combination of anorexia nervosa and other conditions like diabetes and cystic fibrosis. There will be people too who have long term eating disorders who are known to learning disability teams, forensics and older adult teams.

The Haldon

The Haldon is a leading centre treating people with severe eating disorders delivered by Devon Partnership Trust. It has its own unique programme, called The Haldon Approach, offering a comprehensive dialectical behaviour therapy (DBT), including Radical Openess DBT in a specialist residential inpatient service for eating disorders. The unit offers up to 20 places at any time for people with severe eating disorders, both on a residential and non-residential basis. They have 12 bed spaces for people requiring intensive treatment and also have community accommodation nearby for those attending a five day per week intensive, non-residential programme. Referrals can be taken from within Devon and also by NHS referral from outside of area or on a private patient basis. From 2013-14 the commissioning arrangements have changed and patients from across the South West will all have equal access to the available beds on Haldon.

Data from The Haldon

There are variations in the length of waiting times experienced by different referral paths to The Haldon. A certain number of beds are reserved for referrals from outside of Devon and as a result these referrals tend to have lower waiting times. Due to patients from Plymouth being an outside referral, the waiting times are considerably lower. Table 4.3.3 below shows the mean waiting times in days from 2010-2013.

Table 4.3.3 – Devon activity in The Haldon for 2010-11 to 2012-13

Region	Mean waiting time (days)
Devon	78.6
Torbay	85.1
Plymouth	11.6

Source: : The Haldon, Devon Partnership Trust

The following tables show the number of referrals, admissions and lengths of stays from Devon in to the Haldon broken down into patients who are under and over 20 years old.

Table 4.3.4 – Devon activity in The Haldon for 2010-11 to 2012-13 for Under 20 year olds

Patients aged under 20 years	2010/11	2011/12	2012/13
Total number referrals	12	11	11
Total number admissions	8	7	6
Mean length of stay (days)	72.4	129.3	126.3*
	*2 patients excluded as currently admitted		
Duration of illness			
Mean duration of illness (years)	1.9	2.5	4.5
Range (years)	5-1	4-1	7-2

Source: The Haldon, Devon Partnership Trust

Table 4.3.5 – Devon activity in The Haldon for 2010-11 to 2012-13 for 20 year olds and above

Patients aged 20 years and above	2010/11	2011/12	2012/13
Total number referrals	33	34	30
Total number admissions	16	25	19
Mean length of stay (days)	93.1	141.4	74.4*
	*3 patients excluded as currently admitted		
Duration of illness			
Mean duration of illness (years)	13.2	15.4	14.8
Range (years)	26-6	44-1	38-3

Source: The Haldon, Devon Partnership Trust

A higher proportion of referrals and admissions were in the older age group of over 20 year olds and these are likely to be the patients with the more severe and enduring eating disorders and the mean length of stay is slightly longer which is likely to reflect this. The majority of admissions were for patients with a diagnosis of anorexia nervosa. There were admissions for other eating disorders but this breakdown has not been provided as the numbers are too low to be shared. Although the unit can take both male and female patients, the majority of patients were female.

It is also possible to identify where patients are readmitted from the data available. In Devon, table 4.3.6 shows the number of readmissions within 1 year to be 6 for the years 2011-12 and 2012-13. This equates to just under a quarter and just under a third of patients respectively being readmitted within a year.

Table 4.3.6 – Readmissions to The Haldon for 2010-11 to 2012-13 for all ages

Readmissions - all ages	2010/11	2011/12	2012/13
Readmissions within 1 year	0	6	6

Source: The Haldon, Devon Partnership Trust

Similar data is available for patients referred and admitted to the Haldon from within Torbay, however the numbers are clearly lower and therefore the same level of detail cannot be presented. The table below shows activity for 2010-11 to 2012-13 combined and for patients of all ages.

Table 4.3.7 – Torbay activity in The Haldon for 2010-11 to 2012-13 for all ages

Patients - All ages	2010/11 - 2012/13
Total number referrals	20
Total number admissions	11
Mean length of stay (days)	97
Duration of illness	
Mean duration of illness (years)	9.2
Range (years)	42-1

Source: The Haldon, Devon Partnership Trust

Data for Plymouth shows referrals and admissions for 2010-11 to 2011-12, however there were no referrals or admissions for 2012-13. The mean length of stay varies considerably between the two years going from 161 days in the first year down to 30 days in the second.

Table 4.3.8 – Plymouth activity in The Haldon for 2010-11 to 2011-12 for all ages

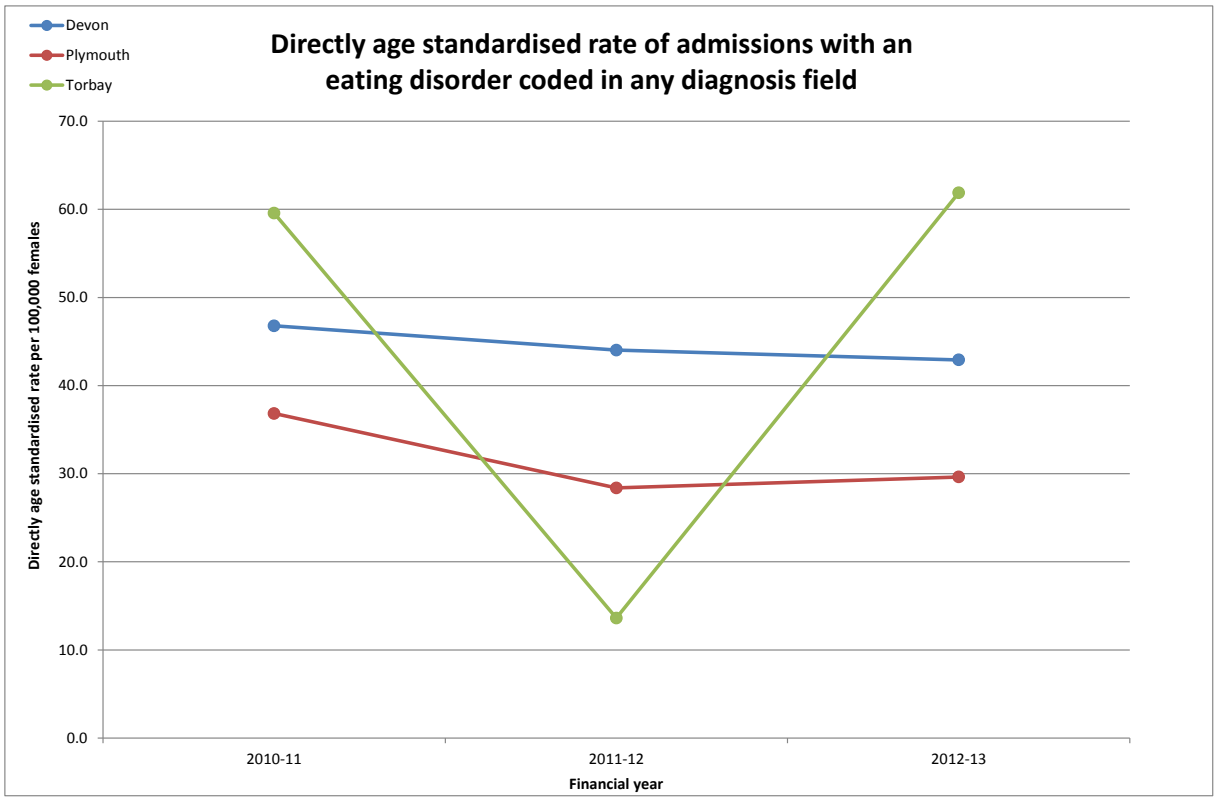
Patients - All ages	2010/11 - 2011/12
Total number referrals	12
Total number admissions	10
Mean length of stay (days)	125.2
Duration of illness	
Mean duration of illness (years)	11
Range (years)	37-3

Source: The Haldon, Devon Partnership Trust

General Hospital Admissions

The table below shows the rates of general hospital admissions where an eating disorder was one of the diagnosis codes. Admissions were predominantly for females and therefore the female population has been used for the calculation of the rates. These rates show a very slight decline in Devon and Plymouth but there are no significant differences in rates over time. In Torbay there is a clear dip in rate in 2011-12 and this does show a significant difference between years.

Figure 4.3.9 – General Hospital activity for patients with a diagnosed eating disorder from 2010-11 to 2012-13



Source: Secondary Uses Service Commissioning dataset

4.4 Student mental health

The transition to student life can be a difficult and vulnerable time for many people. For many this can be the first time of living away from the support of both family and friends whist adjusting to new surroundings, establishing new relationships and starting new courses. Any parts of this can lead to difficulties with stress and anxiety and during time at university many students will experience symptoms of mental ill health. The main mental health problems students experience are depression, eating disorders, bipolar disorder, schizophrenia and problems associated with drugs and alcohol.

To support students at Exeter University suffering with mental health conditions the university provide Reed Mews Wellbeing Centre. This offers evidence-based talking therapies for students with psychological and emotional needs as well as mental health support for students with a broad spectrum of mental health difficulties. The centre is staffed by qualified practitioners, including mental health experienced occupational therapists, psychologists, counsellors and CBT therapists, and psychological wellbeing practitioners. The centre is open every day from 9-5pm and a reduced skeleton service is offered outside of term time. The service estimate they see between 1,000 and 1,300 students a year, of whom most are undergraduate as well as some overseas and international students.

The main problems students present with are depression and anxiety. There are also many life stage associated difficulties that affect the predominantly late adolescent age including transition, attachment and separation difficulties and achieving independence, sexual identity and orientation, bereavement and loss and relationship difficulties.

The service support a number of students with eating disorders for which they do not feel that the NHS services available offer sufficient support to these students. They also find it challenging meeting the needs of students from China and other far eastern destinations for whom the cultural norms of their home countries may conflict with westernised psychological and psychiatric services. The centre also support students with bi-polar and psychotic-spectrum disorders and work alongside NHS crisis teams, Liaison Psychiatry, STEPS and GPs to do this.

The University of Plymouth offers a student counselling service to enable students to become more effective in their lives both within and outside of the university by supporting students to identify and overcome barriers to achieving potential, promote and develop life skills to empower students to make informed choices in their academic, personal and social lives. The student counselling service works alongside established mental health services and does not aim to replicate these. Student counselling offers a range of options including workshops, groups, a variety of self-help resources, 1:1 counselling and CBT, as well as referral to other practitioners and specialist services when appropriate. The service can support students with severe and enduring mental health issues, however, if students have established support from secondary services it is rarely appropriate for the counselling service to become involved apart from as a point of liaison with other services within the university. The service also aims to support tutors and staff with a pastoral care role, to enable them to maximise their effectiveness when working with individuals, particularly those they have concerns about.

The Drake Circus and Marjon sites have access to services Monday to Thursday from 8.45 to 5.00pm and Friday 8.45 to 4.30pm. Students at the knowledge spa on the Truro site have access to services two days a week on Wednesday and Thursday.

Table 4.4.1 below show the number of different contacts that have taken place in the student counselling service. It shows a slight increase between 2010-11 and 2011-12. Table 4.4.2 shows a breakdown of the categories that the issues students presenting with were experiencing in 2010-11. The numbers give an insight in to the number of students of students in Plymouth experiencing different concerns and the need for provision of the service to students.

Table 4.4.1 – Plymouth University Counselling Service contacts statistics

	2010-11	2011-12
Total number of students offered 1-1 intervention	810	977
No of students offered individual appointments	792	840
Average interviews offered (inc DNAs/cancellations)	3.9	3.6
No of individual appts offered	3028	3045

Source: Plymouth University Counselling Service

Table 4.4.2 – General categories of reasons for contacts with the Plymouth University counselling service

Category	No. of individual reports 2010/2011
Anxiety	430
Academic	344
Depression/Mood Changes	321
Relationships	278
Bereavement/Loss	197
Self and identity issues	160
Abuse	125
Self harm (including suicidal ideation/intent)	87

Source: Plymouth University Counselling Service

4.5 Service User Engagement

Engaging with service users is vital to ensure services are accessible and appropriate for young people. In 2011, LINk Devon, who are the local involvement network in Devon, produced a report titled 'Access to Emotional Wellbeing services in Devon'[44]. This report looked at a provisional examination of the concerns raised by adults in the community about accessing these services. At the same time as carrying out work looking at adult's access, case studies from young people were also collected to enable a young people's report to be produced. At the same time, LINk Devon's active network of young people – LOGO – also became involved in raising awareness of the project through peer groups and school and also carried out focus group sessions and workshops with young people to investigate what the term emotional wellbeing means to them. To add to this evidence base, a short survey was carried out, aimed at 14-25 year olds who had sought professional help for an emotional problem to gather feedback and evidence around what works well and where further work may be require. LINk acknowledge in their report that a rapid approach to gathering evidence due to resource limitations, but the information does still provide valuable insights.

[44] http://www.linkdevon.org.uk/uploads/LINkDevonReportFinalEWBJune11.pdf Dowloaded on January 31st

Whilst undertaking this project, LINk Devon was able to engage with a number of other organisations that had also carried out research in to what young people think and feel about services available in relation to emotional wellbeing. Young Devon had carried out a youth enquiry into young people's views on vulnerability and resilience in Devon. Some of the recommendations were to 'make emotional and mental health workers more known and accessible to young people' and to 'promote awareness that young people feel vulnerable to this issue'.

The Intercom Trust organised a conference in 2012 which focused in part on how health services and access to them could be improved for lesbian, gay, bisexual and transgender (LGBT) people. Feedback on the day referred to common issues such as; a fear of disclosing their sexuality to GPs or at school, some experience of homophobia, bullying or threatening behaviour. These issues can often lead to experiences of depression and other health problems. During the day, opportunities were available for exploring how health services could be designed and delivered to ensure they are more inclusive for the needs of LGBT people in the future. Areas considered were awareness raising and education about LGBT in schools, improved access to healthcare and more funding for LGBT peer support networks in the South West.

Plymouth LINk produced a report in 2012 based on the results of a survey that they had carried out with young people in Plymouth. Several recommendations were made in relation to how service commissioners and providers could engage better with young people and a crucial recommendation was to 'identify opportunities to improve staff training in communicating with young people'.

Time to Change is an anti-stigma campaign run by leading mental health charities Mind and Rethink Mental Illness. The aim of the campaign was to work together to attempt to end the discrimination that surrounds mental illness. With the responsibility for public mental health moving across to Local Authorities, the Joint Commissioning Panel for Mental Health published guidance for Commissioning Mental Health Services which urges local authorities to sign up to the Time for Change campaign to tackle stigma in relation to mental disorder.

The conclusions of the LINk Devon report highlight a number of findings that identify important factors that contribute to services working well. These include: Staff establishing a rapport with an individual through good communication, trust and ability to listen. Also important was that young people know where to go to find the help they need and that they can be confident that the service they access is confidential, reliable and meets their needs. It is identified that more work could be done within schools to explore emotional health and wellbeing and to raise awareness of services locally to find information, advice and support.

There was also evidence similar to the adult findings that where communication breakdowns occur between professionals and the individual, this can cause people to disengage with services leading to symptoms worsening. It is highlighted that ensuring good and timely feedback mechanisms are in place to help resolve and address situations quickly and effectively. Similarly where people feel services are

not meeting their needs, individuals should be supported to express concerns so that they can be addressed quickly and not hinder recovery.

The report makes the following recommendations

1. That Healthwatch Devon establishes a robust systematic approach to ensure the voices of children and young people are heard by commissioners and providers of emotional wellbeing services in Devon.

2. That schools and colleges should be encouraged to provide accessible and confidential advice and support for those who are experiencing emotional problems, such as a school counsellor, school nurse or be able to signpost an individual to services such as a peer support group or local charity if the need arises.

3. That more posters are made available around schools, colleges, GP surgeries and community venues informing young people as to where they can go for advice and support and for young people to be involved in the design of this publicity to ensure it is appealing and accessible.

4. That information about peer support groups and other support networks are made available locally, so that the information can be accessed by schools, GP surgeries and statutory and voluntary services.

5. That children and young people are encouraged to feedback their concerns when they are not happy with the service that they are receiving and for them to be supported to do so.

It is recommended that Healthwatch continue to offer support to young people to get help and support in relation to the provision and access to emotional wellbeing services, and that they continue to monitor the outcomes of the recommendations made in the report.

4.7 Employment

Struggling to find work can put a strain on young peoples lives and consequently effect their mental health. Young people with already diagnosed mental health problems may also struggle to find and maintain employment. Being in secure employment can impact on young peoples ability to develop their independence and this is therefore important to their wellbeing in relation to the transition to adulthood. Data around employment is further discussed in section 5.11.

4.8 Recommendations

1 Review current service provision for eating disorders and agree an appropriate care pathway based on the latest NICE guidance

2 Engage with Healthwatch Devon to agree any further consultation and service user engagement in relation to mental health needs and services to build on the work begun by LINk Devon.

5. Adults

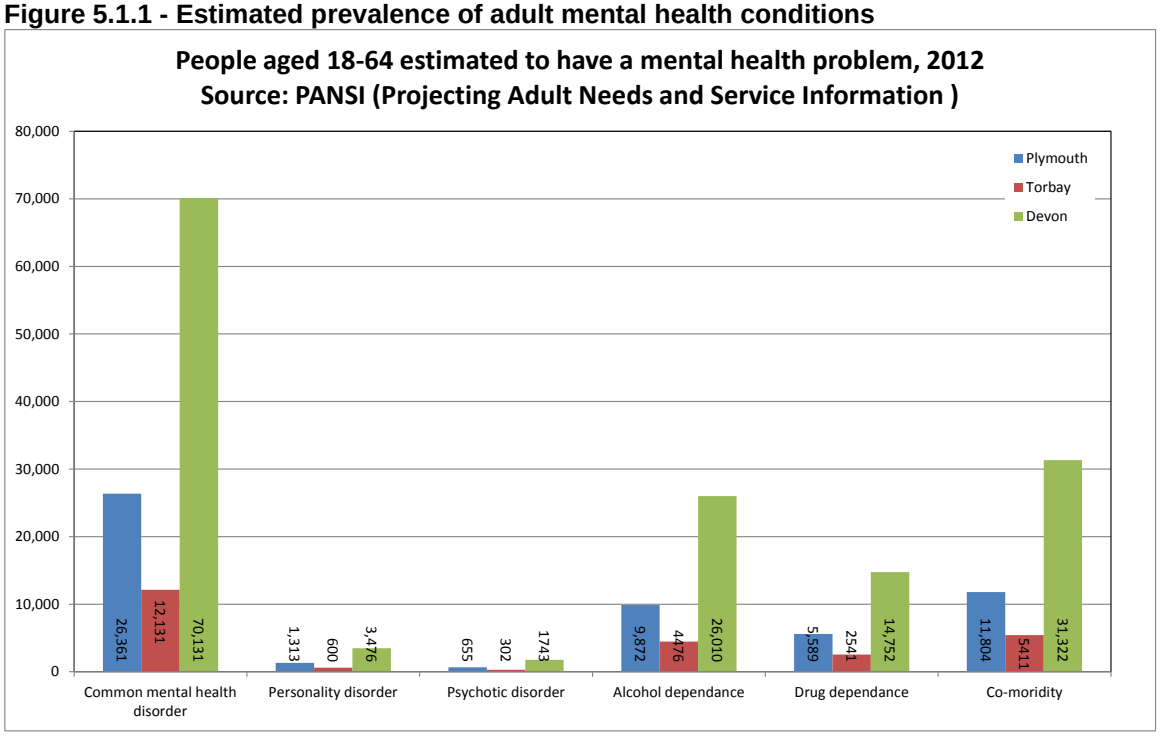
Introduction

During adulthood, mental health can impact upon people's ability to maintain employment, housing and secure family relationships. Some people and groups are more at risk of common mental health problems often as a result of the social, economic or environmental circumstances in which they find themselves. Early identification and supportive intervention, across a range of services and initiatives, will help provide stability and negate the need for further more intensive health care and treatment.

5.1 Prevalence

The following data is taken from PANSI (Projecting Adult Need and Service Information). The numbers are estimated using the results of the Adult Psychiatric Morbidity Survey which is applied to the local populations. Figure 5.1.1 below shows the estimated prevalence of different mental health problems across Devon, Torbay and Plymouth. This shows the greatest burden were common mental health conditions, followed by alcohol and drug dependence. It also shows that a large proportion of people suffer from multiple psychiatric disorders. The data for Devon, Torbay and Plymouth are presented alongside one another but as they are numbers rather than rates they are not comparable as the baseline populations are very different.

Figure 5.1.1 - Estimated prevalence of adult mental health conditions



According to PANSI, 70,131 people in Devon, 26,361 people in Plymouth and 12,131 in Torbay suffer from common mental disorders. Common mental disorders (CMDs) are mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect cognitive ability such as memory but they are able to recognise that they are unwell. Common mental health disorders include different

types of depression and anxiety, and include obsessive compulsive disorder. The Adult Psychiatric Morbidity Survey found that 19.7% of women and 12.5% of men surveyed met the diagnostic criteria for at least one of these conditions.

NEPHO Community Mental Health profiles provide an overview of various indicators around mental health. The profiles give estimated proportions of people with depression and these are calculated using the GP records. They report that the estimated point prevalence for a depressive episode in people aged 16-74 was 2.6% in the UK, with the prevalence rate varying by gender with 2.3% in males and 2.8% in females[45]. The QOF indicators below look at the overall prevalence in the practice population that are likely to reflect a wider definition and improvement in recording since the introduction of the QOF.

5.2 QOF indicators

The Quality and Outcomes Framework is an annual reward and incentive programme for GP practices. It looks at a range of achievement measures or indicators in many different areas of practice. There are a number of QOF indicators looking at how practices care for patients with mental health conditions and these are shown below. The QOF also annually looks at prevalence of a range of conditions including mental health conditions.

The figures below show the estimated prevalence of depression in adults in Devon, Plymouth and Torbay. The prevalence in all three areas is statistically significantly higher than the England average prevalence of 11.7% of the population. The rates in Devon and Torbay are lower than the South West rate of 12.8%.

Table 5.2.1 QOF Prevalence of depression by primary care organisation, 2011-12

	Devon	Plymouth	Torbay	South West	England
2011-12	12.5	15.2	12.5	12.8	11.7

Source: QOF 2011-12, NHS Information Centre

Table 5.2.2 below shows the prevalence of patients within the CCG localities who are recorded on a GP register as suffering from depression and on the GP practice Mental Health Register. The Mental Health register includes patients with schizophrenia, bipolar disorder and other psychoses. Although there is variation between areas, these figures are based on practice registers so differences in recording can affect these prevalence figures.

45 British Medical Association, March 2013. http://bma.org.uk/practical-support-at-work/contracts/independent-contractors/qof-guidance

Table 5.2.2 QOF Prevalence of depression by CCG locality, 2011-12

CCG	Locality	Depression register (18+) Number	%	GP Mental Health Register Number	%
NEW Devon	Eastern Locality	40,638	13.2	2690	0.71
NEW Devon	Northern Locality	16,973	12.8	1350	0.82
NEW Devon	Western Locality	39,687	14.0	2699	0.76
South Devon and Torbay	Coastal	2,873	9.8	313	0.90
South Devon and Torbay	Moor to Sea	3,636	11.2	318	0.81
South Devon and Torbay	Newton Abbot	6,826	12.9	375	0.57
South Devon and Torbay	Paignton & Brixham	7,826	13.0	663	0.91
South Devon and Torbay	Torquay	7,024	12.3	827	1.18
	Devon, Torbay and Plymouth cluster	**125,483**	**13.1**	**9235**	**0.78**
	South West England	**562,911**	**12.8%**	**41,116**	**0.7%**
		5,123,948	**11.7%**	**452,608**	**0.8%**

Source: QOF 2011-12, NHS Information Centre

There are a further 9 QOF indicators around mental health which record the provision of tests for aspects of physical health including alcohol consumption, BMI, blood pressure, glucose testing, cholesterol and cervical screening. There is also an indicator looking at the proportion of patients on the mental health register with an agreed care plan in place and two indicators around patients on Lithium therapy. The data that looks at proportions with testing such as blood pressure, cholesterol and glucose would start to indicate comorbidities. However, the way the QOF data is captured means that only the numbers of tests performed are recorded and not the results of the tests.

Within the QOF, there are further indicators around depression. These are linked to other sections of the QOF around long term conditions, to enable case finding of patients suffering from depression alongside long term conditions. Data is collected around diabetes and coronary heart disease and also looks at the care of people who are identified as suffering from depression by looking at whether an assessment of severity was made and whether further assessments were made in an appropriate time scale. The way the data is collected shows the numbers and proportions of patients offered this intervention and is therefore presented as a percentage. Across Devon, 89% of patients with these long term conditions are being asked about depression compared to 88.6% in England. Of these patients, 94% were assessed for severity and 76% were followed up for a further assessment of severity within the suggested 4-12 weeks. This compares to 91% and 72% respectively in England.

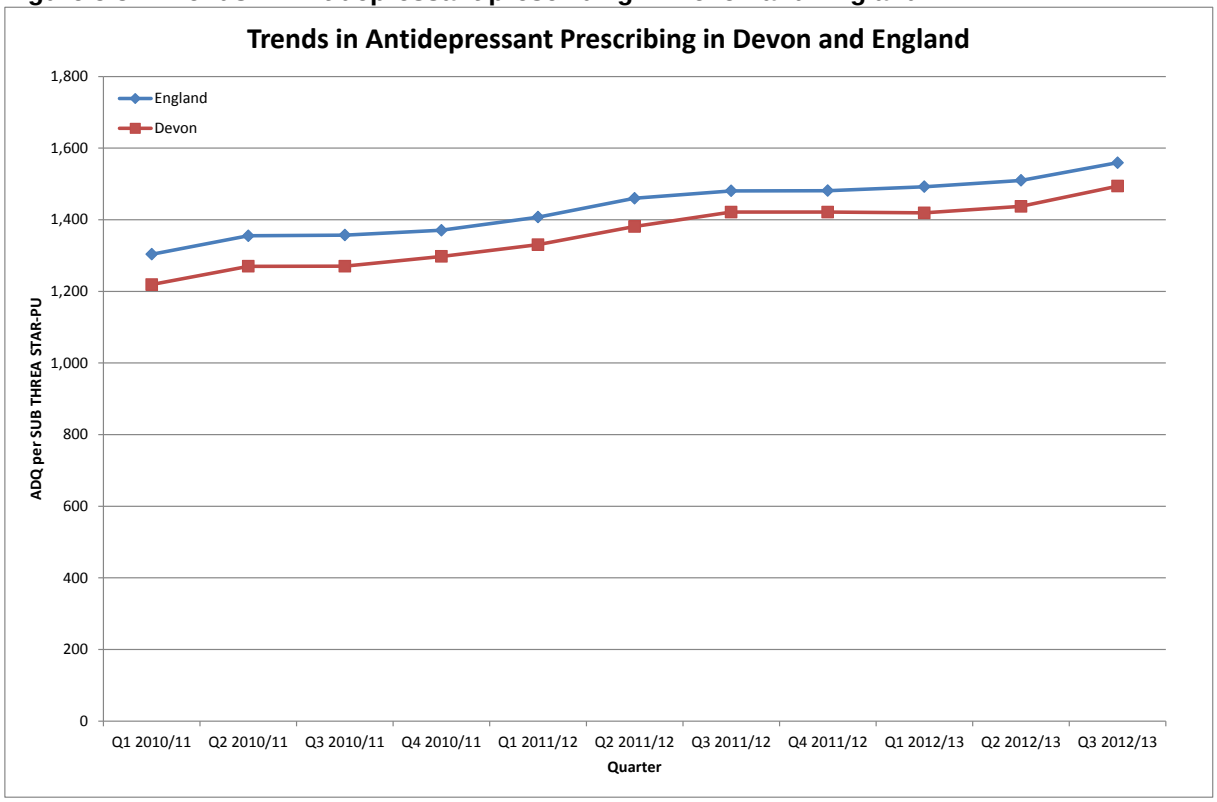
5.3 Prescribing

This Following graphs describe the prescribing of mental health medication across NHS Devon. The prescribing is presented as rates and are weighted to allow comparison between locality areas. Prescribing is presented as an Average Daily Quantity (ADQ) which is a measure of the volume prescribed. The SUB THREA STAR-PU is a weighted measure of the population which reflects prescribing needs based on age, sex and temporary residents and also adjusting for prescribing in a specific therapeutic group.

The following tables look at the trends for Devon overall and for the CCG sub localities across Devon. There is a great deal of variation by practice and showing this by localities can reduce some of the variation. However, in some areas this variation between practices in localities is important and should be investigated further. Prescribing rates by practice are shown in Appendix 1.

Antidepressant drugs are used to treat depression, and also anxiety and other mental health conditions. Figure 5.3.1 shows the trend in antidepressant prescribing in Devon and England. Prescribing in Devon is lower than nationally but is following the same pattern of increase.

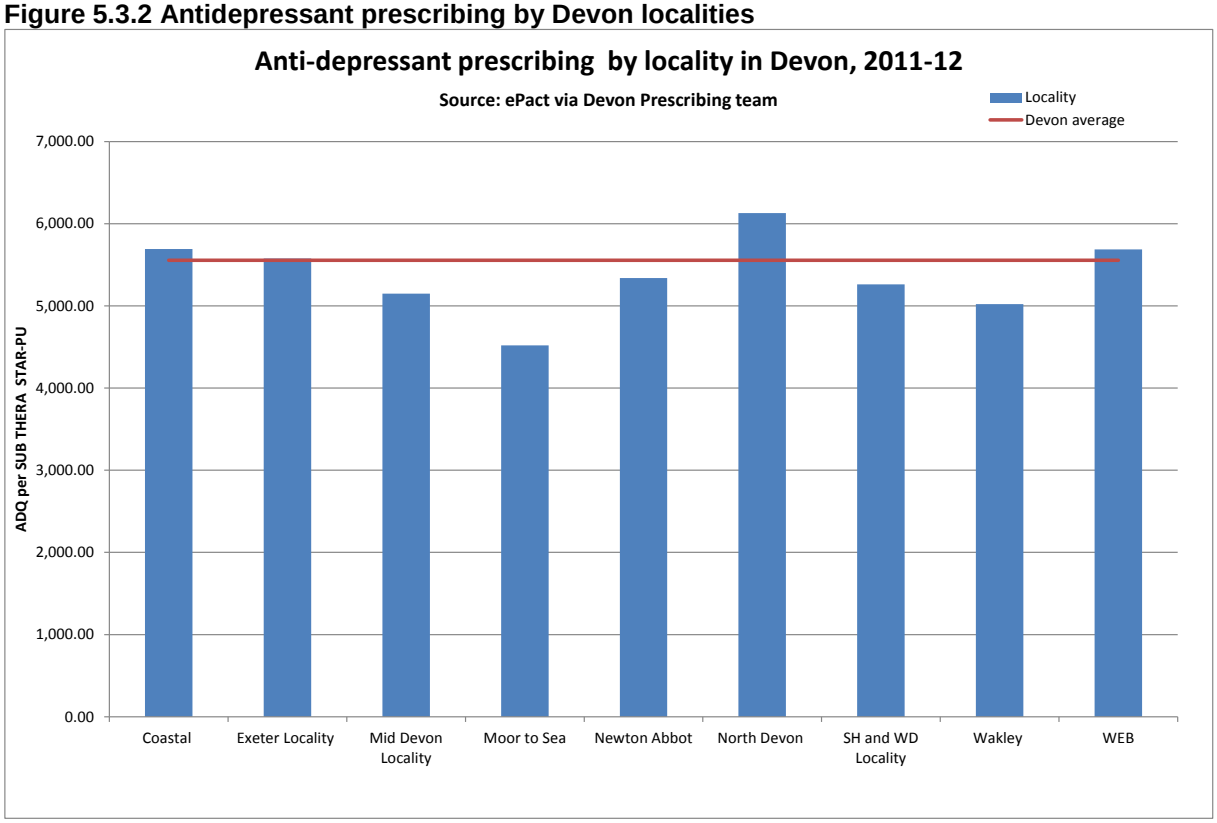
Figure 5.3.1 Trends in Antidepressant prescribing in Devon and England



Source: ePACT via NEW Devon CCG prescribing team

Rates of prescribing antidepressants vary by locality as shown in figure 5.3.2 below, with North Devon showing the highest prescribing rates and Moor to Sea locality showing the lowest. Prescribing by practice shows a great deal of variation and ranges from 2,841 to 9,624 ADQ per SUB THERA STAR-PU (excluding Clock Tower Surgery which has considerably higher prescribing due to the nature of the population).

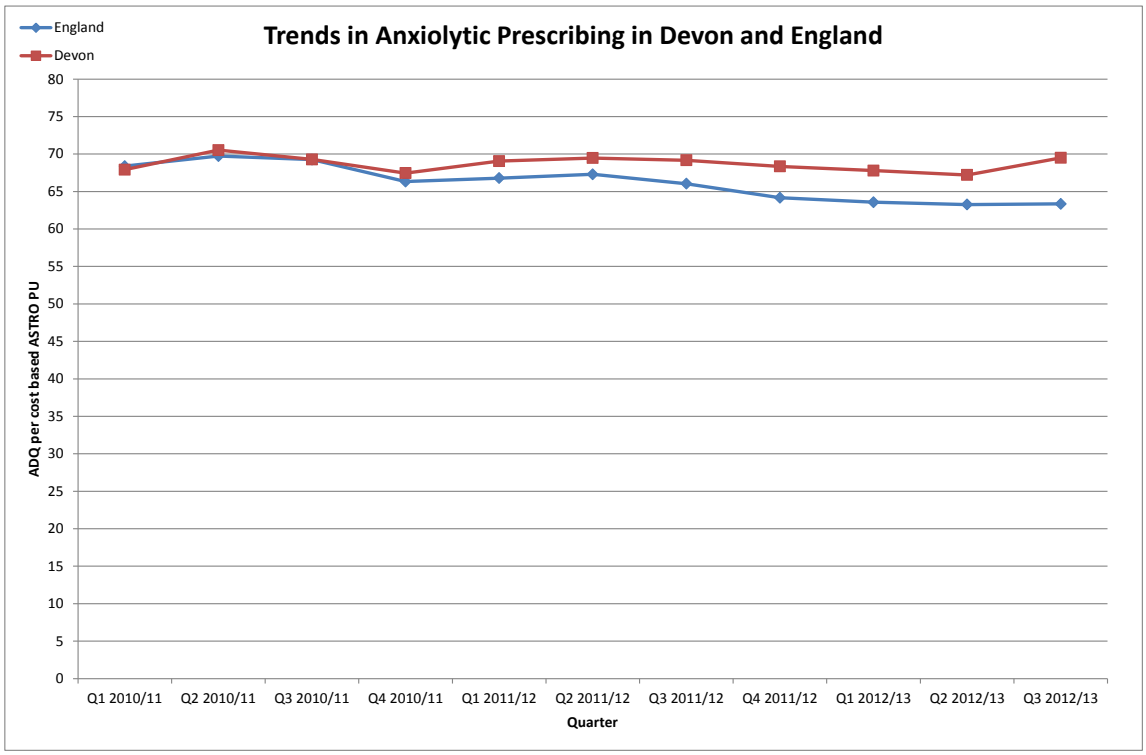
Figure 5.3.2 Antidepressant prescribing by Devon localities



Source: ePACT via NEW Devon CCG prescribing team

Anxiolytics are also known as anti-anxiety drugs and are used for the treatment of anxiety and its related psychological and physical symptoms. The trend graph below shows that prescribing is similar in Devon to nationally. Prescribing in Devon has remained relatively stable over time, whereas nationally there has been a slight decrease in rates.

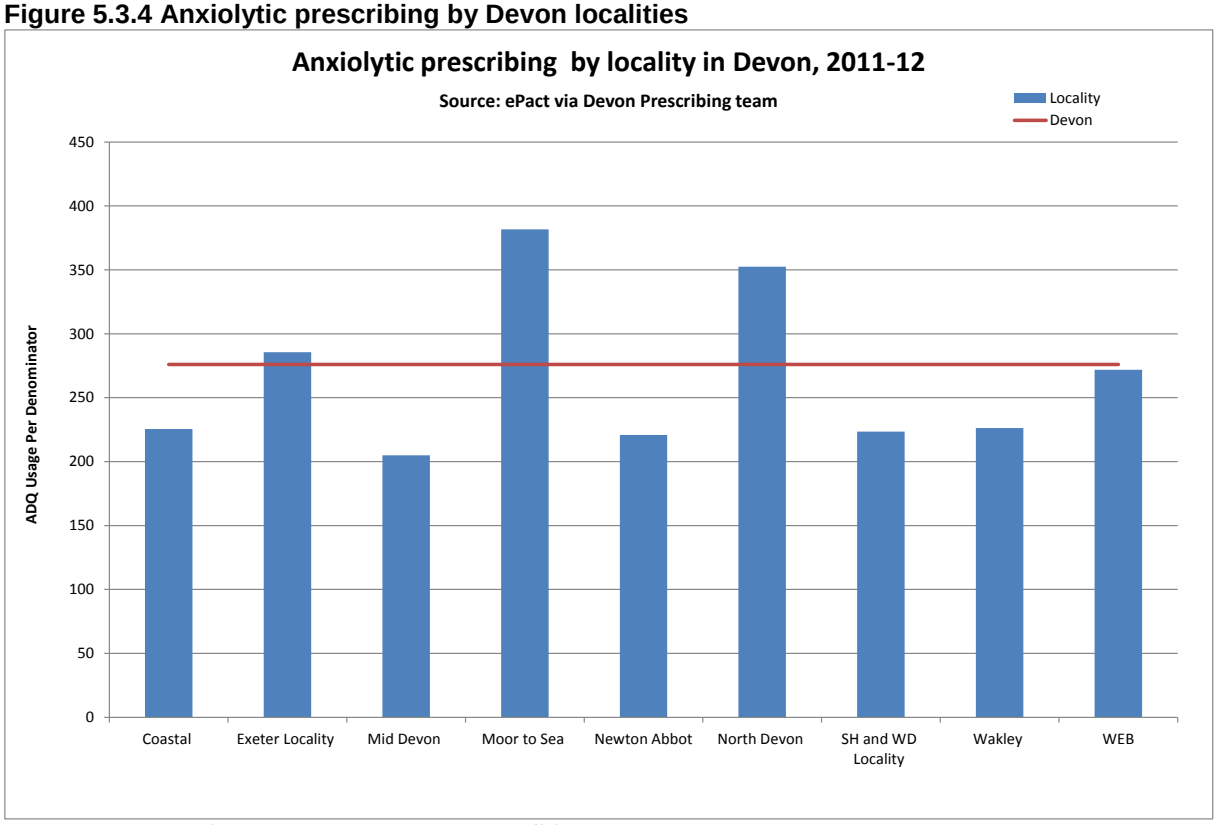
Figure 5.3.3 Trends in Anxiolytic prescribing in Devon and England



Source: ePACT via NEW Devon CCG prescribing team

Prescribing rates of anxiolytics vary widely by CCG sub locality across Devon with the highest rates seen in the Moor to Sea and North Devon sub localities.

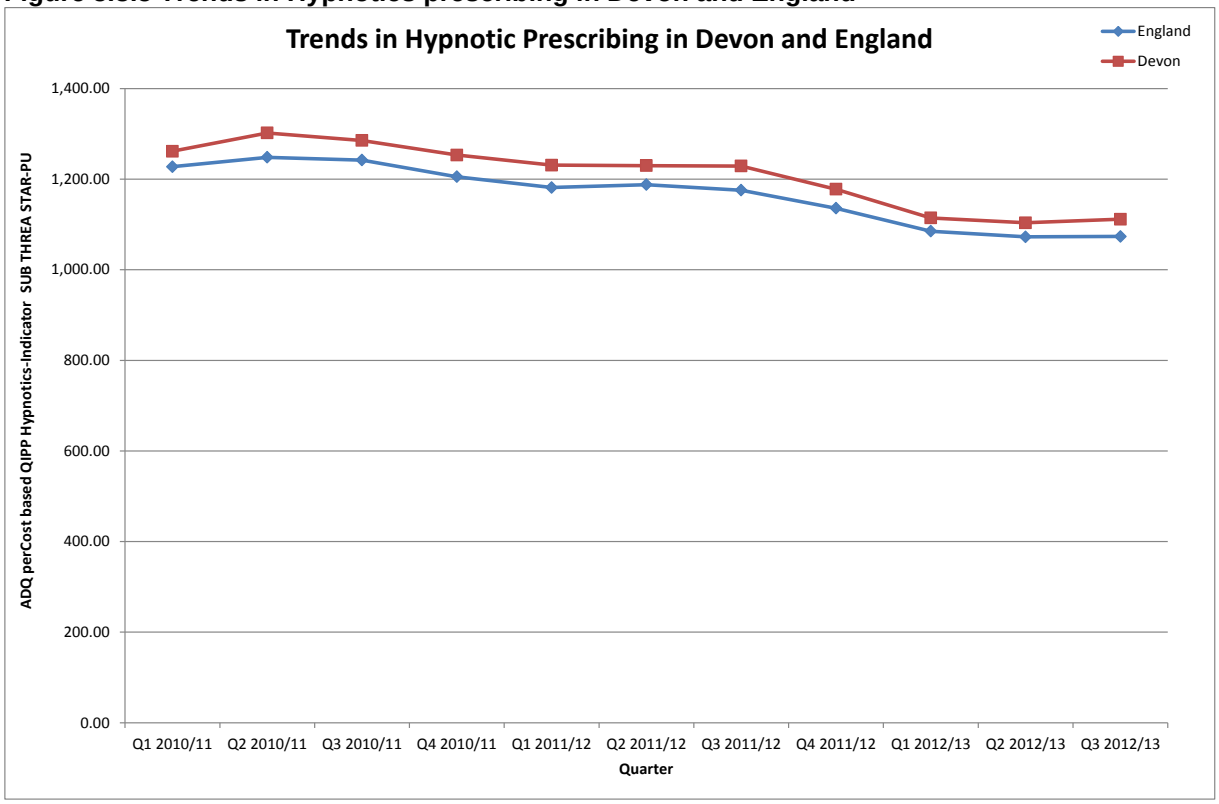
Figure 5.3.4 Anxiolytic prescribing by Devon localities



Source: ePACT via NEW Devon CCG prescribing team

Hypnotics are drugs which are prescribed to treat insomnia. Hypnotic prescribing has to be done with care as they can lead to dependence. Hypnotics are used for some mental health conditions and also for some non-mental health conditions. Hypnotic prescribing is slightly higher than nationally although follows a similar trend.

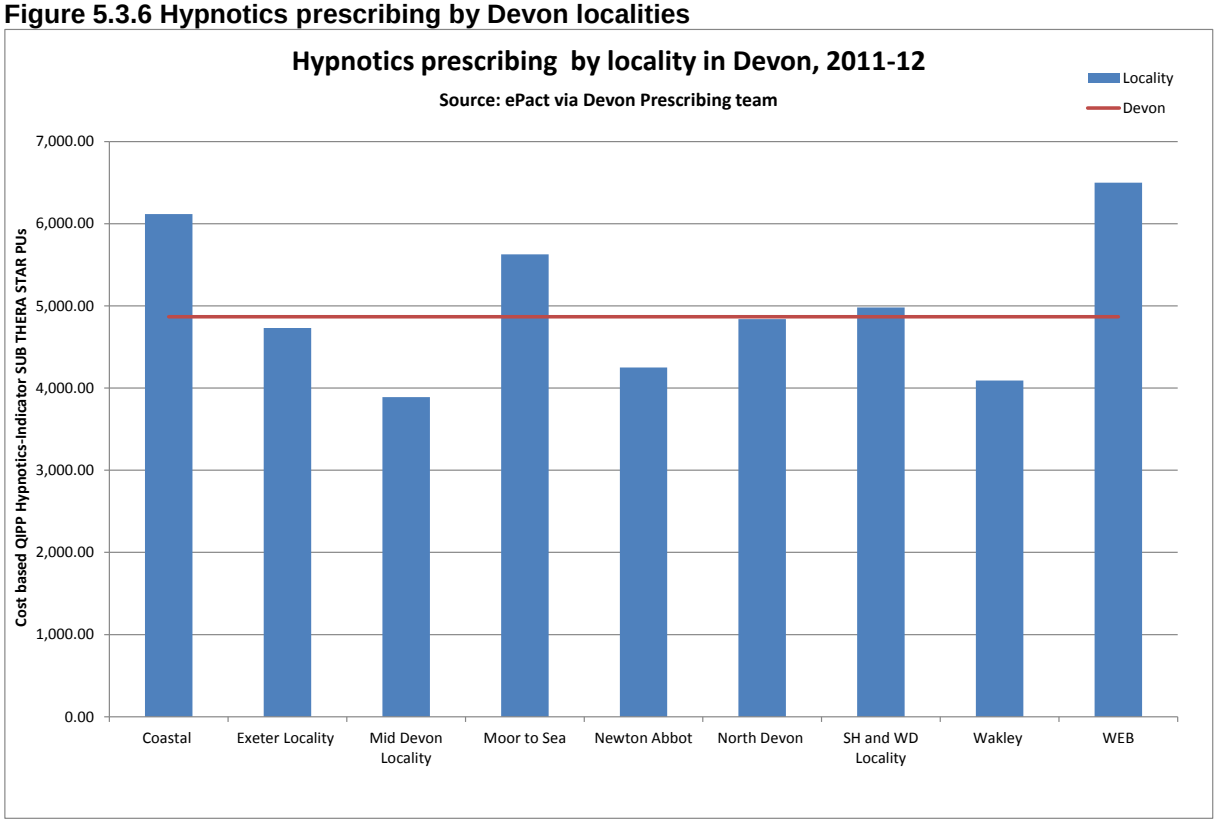
Figure 5.3.5 Trends in Hypnotics prescribing in Devon and England



Source: ePACT via NEW Devon CCG prescribing team

Hypnotic prescribing varies across Devon by localities. Coastal, Moor to Sea and WEB have higher than Devon average rates of prescribing. Lowest prescribing is seen in Mid Devon, Newton Abbot and Wakley.

Figure 5.3.6 Hypnotics prescribing by Devon localities



Source: ePACT via NEW Devon CCG prescribing team

5.4 IAPT Analysis – Depression and Anxiety service

Improving Access to Psychological Therapies (IAPT) is an NHS programme that has rolled out services nationally offering interventions approved by the National Institute of Health and Clinical Excellence (NICE) for treating people with depression and anxiety disorders. In Devon, patients can either self-refer to the depression and anxiety service or can be referred in by their GP or a range of other services. Table 5.4.1 below shows a breakdown of referrals in to the service and shows that in all three areas the majority of referrals are self-referrals. Devon and South Devon have slightly lower self-referrals and referrals from Mental Wellbeing & Access (DPT) than Torbay, however they also both have slightly higher referrals via GPs than Torbay.

Table 5.4.1 Sources of referrals in to the Depression and Anxiety Service 2012

Referral Source	Devon		South Devon (TCT)		Torbay	
	N.	%	N.	%	N.	%
Self	5,559	45%	955	41%	1,688	56%
General Medical Practitioner	4,422	36%	943	41%	605	20%
Mental Wellbeing & Access (DPT)	1,590	13%	273	12%	603	20%
Other NHS Service	383	3%	58	3%	80	3%
Recovery & Independent Living (DPT)	86	1%	8	0%	9	0%
Drug & Alcohol Services (DPT)	52	0%	17	1%	9	0%
Other	52	0%	18	1%	2	0%
Urgent & In-patient Care (DPT)	36	0%	12	1%	3	0%
Dart - Devon Access & Referral Team	41	0%	10	0%	0	0%
Psychol & Psychol Therapy (DPT)	36	0%	6	0%	3	0%
Community Mental Health Team (Older People)	9	0%	1	0%	21	1%
Community Mental Health Team (Adult Mental Health)	23	0%	1	0%	3	0%
Primary Care Health Professional	16	0%	3	0%	0	0%
Local Authority Social Services	10	0%	0	0%	3	0%
Job Centre Plus	4	0%	0	0%	6	0%
Probation Service	5	0%	3	0%	0	0%
Other secondary care specialty	4	0%	0	0%	0	0%
A&E Department	4	0%	0	0%	0	0%
Inpatient Service (Adult Mental Health)	1	0%	0	0%	2	0%
Other Voluntary Sector Organisation	3	0%	0	0%	0	0%
Drug Action Team / Drug Misuse Agency	2	0%	0	0%	0	0%
Community Mental Health Team (Child and Adolescent Mental Health)	0	0%	0	0%	1	0%
Courts	1	0%	0	0%	0	0%
Asylum Services	1	0%	0	0%	0	0%
School Nurse	0	0%	0	0%	1	0%
Eating Disorder Services (DPT)	1	0%	0	0%	0	0%
Learning Disability Services (DPT)	0	0%	0	0%	1	0%
Other Independent Sector Mental Health Services	1	0%	0	0%	0	0%
Police	1	0%	0	0%	0	0%
Grand Total	**12,343**	**100%**	**2,308**	**100%**	**3,040**	**100%**

Key performance indicators are collected and reported around IAPT services and these are reported in to a national data collection by the NHS Information Centre. Tables 5.4.2 and 5.4.3 below show a local view of this data by local authority for 2011-12. It shows the number of people who have been referred to the IAPT service, how many of those have entered in to treatment, how many had completed therapy and how many had moved to recovery.

Table 5.4.2 – IAPT Key Performance Indicators by Local Authority

Key Performance Indicator		East Devon	Exeter	Mid Devon	North Devon	Torridge	South Hams	Teignbridge	West Devon	Torbay	Plymouth	Not known	Grand Total
KPI 3a	Referrals	1,371	2,200	1,001	1,226	745	888	1,663	632	2,388	18	145	12,277
KPI 4	Entered into Treatment	913	1,500	702	911	549	654	1,182	410	1,622	13	96	8,552
KPI 5	Completed Therapy	663	1,011	458	504	357	446	798	250	955	7	53	5,502
KPI 6	Moved to recovery (When initially assessed achieved caseness and at final session did not)	229	410	205	190	150	192	333	111	312	-	22	2,155
KPI 6b	Number of people who have completed treatment who were not at clinical caseness at the start of treatment	108	134	64	70	52	45	84	14	91	-	9	671
KPI 7	Number off Sick Pay and Benefits	31	49	21	21	14	22	57	11	54	-	-	281

Source: IAPT team, Devon Partnership Trust

Table 5.4.3 – IAPT – Patients who have completed treatment by age group and local authority

Gender	Age	East Devon	Exeter	Mid Devon	North Devon	Torridge	South Hams	Teignbridge	West Devon	Torbay
Females	Under 18	-	-	-	-	-	-	-	-	-
	18-64	163	257	116	150	92	133	263	82	205
	65-74	10	10	8	12	7	10	15	5	10
	75-89	-	-	-	-	-	-	5	-	-
Males	Under 18	-	-	-	-	-	-	-	-	-
	18-64	99	140	73	96	50	71	121	37	122
	65-74	6	5	-	-	-	-	9	6	9
	75-89	-	-	-	-	-	-	-	-	-

Source: IAPT team, Devon Partnership Trust

This data is reported quarterly by PCT and also looks at the proportion of people who enter in to treatment as a proportion of the estimated proportion of people with anxiety or depression. These estimates are not available by Local Authority and so therefore cannot be broken down. At the end of 2011-12 8.6% of the estimated population to suffer from anxiety and depression entered in to treatment in Devon and 9.1% in Torbay compared to 8.7% in England overall. The target for referrals is for 15% of the estimated population who suffer from anxiety and depression to enter in to the service so locally and nationally these rates are low. At the end of 2011-12 in Devon, 68.9% of people who were referred in to the service entered in to treatment and in Torbay this was 72.6% compared to the England average of 60%.

Table 5.4.4 below looks at the waits for treatment, proportions of people referred in to the service who entered treatment in 2011-12 by Local Authority, and also looks at the proportion who had moved to recovery when they completed their treatment. There is variation across the county, and from month to month, in the proportion of people who are having to wait for over 28 days to be seen by the service, with the areas showing the longest waits in North Devon and Torridge. All areas showed lower proportions of people waiting over 28 days than nationally at 51.3%. The proportion of people entering treatment from referral is high in all areas compared to the England average of 60%. The proportions who have moved to recovery at the completion of treatment is generally higher than the England average of 45.9% but there is some variation between the local authority areas with some a little lower. The Strategic Health Authority set quarterly targets around the number of people receiving psychological therapy, moving to recovery and completing therapy. Across Devon and Torbay over all four quarters of 2011-12, all targets have been exceeded, with more people receiving therapy, moving to recovery and completing treatment.

Table 5.4.4 - IAPT waiting times, treatment and recovery

	East Devon	Exeter	Mid Devon	North Devon	Torridge	South Hams	Teignbridge	West Devon	Torbay	Not known	Grand Total
% waiting greater than 28 days to enter treatment	34%	26%	37%	42%	48%	32%	25%	30%	36%	25%	33%
% entered in to treatment	67%	68%	70%	74%	74%	74%	71%	65%	68%	66%	70%
% moved to recovery	41%	47%	52%	44%	49%	48%	47%	47%	36%	50%	45%

Source: IAPT team, Devon Partnership Trust

5.5 Mental Health Minimum Dataset

The mental health minimum dataset enables the provision of mental health care to be analysed and is submitted on a quarterly and annual basis by all NHS mental health providers to the NHS Information Centre.

The information presented in the following tables and graphs looks at data relating to 2011-12 for the area of Devon and Torbay. Data has not been requested for Plymouth as a similar analysis was undertaken recently for the Plymouth area. The data covers 15,414 individuals who came in to contact with the mental health service in Devon County area and 6,778 in Torbay.

Table 5.5.1 below shows a breakdown of clients known to mental health services by Local Authority. Overall there were a higher proportion of female contacts with mental health services and there was variation between different Local Authorities. The higher proportions of females were in East Devon, South Hams and Torbay. The variation between local authorities is further developed in figure 5.5.2 below.

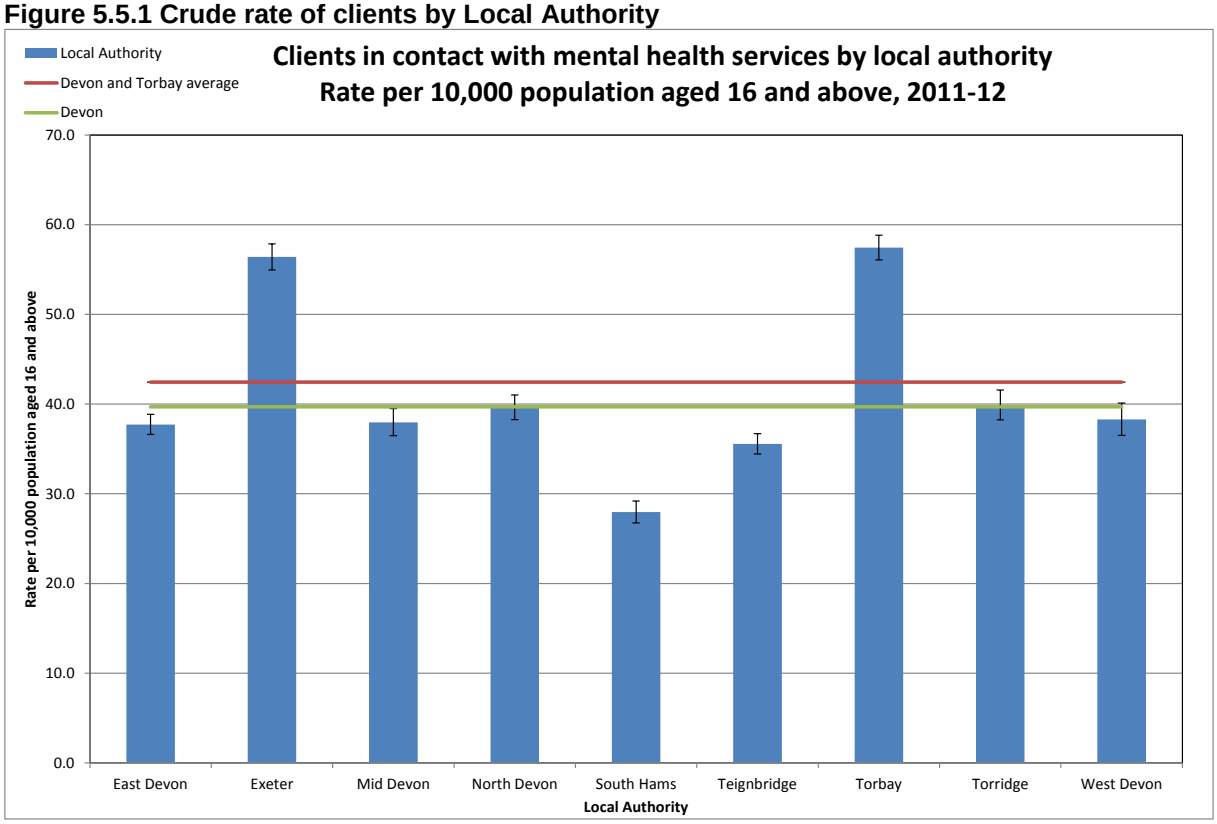
Table 5.5.1 Clients by Local Authority and gender

	Female		Male	
Local Authority	**Numbers**	**%**	**Numbers**	**%**
East Devon	2638	60%	1730	40%
Exeter	3371	58%	2428	42%
Mid Devon	1436	58%	1044	42%
North Devon	1829	57%	1379	43%
South Hams	1237	61%	805	39%
Teignbridge	2262	59%	1600	41%
Torbay	4066	60%	2710	40%
Torridge	1206	54%	1010	46%
West Devon	1009	57%	754	43%
Devon and Torbay	**19054**	59%	**13460**	41%

Source: Devon Partnership Trust

Figure 5.5.1 below shows clients in contact with mental health services as rates of the overall population aged 16 and above. There is variation between local authorities with Torbay and Exeter showing the highest rates. Rates in East Devon, South Hams and Teignbridge are statistically significantly lower than the Devon average compared to rates in other parts of Devon.

Figure 5.5.1 Crude rate of clients by Local Authority



Source: Devon Partnership Trust

Table 5.5.2 below shows a breakdown of clients by market town. This again shows variation between areas and gender. The variation between towns by rates is shown in figure 5.5.2 below. This data does not include Torbay, as is based on the Devon County Council market town boundaries.

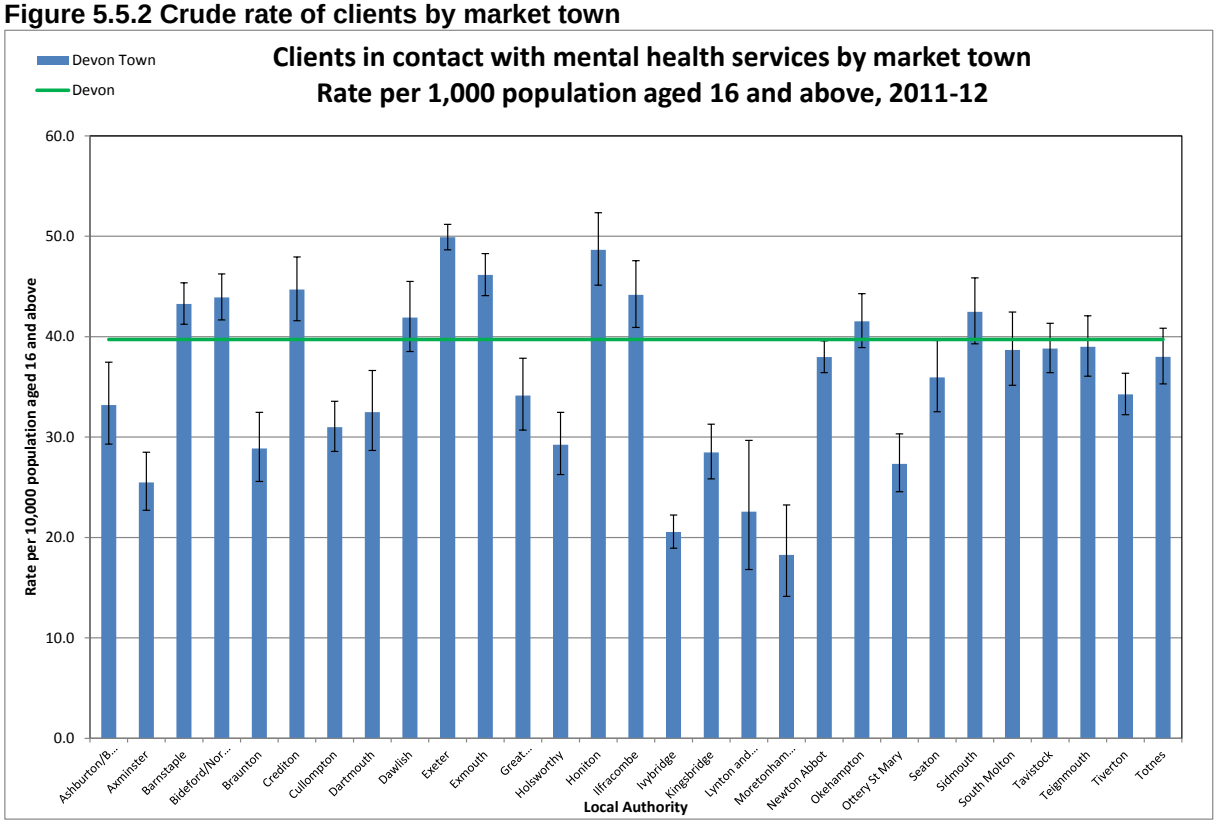
Table 5.5.2 Clients by market town and gender

	Female		Male	
Market town	**Numbers**	**%**	**Numbers**	**%**
Ashburton/Buckfastleigh	150	57.3%	112	42.7%
Axminster	174	56.7%	132	43.0%
Barnstaple	976	57.0%	734	42.9%
Bideford/Northam	781	54.7%	648	45.3%
Braunton	171	61.3%	108	38.7%
Crediton	444	57.3%	331	42.7%
Cullompton	367	60.7%	238	39.3%
Dartmouth	159	60.2%	105	39.8%
Dawlish	294	51.9%	272	48.1%
Exeter	3,449	58.0%	2,496	42.0%
Exmouth	1,119	59.8%	752	40.2%
Great Torrington	191	53.4%	167	46.6%
Holsworthy	188	53.4%	164	46.6%
Honiton	459	64.5%	253	35.5%
Ilfracombe	372	53.7%	321	46.3%
Ivybridge	361	59.4%	247	40.6%
Kingsbridge	261	60.4%	171	39.6%
Lynton and Lynmouth	26	51.0%	25	49.0%
Moretonhampstead	42	63.6%	24	36.4%
Newton Abbot	1,356	60.9%	869	39.1%
Okehampton	527	56.4%	407	43.6%
Ottery St Mary	214	60.3%	141	39.7%
Seaton	256	63.5%	163	40.4%
Sidmouth	400	61.1%	255	38.9%
South Molton	248	56.2%	177	40.1%
Tavistock	565	58.2%	405	41.8%
Teignmouth	372	56.4%	287	43.6%
Tiverton	610	56.7%	465	43.3%
Totnes	456	61.9%	281	38.1%
Grand Total	**14,988**	**58.2%**	**10,750**	**41.8%**

Source: Devon Partnership Trust

There is huge variation between rates in market towns. Rates are statistically significantly high in Barnstaple, Bideford/Northam, Crediton, Dawlish, Exeter, Exmouth, Honiton, and Ilfracombe. Rates are statistically significantly low in Ashburton/Buckfastleigh, Axminster, Braunton, Cullompton, Dartmouth, Great Torrington, Holsworthy, Ivybridge, Kingsbridge, Lynton and Lynmouth, Moretonhampstead, Ottery St Mary and Tiverton.

Figure 5.5.2 Crude rate of clients by market town



Source: Devon Partnership Trust

Patient contacts

In total there were over 260,000 contacts with mental health services in 2011-12. Some of these contacts did not have a recognisable postcode or were from outside the cluster so were not able to be linked up to a geographic area. Where that was possible the contacts are analysed below by Local Authority and Index of Multiple Deprivation quintile.

Table 5.5.3 below shows a breakdown of contacts with mental health services by local authority and gender. There are more contacts with services by females rather than males. There is also variation in the number of contacts between local authorities. This may be a reflection on both need and also demand and availability of services.

Table 5.5.3 Total contacts with services by Local Authority and gender

Local Authority	Females	Males	Total
East Devon	19,756	12,690	32,447
Exeter	24,978	21,286	46,266
Mid Devon	9,130	7,517	16,647
North Devon	18,658	12,650	31,325
Teignbridge	9,167	5,453	14,620
Torridge	15,311	15,799	31,110
South Hams	12,437	7,356	19,793
West Devon	8,106	7,513	15,619
Plymouth	407	1,660	2,078
Torbay	22,766	19,496	42,445

Source: Devon Partnership Trust

The pattern of contacts by deprivation compared to the Devon pattern of deprivation is as would be expected. The proportions of contacts with services are higher in the more deprived quintiles than the least deprived and are slightly higher than the proportion of population in these quintiles, which is to be expected due to the greater need in these quintiles.

Table 5.5.4 Total contacts with mental health services by Deprivation quintile and age group

IMD 2010 Quintile	0 - 19	20 - 29	30 - 39	40 - 49	50 - 59	60 - 69	70+	Total
Q1 - Most Deprived	567	5,306	7,142	9,020	5,673	2,633	3,802	34,143
Q2 - Above Average	1,471	13,385	15,693	19,411	11,718	6,635	12,358	80,671
Q3 - Average	1,522	10,298	12,623	15,455	11,469	8,302	16,370	76,039
Q4 - Below Average	1,043	5,356	6,843	8,094	7,193	5,111	14,173	47,813
Q5 - Least Deprived	201	1,567	1,738	2,272	1,646	1,251	4,474	13,149

Source: Devon Partnership Trust

Table 5.5.5 below shows a breakdown of contacts with mental health services by type of contact and Local Authority. This shows variation in all types of contact in different Local Authorities.

Table 5.5.5 Total contacts with mental health services by Local Authority and type of contact

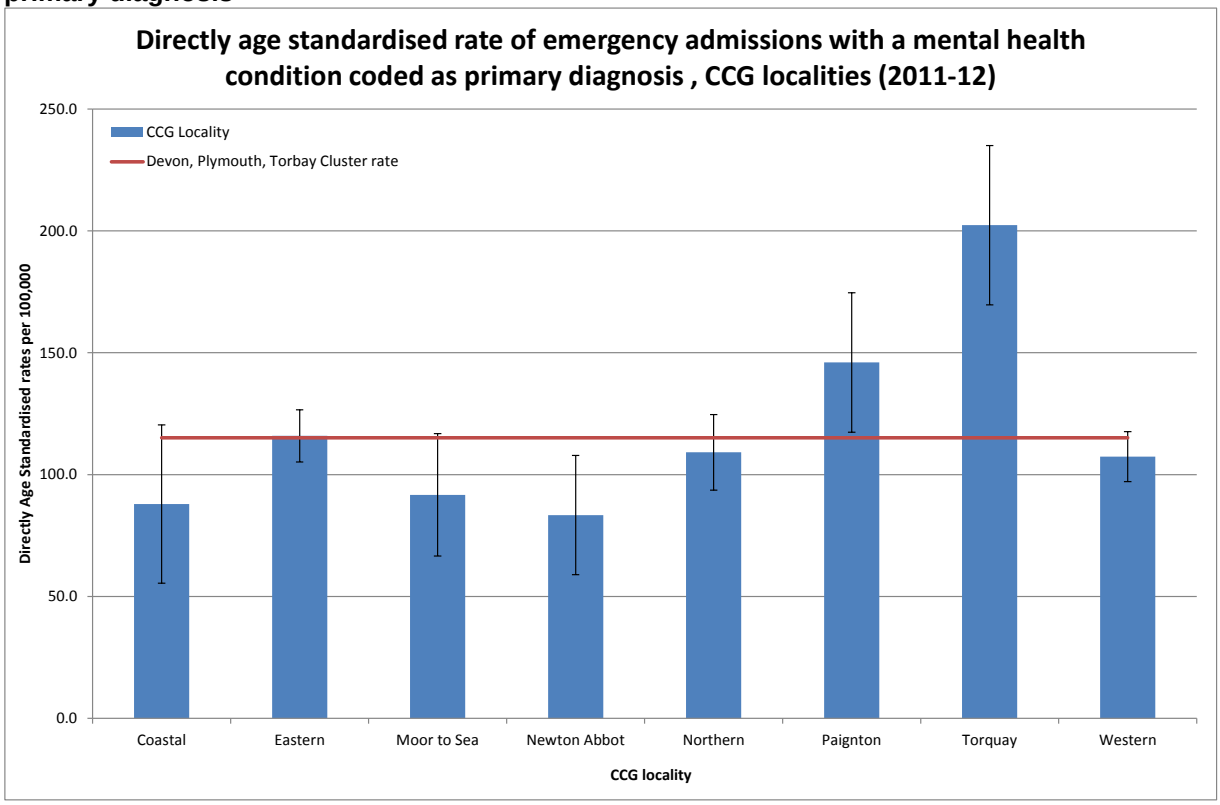
Local Authority	Medical	Nursing (community)	Nursing (in-patient)	Occupational Therapy	Other Therapies	Physiotherapy Professional Advice & Support Staff	Psychological Therapies	Psychotherapy	Social Worker	Speech & Language Therapy	Service unknown
East Devon	2409	12221	18	1237	195	42	3566	481	1106		11172
Exeter	2722	13288	55	2908	467	57	3685	649	1716		20719
Mid Devon	1223	5826	12	503	144	-	1857	342	1285		5455
North Devon	2563	14407	244	1444	-	-	2391	80	2315	8	7869
Teignbridge	2037	5075	158	1186	-	-	1002	107	1136		3917
Torridge	2772	9723	207	5399	27	473	2149	445	1124		8791
South Hams	1493	8701	157	1518	12	-	1345	31	1473	7	5053
West Devon	1609	5762	-	212	60	-	769	185	1202		5819
Plymouth	217	494	3	606	28	15	34		130	5	546
Torbay	3805	14811	91	3669	19	56	2909	281	2851		13953

Source: Devon Partnership Trust

5.6 Emergency admissions

The following graphs show rates of emergency admissions to hospital where a mental health condition was part of the diagnosis. These are broken down in to those where mental health was a primary diagnosis and those where it was any diagnosis code. As numbers are lower where a mental health condition is a primary diagnosis the confidence intervals are wide. Rates of emergency admissions vary between localities but were statistically significantly lower than the Devon, Plymouth and Torbay cluster average in Newton Abbot and statistically significantly higher in Torquay.

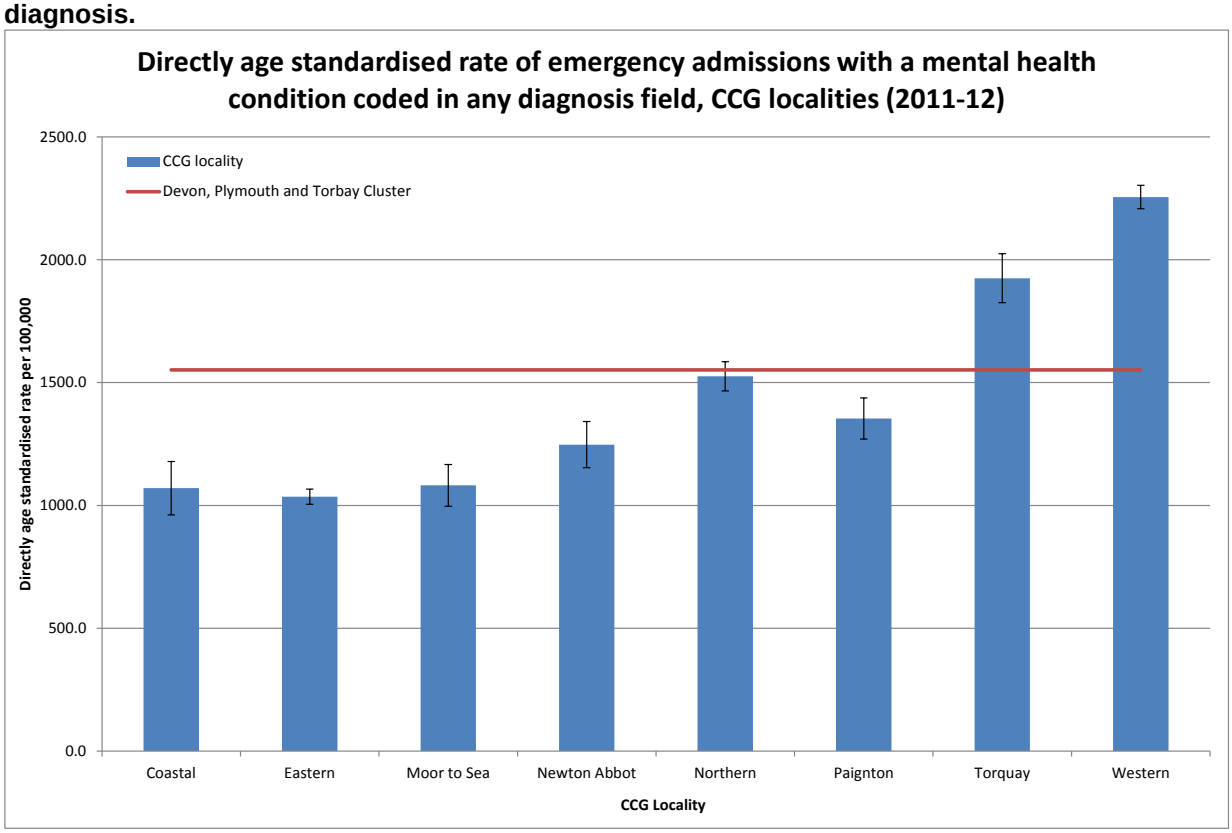
Figure 5.6.1 Emergency Admissions to hospital with a mental health condition coded as primary diagnosis



Source: Secondary Uses Service Commissioning dataset

Confidence intervals are narrower when looking at emergency admissions for mental health in any diagnosis field but rates still vary greatly between localities. Rates were statistically significantly lower than the Devon, Plymouth and Torbay cluster average in the Coastal, Eastern, Moor to Sea, Newton Abbot and Paignton localities and statistically significantly higher in the Torquay and Western localities.

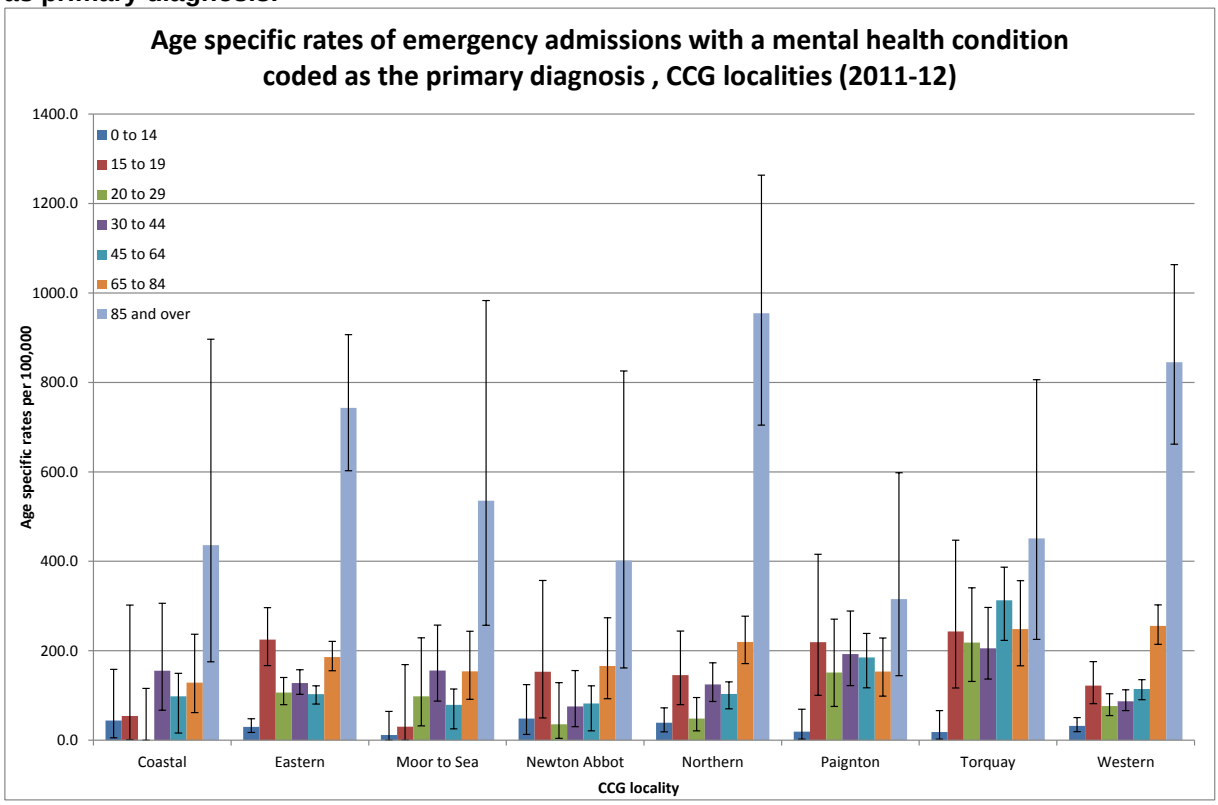
Figure 5.6.2 Emergency Admissions to hospital with a mental health condition coded as any diagnosis.



Source: Secondary Uses Service Commissioning dataset

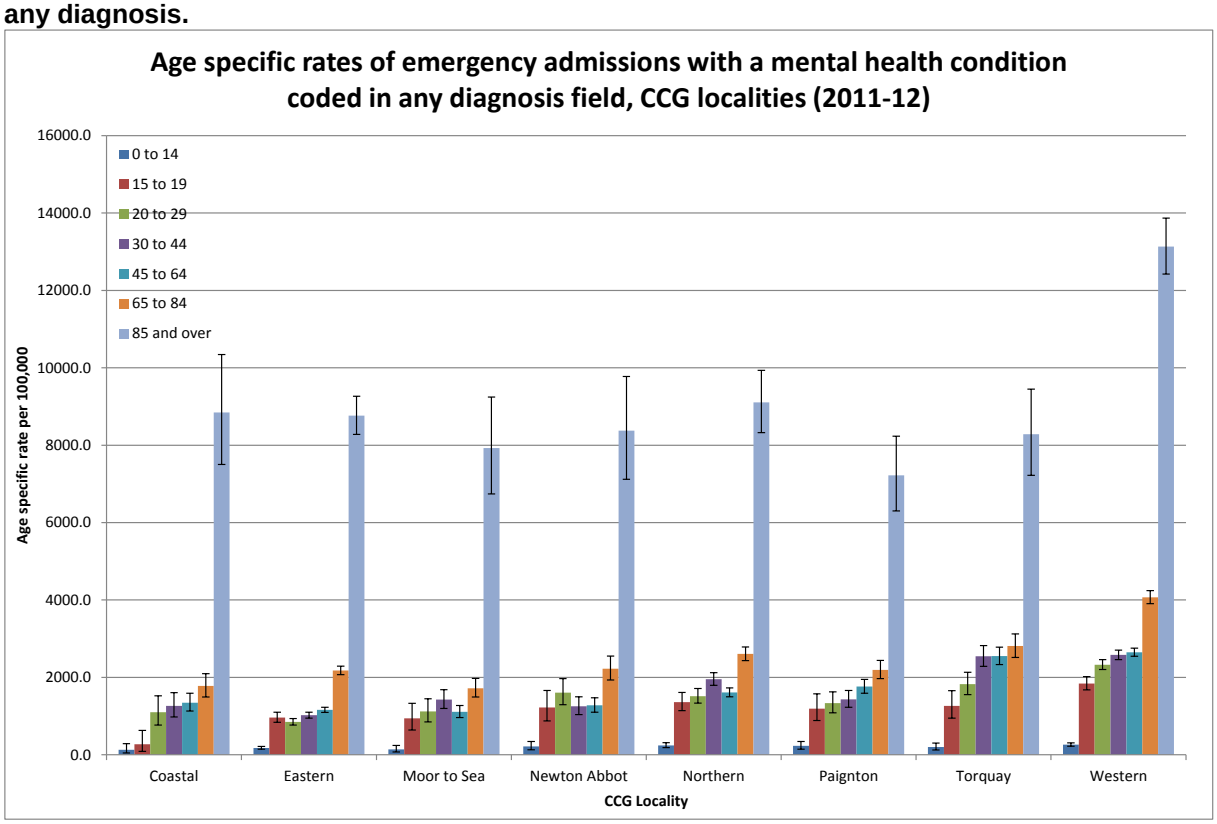
When considering the data by age group the confidence intervals are wide as the numbers are obviously lower in each group. The rates are highest in the over 85 age group for both primary diagnosis or any diagnosis field. For primary diagnosis the rates are higher in the 15-19 age group in all but the Coastal and Moor to Sea localities.

Figure 5.6.3 Emergency Admissions to hospital by age with a mental health condition coded as primary diagnosis.



Source: Secondary Uses Service Commissioning dataset

Figure 5.6.4 Emergency Admissions to hospital by age with a mental health condition coded as any diagnosis.



Source: Secondary Uses Service Commissioning dataset

5.7 Early Onset Dementia

The Alzheimer's Society estimate that there are 17,000 younger people diagnosed with early onset dementia in the UK[46], although as this is based on referrals to services and many people may not seek care at an early stage, it is thought to be an underestimation and rates may be up to three times as high. Although symptoms of early onset dementia are similar to those of older people with dementia, their needs are likely to be very different. Early onset dementia is due to multiple sclerosis, motor neurone disease, parkinson's disease and huntington's disease or alcohol[47]. People with learning disabilities are also at a higher risk of developing early onset dementia.[48]

The PANSI website (Projecting Adults Needs and Service Information) estimates of early numbers of people with early onset dementia by district. These are based on a report published by the Alzheimer's Society in 2007 called *Dementia UK - the full report.* The estimated prevalence by age group taken from this report are shown in table 5.7.1 below. These rates are then applied to the estimated and projected Local Authority populations.

Table 5.7.1 – Estimated prevalence of early onset dementia

Age range	Per 100,000 males	Per 100,000 females
30-34	8.9	9.5
35-39	6.3	9.3
40-44	8.1	19.6
45-49	31.8	27.3
50-54	62.7	55.1
55-59	179.5	97.1
60-64	198.9	118

Source: Dementia UK - the full report, Alzheimer's Society, 2007 via PANSI

The following table gives estimates of prevalence of early onset dementia for both males and females aged 30-64 by Local Authority. This suggests the numbers are not expected to show a considerable increase up to 2020. The numbers are higher for men than for females, which is larger due to higher rates from 50 upwards, but particularly 55-64. There is variation in numbers between Local Authorities but this is due to variations in population size between districts.

[46] http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=164
[47] Medical Research Council Cognitive Function and Ageing Study 2005
[48] Alzheimer's Society. Dementia UK

Figure 5.7.1 Estimated prevalence in early onset dementia in males

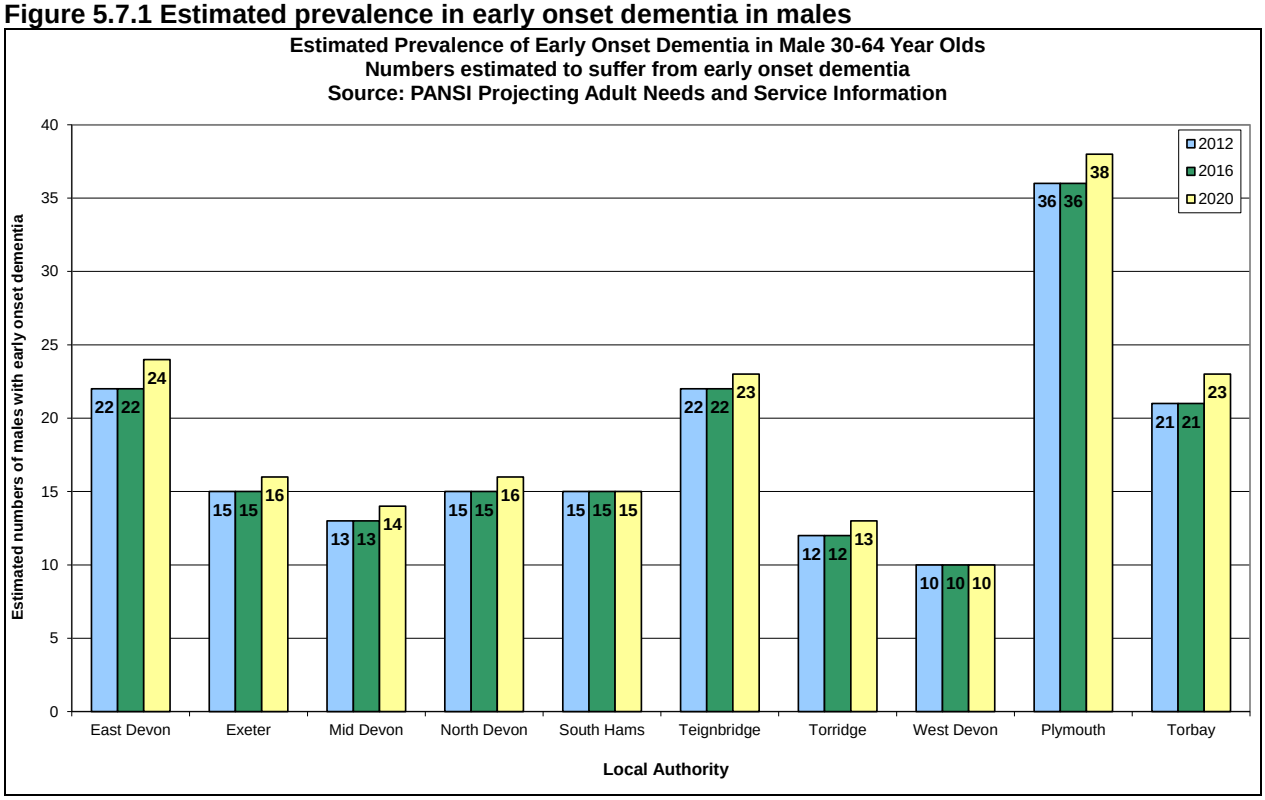
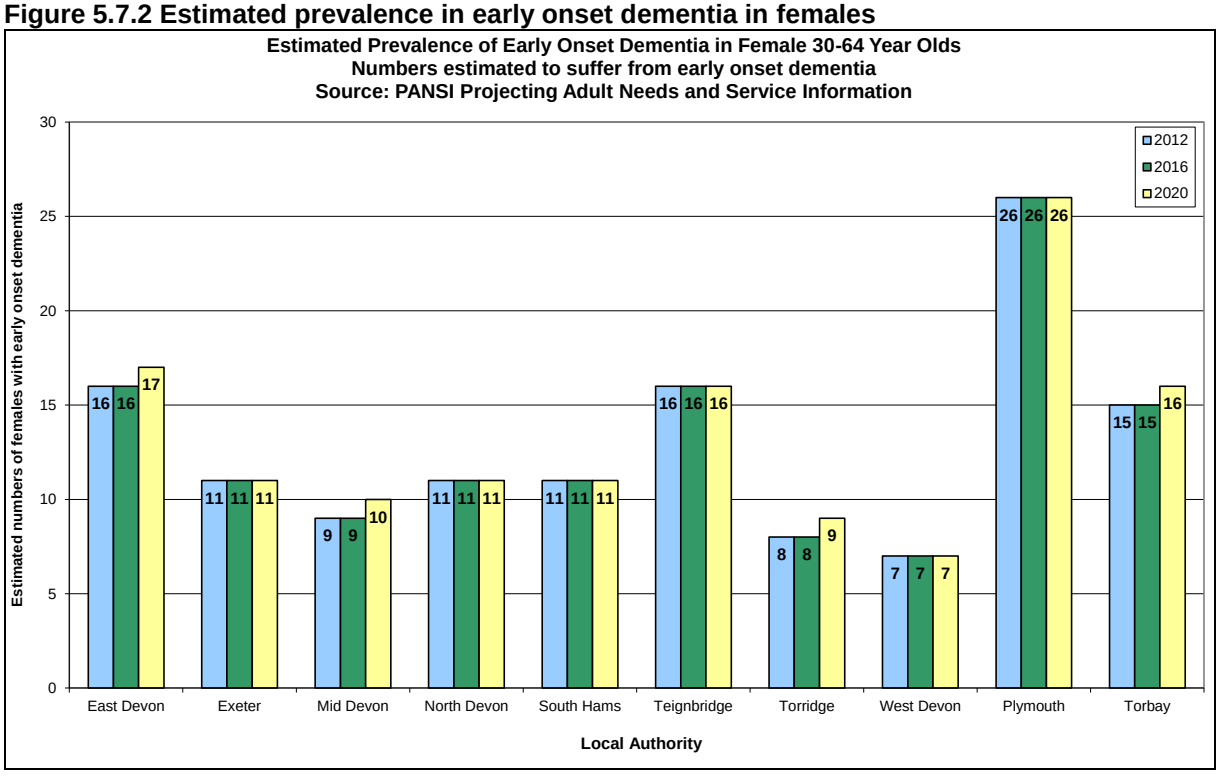


Figure 5.7.2 Estimated prevalence in early onset dementia in females



5.8 Substance Abuse and Mental Health – Dual Diagnosis

NHS Devon is currently undertaking a Substance Misuse Health Needs Assessment. This section around substance misuse and mental health has been taken from work that has fed in to this needs assessment. This section looks specifically at dual diagnosis and for further information around substance misuse the full needs assessment should be accessed.

Substance misuse is usual rather than the exception among people with severe mental health problems and the relationship between the two is complex (DoH 2002), and to make things worse, people with mental health problems are usually more sensitive to the effects of modest amounts of substances due to the psychobiological vulnerability that underlies their psychiatric disorder.

The combination of substance misuse and mental health issues in an individual is commonly referred to as “dual diagnosis”, though in most circumstances there are more than just these two issues. A comprehensive account of dual diagnosis, which extends beyond the brief of this needs assessment can be found in the “Devon and Torbay Dual Diagnosis Strategy”, completed in July 2012.

In 2010-11, there were 6,640 admissions to hospital with a primary diagnosis of a drug-related mental health and behavioural disorder. This is 14.3% more than in 2009-10 when there were 5,809 admissions but 17.3% lower than in 2000-01 when there were 8,027 admissions. More than twice as many males were admitted than females in 2010-11 (4,813 and 1,827 respectively).

Where primary or secondary diagnosis was recorded there were 51,353 admissions in 2010-11 compared with 44,585 admissions in 2009/10, which shows an increase of 15.2%. This is the biggest annual increase for this type of admission in the last ten years. Figures from this type of admission are now nearly twice as high as they were ten years ago at 25,683 admissions in 2000-2001. More than twice as many males were admitted than females in 2010-11 (34,508 and 16,839 respectively).

In addition to these increasing figures, mental health and substance misuse problems are often missed and not recorded or treated because these problems are not fully explored with the individual. As might be expected, lack of recognition and treatment of mental health and substance misuse problems is associated with worse outcomes.

As part of the initial triage, the mental health status of clients entering the substance misuse treatment service is recorded though, the accuracy of this data is open to question as it is not validated to back to mental health service records. It is only recorded when the client is triaged and so is possibly influenced by the client’s willingness to reveal this information at the first appointment.

Alcohol is the most common substance of misuse, cannabis the most common drug of misuse, and poly-substance use frequently occurs. This pattern seems to be largely unrelated to service users’ symptomatology[49] but, rather, is associated with

[49] Brunette *et al.*, 1997 Cited in NHS Devon Substance Misuse Needs Assessment, 2012

the same demographic correlates as for the general population[50]. This suggests that in a similar way to other people who misuse substances, it is the social context and availability of substances that most often dictates substance choices in people with psychosis[51]. The small literature on reasons for substance use in psychosis also suggests that people with psychosis do not differ from other groups, with reasons including response to negative affective states, interpersonal conflict and social pressure[52].

As many as 80% of alcoholics complain of depressive symptoms, including 30% who fulfill criteria for a major depressive disorder[53]. A lifetime history of depressive disorder has been found in 48% of opiate addicts[54].

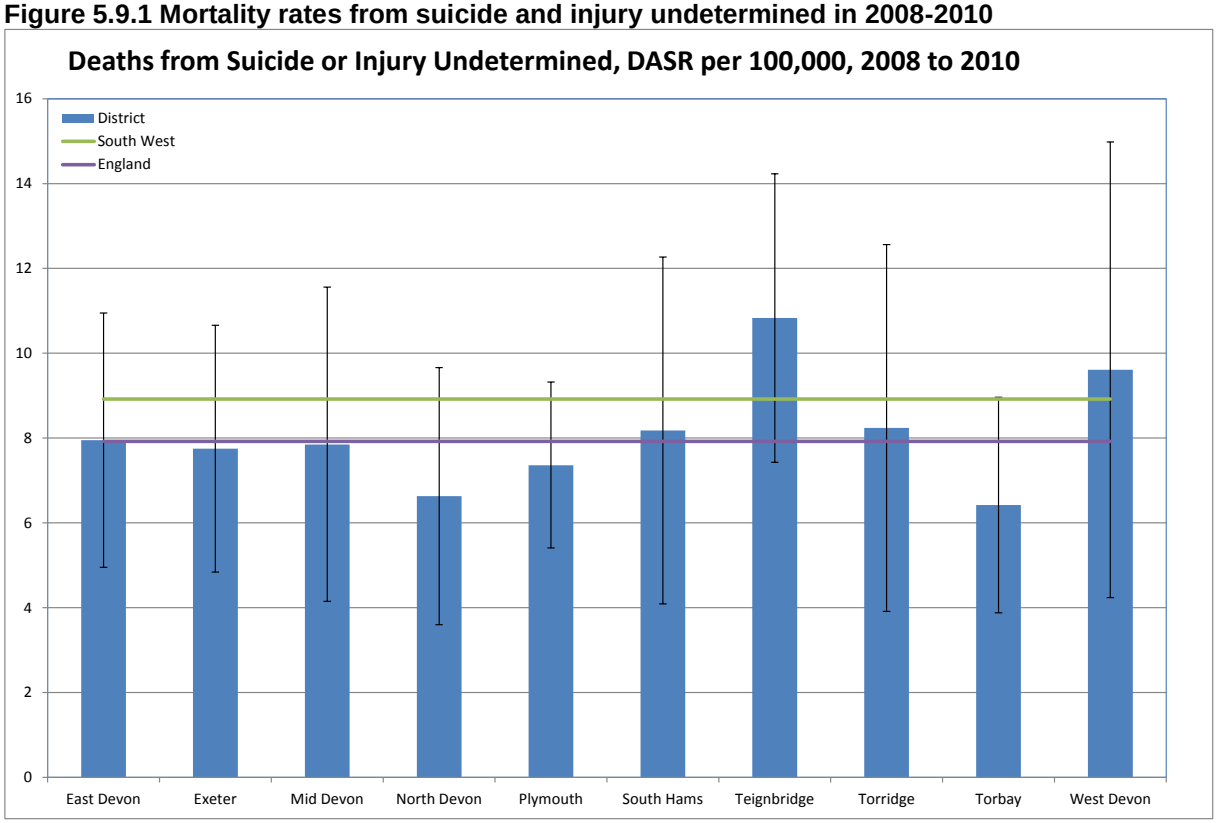
5.9 Suicide and Injury Undetermined

This section looks at deaths from either suicide or where the cause of death is from an injury where it is unclear whether it was accidentally or purposely inflicted. There are many points within suicide that make it an important cause of death to consider. There are inequalities between males and females in risk of suicide, with suicide being three times more likely amongst males than females. Nationally suicides had been showing declining rates for the past ten years, however in the last few years rates have started to show a slight increase. Historically, rates of suicide have been high in young men and these are also now showing a downward trend. With numbers being generally low very small changes in numbers can create changes in rates quite quickly, therefore the slight increase shown over the past few years needs careful monitoring. [55] Although the rates of mortality and numbers of deaths from suicide are generally low compared to other causes of death, the numbers of years lost when people die can be considerably higher than other causes and the impact on surviving family and friends is also considerable. Nationally the age standardised rate of years lost is 25.5 per 10,000 population aged under 75, compared to 26.8 in Devon, 35.7 in Plymouth and 36.0 in Torbay.

The following graphs look at rates of mortality from suicide and injury undetermined. These rates are for people of all ages. Numbers of deaths by age groups are low and it would therefore not be appropriate in this format to present them by age. These rates are produced by the NHS Information Centre nationally using ONS mortality data which enables comparisons between areas to accurately be made. Across Devon, Plymouth and Torbay, although there was fluctuation in rates, there were no statistically significant differences between local authorities in mortality rates.

[50] Teeson *et al.*, 2000 Cited in NHS Devon Substance Misuse Needs Assessment, 2012
[51] Kavanagh *et al.*, 2004; Patkar *et al.*, 1999 Cited in NHS Devon Substance Misuse Needs Assessment, 2012
[52] Conrod & Stewart, 2005; Gregg *et al.*, 2009 Cited in NHS Devon Substance Misuse Needs Assessment, 2012
[53] Raimo & Schuckit, 1998 Cited in NHS Devon Substance Misuse Needs Assessment, 2012
[54] Rounsaville et al, 2001 Cited in NHS Devon Substance Misuse Needs Assessment, 2012
[55] 'Preventing Suicide in England: A cross-government outcomes strategy to save lives' http://www.dh.gov.uk/health/files/2012/09/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf , accessed on February 13th 2013 Cited in NHS Devon Substance Misuse Needs Assessment, 2012

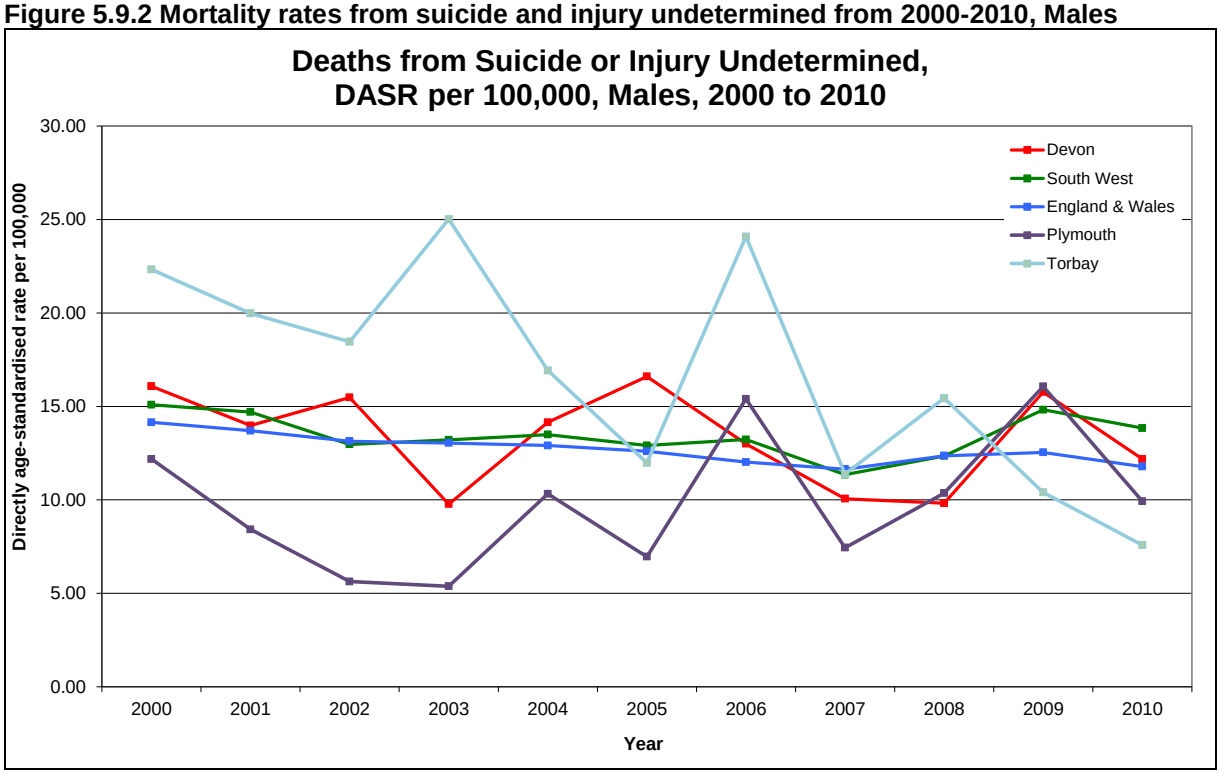
Figure 5.9.1 Mortality rates from suicide and injury undetermined in 2008-2010



Source: Health and Social Care Information Centre, Based on ONS Mortality Files

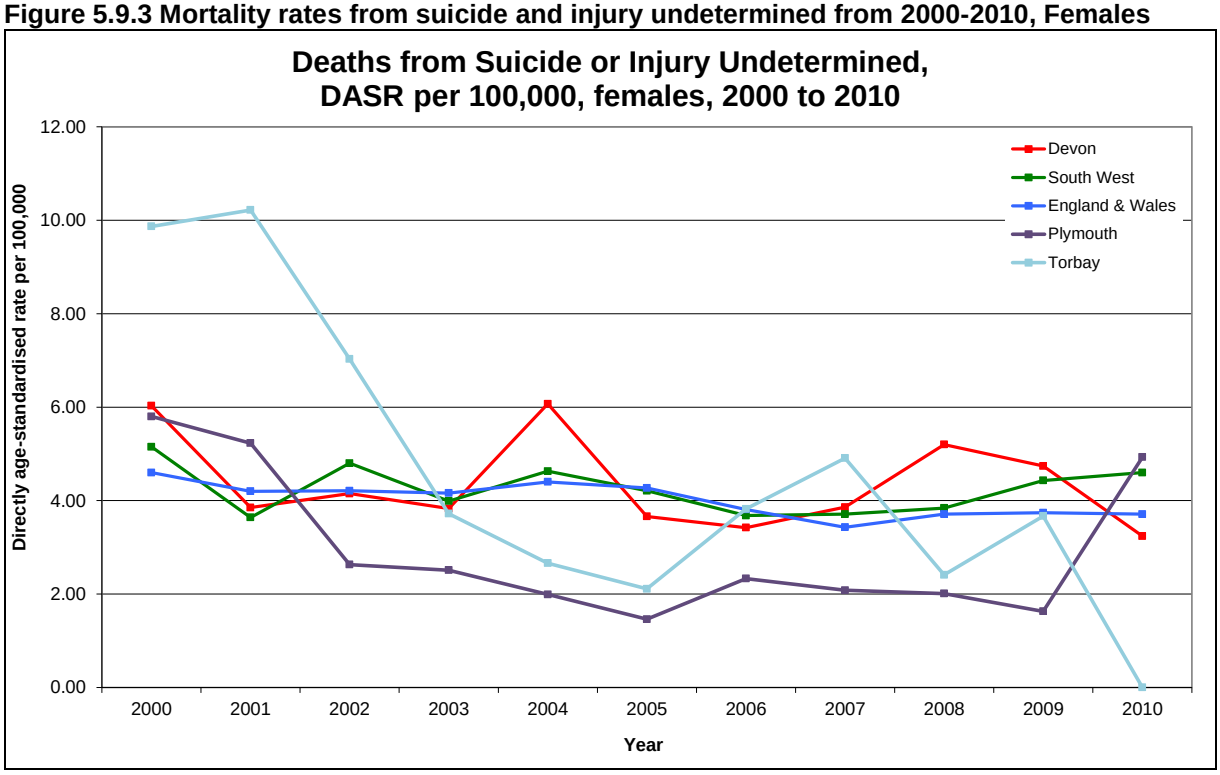
Figure 5.9.2 and 5.9.3 below shows the trends in mortality from suicide and injury undetermined in Devon, Plymouth and Torbay compared with Devon and the South West. This shows the clear difference in mortality between genders and also the fluctuation from year to year. For males, the Plymouth rate has increased over time and by the end of the monitoring period was just below the regional and national rates. The Devon rate fluctuated around the national and regional rates throughout and in Torbay rates started the period above the regional and national rates and then fell to below by the end of the monitoring period. For females, less variation is shown over time. However, by the end of the time period Plymouth had shown an increase in rates to above the regional and national rates, whereas Torbay had dipped considerably to no deaths from suicide and injury undetermined.

Figure 5.9.2 Mortality rates from suicide and injury undetermined from 2000-2010, Males



Source: Health and Social Care Information Centre, Based on ONS Mortality Files

Figure 5.9.3 Mortality rates from suicide and injury undetermined from 2000-2010, Females



Source: Health and Social Care Information Centre, Based on ONS Mortality Files

Suicide strategy

The national suicide prevention strategy was published in 2012. Devon, Plymouth and Torbay all have individual suicide prevention strategies. These all aim to ensure a co-ordinated approach to mental health promotion, treatment and care services and ensure services are relevant and appropriate to meet the varying needs. They also aim to ensure that suicide prevention is considered in the wider public health agenda.

5.10 Social care

Community Based Care

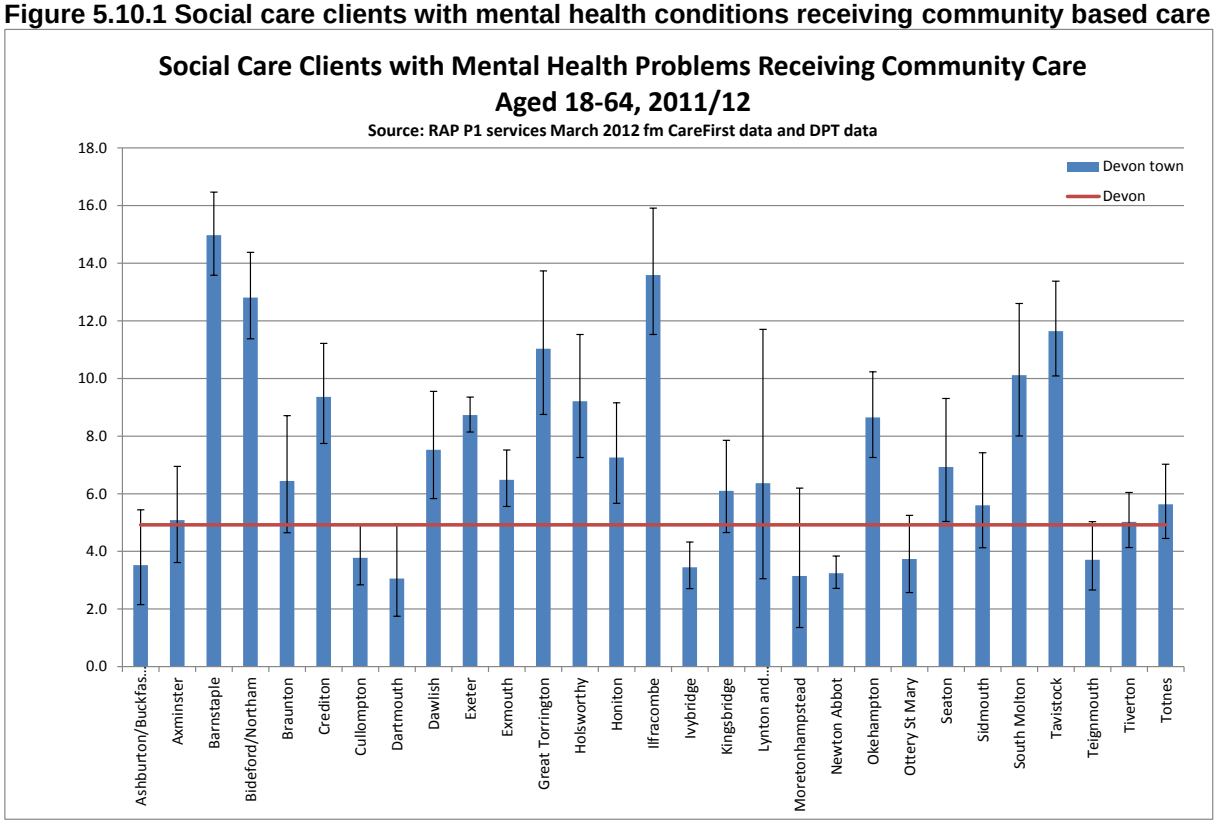
The table and graph below shows the proportion of adults aged 18-64 with a mental health condition receiving community based care. There is variation in rates between towns, with Barnstaple, Bideford/Northam, Crediton, Dawlish, Exeter, Exmouth, Great Torrington, Holsworthy, Honiton, Ilfracombe, Okehampton, South Molton and Tavistock all having statistically significantly high rates. Statistically significantly low rates were seen in Ivybridge and Newton Abbot.

Table 5.10.1 Social care clients with mental health conditions receiving community based care

	18-64 year olds		
Devon Town	Rate per 1,000	LLCI	ULCI
Ashburton/Buckfastleigh	3.5	2.2	5.4
Axminster	5.1	3.6	7.0
Barnstaple	15.0	13.6	16.5
Bideford/Northam	12.8	11.4	14.4
Braunton	6.4	4.6	8.7
Crediton	9.4	7.7	11.2
Cullompton	3.8	2.8	4.9
Dartmouth	3.1	1.7	5.0
Dawlish	7.5	5.8	9.6
Exeter	8.7	8.1	9.4
Exmouth	6.5	5.6	7.5
Great Torrington	11.0	8.8	13.7
Holsworthy	9.2	7.3	11.5
Honiton	7.3	5.7	9.2
Ilfracombe	13.6	11.5	15.9
Ivybridge	3.4	2.7	4.3
Kingsbridge	6.1	4.7	7.9
Lynton and Lynmouth	6.4	3.1	11.7
Moretonhampstead	3.1	1.4	6.2
Newton Abbot	3.2	2.7	3.8
Okehampton	8.6	7.3	10.2
Ottery St Mary	3.7	2.6	5.2
Seaton	6.9	5.0	9.3
Sidmouth	5.6	4.1	7.4
South Molton	10.1	8.0	12.6
Tavistock	11.6	10.1	13.4
Teignmouth	3.7	2.7	5.0
Tiverton	5.0	4.1	6.0
Totnes	5.6	4.5	7.0

Source: Devon County Council Social Care

Figure 5.10.1 Social care clients with mental health conditions receiving community based care



Source: Devon County Council Social Care

Residential or Nursing Care

The number of social care clients with mental health problems aged 18-64 who are in residential or nursing care in Devon is very low at only 31 so is not presented by town.

Carers

Social care services also collect data on the numbers of carers they are aware of caring for their clients with mental health problems. Again, numbers are very low across Devon for clients aged 18-64 with only 31 carers recorded.

5.11 Influences on and risks to mental health

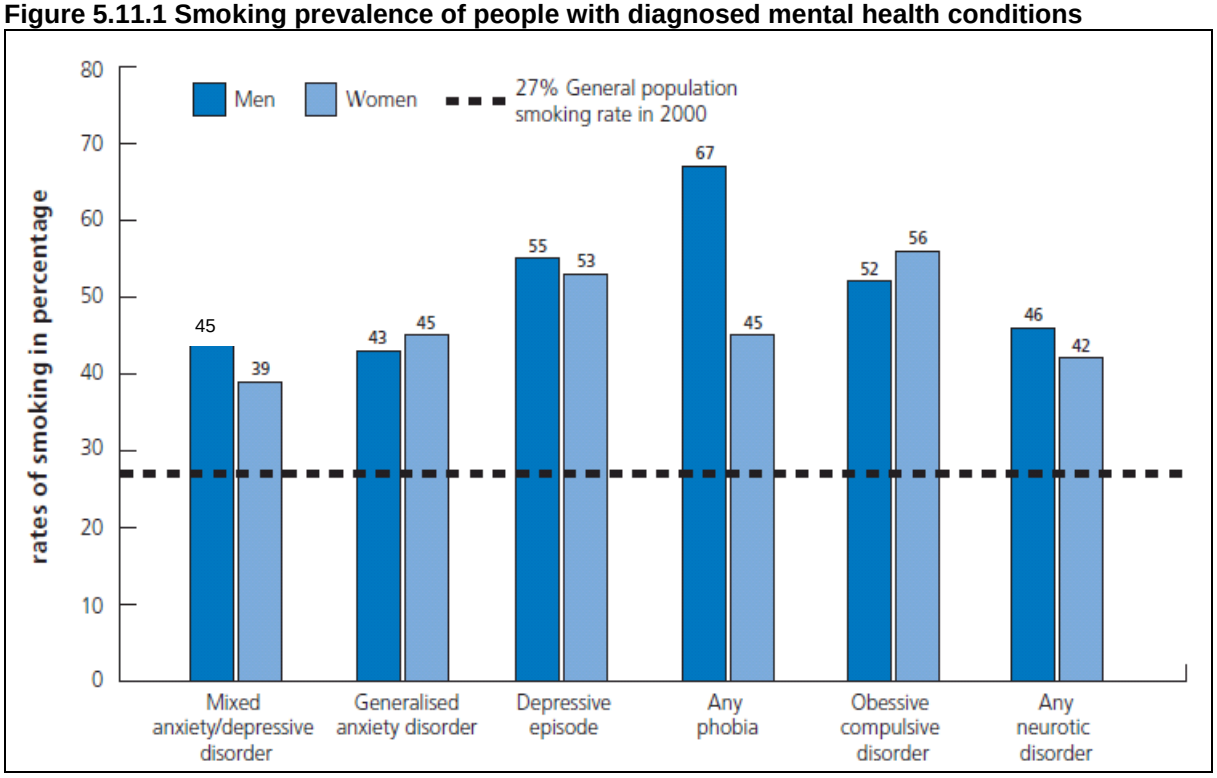
Smoking

Smoking levels are significantly higher amongst people with mental illnesses compared to the general population. They are also more likely to be heavier smokers with over half consuming twenty or more cigarettes a day[56].

The following figure shows the prevalence of smoking in people with diagnosed mental health conditions compared to the rate in the general population. This shows the overall rate is higher, but that also the rate varies between different mental health conditions.

[56] NICE, Smoking and Patients with Mental Health Problems, 2004
http://www.nice.org.uk/niceMedia/documents/smoking_mentalhealth.pdf

Figure 5.11.1 Smoking prevalence of people with diagnosed mental health conditions



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

The Care Quality Commission state in their Monitoring and Mental Health Act report 2010/2011 'About a third of patients who died of natural causes while detained in 2009/10 did so before their 61st birthday. This supports findings of reduced life expectancy amongst people with long term serious mental disorder – this has been attributed to a culmination of factors including multiple social disadvantage, long term antipsychotic medication use and high risk lifestyles, particularly smoking.....'[57]

In July 2008 mental health hospitals became smokefree as other workplaces had the previous year. Two years later the Chartered Institute of Environmental Health (CIEH) and Tobacco Control Collaborating Centre (TCCC) undertook a review of smokefree mental health hospitals on behalf of the Department of Health (DH) Mental Health Team. The review confirmed that compliance with the Smokefree Legislation was excellent almost without exception. However the researchers found significant difference in the approach of service providers to smokefree and views of their role in promoting the physical wellbeing of patients, in particular in preventing/reducing harm by tobacco use.

Researchers calculated that, on average, facilitating and observing of smoking took, on average, one whole time equivalent member of staff each day, This is equivalent to approximately 1.66 whole time equivalent of clinical time per ward per year. This is both a significant financial cost and a distraction from those staffs' clinical roles.

[57] Care Quality Commission, Monitoring the Mental Health Act in 2010/11, http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mha_report_2011_main_final.pdf

The NICE public health Draft Guidance on Tobacco: harm-reduction approaches to smoking (October 2012) cites studies that found mental health patients believed they were not offered adequate advice or assistance to address their smoking.[58] [59] Moreover, they found a relatively low proportion of mental health workers who considered smoking advice was an important part of their role.[60] [61]

Adults with mental health problems, including those who misuse alcohol or drugs, smoke 42% of all the tobacco used in England. Many wish to stop smoking and can do so with appropriate support. Over 40% of children who smoke have conduct and emotional disorders. This is particularly important as most smoking starts before adulthood. People with mental health problems need good access to services aimed at improving health (for example, stop smoking services).

Family breakdown

Family breakdown in all forms, so separation, divorce or family breakdown, is associated with poor mental health adults and also in children. Mental health problems can be both a cause or effect of family breakdown. The Centre for Social Justice Report: Mental Health: Poverty, Ethnicity and Family Breakdown cites that family breakdown and conflict were considered to have the biggest adverse impact on children's wellbeing. Conflict between parents and families where parents are separated, single or step-parents is associated with a range of problems in children including poor peer interaction, ill health, depression, anxiety, low self-esteem, behavioural difficulties, eating disorders, substance misuse and poor attachment[62]

To try and establish the number of families expected to be affected in some way from family breakdown, table 5.11.1 shows results from the 2011 Census looking at the number of people who reported themselves to be divorced or separated and also the number of lone parent families with dependent children. The table shows a higher proportion of people divorced and separated in Torbay and the lowest in West Devon. The greatest proportions of lone parent families with dependent children were in Plymouth and Torbay and the lowest were in East Devon.

[1] www.nepho.org.uk/cmhp Community Mental Health Profiles downloaded January 15th 2013
[58] Ratschen 2010
[59] Green 2005
[60] Ratschen 2009
[61] Ashton 2010
[62] The Centre for Social Justice, *Mental Health: Poverty, Ethnicity and Family Breakdown. Interim Policy Briefing*, The Centre for Social Justice:2011, London (http://www.centreforsocialjustice.org.uk/UserStorage/pdf/Pdf%20reports/MentalHealthInterimReport.pdf)

Table 5.11.1 Numbers of people divorced, separated and lone parent families with dependent children

	Separated (but still legally married or still legally in a same-sex civil partnership)		Divorced or formerly in a same-sex civil partnership which is now legally dissolved		Number of lone parent families with dependent children	
	Number of people	%	Number of people	%	Number of families	%
East Devon	1,783	1.6	7,438	6.8	2,649	4.5
Exeter	1,596	1.7	6,741	7.2	3,147	6.4
Mid Devon	1,143	1.8	3,996	6.4	1,717	5.2
North Devon	1,339	1.8	5,090	6.8	2,319	5.8
Plymouth	4,066	2.0	16,023	7.8	7,894	7.2
South Hams	1,138	1.7	4,972	7.3	1,822	4.9
Teignbridge	1,675	1.7	7,397	7.3	2,933	5.4
Torbay	2,333	2.2	9,590	9.0	4,190	7.1
Torridge	953	1.8	3,554	6.8	1,446	5.2
West Devon	661	1.5	2,737	6.3	1,034	4.6

Source: ONS © Crown Copyright Reserved [from Nomis on 3 June 2013]

Homelessness

The term 'homeless' covers a wide range of experiences from being literally roofless to living in insecure, temporary accommodation. Homelessness and, in particular, rough sleeping is often viewed as a problem which only exists in large cities. In 2011, a Devon Health Needs Assessment[63] was completed which looked at the health needs of the people who are rough sleeping, living in supported accommodation, such as a Hostel or Night Shelter or receiving floating support to help sustain an independent accommodation option. This report shows that there is a significant number of people homeless and rough sleeping in Devon, not just in the larger urban areas such as Exeter, but also in the more rural and remote parts of the county. To support this needs assessment a Heath Audit was undertaken of homeless people. The Toolkit used was devised by Homeless Link and the Department of Health. It was decided to concentrate on three areas of Devon; Exeter, Northern Devon and South Devon. In total there were 259 respondents to the Health Audit: 133 from Exeter, 87 from North Devon and 39 from South Devon. 178 of the respondents were male and 75 female and 216 of respondents described themselves as white British (83%). Additional information was also gathered from the Clock Tower Surgery, Devon County Council (via the Supporting People programme) The Royal Devon and Exeter Hospital and the voluntary sector.

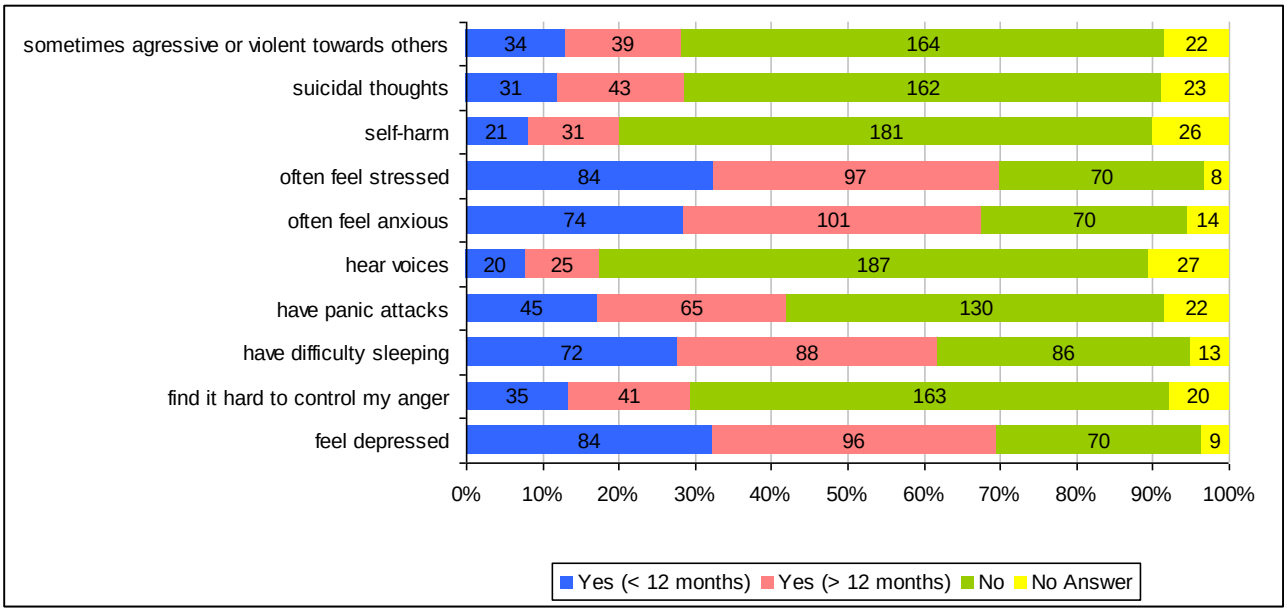
National data shows that homeless people are 40 times less likely to be registered with a GP than the general population (Department of Health 2010). In Devon GP registration among this population is fairly high. 82% of respondents to the Health Audit said that they were registered with a GP as a permanent patient; however this high prevalence is possibly due to there being a specialist service in Exeter (The Clock Tower Surgery) and to support workers motivating their clients to access primary healthcare as part of the 'support planning' process. QOF data for the Clock Tower Surgery in Exeter showed a high prevalence of major mental health problems. The latest 2011-12 practice level data puts the prevalence of major mental health problems in the Clock Tower practice population at 7.8% compared to a Devon average of 0.7% and a national average of 0.8%.

[63] Homelessness Needs Assessment, NHS Devon. http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2011/07/Homelessness-Health-Needs-Assessment-2011.pdf Accessed January 30th 2013

There is a high level of expressed need amongst the homeless population around Mental Health and Wellbeing which arguably can be both a cause and consequence of homelessness. In a study of homeless people (North 1998) it was found that the signs of mental illness antedated their first loss of accommodation in 98% of the sample. The last comprehensive study in the UK (Gill et al 1996) included the following findings:- psychosis in 8% of hostel residents, compared with 0.4% of the general population neurotic disorders in 38% of hostel residents compared with 16% of the general population.

The results shown in the Health audit give a valuable insight in to the mental health needs of the homeless population in Devon.

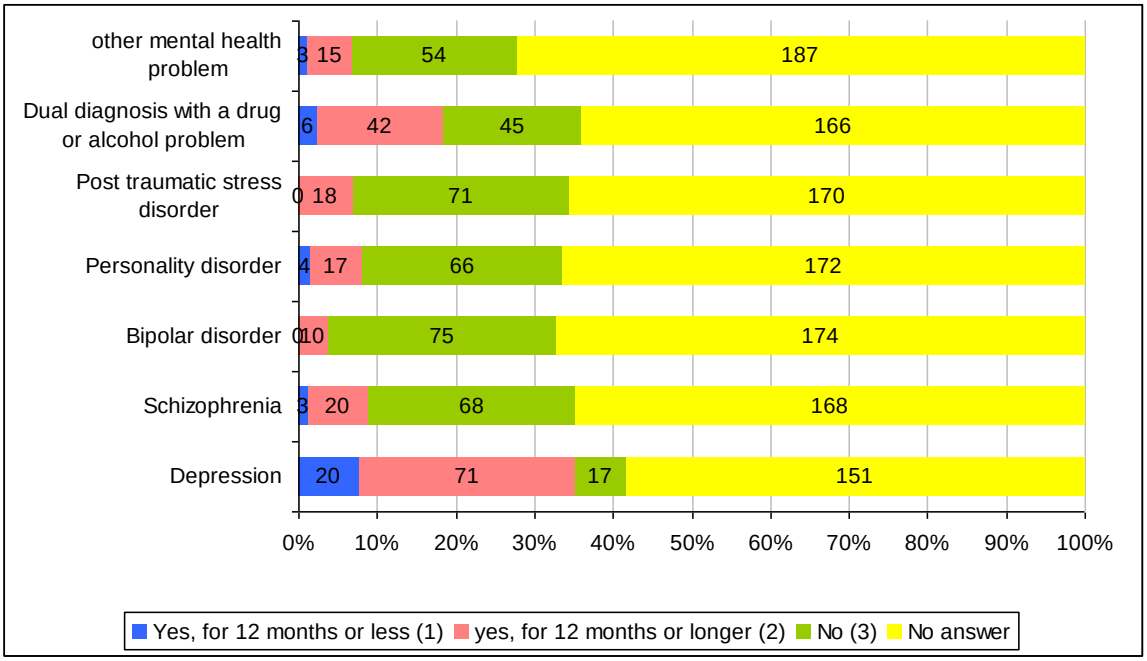
Figure 5.11.1 Expressed mental health need



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

The results above demonstrate high levels of anxiety and depression among those surveyed. This could be seen to support the assertion made that all homeless people suffer from mental health problems due to their rooflessness; lack of decent housing can cause as well as exacerbate conditions such as anxiety, depression and stress.

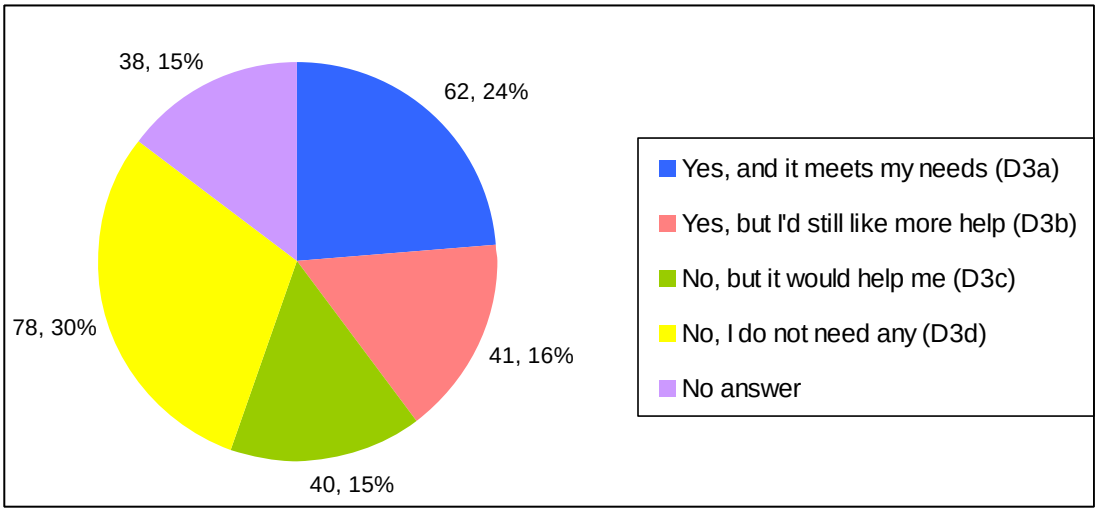
Figure 5.11.2 Diagnosis by a doctor or other health professional



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

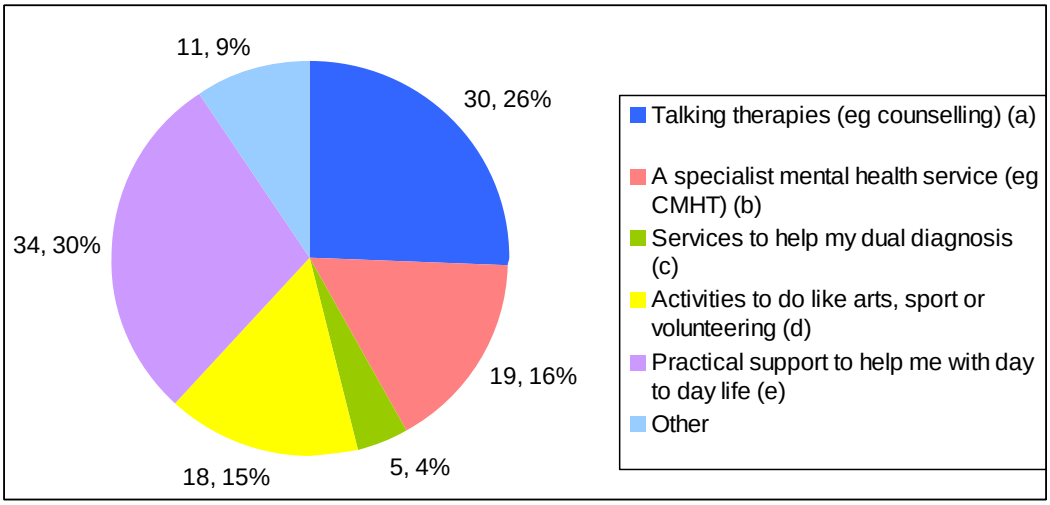
Out of all respondents, 118 had a mental health condition which had been diagnosed by a GP or other health professional. Figure 5.11.2 above shows the diagnosis and how long the person has had the condition. The responses show that most of the respondents had their condition for over 12 months. The ranges of responses show that there are significant numbers of the survey who suffer from a severe and enduring mental health problem. Anecdotally both homeless individuals and services will state that it is difficult for people to access support for their mental health problems.

Figure 5.11.3 Do you get any support for your mental health problem?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

Figure 5.11.4 What kind of support helps you?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

The Health Audit asked whether people got support and if it met their needs. There were further questions asking about the type of support they receive and what type of support they would like to receive. The survey shows that only a small percentage of those surveyed felt that the support they got actually met their needs.

A lot of respondents felt that practical help was useful. This would be provided by a non health professional, possibly a housing support worker. Again this shows that housing support plays a vital role in the recovery process, but workers need the support of health professionals to do their job effectively and prevent burn out. Despite the high levels of expressed and diagnosed mental health problems highlighted in the Health Audit, only 39.77% were getting any support for their mental health condition. Of those 15.83% stated that they got some support but needed more help. 15.44% stated that they received no support for their condition, but felt that it would help them. Talking therapies were viewed as being the most helpful intervention, with practical support to assist with day to day life as second.

The local data is broadly in line with the findings from national research, which shows a disproportionate level of mental health problems among the homeless population. Evidence from the Health Audit shows that people do not feel that they get enough support to help them, but the help they would like does not necessarily need to be provided by a health professional. A lot of support provided by non health professionals such as housing support workers needs to be recognised and mental health services potentially have a role in supporting generic workers by offering clinical supervision and training.

Identifying other areas of health that affect mental health in homeless is complex. Dual diagnosis in the homeless population is common, it is well documented that there is a strong co-morbidity between mental health and substance misuse amongst this population. The London Chain (2009) found 41% of people rough sleeping had a drug problem, 49% had an alcohol problem, 35% had a mental health problem and 25% had all three. There are still barriers to services, where even those with a psychiatric diagnosis can be refused treatment or an assessment because of their

substance misuse. Often mental health services will require a person to have been detoxified before they will assess their mental health, whilst the treatment agencies will often be reluctant to offer treatment until the individual's mental health has been addressed, especially if they exhibit high risk behaviours. Treatment services often like to see a degree of commitment or motivation by the client, this may include cutting down on their substance and attending appointments. Arguably these requirements can provide a barrier to support as the rigours to living on the street make either difficult to achieve.

The prevalence of personality disorders in the general population varies according to the way it is measured, but it is generally acknowledged that around 10% may reach diagnostic levels. However, it is estimated that this rate rises to 60% of adults living in hostels in England. Rough sleepers and young people who have experienced homelessness generally experience higher rates of mental health problems than the general population. The term complex trauma can be understood as the behaviour observed in people with personality disorder that can be described as reactions to and ways of coping with the traumatic experience of difficult childhoods. It may, therefore be more useful to describe personality disorders as 'Complex Trauma'; a reaction to an ongoing and sustained traumatic experience (Maguire 2010).

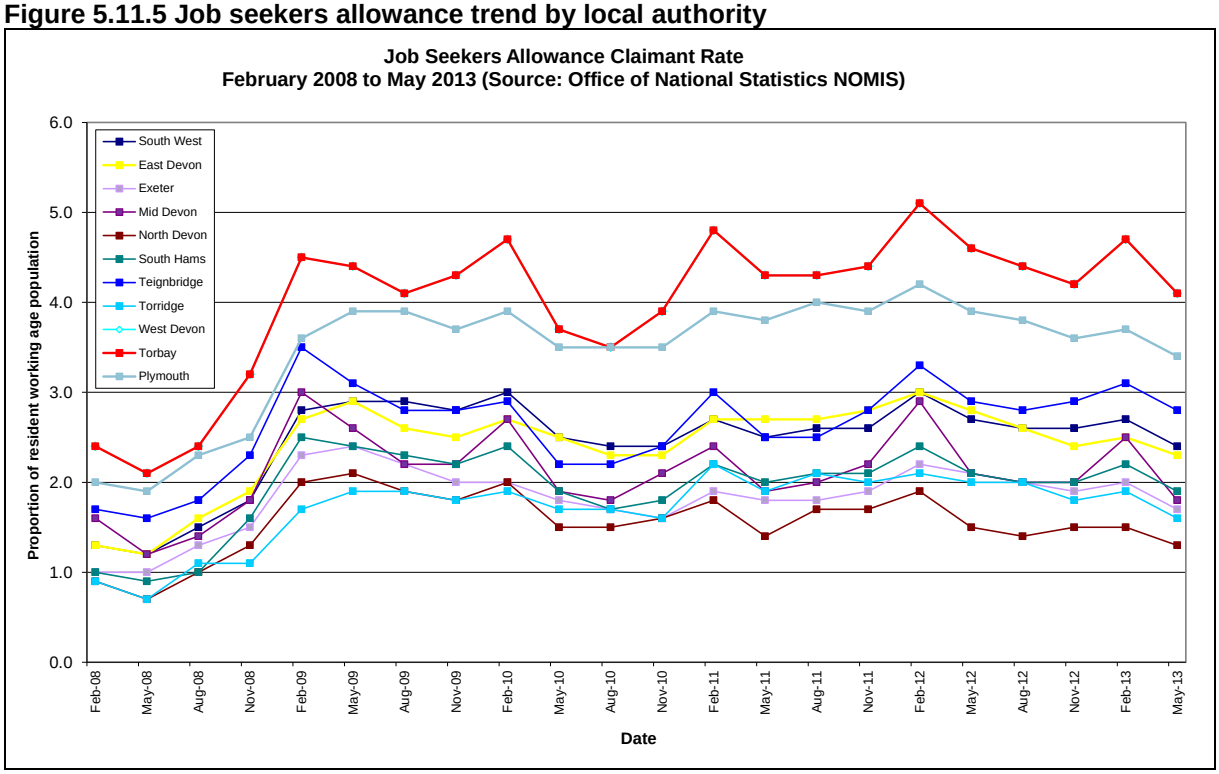
These are people who, with a few exceptions, will not be accessing mainstream mental health services and they can present challenges to which conventional mental health services have not on the whole responded well. In some cases, primary health care may be engaged, though good practice here is far from universal. The term 'complex trauma' does not seek to convey a medical diagnosis, but rather a set of experiences which may underpin emotional, cognitive and behavioural patterns seen in adulthood.[64]

Work and Employment

Being in employment in a job which gives you some element of financial stability and job satisfaction is a protective factor of mental health. However, being unemployed is a risk factor for poor mental health and wellbeing. The unsettled economic situation across the country has had its impact on employment within the cluster area. The rate of unemployment peaked in April 2009 and although rates have dropped a little, they have remained higher than pre-recession. The trend in job seekers allowance claimants is shown in figure 5.11.5.

[64] http://www.nmhdu.org.uk/silo/files/meeting-the-psychological-and-emotionalneeds- of-people-who-are-homeless.pdf

Figure 5.11.5 Job seekers allowance trend by local authority



Source: Nomis Web

Levels of unemployment vary across the cluster, but as of December 2012, all areas have lower levels of unemployment than 4.5% nationally. Rates vary between Local Authorities with the highest levels of unemployment experienced in Torbay, Plymouth and Torridge. The lowest levels of unemployment were in South Hams at 1.5%. Table 5.11.2 below shows the job seekers allowance claimant rates as of the end of December 2012.

Table 5.11.2 Job seekers allowance claimants

Local authority	Total Job Seekers Allowance Claimants
East Devon	1.6%
Exeter	2.3%
Mid Devon	1.9%
North Devon	2.4%
Plymouth	3.4%
South Hams	1.5%
Teignbridge	2.0%
Torbay	4.3%
Torridge	3.0%
West Devon	1.8%
England	**4.5%**

Source: Nomis Web

There is variation in the ages of people claiming job seekers allowance and table 5.11.3 below shows the proportions in each age group. This shows that in some parts of the cluster there are higher proportions of unemployment in the younger age groups than the England average. There are higher proportions of unemployed 18-24 year olds in East Devon, Exeter, Mid Devon, North Devon, North Devon, Plymouth

and South Hams. Exeter and Plymouth have higher proportions of 25-34 year olds unemployed compared with England but all other Local Authorities have lower proportions than England in this age group. It is however noticeable that in areas in Devon where rates of overall unemployment are lower, there are higher proportions in the older age groups.

Table 5.11.3 Proportion of job seekers allowance claimants by age group

local authority	under 18	18-24	25-34	35-44	45-49	50-54	55-59	60-64
East Devon	1%	31%	19%	18%	9%	10%	9%	3%
Exeter	1%	32%	25%	19%	8%	8%	6%	2%
Mid Devon	1%	34%	21%	17%	9%	8%	9%	2%
North Devon	1%	36%	21%	17%	9%	9%	7%	2%
Plymouth	0%	35%	25%	18%	8%	7%	5%	1%
South Hams	~	31%	19%	18%	12%	10%	10%	1%
Teignbridge	1%	30%	19%	19%	12%	10%	8%	2%
Torbay	0%	28%	22%	20%	11%	8%	8%	2%
West Devon	1%	29%	20%	20%	12%	9%	7%	1%
England	0%	30%	24%	20%	10%	8%	6%	2%

Source: Nomis Web

Table 5.11.4 below shows the numbers and proportions of people claiming incapacity benefit or severe disablement allowance for mental and behavioural disorders. There is variation between the different Local Authorities across the area. Exeter, North Devon, Plymouth, Torbay and Torridge all have higher proportions than England and all of these areas except Torbay are higher than the Devon, Plymouth and Torbay cluster proportion of 45%.

Table 5.11.4 Incapacity benefit claimants or sever disablement allowant for mental and behavioural disorders

Local authority	Mental and behavioural disorders (F00-F99)	% of all incapacity benefit/severe disablement claimants
East Devon	960	40%
Exeter	1,360	47%
Mid Devon	630	43%
North Devon	1,050	48%
Plymouth	4,250	48%
South Hams	750	43%
Teignbridge	1,150	41%
Torbay	2,170	45%
Torridge	780	47%
West Devon	450	38%
Devon, Plymouth and Torbay	**13,550**	**45%**
England	**570,000**	**44%**

Source: Nomis Web, December 2012

5.12 Service user engagement

Service user involvement in planning, developing and monitoring services is seen as best practice. This can be difficult to manage, maintain and to ensure effective and this is particularly the case in mental health services. In Devon, service user involvement is promoted and supported by an independent third sector organisation

called Be Involved Devon which provides people with the opportunity and support to enable them to be involved in consultation and feedback on services and to look at the development and evaluation of services. Be Involved Devon are a key delivery partner for Healthwatch working around mental health engagement.

In 2011, LINk Devon, who are the local involvement network in Devon, produced a report titled 'Access to Emotional Wellbeing services in Devon'[65]. This report looked at a provisional examination of the concerns raised by adults in the community about accessing these services, using an evidence base which LINk Devon acknowledges is limited. At the time of the report there were many concerns from respondents to the short survey, advising that accessing emotional and wellbeing services was not a satisfactory experience. The report stated that case studies characterise emotional and wellbeing services as under developed, challenged by the level of existing demand, limited in range and flexibility, of variable quality, under resourced and inaccessible. It must however be noted that this feedback was collected at a time when the service was changing and developing due to the introduction of the Improving Access to Psychological Therapies programme from 2009/10.

The report discusses the level of service commissioned, how this is delivered and responses from service user engagement around patient experience. The report makes a series of 11 recommendations and it is suggested that after a suitable period of time the progress towards these recommendations should be reported and also a further analysis of service users to assess whether these recommendations and any changes to services have improved the experience of service users.

5.13 Recommendations

1 Improve access to prescribing data by age group via the primary care data warehouse to support life course analysis.

2 Review existing local suicide prevention strategies and consider the opportunity to refresh, in the light of the national strategy, on a peninsula wide basis to ensure an alignment of objectives and promote consistent preventive action.

6. Older people

6.1 Prevalence of Depression

The following graphs look at the estimated and projected prevalence of depression in people age over 64. The data is taken from the POPPI (Projecting Older People Population Information system) and is based on estimates of depression taken froma study by McDougall et al.[66] The estimates by age group are shown in table 6.1.1 below. It breaks the level of depression in to two different levels, enabling severe

[65] http://www.linkdevon.org.uk/uploads/LINkDevonReportFinalEWBJune11.pdf Dowloaded on January 31st

[66] McDougall et al, Prevalence of depression in older people in England and Wales: the MRC CFA Study in Psychological Medicine, 2007, 37, 1787–1795.

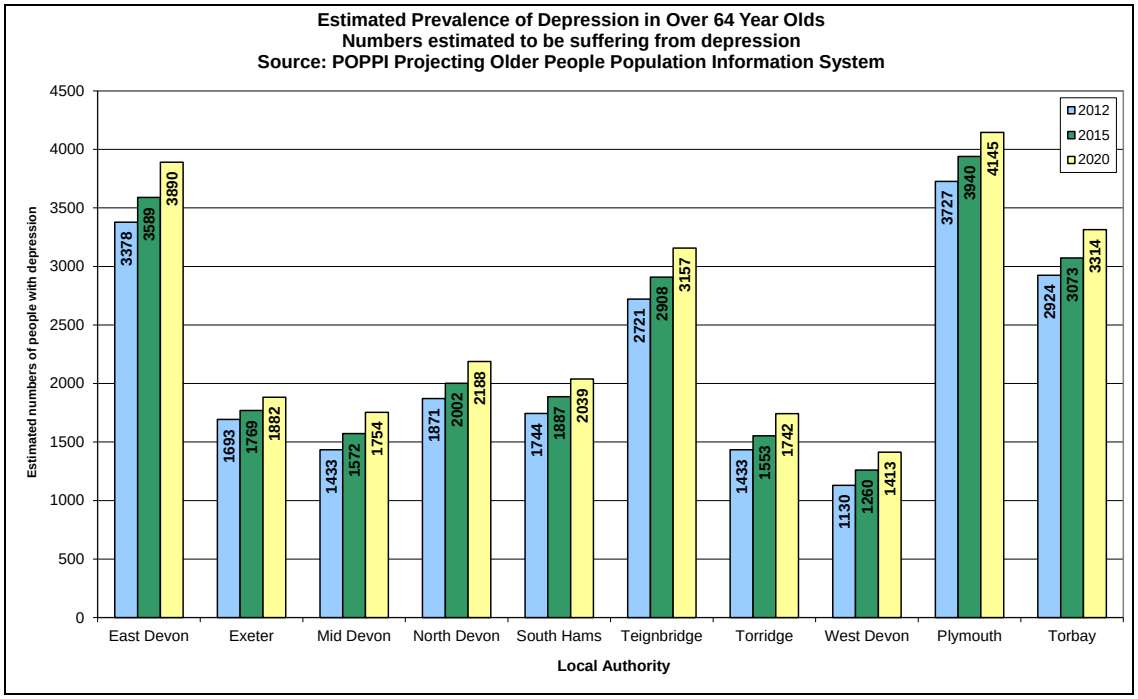
depression to be identified separately. Figure 6.1.1 shows the numbers of people estimated to suffer from depression across the Local Authorities in Devon. The data shows the numbers appear to be increasing over the years as the population increases. There is variation between areas with East Devon, Teignbridge, Plymouth and Toray showing the highest numbers. Figure 6.1.2 shows numbers of people suffering from severe depression. The patterns in this are similar to those with depression.

Table 6.1.1 Estimates of depression and severe depression in over 64 year olds

	Depression		Severe depression
Age range	% males	% females	% people
65-69	5.8	10.9	2.5
70-74	6.9	9.5	1.6
75-79	5.9	10.7	3.5
80-84	9.7	9.2	3
85+	5.1	11.1	3.9

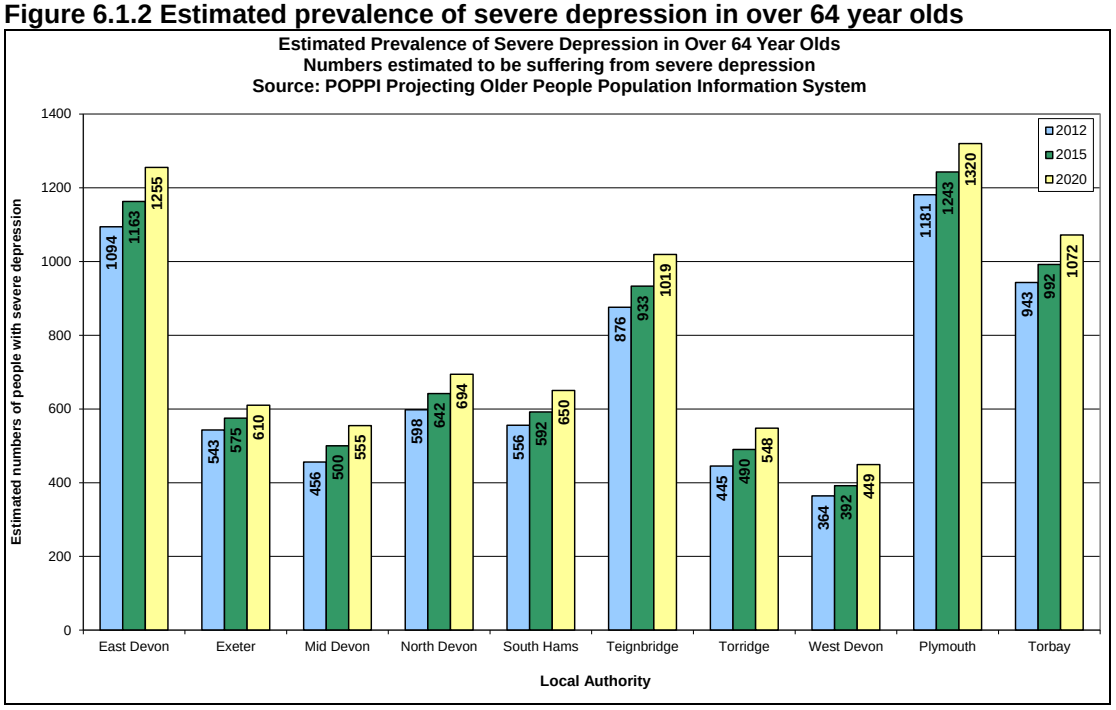
Source: POPPI

Figure 6.1.1 Estimated prevalence of depression in over 64 year olds



Source: POPPI

Figure 6.1.2 Estimated prevalence of severe depression in over 64 year olds



Source: POPPI

Devon County Council's People's scrutiny committee agreed in November 2012 to develop a 'Depression in Older People Task Group'. This was established as a result of work previously carried out around dementia. The terms of reference for the task group were:

1. To evaluate the scale and impact of older people in Devon with depression.

2. To consider services and strategies to address depression in older people.

3. To make detailed recommendations to the People's Scrutiny Committee on the findings of the Task Group.

It was decided that no age boundaries would be set around this work as it was acknowledged that people could be deemed 'older' at different stages and so boundaries would not be useful. The Task Group produced an interim report in March and will continue work once the local elections have taken place in May. The report identified a series of 7 recommendations which are listed below:-

Devon County Council

1. That the role of the County Council in coordinating and enabling voluntary groups including financial support is reviewed.

2. That the County Council ensures there is improved training to carers in the identification of older people with depression. That the County Council also promotes community awareness in trying to recognise depression.

3. That a Public Health campaign be used for low level depression, linked into the Health and Wellbeing Board, focusing on early intervention through identification and the prevention of depression.

Devon Health and Wellbeing Board

4. That the Health and Wellbeing Board initiate a review of existing provision and develop a range of interventions as a model for wider use to address social isolation and depression in Devon.

5. That the Health and Wellbeing Board keeps a watching brief on the commissioning of mental health services from the new Clinical Commissioning Groups (CCGs).

Devon Clinical Commissioning Groups

6. That the new Devon CCGs address the issue of GP identification and treatment of depression focusing on a holistic approach to older people's needs to include social interaction.

Devon Partnership NHS Trust

7. That the Devon Partnership NHS Trust be urged to immediately review its promotion and marketing of the Depression and Anxiety Service, crucially to increase awareness of the public, social care and GPs.

The report highlights concerns around the identification and treatment of depression amongst older people and not just seeing it as a part of the aging process. The close relationship between physical and mental health is also discussed, and consequently this also links to the impact on peoples discharge from hospital and how joint working between health and social care around mental health could help this process. Linkages between depression and social isolation are discussed and also how the rurality of Devon and also the trend of people moving to the county at retirement without family support can add to loneliness and feelings of isolation. The importance of the voluntary and third sector organisations is highlighted and also actions to improve the mapping and signposting of services and also utilising the benefits of volunteering and making a difference on people's health and wellbeing by encouraging volunteering to alleviate depression and enabling people to feel valued after retirement.

There is a need highlighted in the report to support and encourage GPs to take a more holistic approach to identifying older people's needs and about referrals in to the Depression and Anxiety Service. The targets around referrals in to Depression and Anxiety Services show Devon to be referring lower than required, and this is particularly evident in the older age groups.

The report recognises the importance of the public health approach to depression in reducing stigma attached to mental health problems, hopefully removing the barrier to older people feeling able to discuss mental health problems with GPs. It also highlights the need to integrate care, reducing the silos that are in place for mental health, physical health and social care. Involving young people in working with older people was also raised, both to help with valuing and respect of older people, but also to harness a wealth of knowledge and experience.

6.2 Social Care

Community Based Care

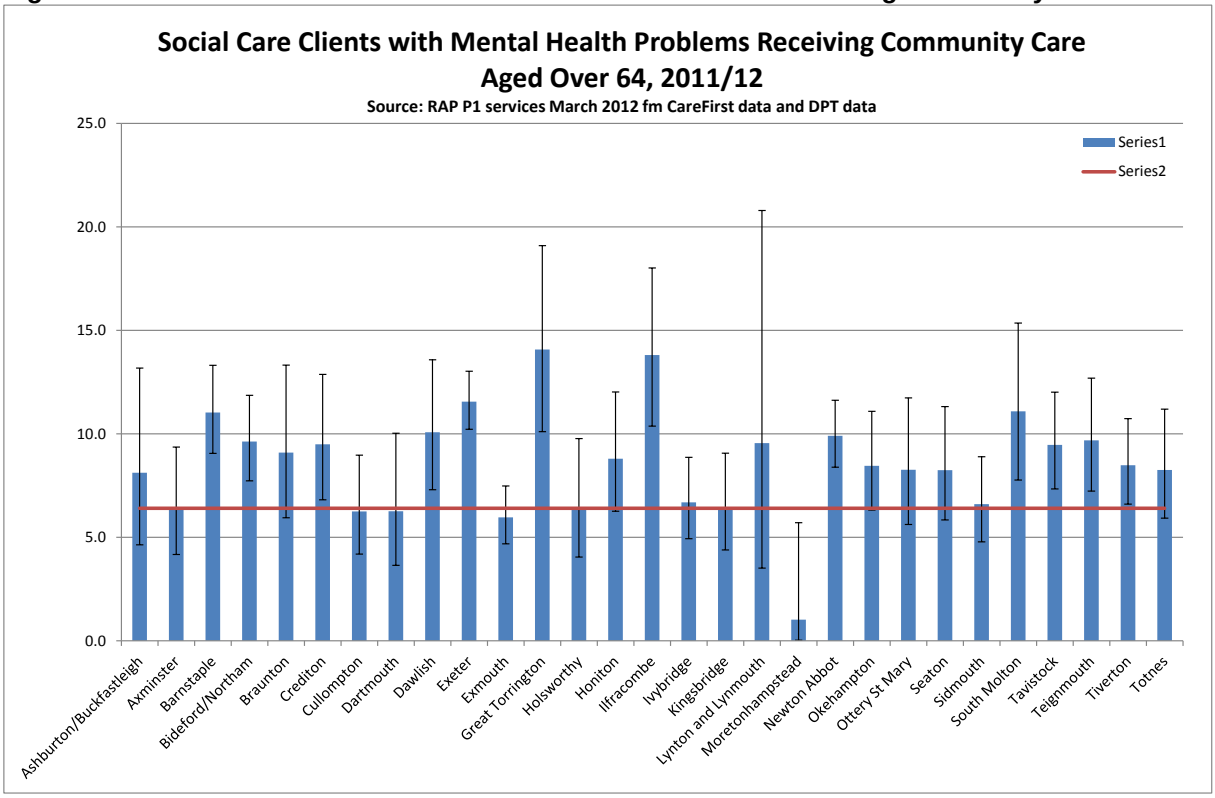
The table and graph below shows the proportion of adults aged over 64 with a mental health condition receiving community based care. There is variation in rates between towns, with Barnstaple, Bideford/Northam, Crediton, Dawlish, Exeter, Great Torrington, Honiton, Ilfracombe, Newton Abbot, South Molton, Tavistock, Teignmouth and Tiverton all having statistically significantly high rates. Statistically significantly low rates were seen in Moretonhampstead.

Table 6.2.1 Social care clients with mental health conditions receiving residential or nursing care

	65 and above		
Devon Town	Rate per 1,000	LLCI	ULCI
Ashburton/Buckfastleigh	8.1	4.6	13.2
Axminster	6.4	4.2	9.4
Barnstaple	11.0	9.1	13.3
Bideford/Northam	9.6	7.7	11.9
Braunton	9.1	5.9	13.3
Crediton	9.5	6.8	12.9
Cullompton	6.2	4.2	9.0
Dartmouth	6.3	3.6	10.0
Dawlish	10.1	7.3	13.6
Exeter	11.6	10.2	13.0
Exmouth	6.0	4.7	7.5
Great Torrington	14.1	10.1	19.1
Holsworthy	6.5	4.0	9.8
Honiton	8.8	6.3	12.0
Ilfracombe	13.8	10.4	18.0
Ivybridge	6.7	4.9	8.9
Kingsbridge	6.4	4.4	9.1
Lynton and Lynmouth	9.6	3.5	20.8
Moretonhampstead	1.0	0.0	5.7
Newton Abbot	9.9	8.4	11.6
Okehampton	8.5	6.3	11.1
Ottery St Mary	8.3	5.6	11.7
Seaton	8.2	5.8	11.3
Sidmouth	6.6	4.8	8.9
South Molton	11.1	7.8	15.3
Tavistock	9.5	7.3	12.0
Teignmouth	9.7	7.2	12.7
Tiverton	8.5	6.6	10.7
Totnes	8.3	5.9	11.2

Source: Devon County Council Social Care

Figure 6.2.1 Social care clients with mental health conditions receiving community based care



Source: Devon County Council Social Care

Residential or Nursing Care

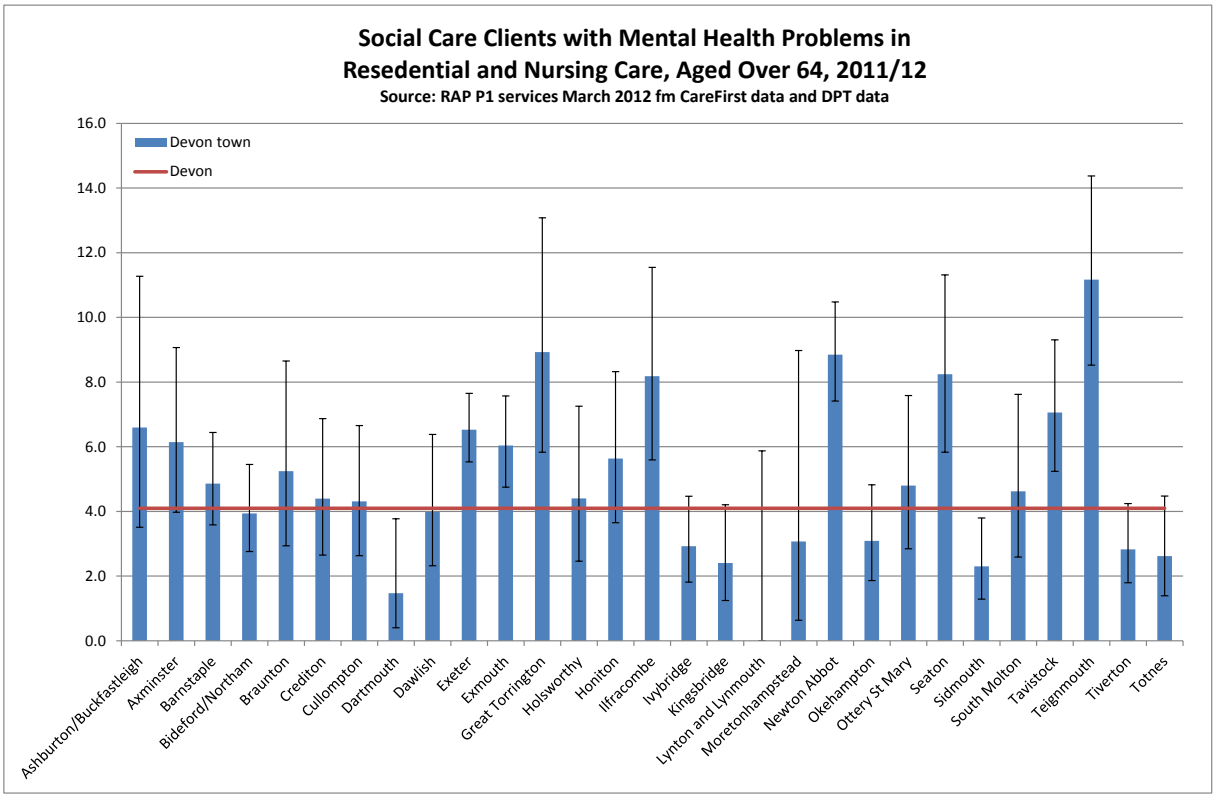
The table and graph below shows the proportion of adults aged over 64 with a mental health condition receiving residential or nursing care. There is variation in rates between towns, with Exeter, Exmouth, Great Torrington, Ilfracombe, Newton Abbot, Seaton, Tavistock and Teignmouth all having statistically significantly high rates. Statistically significantly low rates were seen in Dartmouth and Sidmouth.

Table 6.2.2 Social care clients with mental health conditions receiving residential or nursing care

Devon Town	Aged 65 and above		
	Rate per 1,000	LLCI	ULCI
Ashburton/Buckfastleigh	6.6	3.5	11.3
Axminster	6.1	4.0	9.1
Barnstaple	4.9	3.6	6.4
Bideford/Northam	3.9	2.8	5.5
Braunton	5.2	2.9	8.7
Crediton	4.4	2.6	6.9
Cullompton	4.3	2.6	6.7
Dartmouth	1.5	0.4	3.8
Dawlish	4.0	2.3	6.4
Exeter	6.5	5.5	7.7
Exmouth	6.0	4.8	7.6
Great Torrington	8.9	5.8	13.1
Holsworthy	4.4	2.5	7.3
Honiton	5.6	3.6	8.3
Ilfracombe	8.2	5.6	11.5
Ivybridge	2.9	1.8	4.5
Kingsbridge	2.4	1.2	4.2
Lynton and Lynmouth	0.0	0.0	5.9
Moretonhampstead	3.1	0.6	9.0
Newton Abbot	8.8	7.4	10.5
Okehampton	3.1	1.9	4.8
Ottery St Mary	4.8	2.8	7.6
Seaton	8.2	5.8	11.3
Sidmouth	2.3	1.3	3.8
South Molton	4.6	2.6	7.6
Tavistock	7.1	5.2	9.3
Teignmouth	11.2	8.5	14.4
Tiverton	2.8	1.8	4.2
Totnes	2.6	1.4	4.5

Source: Devon County Council Social Care

Figure 6.2.2 Social care clients with mental health conditions receiving residential or nursing care



Source: Devon County Council Social Care

Carers

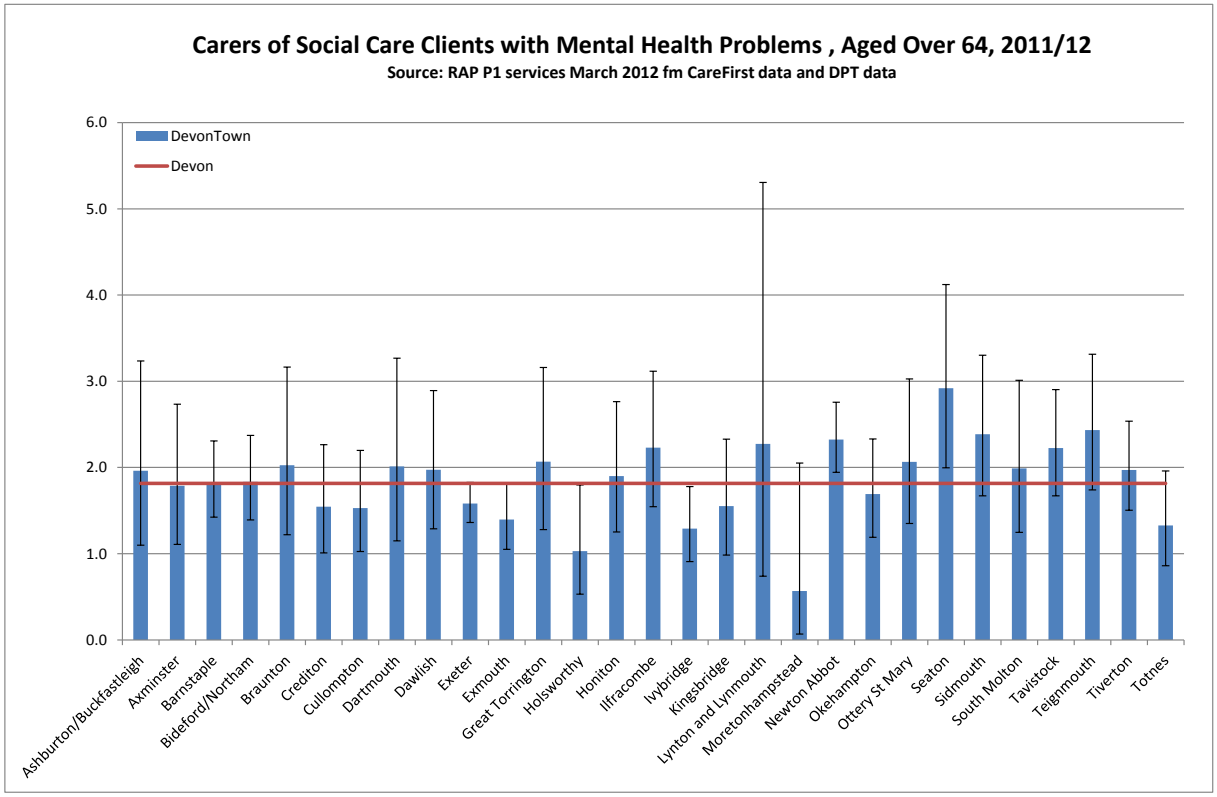
Social care services also collect data on the numbers of carers they are aware of caring for their clients with mental health problems. The table and graph below the rates of carers as a proportion of all people aged over 18. Rates vary across Devon, with Seaton showing the highest rate.

Table 6.2.3 Carers of Social care clients with mental health conditions

Devon Town	Rate per 1,000	LLCI	ULCI
Ashburton/Buckfastleigh	2.0	1.1	3.2
Axminster	1.8	1.1	2.7
Barnstaple	1.8	1.4	2.3
Bideford/Northam	1.8	1.4	2.4
Braunton	2.0	1.2	3.2
Crediton	1.5	1.0	2.3
Cullompton	1.5	1.0	2.2
Dartmouth	2.0	1.2	3.3
Dawlish	2.0	1.3	2.9
Exeter	1.6	1.4	1.8
Exmouth	1.4	1.1	1.8
Great Torrington	2.1	1.3	3.2
Holsworthy	1.0	0.5	1.8
Honiton	1.9	1.3	2.8
Ilfracombe	2.2	1.5	3.1
Ivybridge	1.3	0.9	1.8
Kingsbridge	1.6	1.0	2.3
Lynton and Lynmouth	2.3	0.7	5.3
Moretonhampstead	0.6	0.1	2.1
Newton Abbot	2.3	1.9	2.8
Okehampton	1.7	1.2	2.3
Ottery St Mary	2.1	1.3	3.0
Seaton	2.9	2.0	4.1
Sidmouth	2.4	1.7	3.3
South Molton	2.0	1.2	3.0
Tavistock	2.2	1.7	2.9
Teignmouth	2.4	1.7	3.3
Tiverton	2.0	1.5	2.5
Totnes	1.3	0.9	2.0

Source: Devon County Council Social Care

Figure 6.2.3 Carers of Social care clients with mental health conditions



Source: Devon County Council Social Care

7. What Works – Evidence of Effectiveness

This is an overview of the current evidence base for mental health services over the life course, drawn largely from the relevant NICE guidelines, NICE quality standards, the National Standards Framework and NHS evidence.

7.1 Major themes

Image

A positive image of mental health should be promoted, emphasising that recovery from mental illness is possible[67]. Healthcare practitioners should be aware of the potential discrimination faced by many service users and adopt a non-judgemental approach, to reduce the stigma associated with mental illness[71].

Inequalities

The Health and Social Care Act 2012 states that one its main objectives is *placing inequalities at the heart of the NHS,* to reduce the inequalities in the benefits which can be derived from health services[68].

[67] National Institute for Health and Clinical Excellence (2011) QS8 *Depression in adults*. London: National Institute for Health and Clinical Excellence.
[68] Department of Health (2012) The Health and Social Care Act 2012: Factsheet C2 *Reducing health inequalities*.

Access to services
There should be prompt access to mental health services for all, with strong community mental health teams, which work alongside primary care services and allow for familiarity and continuity of care[69]. Practitioners should signpost to other agencies like MIND and the Good Samaritans, with escalation to specialist services where appropriate. Service-users should be able to access support round the clock in a crisis[70]. Information should be made accessible to those with learning difficulties, those with visual impairments or those who do not speak English as their first language[71].

Improvement of services
Everyone should be able to access evidence-based therapies. Interventions should be performed by qualified, certified professionals according to a manual, who should have regular supervision. Services should be integrated across primary and secondary care[72], with a collaborative approach to service development, involving service users, their families and carers in service redesign where possible[71]. Good communication across services is essential, with strategies put in place for information sharing where appropriate. Referral pathways should be developed locally with links to other relevant pathways, such as monitoring of physical health[73].

Early identification of mental illness
Greater emphasis should be put on early identification of mental illness, targeting at risk groups. Health professionals should be screening for mental health disorders where validated brief screening questions exist, and be aware of the increased risk of mental ill health in at risk groups. [67,74]

Holistic approach
Health practitioners should adopt a holistic approach to assessment and patient care, recognising the need for mental health input in chronic medical conditions, and recognising the need for physical health input in those with mental health conditions[67,73,75,85,87]. Efforts should be made to tackle concurrent problems of smoking, alcohol dependence and substance misuse[85,86].

Empowering patients
A patient-centred approach should be adopted, engaging with service users and promoting autonomy[71]. Service users should be involved in shared-decision making

[69] National Institute for Health and Clinical Excellence (2011) QS14 *Quality standard for service user experience in adult mental health*. London: National Institute for Health and Clinical Excellence.
[70] Department of Health, National service framework for mental health - modern standards and service models: executive summary, 1999
[71]National Institute for Health and Clinical Excellence (2011) CG133 *Self-harm: longer-term management*. London: National Institute for Health and Clinical Excellence.
[72] Department of Health. *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. London: Stationery Office; 2011.
[73]National Institute for Health and Clinical Excellence (2011) CG123 *Common mental health disorders: Identification and pathways to care*. London: National Institute for Health and Clinical Excellence.
[74] National Institute for Health and Clinical Excellence (2010) PH24 *Alcohol-use disorders: preventing harmful drinking*. London: National Institute for Health and Clinical Excellence.
[75]National Institute for Health and Clinical Excellence (2011) CG115 *Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence.* London: National Institute for Health and Clinical Excellence.

wherever possible, including service users who are detained under The Mental Health Act[69]. Specific training should be given to healthcare professionals needing to make assessments of capacity in young people and in older people, particularly patients with dementia. Verbal and written information should be given to patients about their condition[67,73,85]. Interventions should be geared towards empowering patients to help themselves, with practitioners retaining an optimistic approach[69]. Self-help programmes, including computer-based cognitive behavioural therapies (C-CBT), attendance at self-help groups or group exercise programmes have been shown to be effective in certain conditions[67,85,76]. Service users should have a copy of their individual care plan and be aware of the need for regular reviews[69].

Carers and families

Information should be provided to families and carers about the mental health condition and about local support groups and voluntary organisations, and how they can access these[67]. They should know who to contact in a crisis[70]. Health practitioners should negotiate confidentiality and the sharing of information between the person and their family or carers early on. General Practitioners should be offering to conduct carers' assessments[67], and should assess whether families and carers are at any risk of harm from the service user[77].

7.2 Early years

It has been recognised that disadvantage even before birth can have long lasting negative health effects, which is why the government is placing greater emphasis on the importance of every child getting the best start in life[78]. This begins with the good health of mothers during pregnancy and in the perinatal period. Those providing healthcare in this setting should be trained in perinatal mental health[79].

Services influencing a child's social and emotional wellbeing include maternity, child health, social care, early education and family welfare. All of these services should be working in line with local child safeguarding policies.[78]

7.3 Children's and Young People's mental health

Focusing on mental health amongst young people is particularly important, with half of all lifetime mental illness starting before age 14. Poor mental health in childhood is associated with educational attainment, likelihood of smoking, alcohol and drug use in later life[80]. Schools and colleges should be promoting good mental health, with targeted support for those particularly at risk of mental health problems[72]. Older children and young people should be assessed to see whether they have capacity to consent. Health professionals should be trained in the legal aspects of capacity[71].

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[76] National Institute for Health and Clinical Excellence (2007) CG51 *Drug misuse – psychosocial interventions*. London: National Institute for Health and Clinical Excellence.

[77] National Institute for Health and Clinical Excellence (2011) QS11 *Alcohol dependence and harmful alcohol use Quality standard*. London: National Institute for Health and Clinical Excellence.

[78] National Institute for Health and Clinical Excellence (2012) PH40 *Social and emotional wellbeing - early years: guidance*. London: National Institute for Health and Clinical Excellence.

[79] O'Hara, M.W. and Swain, A.M. (1996) Rates and risk of postpartum depression – a meta-analysis. International Review of Psychiatry; 8(1): 37–54 *In Department of Health, 2010. Our Health and Wellbeing Today*

[80] Department of Health. *Our Health and Wellbeing Today*. London: Stationery Office; 2010.

Autistic spectrum disorders
Cases of suspected autism should be referred to a local autism multi-agency strategy group, where a comprehensive assessment should be carried out, considering differential diagnoses. The autism team should liaise with parents or carers about allowing the assessment profile to be made available to professionals in education so it can contribute to the child or young person's individual education plan and needs-based management plan[81].

Eating disorders
Anorexia nervosa should be managed on an outpatient basis where possible, with psychological input. Inpatient management should be limited to those in need of re-feeding. This should be carefully managed, with close monitoring[82].
Bulimia patients should be offered an evidence-based self-help programme, with specific Cognitive Behavioural Therapy for Bulimia Nervosa (CBT-BN). Antidepressant therapy may be trialled[82].

Self-harm
Self-harm is particularly common amongst young people and the full range of services offered to adults should be offered to young people via CAMHS.[71]

Alcohol misuse in young people
Health practitioners should be aware of the increasing numbers of young people with alcohol dependence, and take alcohol histories from a younger age. They should focus efforts on vulnerable or at risk groups, such as those with family problems, with a history of substance misuse, low achievers, or in high risk settings such as genito-urinary medicine (GUM) clinics, or those known to safeguarding teams. Information should be provided on local specialist addiction services and referral should be made to CAMHS if further input required[83].

Managing transitions to adult services
The transition between child and adult mental health services is often distressing and service users should be supported through the change, with early warning and discussions. If it may be feasible that there will not be an ongoing need for mental health follow-up, then CAMHS services should aim to continue to provide for that young person beyond their 18th birthday until they can safely be discharged[71,81].

7.4 Adult mental health

Depression and Anxiety
The new Improving Access to Psychological Therapies (IAPT) programme aims to deliver evidence based psychological services to those with depression and

[81] National Institute for Health and Clinical Excellence (2011) CG128 A*utism diagnosis in children and young people: Recognition, referral and diagnosis of children and young people on the autism spectrum*. London: National Institute for Health and Clinical Excellence.
[82] National Institute for Health and Clinical Excellence (2004) CG9 *Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders*. London: National Institute for Health and Clinical Excellence.
[83] National Institute for Health and Clinical Excellence (2010) PH24 *Alcohol-use disorders: preventing harmful drinking*. London: National Institute for Health and Clinical Excellence.

anxiety[84]. These may be used in combination with pharmacological therapies for moderate-severe depression[63] or in anxiety that has not responded to low intensity psychological therapies[85]. In addition to cognitive behavioural therapy (CBT) and interpersonal therapy (IPT) offered by IAPT, there is good evidence for the effectiveness of self-help therapies including computerised CBT, group physical activity programmes, and group-based peer-support programmes in depression[67]; and CBT, applied relaxation therapy, self-help and psychoeducational groups for anxiety.[85] Steps should be taken to reduce likelihood of recurrence, including continuing drug therapy for appropriate durations, and considering ongoing psychological support, such as CBT or mindfulness therapy[67].

Self-harm and suicide

A comprehensive psychosocial assessment should be carried out, taking into account the wider socioeconomic situation. This should form the basis of a risk assessment, which should be discussed with the service user. Risk assessment scales or tools should not be used to predict future events[71]. Care plans should be drawn up, identifying achievable long and short term goals. These should have multidisciplinary input and include discussion with the service user and their family or carers. This should include a crisis plan for when self-help strategies fail[71]. Psychological therapies may be helpful in the short term, to include cognitive-behavioural, psychodynamic or problem-solving aspects[71].

Alcohol and substance misuse

An important priority is the prevention of alcohol-related disorders, by means of enforcement of minimum pricing, reducing availability of alcohol, limiting advertising and protecting young people, including strict sanctions for those found serving underage drinkers[74]. Screening for alcohol misuse should become an integral part of everyday practice, with training of healthcare practitioners to facilitate this. Brief interventions should be offered initially, followed up by extended interventions and referral to specialist services if required[74]. Brief interventions should also be offered to substance misusers. Practitioners may have to be opportunistic. Harm reduction measures such as education, needle exchange programmes, testing for blood-borne viruses, with vaccination for hepatitis B, should be put in place. Service users should be appointed a key worker who can offer psychosocial interventions and address the wider socio-economic picture, signposting to agencies that can provide assistance with housing, personal finance, education and employment[86].

Schizophrenia

Treatment plans should involve CBT, family interventions and anti-psychotic medications. Clozapine should be tried in resistant schizophrenia, with close

[84] *NHS Improving Access to Psychological Therapies* (IAPT) [online] http://www.iapt.nhs.uk/about-iapt/ (accessed 19/3/13)

[85] National Institute for Health and Clinical Excellence (2011) CG113 *Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: Management in primary, secondary and community care.* London: National Institute for Health and Clinical Excellence.

[86] National Institute for Health and Clinical Excellence (2012) QS23 *Quality standard for drug use disorders*. London: National Institute for Health and Clinical Excellence.

monitoring. Concurrent monitoring of physical health is essential due to the increased risk of cardiovascular disease[87].

Bipolar disorder

Mood stabilisers and antipsychotic medications should be used to manage bipolar disorder, with special care taken to avoid valproate in women of childbearing age. Antidepressants may be used in the short term to manage acute depressive episodes. General practitioners should perform annual health reviews including monitoring of lipid profile, glucose, blood pressure and weight, along with a review of smoking and alcohol status[88].

Personality disorder

The management of personality disorder should focus on promoting autonomy and patient choice, involving the patient in the treatment plan. The practitioner should encourage engagement with services, maintaining an atmosphere of hope and optimism, and emphasising the idea of recovery. Mental health teams should develop comprehensive multidisciplinary care plans, identifying short and long term goals, and a crisis plan which should be shared with GP and the service user. This should form part of specialist personality disorder services in each trust. Psychological therapy may be useful if certain circumstances, with defined outcomes. Drug treatment is not recommended[89].

7.5 Older people's mental health

Dementia

With the growing prevalence of dementia, robust services are needed. Early diagnosis is important and should be via dedicated memory assessment clinics[90].
There should be integration of health and social care to support both patients and carers. Challenging behaviour is best managed with a biopsychosocial assessment of the cause, and care plans put in place to guide management. All healthcare staff should receive dementia care training[90]. Carers should be offered psychological support, with their own care plan where appropriate, and access to a range of options for respite[90,91].

The Mental Capacity Act 2005 should be used to assess if patients have capacity to make decisions[90]. While patients have capacity, they should have the opportunity to discuss their wishes, including advanced care directives, advanced decisions to refuse treatment and lasting power of attorney[91].

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[87] National Institute for Health and Clinical Excellence (2009) CG82 *Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care*. London: National Institute for Health and Clinical Excellence.
[88] National Institute for Health and Clinical Excellence (2006) CG38 *Bipolar disorder: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care*. London: National Institute for Health and Clinical Excellence.
[89] National Institute for Health and Clinical Excellence (2009) CG78 *Borderline personality disorder: Treatment and management.* London: National Institute for Health and Clinical Excellence.
[90] National Institute for Health and Clinical Excellence (2006, modified 2007) CG42 *Dementia: Supporting people with dementia and their carers in health and social care*. London: National Institute for Health and Clinical Excellence.
[91] National Institute for Health and Clinical Excellence (2010) QS1 *Dementia quality standard*. London: National Institute for Health and Clinical Excellence.

Summary

- Good mental health should be promoted, with an **optimistic** approach to treating mental illness
- Those with mental illness should not experience **stigma** or discrimination
- Service users should be **empowered** to improve their own mental health and wellbeing
- Good **communication** is paramount: between practitioners and service users, families and carers; and between agencies to ensure effective **joined-up working**
- Access to services should be improved, reducing health **inequalities**
- Continuous service monitoring and evaluation should lead to **service improvements**

8. Mapping of Current Services

There are many services offering different levels of mental health services. The following section begins the process of trying to map these services to identify any gaps. Although being able to visualise services, there are a number of identified problems with this. The maps in this document will only look at services locally commissioned. Although understanding what community and voluntary services are available in areas is incredibly important as they provide an invaluable resource, it is difficult to make an assessment of the effectiveness and appropriateness of these services and therefore not possible to say what level of service they do provide. Due to the size of the area covered it is likely that some services are missing from this mapping exercise, in particular around Torbay and Plymouth. As a result of all of these considerations, a recommendation of further work to develop this service mapping is made below.

The following maps show services grouped by type of service. This has been done to reflect the service as appropriately as possible but there are some services which offer services which would fit in to a number of categories. This is something that can be developed further in future work.

8.1 Maps of service

The first eight maps show specific groups of services that are commissioned to support people to maintain good mental health. For some services, the maps are likely to show the point at which the service is based so if the service is delivered by a team, the area the service is delivered to may be wider. The maps do not attempt to display what level of service is delivered or how often the service is available. This would require further work and would again fall under the recommendation of developing the work within this section further.

Figure 8.1.1 Map showing commissioned mental health advice and information services

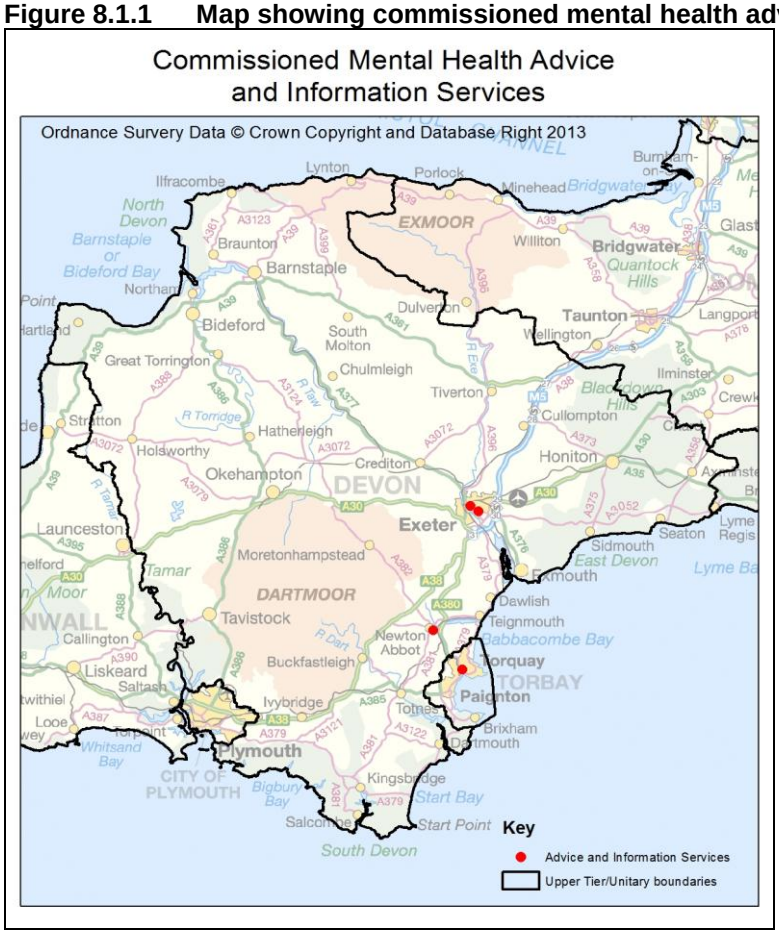


Figure 8.1.2 Map showing commissioned mental health assertive outreach services

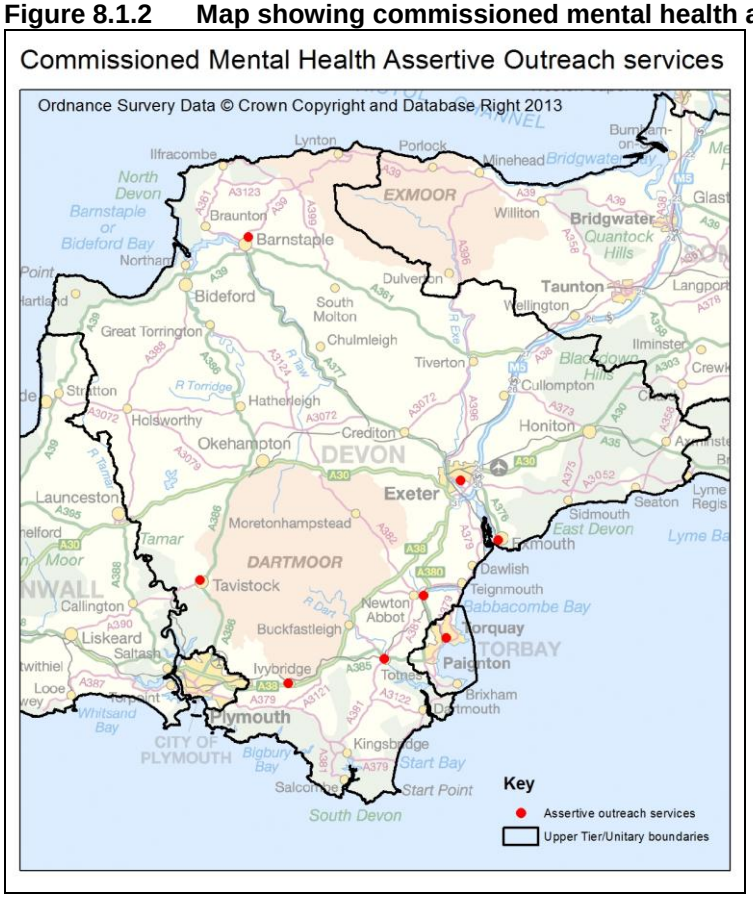


Figure 8.1.3 Map showing commissioned mental health assessment services

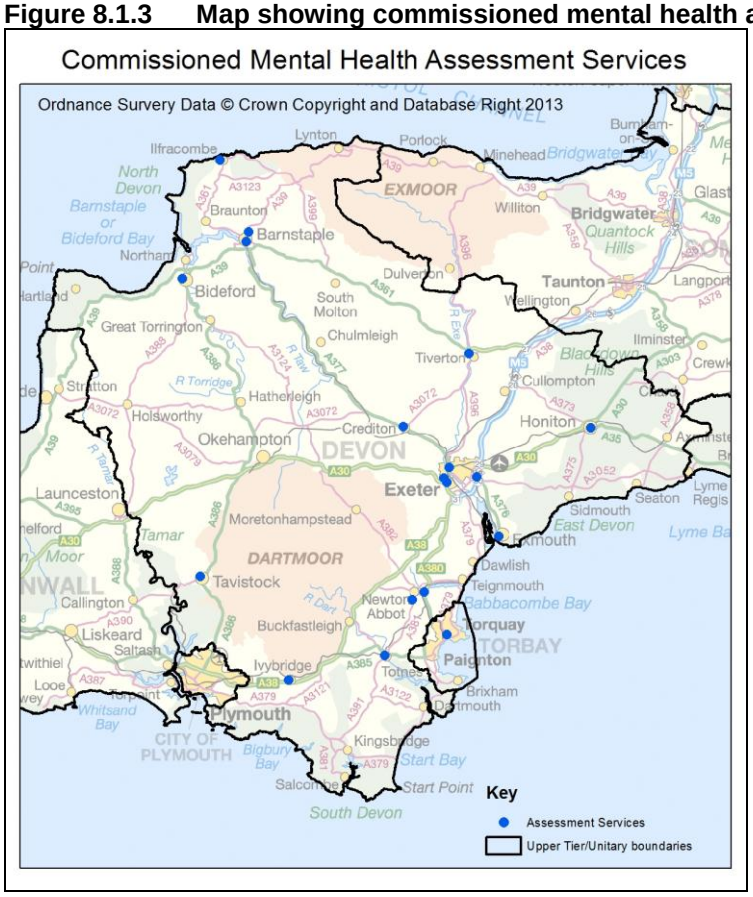


Figure 8.1.4 Map showing commissioned mental health crisis resolution services

Figure 8.1.5 Map showing commissioned mental health depression and anxiety services

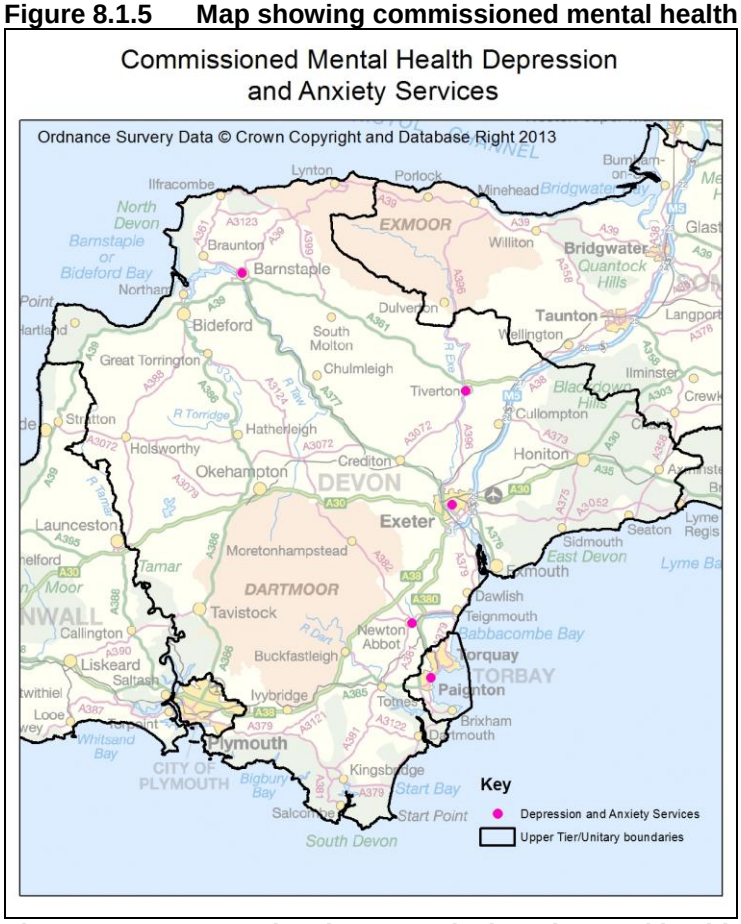


Figure 8.1.6 Map showing commissioned mental health inpatient services

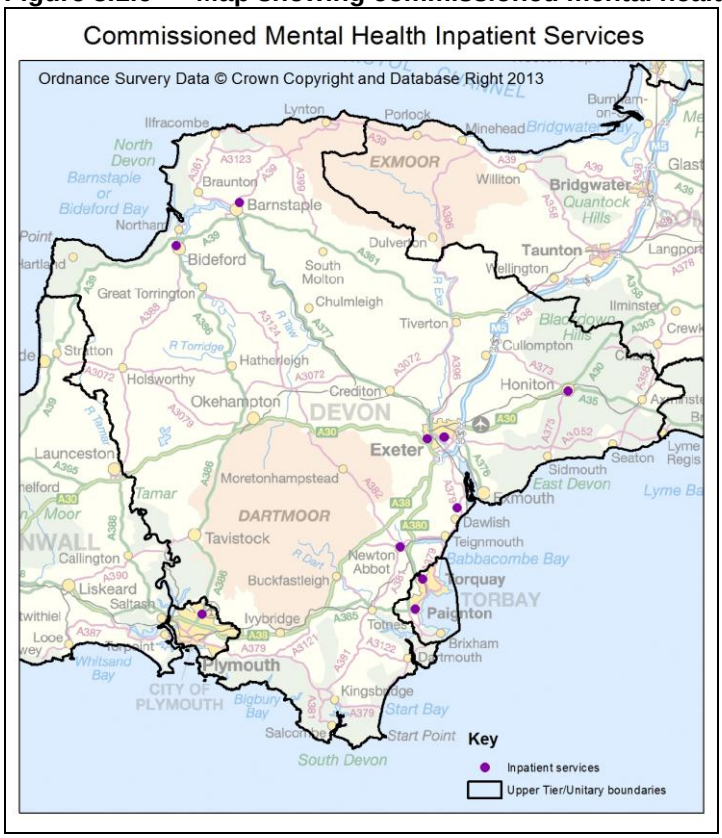


Figure 8.1.7 Map showing commissioned mental health older people services

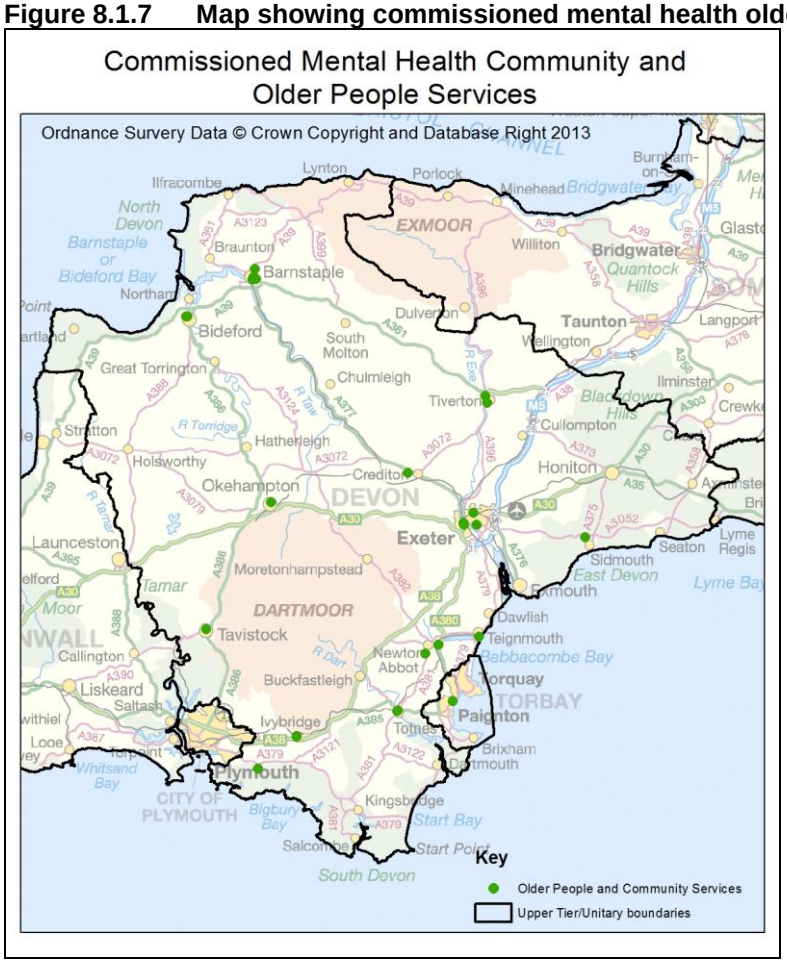


Figure 8.1.8 Map showing commissioned psychological therapies and psychotherapy services

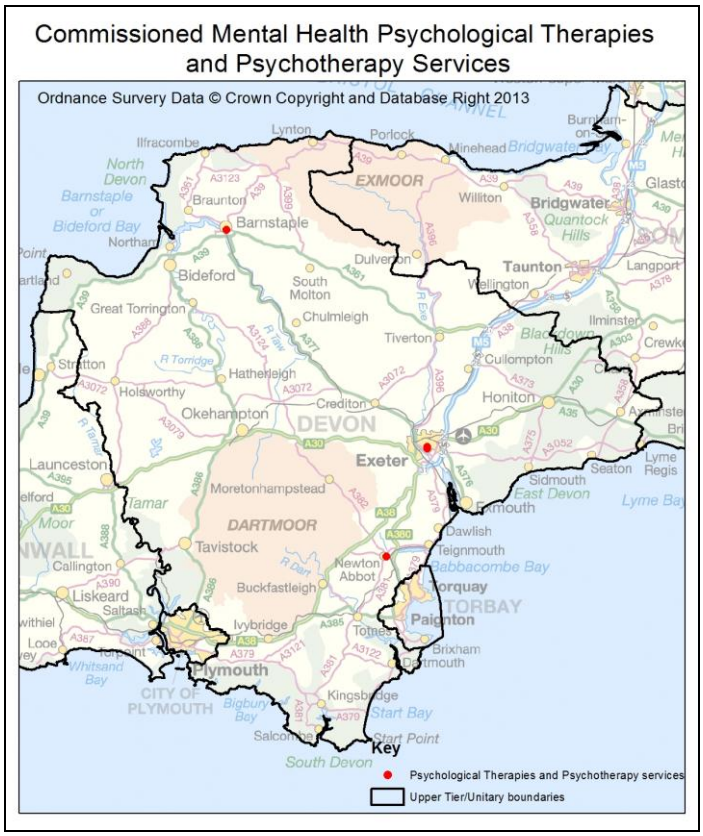


Figure 8.1.9 Map showing commissioned mental health services including art therapy, CAMHS, carers support, childhood sexual abuse service, eating disorder services and liason services

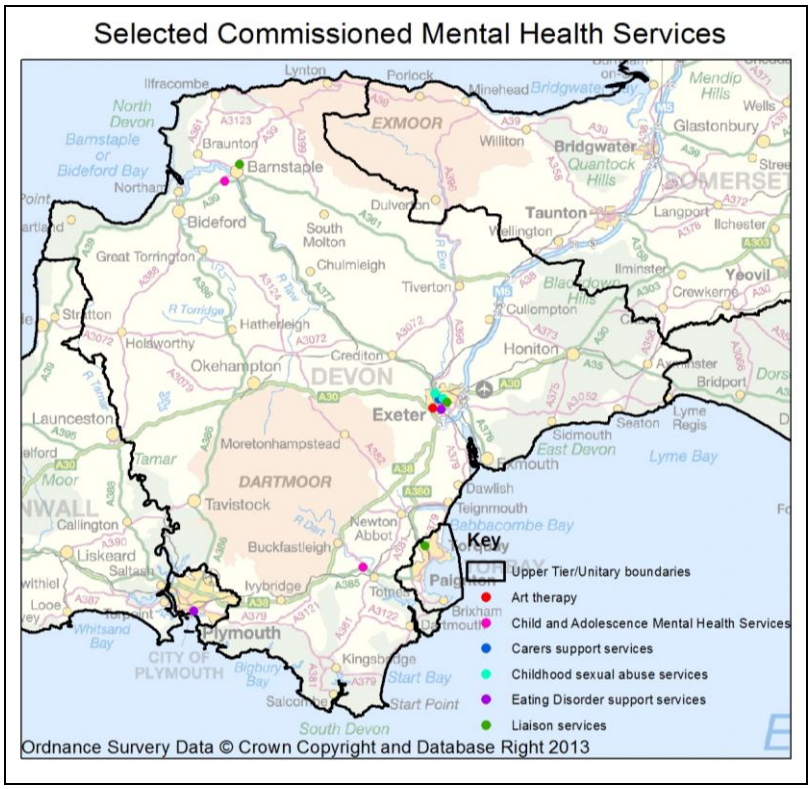
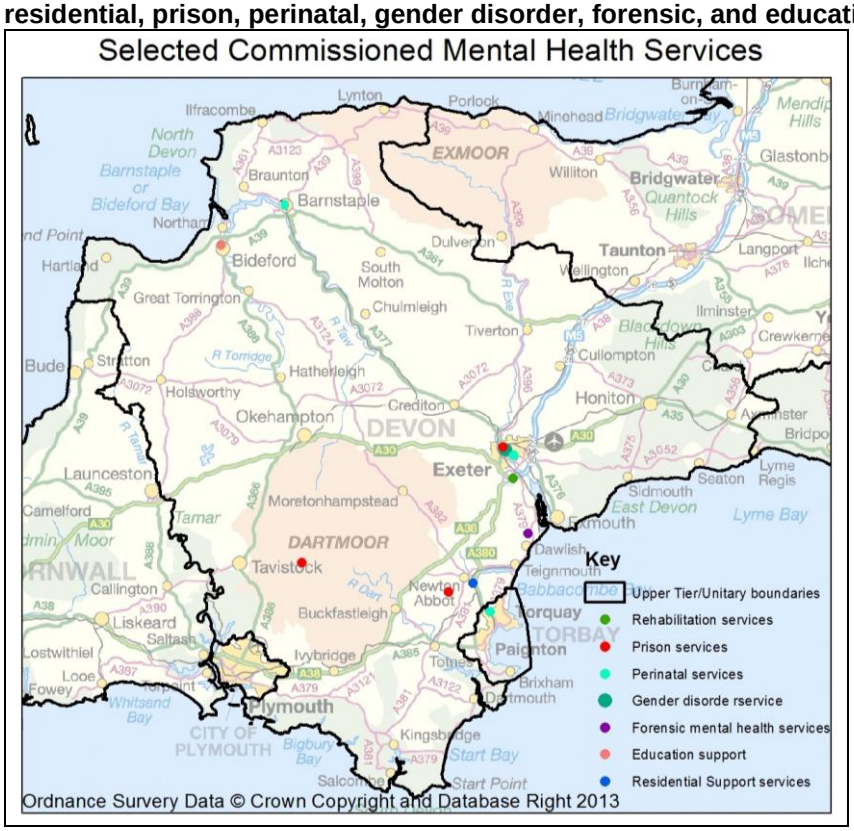


Figure 8.1.10 Map showing commissioned mental health services including rehab, residential, prison, perinatal, gender disorder, forensic, and education services



8.2 Recommendations

1 Commissioners to undertake an improved audit and mapping exercise of the access to both commissioned mental health services and wider community based mental health support services to inform future commissioning.

9. Recommendations

Within each section of the report a number of recommendations have been made. There are many areas where information has highlighted needs but the following recommendations reflect areas which have been highlighted as requiring further direction or analysis where work is not currently already being undertaken.

1 As part of the planned CAMHS service review by the Partnership Directorate later this year, service activity recording and data quality are reviewed with plans for improvement agreed where necessary.

2 Carry out further analysis of self-harm activity data to gain a better understanding of the variation shown to inform future service provision.

3 Review current service provision for eating disorders and agree an appropriate care pathway based on the latest NICE guidance.

4 Engage with Healthwatch Devon to agree any further consultation and service user engagement in relation to mental health needs and services to build on the work begun by LINk Devon.

5 Improve access to prescribing data by age group via the primary care data warehouse to support life course analysis.

6 Review existing local suicide prevention strategies and consider the opportunity to refresh, in the light of the national strategy, on a peninsula wide basis to ensure an alignment of objectives and promote consistent preventive action.

7 Commissioners to undertake an improved audit and mapping exercise of the access to both commissioned mental health services and wider community based mental health support services to inform future commissioning.