Adult Mental Health Needs Assessment for Plymouth

Public Health Plymouth
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Version Control
This is the final version of the Plymouth Mental Health Needs Assessment 2012.

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1. Introduction

1.1 Mental Health and Well-being

The World Health Organisation defines mental health as:

‘a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.’\(^1\)

This means that promoting mental health and well-being is about more than just preventing and treating mental illness, although that is also an important goal. Even those who do not meet the criteria for a disorder may have poor mental health and well-being which affects their functioning and ability to contribute to their families and communities. It is important therefore to promote positive mental health, which can improve productivity, academic achievement and physical health and reduce inequalities.\(^2\)

1.2 The case for action: personal, social and economic importance of mental health

After many years of emphasis on physical health, there has been increasing recognition of the huge significance of mental health for the UK. Mental health problems constitute the largest single burden of disease nationally at almost a quarter of the total, and depression alone accounts for 7\%.\(^2\) According the Royal College of Psychiatrists:

‘No other health condition matches mental illness in the combined extent of prevalence, persistence and breadth of impact.’\(^2\)

Mental health across the lifespan

Mental health problems also often begin earlier than other causes of disability such as heart disease and cancers, affecting the most productive years of people’s lives.\(^2\) There is also continuity between mental health problems in childhood and adulthood; we know that 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.\(^3\) Parental mental health problems and issues such as domestic abuse can have a significant impact on the mental well-being of the child.\(^4\) At the other end of the scale, depression in older people affects up to 25\%, and up to 40\% of those in care homes.\(^5\) The prevalence of dementia is also predicted to rise with our ageing population; it affects 1 in 5 of those over 80. Mental health is therefore a lifetime issue, requiring a joined up approach across the lifespan.\(^4\)
Impacts of poor mental health

Mental health problems are associated with multiple negative personal and social impacts, for example:  
- Poor physical health and reduced life expectancy  
- Smoking and obesity  
- Unemployment and deprivation  
- Social exclusion, stigma and discrimination

Many of these factors are complex and work both ways, for example, unemployment increases the risk of mental health problems and is also a consequence of mental illness in many cases.

Economic impact

Mental health problems also have a considerable economic impact. They represent the largest single cost to the NHS, and are estimated to cost the country over £100 billion per year, of which anxiety is estimated at £8.9 billion and dementia £17 billion. This includes over £30 billion per year for work-related ill-health, and almost half of people on long term health related benefits have mental health disorders as their primary illness. The economic impacts of child mental health disorder are also high - emotional and behavioural disturbances and conduct disorders in children cost up to £60,000 per child per year.

Economic case for action

Optimal treatment for mental illness covering those that need it has been calculated to reduce the burden of mental ill health by over a quarter, reducing the economic and social burden. In addition to treatment; prevention and promotion are likely to reap significant benefits. Figures from a report published by the Department of Health suggest that there is a substantial return on investment in many areas of mental health promotion and prevention of mental illness:

- For every £1 invested in early detection of psychosis, total economic returns of £10.37
- For every £1 invested in early workplace detection and treatment of depression, total economic returns of £5.03
- For every £1 invested in workplace health promotion, total returns of £9.69

The returns for early intervention in children and young people are even more striking, with over £83 return for every £1 invested in the prevention of conduct disorder, and £7.98 for early intervention in the same disorder.

Other cost-effective interventions include:

- Health visitor interventions to reduce postnatal depression
- Early intervention for depression in diabetes
• Early intervention for medically unexplained symptoms
• Early intervention in psychosis
• Screening for alcohol misuse

For an overview of the overview of the evidence of what works in terms of outcomes for mental health and well-being, suicidal and self-harming behaviours and ideation see Appendix 3.

1.3 National policy context

Mental health has finally been pushed to the top of the agenda in recent years.

New Horizons\(^7\), published by the Department of Health in 2009, was a cross-government programme of action with the twin aims of improving the mental health and well-being of the population and improving the quality and accessibility of services for people with poor mental health.

The new national strategy for mental health - No Health without Mental Health\(^4\) followed this in early 2011. The six outcomes identified were:

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

The importance of investing in public mental health, and in particular in prevention and promotion was also highlighted by the Royal College of Psychiatrists’ report No Health without Public Mental Health, produced in 2010\(^2\). The New Economic Foundation also published Five Ways to Well-being,\(^8\) a set of evidence based actions to promote mental well-being.

Finally, the significance of inequalities in health; including mental health, has been increasingly recognised. The Marmot Review of 2010\(^9\) made a compelling social and economic case for addressing these inequalities and made six key recommendations which have resonance with many of the issues discussed in this Needs Assessment:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities


1.4 Regional and local policy context

The Plymouth 2020 Health and Social Care and Well-being Strategy included reducing health and well-being inequalities and mental health promotion as two of the five key priorities for Plymouth until 2020.\textsuperscript{10} The Plymouth Mental Health Promotion Strategy was published in June 2011. The strategy aims to:

"Enable more people of all ages and backgrounds to have better well-being and good mental health and for fewer people to develop mental health problems, by starting well, developing well, living well, working well and ageing well. The strategy accepts that timely access to evidence based interventions will deliver better mental health and so also deliver better physical health, recognising the interdependent relationship between mental and physical health. It also aims to improve public understanding of mental health and, as a result, to decrease negative attitudes and behaviours towards people with mental health problems.

Against a background of increasing mental health problems and illnesses, and at a time of severe economic difficulty and austerity of public services, the promotion of mental health and well-being is not only the right thing to do for the health of people living in Plymouth, but it is essential, in order to manage demand on our health and social care services."\textsuperscript{11}

1.5 Purpose of the needs assessment

Health needs assessment is used to understand the needs of a population in order to better inform the commissioning of resources and services. It can be done for a particular condition or group of conditions, or for a particular population, such as older people. Health needs assessment can be briefly defined as:

‘a systematic review of the health issues facing a population leading to agreed priorities and resource allocation that will improve health and reduce inequalities’\textsuperscript{12}

This needs assessment is intended to examine the mental health needs of Plymouth residents aged 18 and over, in order to better shape strategies to improve mental health and well-being within the City. The specific aims are:

- To understand the local situation in terms of the factors which promote good mental health, and those which increase the risk of poor mental health, and to describe the groups within the City who are particularly at risk of mental health problems
To attempt to quantify the burden of mental illness in Plymouth in terms of numbers of people with common mental disorders and severe mental illness; and to consider how this may change in the future

To describe the supply, funding, and activity of mental health services and resources within the City

To highlight areas where there are marked inequalities in mental health and where resource allocation and distribution do not match need for services

To identify gaps in intelligence and understanding about mental health and illness in the City

To provide evidence based recommendations, both in terms of building on Plymouth’s strengths and addressing risk factors and unmet need for mental health resources and services

1.6 Methodology of the needs assessment

Timescale
This was a rapid needs assessment, carried out by the Plymouth Public Health Development Unit, with help from partners from November 2011 to January 2012.

The Mental Health Strategic Quality Improvement Partnership (formally the Mental Health Local Implementation Team) members and other stakeholders were consulted about the intended contents and structure of the needs assessment, however due to the relatively short timescale, full consultation and engagement at all stages although desirable, was not possible.

Methods
The needs assessment was therefore mainly a ‘desktop exercise’ which involved collating and analysing information from many sources rather than collecting new information. This also means that, where existing data is lacking, this document has sought to highlight this rather than to begin new assessments or surveys in these areas. In this respect it outlines what we don’t know as well as what we do know. Public Health in Plymouth produced a Mental Health Atlas in 2009, which is used by commissioners and providers within the City; the needs assessment also aimed to review and update data from this and to draw attention to any new findings or differences.

Geographical focus
Where possible, we have also tried to look at mental health not only for the City as a whole, but also by ward, sub-locality and neighbourhood, where the information is appropriate and available. This can help to identify where resources need to be targeted. The neighbourhoods used in this needs assessment are the 43 identified in 2003 by the Local Strategic Partnership.
Structure
The structure of the needs assessment encompassed looking at the usual areas of need, supply, and demand. Need can be defined as the ability to benefit from services or resources. Supply refers to the number, type and distribution of services and resources available from all providers within the Plymouth, public, private and third/voluntary sector. Demand is the services that people ask for and use, and can be difficult to measure. In this report we have used activity (i.e. numbers of people accessing and using services) to describe demand.

The final structure of the needs assessment is given below:

- Plymouth profile – an overview of population, employment, deprivation, health and inequalities in the City
- Mental health need – a description of protective factors, risk factors, risk groups and mental health problems
- Mental health resources and service mapping – outlining the supply of services and resources in Plymouth
- Mental Health Service Activity and Uptake - examining demand
- Findings
- Summary of Gaps and Recommendations
References


2. Plymouth Profile

2.1 Population

258,700 people live in Plymouth. The pyramid below displays the population distribution, in red for females and blue for males, against the blank bars which represent the whole UK population. There are similar numbers of males and females in each age group until the age band 70-74, where there are approximately 1000 more women than men, which fits with what we know about women’s longer life expectancy. There is also an excess of young people in the 20-24 age group which is likely to be due to Plymouth’s large student population.

Figure 1: Population pyramid for Plymouth in 2011

2.1.1 Population Projections

The biggest change in population composition over the next twenty years in Plymouth is likely to be the growth in the population of older people. POPPI forecasts that there will be a 20% increase in the number of people aged 80-84 by 2020, and a 65% increase by 2030. The greatest growth is likely to be in the ‘oldest old’ – by 2030 there is predicted to be a 127% increase in those aged 90 or more in Plymouth. This is illustrated in Figure 2, which shows a steep increase in numbers, particularly in the oldest age groups.
2.1.2 Ethnic minorities in Plymouth

Plymouth has a relatively small ethnic minority population in comparison to many urban centres, and to England as a whole. The data below is from 2009 Office for National Statistics Estimates.2

- In all age groups except the 25-34 group, the population is over 90% white.
- The largest ethnic minority group is Asian/Asian British: over 6% of those aged 25-34 described themselves this way
- The proportion of ethnic minority groups decreases with age, over 99% of those aged 65 and over are white

The pie chart below displays Plymouth’s ethnic composition by percentage in 2009 – for example, in 18-64 year olds the biggest single ethnic minority group are Asian/Asian British people who comprise 3% of the population.
2.2 Plymouth’s Economy and Employment

Key facts:

- Plymouth’s top employers are service industries such as the health and education sectors; however there are more jobs in manufacturing than the national average\(^3\)
- Unemployment and benefits claimant figures are higher than the national and regional averages\(^3\)

2.2.1 Deprivation

Deprivation is a key issue affecting the mental and physical health and life chances of people in Plymouth. It can be defined as follows:\(^4\)

“Deprivation is a much wider definition than ‘poverty’, poverty is usually considered to be a lack of money, whereas deprivation includes a lack of the opportunities and resources to which we might expect to have access to in our society, for example; good health, protection from crime and a clean and safe environment. Multiple deprivation therefore refers to the different types of deprivation that might occur, many people and households in some communities experience relative multiple forms of deprivation”

The Indices of Deprivation 2010 (IMD 2010) use a group of statistical indicators to rank the 32,482 Lower Layer Super Output Areas (LSOAs) in England in terms of aspects of their deprivation. Over 30 such indicators are combined to produce an overall Index of Multiple Deprivation (IMD). Subsets of these indicators are also used to rank areas within seven different “domains” of deprivation: Income; Employment; Health Deprivation and Disability; Education, Skills and Training; Barriers to Housing and Services; Crime; and Living Environment.\(^5\)
Plymouth overall is ranked 72 out of 326, placing it just above the bottom 20% most deprived districts in England.

Plymouth ranks most highly (i.e. most deprived) on Income and Employment domains.

Plymouth has 5 LSOAs in the most deprived 3% in the whole of England, home to 7458 people.

2.2.2 Deprivation by neighbourhood

The most deprived neighbourhoods according to the IMD-2010 are:

- Devonport
- Stonehouse
- North Prospect
- Morice Town
- Barne Barton

Relative deprivation within Plymouth is shown in Figure 4.

Figure 4: Deprivation within Plymouth as measured by IMD-2010
2.3 Health in Plymouth

Over the last 10 years, health has generally been improving in Plymouth residents with less people dying and death rates being similar to England as a whole:

- Life expectancy for men in Plymouth is 77.2 years – significantly worse than the national average of 78.3 years\(^6\)
- Life expectancy for women is 82 years – this is not significantly different from the national average\(^6\)

There are still a number of areas where health in Plymouth is worse than England as a whole:\(^6\)

- The number of smoking-related deaths is higher than the England average, at 229.4 per 100,000 people aged over 35 per year
- Plymouth also experiences a higher rate of early deaths under 75 due to heart disease and stroke than England as a whole
- Other areas of concern are hospital stays for alcohol-related harm, high rates of malignant melanoma, and high rates of drug abuse and smoking in pregnancy
- The mental health needs of Plymouth are estimated to be over 20% higher than would be expected for a city this size, indicating that the City has a high burden of mental ill health\(^7\)

2.3.1 Health Inequalities

Health inequalities are a major challenge for Plymouth. These are differences in health experience by people in different social classes. They are, in essence, avoidable and unfair. According to the Marmot Review:\(^8\)

‘Inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age’

Most health indicators in Plymouth are worst in the poorest neighbourhoods and best in the most affluent – this includes mental health indicators as will be seen later in the report. Most strikingly, the gap in life expectancy between the most deprived and least deprived neighbourhoods is as much as 16.9 years. The bus route picture on the next page demonstrates how moving inwards from more affluent neighbourhoods in to the more deprived central neighbourhoods represents years of life lost.
2.4 Plymouth’s comparator cities

Statistical neighbours models provide a method of benchmarking, allowing more meaningful comparison between areas. For each local authority, these models designate a number of other local authorities deemed to have similar characteristics. These designated local authorities are known as statistical neighbours. Any local authority may compare its performance against its statistical neighbours to provide an initial guide as to whether their performance is above or below the level that might be expected.

Plymouth’s statistical neighbours are:

- Portsmouth
- Torbay
- Southampton
- Telford and Wrekin
- Peterborough
- Southend-on-Sea
- Bournemouth
- Rotherham
- Sheffield
- Isle of Wight

Throughout the Needs Assessment comparisons where appropriate will be made with these comparator cities and areas, in particular Sheffield, Portsmouth and Southampton to illustrate how Plymouth is performing in terms of mental health.
References


2. Institute of Public Care. POPPI (Projecting Older People Population Information System). [link](http://www.poppi.org.uk/)


3. Mental Health Profile: Need

3.1 Introduction

This section is intended to be a rapid appraisal of the mental health need of adults aged 18 and over in Plymouth. It is important to understand the factors which affect mental health and well-being locally, both in terms of what the protective factors are, and what the risks are to mental health. This section also aims to describe the types of mental health problems that people in Plymouth experience, and how many people are likely to be affected, both now and in the future.

Ideally, a needs assessment would involve full consultation with all groups involved, public, professionals, and service users and expert patients, to describe their perspectives on need. Within the timescale this has not been possible, although a section on service user perspectives has been included. The information that is available and that can be gathered in a short period of time is also limited, and where there are areas of uncertainty and a need for more data, we have attempted to highlight those.

This section will therefore cover the following areas:

- What protective factors against mental health problems are there in Plymouth?
- What are the population-level risk factors for mental health problems?
- At risk groups and groups with protected characteristics
- Estimated prevalence of mental health problems in Plymouth
- Self-harm
- Suicide
- The Mental Health Needs Index for Plymouth
- Physical Health in those with a mental health problem
- Service User Perspectives

3.2 What protective factors against mental health problems are there in Plymouth?

There are many factors which promote mental health and well-being and may protect against developing mental health problems. These factors may be individual or familial, or relate to the community and wider society. A key part of improving the mental health of people in Plymouth is to recognise and build on the strengths and protective factors in the local area.
Protective factors can be seen as:

- Enhancing control
- Increasing resilience and community assets
- Facilitating participation and promoting inclusion

The factors that will be specifically discussed in this section in relation to Plymouth are:

<table>
<thead>
<tr>
<th>Employment</th>
<th>Education</th>
<th>Physical activity</th>
<th>Green space</th>
<th>Social capital and community cohesion</th>
</tr>
</thead>
</table>

### 3.2.1 Employment

Being in employment is generally good for mental health, providing identity, status, structure, social contacts and a sense of achievement. Of course, work which is of poor psychosocial quality (in terms of levels of control, demands and complexity, job insecurity, and unfair pay) can be bad for mental health; and this aspect of mental health and work should not be neglected.

According to the Royal College of Psychiatrist’s report on Mental Health and Work, those who already have a mental health problem are more sensitive to the negative effects of worklessness. Being out of work exacerbates feelings of social exclusion; so being in work is important both for prevention and for recovery and inclusion once a person has become unwell.

In Plymouth in 2010/2011, almost 75% of people aged 16-64 were classed as economically active. The largest employers are the local health services, the education sector including the University, and other public sector employers such as Plymouth City Council. Private sector employers are largely small and medium enterprises. The biggest single sector is public administration, education and health. Plymouth has emerging strengths to build on in terms of natural environment and waterfront setting; expanding education and cultural sectors, and its industrial and military heritage.

Table 1 shows the percentage of jobs by industry in Plymouth compared to the South West and Great Britain as a whole.
Table 1: Employee jobs by type in Plymouth 2008

<table>
<thead>
<tr>
<th>Employee jobs by industry</th>
<th>Plymouth (employee jobs)</th>
<th>Plymouth (%)</th>
<th>South West (%)</th>
<th>Great Britain (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total employee jobs</td>
<td>106,900</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Full-time</td>
<td>69,500</td>
<td>65.0</td>
<td>64.7</td>
<td>68.8</td>
</tr>
<tr>
<td>Part-time</td>
<td>37,500</td>
<td>35.0</td>
<td>35.3</td>
<td>31.2</td>
</tr>
<tr>
<td><strong>Employee jobs by industry</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manufacturing</td>
<td>13,400</td>
<td>12.5</td>
<td>10.7</td>
<td>10.2</td>
</tr>
<tr>
<td>Construction</td>
<td>3,600</td>
<td>3.4</td>
<td>4.4</td>
<td>4.8</td>
</tr>
<tr>
<td>Services</td>
<td>89,000</td>
<td>83.2</td>
<td>82.5</td>
<td>83.5</td>
</tr>
<tr>
<td>Distribution, hotels &amp; restaurants</td>
<td>24,700</td>
<td>23.1</td>
<td>25.2</td>
<td>23.4</td>
</tr>
<tr>
<td>Transport &amp; communications</td>
<td>5,800</td>
<td>5.4</td>
<td>4.8</td>
<td>5.8</td>
</tr>
<tr>
<td>Finance, IT, other business activities</td>
<td>14,400</td>
<td>13.4</td>
<td>19.1</td>
<td>22.0</td>
</tr>
<tr>
<td>Public admin, education &amp; health</td>
<td>39,500</td>
<td>36.9</td>
<td>28.7</td>
<td>27.0</td>
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<tr>
<td>Other services</td>
<td>4,700</td>
<td>4.4</td>
<td>4.7</td>
<td>5.3</td>
</tr>
<tr>
<td>Tourism-related†</td>
<td>8,600</td>
<td>8.0</td>
<td>9.0</td>
<td>8.2</td>
</tr>
</tbody>
</table>

3.2.2 Education

Education has also been shown to be beneficial for mental health; the impact is greatest for women, and for completing low and mid-level education such as GSCEs. It is estimated that having a secondary education qualification such as 5 GSCE passes reduces the risk of depression as an adult by 5-7%.

In 2009/10, 54% of young people in Plymouth passed 5 or more GCSEs at A-C, a figure almost identical to the national average and higher than Portsmouth (42.8%), Sheffield (49.2%) and Southampton (47.7%), which suggests that Plymouth is performing better than would be expected. The percentage gaining A-C grades in sciences and languages was actually higher than the national average. However, this achievement is not uniform across Plymouth, and GSCE passes are higher in some areas than in others.
3.2.3 Physical Activity

Physical activity has been shown to have both preventative and therapeutic effects on mental ill health. It decreases the risk of depression and reduces clinical symptoms in those with depression and anxiety disorders. There are also benefits to mental well-being in terms of improved self-esteem, reduced stress and better subjective mood.

Based on the Health Survey for England, in 2011 around 1 in 10 Plymouth adults were estimated to be physically active, meaning that they were participating in moderate intensity exercise or sport. This is not significantly different from the England average. It is lower than the figure for the comparator cities of Sheffield and Portsmouth but similar to Southampton.

However, the PLACE survey, which was carried out for local government, found more encouraging results, reporting that 66% of Plymouth residents participated in ‘sport or active recreation’ at least three times a week. 29% said that they participated 5 times a week or more, meeting the current recommended levels of physical activity.
3.2.4 Access to green space

Reviews of the links between green space and mental health and well-being suggest that:

“the more time people spend in outdoor green space, the less stressed they feel.” 10

Benefits of green space include opportunities for exercise and relaxation, increased community pride, natural daylight and relief from the urban landscape.

Figure 7: Map of green space in Plymouth: allotments, parks and nature reserves (with neighbourhood overlay)

According to the Council’s Green Space Strategy,11 Plymouth is well-supplied with green spaces in terms of city parks, local parks, allotments and other spaces; however, these are unevenly distributed across the City. The south of Plymouth in particular is more poorly supplied. Stonehouse, Devonport, City Centre, North Prospect and Barne Barton, which are
amongst the most deprived neighbourhoods, were reported in 2009 as having deficiency of access to green space.

Regeneration affecting various neighbourhoods in the City may have both positive and negative effects on the amount and quality of green and open spaces. Overall, according to the PLACE survey\(^9\) 2008/09, two-thirds of Plymouth residents were satisfied with parks and open spaces in the City. Plymouth also benefits from ‘blue space’ due to its Waterfront setting and this is another asset that can be built upon.

### 3.2.5 Social capital and community cohesion

Connecting with others in the community and giving through volunteering or other activities are two of the Five Ways to Well-being\(^{12}\) recommended for good mental health. Participation in social and community life is thought to enhance life satisfaction and feelings of happiness and inclusion.

#### Cohesion and belonging

In the PLACE survey\(^9\) 2008/2009:

- 70% of Plymouth residents said that they lived in a cohesive community – this was less than the national average of 76%
- 55% felt that they belonged strongly to their neighbourhood (67% of those over 55 agreed with this compared to just 31% of under-35s)
- The majority felt that people were treated with respect and consideration in their community, but 32% didn’t agree; this fell from 44% who didn’t agree in 2006/2007

There was variation by area. Plympton, Plymstock and Central and North East residents were more likely to say they lived in a cohesive community (83%, 81% and 79% respectively) compared to just 51% in the North West locality. The South West locality also had significantly lower perceived cohesion levels than average (58%).

#### Volunteering and participation

The PLACE survey\(^9\) also reported that:

- 20% of Plymouth residents had volunteered for groups, clubs or organisations within the last month, compared to a national average of 23%
- 14% had been part of local decision-making or other civic participations within the past year. This figure was highest in the South East (20%) and Plympton (19%) and lowest in Central and North East (10%) and North West (9%)
3.3 What are the population risk factors for poor mental health and well-being?

Risk factors increase the likelihood of experiencing poor mental health and well-being. Many of these risk factors are complex and inter-related. By understanding the risk factors operating in Plymouth at a population level we can attempt to implement measures to reduce their severity and their impact, to improve the mental health and well-being of all residents. The types of risk factors which affect mental health can be broken down into 3 categories:

- The incidence or the impact of negative life events and experiences for individuals, e.g. abuse, relationship breakdown, long term illness or disability
- Social isolation and exclusion
- The impact of deprivation and inequalities in health

This Needs Assessment will focus on just some of these population risk factors which affect the mental health and well-being of Plymouth residents, outlined in the box below:

```
Housing
Deprivation and Inequality
Unemployment
Crime
Poor physical health
Drugs and alcohol misuse
```

3.3.1 Housing

There is increasing focus on the links between housing and health in general. A recent report by the Housing Learning and Improvement Network emphasises the importance of housing for public mental health. Research has linked poor quality housing, noise, dampness and structural problems with depression and anxiety as well as with physical health problems. This relationship runs both ways; as many people with mental health disorders experience housing difficulties in terms of tenancy breakdown, being dissatisfied with their housing, and homelessness. It is estimated that from one third up to over two-thirds of all homeless people suffer from mental health problems.
Settled and secure accommodation is central to recovery, and to social inclusion for all vulnerable groups.\textsuperscript{16} There are a number of threats to good quality and settled housing, discussed below.

**Homelessness and temporary accommodation**

According to Shelter:\textsuperscript{17}

- In 2010, 283 households were accepted as homeless in Plymouth
- 73 households were in temporary accommodation at the end of 2010
- In Quarter 2 of 2011 there were 70 possession claims made by mortgage lenders and 145 made by landlords
- The statutory rate of homelessness per 1,000 households in 2009/2010 is reported as 2.24; worse than the England average of 2 per 1000 but lower than Portsmouth at 4.7 per 1000 and Sheffield at 4.19 per 1000\textsuperscript{9}

**Housing conditions**

According to the draft Plymouth Housing Plan 2012-2017\textsuperscript{18}:

- Housing conditions are worst in the private rented sector, which makes up 19.6\% of all stock in Plymouth as opposed to 15.6\% nationally.
- There are 29,930 'non decent' private sector dwellings, of which 9,500 dwellings are occupied by vulnerable residents.
- 18,800 private sector dwellings have Category 1 health and safety hazards, failings are 'excess cold', poor 'thermal comfort', trips and falls and disrepair.

**Fuel poverty**

The recent report by the Institute for Health Equity\textsuperscript{19} on the health effects of fuel poverty highlighted the potential impact on mental health. Cold homes are associated with anxiety and depression, and the effects on mental health are most marked for children and young people. The latest figures for 2011\textsuperscript{20} suggest that over 12,000 households in Plymouth are in fuel poverty, constituting over 11\% of the population.

**Unaffordable homes and need for settled housing**

In 2010, the average cost of a Plymouth home was £140,000 \textsuperscript{17} with the average income needed to buy a home standing at £31,000. This compares with the average actual income of Plymouth residents at just under £20,000. The proportion of affordable housing needed that was delivered in 2008/09 was only 19\%.\textsuperscript{17}

- In 2010, there were over 9000 households in Plymouth on the council housing waiting list
At the rate that social housing lettings are being made, it would take 8 years to clear this list.

**Impacts of poor housing**

Figure 9, from the Chartered Institute of Environmental Health\(^{21}\) illustrates some of the links discussed above, along with others which there is not space to include.

**Figure 9: The impacts of poor housing**

![Diagram illustrating the impacts of poor housing]

Source: CIEH: Good Housing Leads to Good Health: a toolkit for environmental health practitioners\(^{21}\)

### 3.3.2 Deprivation and Inequality

Mental health and deprivation are closely linked. Deprivation is thought to play a role as a cause and sometimes a consequence of poor mental health. People in lower social classes where there is inequality in society are more vulnerable to stress and exclusion; and have the most limited resources to deal with those stressors.\(^{22}\)

The 2007 Adult Psychiatric Morbidity Survey\(^{23}\) demonstrated that those with the lowest income were more likely to have a common mental health disorder (CMD) than those with the highest. This was particularly marked for men – those in the lowest household income group were three times more likely to have a CMD than those in the highest income households (23.5% and 8.8% respectively).

In general, wage levels in Plymouth are lower than in the rest of the South West and Great Britain; unemployment levels are also higher, \(^{7}\) which is discussed further in the next section. A greater proportion of people in
Plymouth are claiming key benefits than the national and regional average – in particular there are more claiming ESA (Employment and Support Allowance) and incapacity benefit. This is even the case when looking at many of Plymouth's comparator cities. According to the ONS, in Sheffield, 15.2% of residents are claiming key benefits; and 6.5% are claiming incapacity or ESA benefits; this compares to 16.5% and 8% in Plymouth. These figures are also higher than Southampton and Portsmouth, where 5.9% and 5.7% of residents respectively are on incapacity benefits.

3.3.3 Debt and mental health

Being in debt and mental health are closely related. Debt may cause or contribute to the development of mental illness, or it may be that having a mental health problem can lead to getting into debt, for example, through being unable to work, or through finding it hard to manage money. According to the Royal College of Psychiatrists, one in two people in debt have a mental health problem – and one in four people with a mental health problem is also in debt. Personal levels of debt in the UK in 2011 are at a high, with an average debt per person of £9,606. Average debt in the South West is even greater at an average of £10,737 per person. Due to the higher than average number of people out of work, and claiming benefits in Plymouth, there is likely to be a significant burden of debt in the City with the consequent mental health impacts.

Table 2: Key benefit claimant groups in Plymouth

<table>
<thead>
<tr>
<th></th>
<th>Plymouth (numbers)</th>
<th>Plymouth (%)</th>
<th>South West (%)</th>
<th>Great Britain (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total claimants</td>
<td>28,710</td>
<td>16.5</td>
<td>12.0</td>
<td>14.5</td>
</tr>
<tr>
<td>By statistical group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job seekers</td>
<td>6,300</td>
<td>3.6</td>
<td>2.4</td>
<td>3.6</td>
</tr>
<tr>
<td>ESA and incapacity benefits</td>
<td>13,890</td>
<td>8.0</td>
<td>5.8</td>
<td>6.5</td>
</tr>
<tr>
<td>Lone parents</td>
<td>2,580</td>
<td>1.5</td>
<td>1.1</td>
<td>1.5</td>
</tr>
<tr>
<td>Carers</td>
<td>2,300</td>
<td>1.3</td>
<td>1.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Others on income related benefits</td>
<td>760</td>
<td>0.4</td>
<td>0.4</td>
<td>0.5</td>
</tr>
<tr>
<td>Disabled</td>
<td>2,580</td>
<td>1.5</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Bereaved</td>
<td>300</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Key out-of-work benefits†</td>
<td>23,530</td>
<td>13.5</td>
<td>9.8</td>
<td>12.1</td>
</tr>
</tbody>
</table>

Source: DWP benefit claimants - working age client group.
Note: % is a proportion of resident population of area aged 16-64
† Key out-of-work benefits include the groups: job seekers, ESA and incapacity benefits, lone parents and others on income related benefits. See the Definitions and Explanations below for details.

The situation of welfare in the UK is changing under the Coalition Government. Those on incapacity benefit are being assessed through...
ATOS as to whether they are fit to join a work programme; this is likely to be a stressful process for many, not only those who are already claiming incapacity benefit for mental health reasons (up to half of all those claiming this benefit). This change may have some positive impacts in terms of personalised support for people to enable them to re-enter the world of work – however there are also risks to mental health from both the assessment process, and from returning to work that is inappropriate or insufficiently well-supported. Some may find themselves worse off.

Similarly, the housing benefit changes may require some vulnerable people to leave their present accommodation – the consequent disruption may also have mental health and well-being impacts. Due to the high proportion of people claiming benefits, these changes are likely being highly significant consequences for Plymouth in the coming months and years.

We know that some neighbourhoods in Plymouth are significantly more deprived than others; consequently their need for mental health promotion, prevention and services is likely to be greater.

### 3.3.4 Unemployment

**Plymouth’s employment market**

According to the Plymouth Local Economic Strategy, Plymouth has some disadvantages in the employment market. There are fewer new businesses started in Plymouth than the national average, and productivity as measured by the Gross Value Added (GVA) lies below the national and regional average. The number of businesses operating per head of population is much lower in Plymouth than the position regionally and nationally. In addition, there is a lower proportion of people with higher level NVQ 4 or above qualifications than both the national and regional averages (25.8% compared to 31.5% and 31.3%), and a higher proportion with no qualifications than in the rest of the South West.
Table 3: Qualification levels in Plymouth 2010

<table>
<thead>
<tr>
<th>Qualifications (Jan 2010-Dec 2010)</th>
<th>Plymouth (numbers)</th>
<th>Plymouth (%)</th>
<th>South West (%)</th>
<th>Great Britain (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NVQ4 and above</td>
<td>44,000</td>
<td>25.8</td>
<td>31.5</td>
<td>31.3</td>
</tr>
<tr>
<td>NVQ3 and above</td>
<td>87,400</td>
<td>51.3</td>
<td>53.3</td>
<td>51.0</td>
</tr>
<tr>
<td>NVQ2 and above</td>
<td>116,200</td>
<td>68.2</td>
<td>71.0</td>
<td>67.3</td>
</tr>
<tr>
<td>NVQ1 and above</td>
<td>144,100</td>
<td>84.5</td>
<td>84.5</td>
<td>80.2</td>
</tr>
<tr>
<td>Other qualifications</td>
<td>9,300</td>
<td>5.5</td>
<td>7.2</td>
<td>8.5</td>
</tr>
<tr>
<td>No qualifications</td>
<td>17,000</td>
<td>10.0</td>
<td>8.4</td>
<td>11.3</td>
</tr>
</tbody>
</table>

Source: ONS annual population survey

Notes: For an explanation of the qualification levels see the definitions section.
Numbers and % are for those of aged 16-64
% is a proportion of resident population of area aged 16-64

Unemployment and Jobseekers

The modelled rate of unemployment in Plymouth was 7.4% in 2010-2011, compared with 8.1% in Portsmouth and 8.6% in Sheffield. 5.3% of all men, 2.4% of all women, and 3.9% overall were claiming Jobseekers Allowance as of November 2011. This is lower than Sheffield (4.6% claiming JSA) and similar to Plymouth’s southern comparators. The age group with the highest proportion of people on JSA is the 18-24 age groups, where 6.3% were claiming as of November 2011. This is in line with trends across the nation.

Table 4: Jobseekers Allowance claimants in Plymouth 2011

<table>
<thead>
<tr>
<th>Total JSA claimants (November 2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
</tr>
<tr>
<td>All people</td>
</tr>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Females</td>
</tr>
</tbody>
</table>

Source: ONS claimant count with rates and proportions

Note: % is a proportion of resident population of area aged 16-64 and gender

3.3.5 Crime

Both actual and perceived levels of crime can affect people’s quality of life and mental well-being. Some groups are more vulnerable than others to becoming victims of crime. According to the British Crime Survey, young households, lone parents and the unemployed are at higher risk of violent
crime and burglary People with serious mental illness are also more likely to be victims of violent crime – much more likely than being perpetrators.

The rate of violent crimes against the person in Plymouth in 2009/2010 was 21.9 per 1000 people\textsuperscript{7}. This is much higher than the UK average of 14.8. It is lower than some comparator cities; for example, the rate in Southampton is 31.9 per 1000 people.

Table 5 shows rates for specific crimes in Plymouth compared to the UK average.\textsuperscript{26} Some crimes, such as robbery and burglary appear to be less common in the City. However, the rate of some offences is much higher, for example criminal damage and violence against the person. Sexual offences also appear to be more common. Both sexual offences and violence against the person are particularly likely to have a detrimental impact on the mental health of the victim.

Table 5: Crime rate per 1000 2010/2011

<table>
<thead>
<tr>
<th>Crime</th>
<th>Plymouth City</th>
<th>UK average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burglary</td>
<td>6.5</td>
<td>9.6</td>
</tr>
<tr>
<td>Criminal damage</td>
<td>16.3</td>
<td>12.7</td>
</tr>
<tr>
<td>Drug offences</td>
<td>5.4</td>
<td>4.2</td>
</tr>
<tr>
<td>Fraud and forgery</td>
<td>1.9</td>
<td>2.7</td>
</tr>
<tr>
<td>Offences against vehicles</td>
<td>6.6</td>
<td>8.2</td>
</tr>
<tr>
<td>Robbery</td>
<td>0.6</td>
<td>1.4</td>
</tr>
<tr>
<td>Sexual offences</td>
<td>1.7</td>
<td>1.0</td>
</tr>
<tr>
<td>Violence against the person</td>
<td>21.9</td>
<td>14.8</td>
</tr>
</tbody>
</table>

Source: Home Office, collated by ‘Up my Street’\textsuperscript{26}

**Domestic violence**

Much research has been done into the impact of domestic violence on mental health. Women’s Aid reviewed the evidence and reported that:\textsuperscript{27}

- Domestic violence and abuse were the most common cause of depression in women
- Up to three-quarters of victims of domestic violence experienced depression or anxiety disorders
- Domestic violence is implicated in one third of all female suicide attempts.
- In addition, children who live with domestic violence are at increased risk of behavioural problems and emotional trauma, and mental health difficulties in adult life

Domestic Abuse accounts for 7% of all crime and 30% of all violent crime in Plymouth that is reported to the police. Plymouth Domestic Abuse Service
(PDAS) receives an average of 259 referrals per month predominantly from the police with approximately 17 per cent engaging with the service.\textsuperscript{27}

The Health Visitors’ Survey in 2010\textsuperscript{29} found that, compared to the city average of 10.6\%, the North West locality had the highest percentage of families experiencing ‘violence in the family’ (17.1\%) and the Plympton and Central/North East localities had the lowest percentages (5.1\%). Figure 10 shows that the Barne Barton neighbourhood had the highest percentage of families experiencing ‘violence in the family’ in 2010 (26.4\%). This compares with Hartley & Mannnamead where the value was 1.9\% in the same period.

Figure 10: Families experiencing ‘violence in the family’ by neighbourhood in 2010 (%)

Source: Health Visitor’s Survey 2010\textsuperscript{29}

Fear of crime

Fear of crime is associated with poorer mental health, which is likely to be partly due to reduced social and physical activities. Fear of crime is not necessarily related to the actual risk of crime in an area – it has been shown that people overestimate the frequency of crime in the UK.\textsuperscript{30}

According to one longitudinal study, ‘participants reporting high levels of fear were 50\% more likely to exhibit symptoms of common mental disorder and more than 90\% more likely to exhibit symptoms of depression than were those with the lowest levels\textsuperscript{30}

The recent PLACE survey\textsuperscript{9} found that although the majority of residents felt safe outside in the daytime, less than half (48\%) feel safe after dark. Younger residents and social tenants were more likely to report that crime and antisocial behaviour were a problem in their area, as were residents in the South West of the City.
3.3.6 Poor Physical Health

There is a strong association between mental and physical ill health. People with long-term conditions, such as diabetes or cardiovascular disease, have significantly raised rates of depression, anxiety and other mental health problems. Depression is the most common condition, for example, up to 33% of patients experience depression after a heart attack.31

There are a number of barriers to detecting mental illness amongst those with long term conditions, as traditionally physical health has overshadowed mental health problems, and depression has been sometimes regarded as ‘natural’ in those with serious illnesses. However, the Quality and Outcomes Framework now has an indicator for case finding for depression in CVD and diabetes patients – the compliance rate for Plymouth in 2010 for this was almost 85%.32

The health of people in Plymouth is generally worse than the England average; 7 meaning that there is likely to be a greater burden of disease with the consequent mental health impacts. There are over 11,000 people in Plymouth who receive Disability Living Allowance.33 The estimated prevalence of some of the most common long term conditions in Plymouth is shown below:

- Diabetes 7.3%34
- Chronic Obstructive Pulmonary Disease 3.28%35
- Coronary Heart Disease 5.9% 36

The estimated prevalence of diabetes in Plymouth is higher than many of its southern comparators such as Portsmouth (6.5%) and Southampton (6.6%); but is lower than Sheffield (7.6%). COPD appears to be less common than in Plymouth’s comparators. Coronary heart disease is estimated to affect a greater proportion of people in Plymouth than in any of these three comparator cities.36

3.3.7 Drugs and Alcohol

Substance use is closely linked with poor mental health. Firstly, intoxication, harmful use, withdrawal and dependence can all trigger or exacerbate mental health problems, even if these problems don’t constitute a psychiatric diagnosis. Secondly, mental health problems can lead to drugs and alcohol misuse. Co-existing mental health and substance use problems are known as ‘dual diagnosis’, and are very common, estimated to affect between 30% and 70% of those presenting to health and social care services37 – the social, family and economic impact of these is highly significant.
Substance misuse is most commonly associated with depression, anxiety and psychoses. For example, cannabis use in young people has been found to increase the risk of psychotic symptoms later in life, particularly amongst those who already have risk factors for mental illness.  

**Local situation**

- Over 10,000 people in Plymouth aged 18-64, 7000 of them male, are predicted to be alcohol dependent
- According to the Association of Public Health Observatories health profiles, a quarter of adults in Plymouth’s alcohol consumption is ‘increasing and higher risk’
- The rate of hospital stays for alcohol related harm in Plymouth is significantly higher than the England average; and higher than comparators Southampton, Sheffield and Portsmouth
- Nearly 6000 people are estimated to be dependent on drugs

**3.4 At-risk groups and groups with protected characteristics**

Whilst anyone can develop mental health problems or experience poor mental well-being, some groups are at higher risk due to their background or circumstances. They may benefit from specific or targeted interventions to improve mental health. The term ‘protected characteristics’ is from the Equality Act, and refers to characteristics which must not be discriminated against, including when services or resources are concerned.

The characteristics that are protected by the Equality Act 2010 are:

- Age
- Disability
- Marriage or civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- Gender identity and gender reassignment

Those ‘protected characteristics’ that may have specific mental health implications, as well as other at-risk groups are considered below where possible. Information at a local level on many of those at risk can be limited, but where this is lacking there is likely to be a case for more research or data collection.
3.4.1 Pregnancy and Maternity

Although pregnant women and new mothers can experience the same mental health problems as any other adult, there are some specific risks during pregnancy and the post-natal period. Women with a pre-existing mental health problem may stop, reduce or change their medication during pregnancy or when breastfeeding, and are at increased risk of another episode. For example, those with a history of depression or bipolar disorder have a higher risk of experiencing further episodes during or after pregnancy. There is also an increased risk for new mothers of developing depression for the first time within 3 months of birth. Post-natal psychosis, whilst rare, can happen very rapidly and need more urgent intervention than other psychoses. In addition, there is the well-being of the mother, the baby and the entire family to consider at this crucial time, meaning that particular advice, support and services may be required.

In Plymouth in 2010 there were 3280 live births. The total fertility rate, which is the number of children an average woman at current fertility rates would have over a lifetime, was 1.83. With an estimated prevalence of postnatal depression of 12-13%, we would expect around 400 women each year to experience this condition.

3.4.2 Care leavers

Young people leaving care are at higher risk of having, or developing mental health problems. Reports of the prevalence of psychopathology among children looked after by local authorities vary between 17-89%, which compares with estimates of 3-18% for children outside the care system. In addition, they face worse outcomes in terms of homelessness or poor housing, low educational attainment and economic participation, drug use and offending. Enhanced support for the leaving care transition, interim services and an emotional well-being plan for care leavers have been recommended by the Local Government Agency.

- In the year ending 2011 in Plymouth there were 35 19 year olds defined as care leavers
- 88% were in suitable accommodation
- Of those leaving care in 2010, almost 80% were in education, employment or training

3.4.3 Transition from Child and Adolescent Mental Health Services

There is a correlation between mental health problems as a child or young person, and mental health disorders as an adult. Some neurodevelopmental difficulties, such as autism, will also affect a person for life. In one study, half of those with a mental health disorder aged 26 had
first met criteria between the ages of 11 and 15. We know however that even if a young person is in contact with Child and Adolescent Mental Health Services (CAMHS), they may not meet service criteria for Adult Mental Health Services (AMHS); and there will be occasions where young people ‘fall through the gaps’. For many reasons, transition can be difficult time for vulnerable young people. There are at present, no numbers from the Needs Analysis for the Children and Young People’s Plan on the numbers of 16 to 18 year olds with a mental health disorder. The Needs Analysis estimated that in Plymouth amongst 5-15 year olds there are:

- 685 with more than one mental health disorder
- 2090 with a conduct disorder
- 1333 with an emotional disorder
- 541 with hyperactivity

Given the levels of deprivation in Plymouth, it is possible that these figures could represent an underestimate.

### 3.4.4 Students in Higher Education

According to a 2011 report by the Royal College of Psychiatrists on student mental health:

“social changes such as the withdrawal of financial support, higher rates of family breakdown… and economic recession are all having an impact on the well-being of students”

As well as coping with the economic environment and the transition from home to University, young adults in the 18-25 age group, which includes most students, are also in a higher-risk group for developing serious mental illnesses such as schizophrenia and bipolar disorder; and eating disorders. Excessive alcohol use in UK universities, alongside substance misuse, also places students at risk. The report concluded that ‘psychiatric disturbance is widely prevalent in the student population’. International students may be particularly vulnerable. Low take-up of treatment by students with mental health problems has been identified in some studies, and there is a general lack of research into student mental health here in the UK.

Plymouth has a large student population, with UCAS in 2011 reporting student numbers of over 28,000 at the University of Plymouth, almost 2000 at Plymouth College of Art and 4000 at the University College of St Mark and St John.
3.4.5 Vulnerable families

The Plymouth Health Visitor Surveys collect information about the families on the caseloads of Health Visitors in the City. Specifically, information is gathered on 26 family-related health needs factors; such as parents smoking, parents with mental health problems, and violence in the family. From the 2010 survey:

- Almost 1,500 (11.7%) were classified as vulnerable (experiencing more than 4 risk factors)
- In 9.1% of families, at least one parent was depressed or mentally ill

Location of vulnerable families

Compared to the city average of 11.7%, the North West locality had the highest percentage of vulnerable families (19.1%) and the Plympton locality had the lowest percentage (2.0%). Figure 11 shows that the Barne Barton neighbourhood had the highest percentage of vulnerable families in 2010 (35.0%). This compares with Chaddlewood where the value was 1.2% in the same period.

The South West locality had the highest percentage of ‘depressed/mentally ill parents’ (12.5%) and the Plympton locality had the lowest percentage (3.6%). The Barne Barton neighbourhood had the highest percentage of ‘depressed/mentally ill parents’ in 2010 (19.7%). This compares with Eggubuckland where the value was 1.5% in the same period.

Figure 11: Percentage of families classed as vulnerable, by neighbourhood
3.4.6 People with Learning disabilities

Both children and adults with learning disabilities are much more likely to experience mental health problems than those without. Estimates of the proportion of adults with LD affected by mental illness range from 30-50%.\textsuperscript{47} There are overlapping risk factors in terms of physical disabilities and epilepsy which can accompany LD. Some syndromes are known to bring a higher risk of specific disorders, for example, Down’s syndrome carries an increased risk of dementia and depression. There have also been issues raised about people with LD getting full access to mental health services and therapies, and of symptoms being overlooked or being attributed to the learning difficulty rather than to mental illness. Estimated prevalence of learning disabilities in Plymouth: \textsuperscript{33}

- Over 4,200 people aged 18-64 are predicted to have a learning disability
- Almost 1,000 are predicted to have a moderate or severe learning disability
- Over 100 are estimated to have Down’s Syndrome

According to the Joint Dementia Strategy, \textsuperscript{48} there are 1,700 adults with known learning disabilities in Plymouth; 142 people with Down’s syndrome are on the Learning Disability Partnership register. They are offered regular screening for dementia in line with best practice.

Adults with neurodevelopmental disorders

Many neurodevelopmental disorders are lifelong conditions, such as autism. Autism is a developmental disorder involving problems and difficulties with social interaction, impaired language and communication skills, and unusual patterns of thought and physical behaviour. People with autistic spectrum disorders often have an accompanying learning disability (IQ of less than 70), but many do not. People with Asperger’s syndrome are often referred to as having ‘high functioning autism’. These people have an IQ in the normal range, and no delays in language development. They often fall into the gaps between learning disability services and mainstream mental health services, and face high levels of social exclusion due to low levels of employment and their difficulties in relating to the social world. Mental health disorders such as depression are more common in people with autistic spectrum disorders, but even if they do manage to gain access to services their needs may be poorly understood, and they may go undiagnosed.

- PANSI estimates that around 1,700 people in Plymouth aged 18-64 are likely to have an autistic spectrum disorder\textsuperscript{33}
3.4.7 Survivors of abuse

According to the Department of Health, 49

‘Child physical, emotional or sexual abuse and neglect and domestic violence are causal factors in the mental and physical ill health of children, adolescents and adults and affect a significant proportion throughout their lives’

Long term consequences of childhood sexual abuse include depression, anxiety, post-traumatic stress disorder, psychosis, substance abuse, eating disorders, self-harm and suicide. Studies have consistently reported that a high proportion of those using mental health services have been sexually and/or physically abused as children. Witnessing domestic violence as a child also has mental health impacts in terms of emotional and behavioural problems such as anti-social behaviour, anxiety and drug abuse.

National estimates 49 suggest that up to 20-30% of girls and 5-10% of boys experience sexual abuse, and up to 20% of children are subjected to regular physical violence.

In Plymouth, there are predicted to be almost 20,000 adults aged 18-64 who are survivors of sexual abuse, 13,616 of them female. 33

3.4.8 Hearing and visually impaired people

We know that deaf children are significantly more likely to experience mental health problems. Deaf adults may also be at higher risk due to underlying neurological conditions, greater social and emotional stress, and delays and barriers in diagnosis and accessing services. Up to 50% of the profoundly deaf will experience a mental health difficulty at some point in their lives. 50

There is little research specifically into the mental health of visually impaired people, 51 although it has been shown that those who lose their sight later in life are likely to experience mental health difficulties as they adjust, akin to a bereavement response. There is a significant risk of depression, which may be underdiagnosed and overlooked. People with all sensory impairments may also suffer social exclusion and isolation, which can contribute to their risk of mental ill-health.

In 2011, PANSI 33 estimated that there would be around 50 people between 18 and 64 with a profound hearing impairment in Plymouth and almost 6000 with moderate, severe or profound deafness. In the over 65 age group, there are predicted to be over 18,000 with moderate, severe or profound deafness. 52 Serious visual impairment is less common, with around 100
people under 65 estimated to be affected in Plymouth; and over 1000 people aged 65 and over.

3.4.9 Carers

Providing care to someone with physical or mental health problems can be stressful and demanding, affecting the carer’s own quality of life whilst they undertake this vital role. Levels of psychological distress have been found to be up to twice as high amongst carers as in the general population; and they are therefore at greater risk of developing mental health problems themselves.

According to the Plymouth Carers Strategy, based on the 2001 census:

- Over 24,000 people in Plymouth identify themselves as unpaid carers
- Almost 9000 carers provide more than 20 hours per week
- There are 4309 carers aged 65 or over (41% of whom provide more than 50 hours per week of care)
- The total number of all carers is highest in Honicknowle ward (1541); and the greatest number of carers over 65 is in Plymstock Dunstone (325)

3.4.10 Asylum seekers

Asylum seekers are at higher risk of mental health problems, not only due to the circumstances that caused them to seek asylum, but also from the consequences of their move to a new country. Post-traumatic stress disorder may be underestimated and under-diagnosed in this vulnerable group; in addition to depression and anxiety. There may be further barriers to care due to cultural differences in understanding of mental illness; and inadequate mental health services for this group nationally as identified by the Faculty of Public Health.

According to the City Council, there are currently around 350 asylum seekers in Plymouth.

3.4.11 Gypsies and travellers

There is a lack of good evidence about the mental health of gypsies and travellers, although we know that their mental health status is generally worse than the rest of the population. Studies have identified raised levels of depression and anxiety, particularly in women. Although this is not a homogenous group, research has suggested that many Gypsies and Travellers feel that the difficulties of maintaining their way of life, such as
finding sites for their caravans affects their mental health. Strong beliefs about self-reliance and distrust of services are likely to constitute barriers to traditional services, and specific approaches may be needed.

A recent Plymouth needs assessment of the health of gypsy and traveller children\textsuperscript{57} highlighted the importance of good data collection, appropriate accommodation and joined up geographical strategies to cater for the fluidity of their lifestyle. A large shortfall in the number of caravan pitches in Devon has been identified. Although there are no reliable figures, it is thought that Gypsies and Travellers make up 0.6% of the population in the UK. The last count of Gypsy and Traveller caravans on sites in Plymouth found 20 authorised caravans in place.

3.4.12 Black and minority ethnic groups

The mental health of ethnic minority groups is a complex area. The many different ethnic groups in the UK cannot be put together in one ‘category’ and are very diverse. In addition, there are cultural differences in the way that mental illnesses are experienced and reported that mean a one-size-fits-all approach is not likely to be appropriate. Social factors such as deprivation and migration disproportionately affect many from BME groups, and are also risk factors for mental health problems.

According to the Mental Health Foundation\textsuperscript{58} and in general, people from black and minority ethnic groups living in the UK are:

- More likely to be diagnosed with mental health problems
- More likely to be diagnosed and admitted to hospital
- More likely to experience a poor outcome from treatment
- More likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health

In the 2007 Adult Psychiatric Morbidity Survey\textsuperscript{23} South Asian women reported more symptoms of common mental illness, such as anxiety and depression. The prevalence of psychotic disorder was significantly higher among black men (3.1%) than men from other ethnic groups (0.2% of white men).

In Plymouth, the relatively lower number of people of BME origins means that these groups are more vulnerable to isolation and discrimination, which can contribute to poor mental health. The proportion of people from BME origins is smaller than in Plymouth’s comparator cities of Sheffield, Portsmouth and Southampton.\textsuperscript{33} Smaller numbers can lead to a lack of peer support; and to a lack of culturally appropriate services.
3.4.13 Lesbian, gay and bisexual (LGB) and transgender people

One survey has reported that lesbian and gay people and others who are non-heterosexual experience higher levels of anxiety, depressive episodes, obsessive–compulsive disorder, phobic disorder, probable psychosis, suicidal thoughts and acts, self-harm and alcohol and drug dependence. This is thought to be at least partly due to discrimination, abuse and bullying. In the same study, this group also consulted their GP more often for mental health problems, and used community based services more frequently. There is less research into the health of transgender people, although one UK survey of transgender people found that 34% have attempted suicide, highlighting levels of extreme distress.

The Government estimates put the numbers of LGB people as between 5-7% of the population. The size of the transgender population is even more difficult to estimate than the LGB population, but is much smaller. In a city the size of Plymouth we would expect there to be upwards of 12,000 LGB people.

3.4.14 Offenders and Ex-offenders

Offenders who are both in and out of custody are at higher risk of mental health problems. They will often be affected by multiple risk factors such as early abusive home relationships and poor educational achievement, deprivation and social exclusion. Drug and alcohol dependency, personality disorder, depression and anxiety and psychosis are all much more common in the prison population than the general public. According to the UK Public Health Association report on criminal justice; four in ten offenders in the community have mental health problems, along with one third of women on probation.

Plymouth does not have a prison, but there are a number in Devon. It is estimated that around 9000 people leave prison out into South West England each year, and that 22% come to Devon; the 2005 Needs Analysis for Plymouth estimated that around 700 people leaving prison return to Plymouth annually.

3.4.15 Veterans and Service Personnel

There are higher than average levels of homelessness and alcohol use in ex-service personnel, both of which are linked to mental health problems. A significant number of veterans experience high levels of mental health problems, such as anxiety, depression and post-traumatic stress disorder. Many seek help late, feeling the stigma of mental illness. The organisation Combat Stress estimates that their clients wait an average of 13 years
before contacting them. They report a current caseload of more than 4,600 individuals nationally – including 211 Afghanistan and 583 Iraq Veterans.

There are an estimated 5 million veterans in the UK, and a further 20,000 personnel leave the forces each year. The Naval Base at Devonport employs around 5000 military and civilian personnel. There are also a number of Marine bases in Devon. Many return to live in the area after leaving the Services and therefore the mental health of ex-service personnel is an important issue for Plymouth. Particularly vulnerable groups are likely to be Reservists and early Service leavers.\(^6^5\)

Whilst serving personnel are covered by the Defence Medical Service, their families also face extra stresses and may be in need of mental health and well-being support. Many are vulnerable due to risk factors such as substandard accommodation (nearly a third of respondents in the National Audit Office report on Service Families’ Accommodation\(^6^6\) said that it was ‘poor’) and frequent moves and instability.

3.4.16 Older people

Many older people have good mental health and well-being. They are however more likely to experience events that affect emotional well-being, such as bereavement or disability, and may experience increased levels of isolation. They may also develop dementia, the risk of which increases with age (see Dementia section below). Estimates suggest that 40 per cent of older people seeing their GP, 50 per cent of older people in general hospitals, and 60 per cent of care home residents, have a mental health problem.\(^6^7\)

Under-diagnosis of mental health problems in this age group is a significant issue. According to a 2007 report by Age Concern:\(^6^8\)

- Only 1 in 3 older people with depression discuss this with their GP
- Of those that do tell their GP, only half will be diagnosed and treated
- Under half of those with dementia ever receive a diagnosis

As discussed in the Plymouth Profile section of this Needs Assessment, there is expected to be a rise in the number of older people in the City, particularly the ‘oldest old’, meaning that appropriate services for this group will be even more important.
3.5 What is the estimated prevalence of mental health problems in Plymouth?

3.5.1 Background

The estimates in this section are from PANSI\textsuperscript{33} (Projecting Adult Need and Service Information) and POPPI \textsuperscript{52} (Projecting Older People Population Information), both provided by the Institute for Public Care. They are modelled from responses to the Adult Psychiatric Morbidity Survey\textsuperscript{23} (APMS) which took place in 2007; and applied to the Plymouth population. Where these estimates are significantly different from those in the 2009 Mental Health Atlas this has been highlighted. Numbers have not been given for Plymouth’s comparator cities as these are numbers rather than rates; and as the cities are of different sizes comparison is not as meaningful.

**Figure 12: Estimated 2010 prevalence of mental health problems in 18-64 year olds in Plymouth**

![Graph showing estimated number of cases for different mental health issues]

Source: PANSI\textsuperscript{33}

Figure 12 demonstrates that common mental health problems, including depression, anxiety and obsessive-compulsive disorder, constitute the greatest proportion of the mental health burden in Plymouth. Drug and alcohol dependence; as well as psychiatric co-morbidity are also very significant. However, the need for services is not necessarily proportionate to the numbers; for example a person with a psychosis may require repeated episodes of inpatient care and greater input from specialist services than a person suffering from a mild depressive illness.

3.5.2 Common mental health problems

- Over 27,000 18-64 year olds are estimated to have a common mental health disorder: 16,764 female, and 10,675 male
- Over 3,500 over-65s estimated to suffer with depression
Common mental health problems are defined as conditions causing emotional distress and interference with functioning, but where the person recognises that they are unwell (has insight) and retains cognitive abilities such as memory. This category includes different types of depression, anxiety and obsessive-compulsive disorder.

According to PANSI,\textsuperscript{33} over 27,000 people aged 18-64 suffer from a common mental health problem in Plymouth, based on APMS figures of 19.7\% of women and 12.5\% of men suffering from at least one of these disorders.

This figure is lower than the figure of 36,729 predicted to have common mental health problems in the 2009 Mental Health Atlas. The figures in the Atlas are for the year 2000 and are for 16-74s and therefore encompass a wider age range, in addition, as with the estimates in the section below, they are based on a tool which takes population characteristics into account, which PANSI does not.

POPPI\textsuperscript{52} predicts that over 3,500 people over 65 have depression, and over 1000 have severe depression.

Over the next decade, the number of cases is predicted to increase in line with population growth to just over 29,000 18-64 year olds in 2030.

**Estimated numbers with specific common mental health problems**

The North East Public Health Observatory (NEPHO)\textsuperscript{69} produced figures estimating sufferers from common mental disorders on the basis mainly of findings from the 2000 National Psychiatric Morbidity Survey, with some adjustment for population characteristics. The aim of this was to inform planning for the Improving Access to Psychological Therapies programme (IAPT). The results of this as applied to the 2011 Plymouth population aged 18 plus are displayed in the table below. The term ‘neurotic disorders’ is used to cover common mental health problems such as anxiety and depressive disorders.

The Adult Psychiatric Morbidity Survey 2007\textsuperscript{23} as used by the PANSI and POPPI sites estimated that 17.6\% of the population aged 18-64 would have a common mental health problem (or around 27,000 people). Table 6 estimates that over 42,000 would have a neurotic disorder. This figure may be higher as there is some adjustment for population characteristics – it also covers the over-65s as well.

Not all sufferers of a mental health problem will need a treatment intervention. The 2007 APMS survey found that 50\% of adults with a CIS-R score (ratings scale for CMD) indicating neurotic symptoms had symptoms of a level of severity likely to require treatment. If this is applied to our population, we can see that over 20,000 people in Plymouth are likely to
suffer with a ‘neurotic disorder’ which requires treatment. Many may already be receiving treatment, or may not want it.

The North East Public Health Observatory has estimated that the number of people with CMDs requiring a new psychological therapy is approximately one fifth of the number of cases of CMD.

Table 6: Estimated prevalence of neurotic disorders in all Plymouth residents aged 18 plus using NEPHO figures

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Rate per 1000</th>
<th>Estimated number</th>
<th>Estimated number of a severity needing treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any neurotic</td>
<td>201.2</td>
<td>42,775</td>
<td>21,387</td>
</tr>
<tr>
<td>All phobias</td>
<td>15.8</td>
<td>3,359</td>
<td>1679</td>
</tr>
<tr>
<td>Depressive episode</td>
<td>22.8</td>
<td>4847</td>
<td>2423</td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td>49.0</td>
<td>10,417</td>
<td>5209</td>
</tr>
<tr>
<td>Mixed anxiety and depression</td>
<td>115.3</td>
<td>24,512</td>
<td>12,256</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>10.6</td>
<td>2,253</td>
<td>1,126</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>7.6</td>
<td>1,616</td>
<td>808</td>
</tr>
</tbody>
</table>

3.5.3 Personality disorders

- More than 700 people in Plymouth aged 18-64 are predicted to have borderline personality disorder
- Almost 600 people aged 18-64 are estimated to have antisocial personality disorder

Personality disorders are longstanding problematic personality features which cause the person to have difficulty functioning and in making and sustaining relationships. There are various types but these two are particularly important in terms of need for health and other services. Borderline personality disorder is significant because this condition involves high levels of emotional instability, self-harm and suicide. Antisocial personality disorder, characterised by an aggressive and irresponsible pattern of behaviour, also has a wider impact on society as it is linked with crime and violence.
3.5.4 Psychosis

- Almost 700 people aged 18-64 are estimated to have some type of psychosis.

Psychosis is a term for disturbance of perception, thought and insight. For example, people may experience hallucinations which are false or distorted sensations, such as hearing and seeing things that are not there in external reality. These experiences may be frightening and distressing. A lack of insight means that sufferers may not recognise that they are unwell or that they could benefit from treatment. Psychotic symptoms occur in psychotic illnesses such as schizophrenia, and can also accompany mood disorders such as bipolar affective disorder.

3.5.5 Psychiatric co-morbidity

- Over 12,000 people aged 18-64 are estimated to have more than one mental health problem.

It is common for people to suffer with more than one mental health problem, including co-morbid alcohol or drug dependency. This is important as it associated with greater severity, difficulty in functioning and use of health services.

3.5.6 Drug and alcohol dependence

- Over 10,000 people in Plymouth aged 18-64, 7000 of them male, are predicted to be alcohol dependent.
- Nearly 6000 are estimated to be dependent on drugs.
- Just over 1000 of these are predicted to be accessing effective treatment.

Alcohol dependence is a syndrome where there are difficulties in controlling drinking, and includes features such as a strong desire to drink, persisting in drinking despite the problems that it creates, and physical withdrawal symptoms. Both drug and alcohol dependencies are significant not just for the personal health consequences, but for wider services too.

3.5.7 Dementia

Dementia is a syndrome or collection of progressive symptoms which are due to a decline in the functioning of the brain. Symptoms of dementia include memory loss, and problems with thinking, language, judgement and understanding. Personality and behavioural changes and mood disturbances such as depression may also occur. There are various types
of dementia, two of the most common being Alzheimer’s disease and vascular dementia.

Dementia becomes more common with age, and is rare under the age of 65. The proportion of people with dementia doubles for every 5 year age group, until around one third of people over 95 have dementia.

With an ageing society, dementia is becoming steadily more common and more significant – the emotional, social and financial costs to the person, family, community and wider society are considerable. Understanding the local situation is very important to providing early diagnosis and appropriate support to people and their carers. The Plymouth Joint Dementia Strategy explores the picture of dementia in Plymouth in greater detail. According to this, in 2012, only 51% of those with dementia will be known to services; the remainder may be in the system without a diagnosis, or in the early stages and relying on support from relatives and friends. Estimates of numbers of people in Plymouth with dementia from POPPI are given below.

- Approximately 60 people aged 30-64 in Plymouth are estimated to have early-onset dementia
- 3000 over-65s are predicted to suffer with the condition in 2011
- The number of cases of dementia is projected to increase over time, reaching 5000 by 2030

As part of the Quality and Outcomes Framework, GP practices keep registers of patients diagnosed with dementia. According to the Joint Dementia Strategy, almost 1000 people are on the GP practice dementia registers in Plymouth. The neighbourhood with the highest number of the registers is Stoke with 125; in Keyham in contrast there were only 2 on the registers.
These estimates are from POPPI which used prevalence rates applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia to 2030. They do not differ significantly from the projected prevalence’s given in the 2009 Mental Health Atlas, which does contain more detail.

3.5.8 Other Mental Health Disorders

PANSI and POPPI do not include estimates for some specific disorders and some of the less common mental health disorders. It is possible to look at national estimates and to apply them to the local population to give an approximate indication of the likely scale of need.

**Bipolar affective disorder**

Bipolar affective disorder is a ‘cyclical mood disorder’ where abnormally elevated mood (known as mania or hypomania) and/or irritability alternate with depressive mood. There can sometimes be psychotic symptoms. The first episode usually occurs before the age of 30, with a peak in onset occurring between the ages of 15 and 19 years of age.\(^70\)

The annual incidence of bipolar disorder is 7 per 100 000, and the lifetime prevalence is 1.3%, affecting just over one in a hundred people over their lifetime.\(^70\) In a city the size of Plymouth we would therefore expect in the region of 15 new cases a year.

**Schizophrenia**

Schizophrenia is the most common psychotic disorder.\(^71\) It is a severe and enduring psychiatric disorder (or cluster of disorders) that alters an individual’s perception, thoughts, affect and behaviour. Individuals who develop schizophrenia will each have their own unique combination of
symptoms and experiences, the precise pattern of which will be influenced by their particular circumstance.

The incidence of new cases is around 15 per 100,000 people per year.\textsuperscript{71} Around 1 in 100 people will be affected over a lifetime; and the point prevalence at any one time is in the region of 2-5 per 1000, i.e. from 0.2-0.5%. Prevalence of the disorder varies with age, but applying these figures to the Plymouth population aged over 18 would give a number in the range of 400 to 1000 people.

**Eating Disorders**

Eating disorders include anorexia nervosa, bulimia, and Eating Disorders Not Otherwise Specified (EDNOS). Anorexia is characterised by a preoccupation with low body weight, and weight restriction which can be severe and even fatal. The main features of bulimia are recurrent binge eating teamed with compensatory behaviours such as purging. There are many people with disordered eating who may not meet the criteria for these illnesses but may have an EDNOS.

Incidence estimates for anorexia in 18-65 year olds are in the region of 19 new cases per 100,000 people per year for women, and 2 per 100,000 per year for men.\textsuperscript{72} The prevalence of bulimia amongst young women has been estimated at between 0.5-1%. The numbers suffering with EDNOS may be higher still. In the Adult Psychiatric Morbidity Survey 2007,\textsuperscript{23} 6.4% of adults screened positive for a possible eating disorder in the past year. The proportion who screened positive and also reported that their feelings about food had a significant negative impact on their life was 1.6%.

Given these figures we might expect in the region of 16 new cases of anorexia per year in women in Plymouth, and 1-2 new cases per year in men. Bulimia is more common; given the prevalence of bulimia, at any one time there may be around 350-400 women under 35 with the condition.

**Adult Attention Deficit Hyperactivity Disorder**

Attention Deficit Hyperactivity Disorder (ADHD) is most common in children and young people. The symptoms include impulsivity, hyperactivity and inattention, and may not persist into adulthood in many cases. However, symptoms will persist into adulthood in up to half of young people. Services for adults with this condition have historically been poor or non-existent.

- NICE\textsuperscript{73} estimate that 1.81% of men and 0.43% of women over 18 will have adult ADHD. In Plymouth, this would suggest around 1500 men and 350 women are likely to have the condition.
3.5.9 Self-Harm

Self-harm can include self-poisoning and other injuries such as cutting or burning. It can be associated with disorders such as depression or borderline personality disorder, or can be a reaction to distressing events. Self-harm may not occur with suicidal intent, but may be a means of release or of coping with difficulties such as relationship breakdown.

Whilst not all cases of self-harm will present to services, the number of A and E attendances can paint a picture of the prevalence of this problem. The information below is from Plymouth Hospitals NHS Trust for 2010/2011:

- In 2010/2011, there were 1,246 self-harm attendances at A and E amongst all ages
- The number of hospital stays for self-harm in Plymouth is higher than the national average and
- This has more than doubled since 2008/2009 where there were only 489
- The rate in 2008/2009 was 178.3 attendances per 100,000; in 2010/2011 this increased to 453.6 per 100,000
- 269 of these were in people aged 19 or under – the highest numbers were in this age group, closely followed by the 20-24 age band
- 8 were in over 75s
- 1055 were cases of self-poisoning with paracetamol or other drugs
- 191 were cases of self-harm by cutting or other means
- The rate of admissions for self-harm is higher than the England average, but although the Plymouth rate is higher than the South West rate this difference is not statistically significant

**Self-harm by neighbourhood**

- Over twice as many A and E attenders who self-harmed came from the most deprived neighbourhoods as the least deprived

After accounting for differences in population and age structure, the neighbourhoods with the highest rate of self-harm attendances were Stonehouse, Ernesettle and the City Centre, Glenholt, Woodford and Higher Compton had the lowest rates.
3.5.10 Suicide and Injury of Undetermined Intent

Suicide in this section refers to ‘suicides and deaths from injury undetermined whether accidentally or purposely inflicted.’ This is shortened to ‘suicide and undetermined deaths’ or, ‘suicide.’

Many factors have been identified as being associated with suicide. Men are more likely to commit suicide than women, and young men are most likely to die from this cause. The highest rates of suicide occur amongst people in the lowest social classes. Most people who commit suicide are not in contact with Mental Health services at the time; only approximately 25% are in current contact.74

Other risk groups for suicide include: 74

- Self-harm: people who have self-harmed have an increased risk of subsequent suicide (approximately 5% over a 10 year period)
- People with histories of childhood sexual abuse or recent adverse life events (bereavement, separation and divorce)
- Isolation, living alone, and alcohol abuse are also risk factors
Suicide in Plymouth

Figure 15 shows, in line with national figures, the suicide rate in men in Plymouth is always greater than the rate in women. The overall all-person rate was highest in 1999 at over 25 per 100,000 population, and at the lowest in 2005. With such small numbers there is likely to be ‘random’ variation in the rate over time.

Figure 15: Suicide rate per 100,000 for Plymouth: Trends over time

The rate of suicide in Plymouth is similar to the rest of the South West. The rate for Plymouth appears to vary wildly compared to the England rate, this is due to the much smaller numbers involved; however overall the Plymouth rate is higher (see dotted linear line on Figure 16).

Figure 16: Suicide rate per 100,000 in Plymouth and England as a whole compared over time
Figure 17 shows the actual numbers of deaths recorded as suicides or undetermined injury from 1986 to 2009 by sex. The annual average number from 1986 to 2009 was 25 deaths per year (19 amongst men and 6 amongst women).  

Figure 17: Numbers of suicides and undetermined injury deaths over time in Plymouth

Deaths by sub-locality
Table 7 shows the total number of deaths from 1981-2007 and the percentage of total number from each locality. The highest number and percentage are from the South West of the City, making up 32.7% of all suicides – the next highest percentage is some way behind at 18.8% from the Central/North East. Plympton and Plymstock made up only 9% and 6.9% respectively.

Table 7: Deaths from suicide and undetermined injury by sub-locality 1981-2007

<table>
<thead>
<tr>
<th>Neighbourhood</th>
<th>1981-2007 (number)</th>
<th>% of total number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central/North East</td>
<td>131</td>
<td>18.8</td>
</tr>
<tr>
<td>North West</td>
<td>102</td>
<td>14.6</td>
</tr>
<tr>
<td>Plympton</td>
<td>63</td>
<td>9.0</td>
</tr>
<tr>
<td>Plymstock</td>
<td>48</td>
<td>6.9</td>
</tr>
<tr>
<td>South East</td>
<td>126</td>
<td>18.1</td>
</tr>
<tr>
<td>South West</td>
<td>228</td>
<td>32.7</td>
</tr>
<tr>
<td>Plymouth City</td>
<td>698</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Suicide and undetermined injury deaths by cause
From 1981 to 2007, the most common method of suicide and undetermined injury in Plymouth was 'poisoning by solid or liquid substances' (44%). This is 26 percentage points higher than the next most common method (hanging, strangulation or suffocation (18%).

Figure 18: Percentage of deaths by cause 1981-2007

3.6 The Mental Health Needs Index
Different areas with different characteristics are likely to experience different levels of mental health need – i.e. people will be more or less likely to suffer with mental illness. The Mental Health Needs Index 2000 (MINI 2000) is a tool which attempts to put a figure on need and allows areas to be compared. The MINI 2000 is based on data from over 10 years ago, and has not been updated – however it is worthwhile to briefly consider what it tells us, given that many of the factors that it uses have not radically changed.

The MINI 2000 gives an indication of those people likely to be suffering from severe and enduring mental health issues who may require admission from time to time. This uses census data to predict the need for mental health services at electoral ward level. Census variables found to be best able to predict need for mental health services are: single / widowed / divorced, absence of car, permanent sickness, unemployment, households not self-contained/ hostels/lodging houses. The population of any electoral ward is weighted according to these variables.

Table 8 shows the MINI-2000 scores for sub-localities in Plymouth. These are all based on Plymouth’s 1998 population and on MINI-2000 so are not up-to-date. They are however still interesting. A MINI score of greater than
suggests that the mental health needs of that sub-locality are greater than would be expected for that size of population. When adjusted for mental health needs, the population can become bigger or smaller. For example, the mental health needs of the Southwest locality were equivalent to an area which has a population 76.4% larger, or with over 28,000 more people. In Plympton and Plymstock, the mental health needs index were both below 1, suggesting that their needs would be equivalent to a smaller area.

For Plymouth as a whole however, the MINI 2000 was 1.28, meaning that Plymouth had an increased level of need relative to its actual population size, in fact, 28% more illness than the country as a whole. The MINI-2000 score is higher than for Sheffield (1.15), Southampton (1.13), and Portsmouth (1.22), all socio-economic comparator areas, suggesting that Plymouth does have particularly high levels of need.

Table 8: The MINI-2000 by Plymouth sub-locality

<table>
<thead>
<tr>
<th>Sub-locality</th>
<th>MINI-2000</th>
<th>Change in population</th>
<th>Percentage change in population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central/Northeast</td>
<td>1.11</td>
<td>3428</td>
<td>10.9</td>
</tr>
<tr>
<td>Northwest</td>
<td>1.31</td>
<td>9014</td>
<td>30.6</td>
</tr>
<tr>
<td>Plympton</td>
<td>0.79</td>
<td>-3663</td>
<td>-20.9</td>
</tr>
<tr>
<td>Plymstock</td>
<td>0.82</td>
<td>-2278</td>
<td>-17.7</td>
</tr>
<tr>
<td>Southwest</td>
<td>1.34</td>
<td>7790</td>
<td>33.8</td>
</tr>
<tr>
<td>Southeast</td>
<td>1.76</td>
<td>28048</td>
<td>76.4</td>
</tr>
<tr>
<td>Plymouth City</td>
<td>1.28</td>
<td>42339</td>
<td>28.0</td>
</tr>
</tbody>
</table>

3.7 Physical Health in those with a mental health problem

People with a serious mental illness (SMI) such as schizophrenia have worse physical health and reduced life expectancy than the general population. This gap in life expectancy has in fact widened over recent years. Whilst suicide does account for some of this, cardiovascular disease is the major cause of death. Compared with the general population, people with depression are twice as likely to develop type 2 diabetes, three times more likely to have a stroke and five times more likely to have a myocardial infarction. Some of the ‘lifestyle’ factors associated with serious mental illness include:

- A diet higher in fat
- Higher BMI
- Lack of exercise
- Substance misuse
- Smoking
There are also other factors such as the side-effects of medication (e.g. anti-psychotics) causing weight gain. People with a SMI are therefore more likely to have diabetes, high blood pressure and high lipid levels.

3.7.1 Smoking and mental health

Adults with mental health problems are two to three times more likely to smoke.\textsuperscript{80} Up to 7 out of 10 adults in mental health inpatient units smoke, one of the highest rates in the whole population.\textsuperscript{80} A significant proportion of excess mortality in people that are mentally ill is due to the burden of smoking behaviour. According to the Faculty of Public Health,\textsuperscript{80} “those with mental health problems smoke significantly more, have increased levels of nicotine dependency and are therefore at even greater risk of smoke-related harm”

Smoking is associated with higher levels of mental illness; and there is some evidence to suggest that it increases the risk of developing a mental health problem, although this is a complex relationship.\textsuperscript{80}

It is estimated that 22.3\% of adults in Plymouth smoke, slightly higher than the national average of 21.2\%, but not significantly different.\textsuperscript{7} This is the same percentage as Southampton, and lower than the rates of smoking in Sheffield and Portsmouth.

3.7.2 Need for appropriate physical healthcare

According to the Royal College of Psychiatrists,\textsuperscript{78} “people with a diagnosed mental health disorder too often find their symptoms of physical illness dismissed as simply being ‘all in the mind’, leading to delays in diagnosis and inappropriate treatment”. There have also been issues with deciding with which professionals the responsibility for physical health of mental health patients lies.

The same report suggests that:

“In light of this evidence, the government’s health inequality agenda should broaden its indicators of disadvantage to include mental illnesses and learning disability. In particular, as recommended by the Disability Rights Commission people with learning disabilities and mental health problems should be screened for, and receive, appropriate physical healthcare. This includes ensuring that current policy initiatives such as the annual physical health check for people with a learning disability are realised in practice”

The Quality and Outcomes Framework in Primary Care has a number of indicators for primary care providers to monitor the physical health of those with an SMI – this is discussed further in the Activity section.
3.8 Service User Perspectives on Need

Nationally, the contribution of service users and carers to our understanding of mental health needs has been growing. In Plymouth, service users and carers are key stakeholders in the assessment of need and the development of strategy.

Important themes which emerged from service user consultations around need for resources and services in Plymouth are identified below:

- The need for shared values, principles and ground rules between service users and services
- Engagement approach and strategy
- Sharing information and communications
- Anti-discrimination and stigma
- Recovery approach
- Promoting protective factors for positive mental health and well-being at all levels
- Reducing risk factors for poor mental health and well-being

3.8.1 Service User Perspectives on Community Mental Health Services in Plymouth

The Care Quality Commission 2011 Survey of Users of Plymouth Teaching PCT (as it was, now Plymouth Community Healthcare) community mental health services reported that overall, satisfaction with this service was average compared to other Trusts across the country. Local services scored well on supporting users in finding accommodation, in having regular care reviews and a crisis plan. The lowest score was around access to talking therapies.

The scores in each area are given on the next page, compared to the national average scores, with some explanation on what the sections contained.

1. 6.5/10
   Talking Therapies
   
   This section was about whether the service user could access talking therapies and whether they were useful. The individual scores are not given for this section.

2. 8.7/10
   Health and social care workers
This section contained questions on how well staff listened, involved patients and treated them with respect and dignity. The best score in this section was 9.4/10 for being treated with respect and dignity; the lowest score was 8.2/10 for having trust and confidence in staff – although this is still a high score.

3. 7.4/10 Medications

This section involved questions about how well informed patients felt about their medication in terms of general information, side effects and purpose; as well as how involved they felt and how often they had reviews. The lowest score was 6/10 for being told about the side effects of medication, and the highest 8.5/10 indicating that service users felt well-informed about the purpose of their medication.

4. 8.5/10 Care Coordinator

This section asked about whether service users knew who their care coordinator was, whether they were able to contact them and how well organised they were. All of these scored over 8/10.

5. 7.1/10 Care Plan

This section asked questions about the care plan, such as whether the service user had one, how much they were involved in and understood it and the goals for the plan. The Trust scored higher than average for patients having a care plan and a crisis plan. The lowest score in this section was 6.3/10 for feeling that the service plan set useful goals.
6. 7.9/10
Care review

This section covered the care review; whether service users had one every 12 months, how helpful it was, how prepared and supported they were for it and how much they could express their views. Again, there were higher than average scores for actually having a review and for being able to bring support.

7. 6.9/10
Crisis Care

The Crisis care section asked about having out of hours contact numbers, how easy it was to get through to staff and how helpful they were. The lowest score was 5.8 for having a number to get through to local out of hours teams; however 7.6/10 was the score for being able to get through to someone.

8. 6.2/10
Day to Day Living

Here service users were asked about the support they received with benefits, accommodation, employment, physical health needs and care responsibilities.

Overall this section scored better than the national average, especially in support with accommodation.

9. 6.8/10
Overall
3.9 Summary

Plymouth’s Protective Factors
The City benefits from a number of factors which promote good mental health and well-being, such as:

- Most residents are satisfied with access to green space and parks in the City
- A number of regeneration initiatives aimed at improving housing and the built environment (although these can also have adverse impacts on mental health)
- A better record of GCSE passes than many socio-economic comparator cities; along with a thriving higher education sector
- A good history of providing for some at-risk groups such as looked after children and care leavers

Plymouth’s Risk Factors
There are a number of population level risk factors for poor mental health in the City; and in some areas residents of Plymouth are more likely to experience these compared to the national average:

- High levels of socio-economic deprivation; and increased numbers of people in receipt of all benefits, in particular incapacity benefit
- Levels of health inequality between neighbourhoods are greater than the national average
- Increased rates of violent crimes including sexual offences are likely to have an impact on the mental health and well-being of residents
- A significant number of families are classed as vulnerable and experience risk factors such as violence within the family, particularly in more deprived areas
- The physical health of people in Plymouth is worse than the national average; and the prevalence of long-term conditions such as diabetes and CHD is higher than in some comparator cities
- Alcohol and drug dependence are important issues for Plymouth; over 10,000 people are estimated to be alcohol dependent; and alcohol consumption and admission figures are greater than average

Mental Health Problems in Plymouth
- Over 40,000 people are likely to have a common mental health problem such as depression and anxiety, although only half may need specialist treatment
• Dementia services and carer support will be increasingly needed, especially amongst the over-80 age group as this population expands

• The number of hospital attendances for self-harm has been growing, and over twice as many came from the most deprived neighbourhoods as compared to the least deprived

**Overall Picture**

Plymouth is likely to face an increased level of need relative to population size, heavily influenced by its relatively disadvantaged economic position. The inequalities between the most and least deprived areas also pose a great challenge.

There are positives in terms of the overall performance of community services as rated by service users, and a number of protective factors which can be built upon. In order to address the risk factors for poor mental health and well-being, an approach is needed to address all these varied determinants such as employment, education, housing and early years support for vulnerable families.

There are also a number of at-risk groups where more must be known in order to be able to better address their mental health needs.

**Need: Gaps and Recommendations**

**Gaps in Information and Intelligence**

• Information relating to the needs of the key at-risk groups is not as comprehensive as desired. Without detailing every gap, there are some specific areas where more information is required as a priority:

  o Information on the mental health needs of women during pregnancy and after childbirth is lacking in this Needs Assessment. There are no specific figures on the numbers with mental health problems, or the number accessing services in Plymouth. There is also a lack of knowledge about the range of City and out-of-City services available for this group.

  o The mental health needs of service families and ex-service personnel have not been fully assessed, due to a need for more information about the numbers of both groups resident in the Plymouth area. There is also an opportunity to confirm exactly what services and resources exist for this group to see if this meets the need identified.
Further information is required on the numbers of people who are lesbian, gay, bisexual and/or transgender in Plymouth; and whether they are accessing services equitably.

Information is also needed on the size of the offender and ex-offender population in Plymouth to confirm whether the services identified are adequate to meet the needs of this group.

Whereas a range of services available for BME groups, refugees and asylum seekers have been identified, information about the specific needs of these groups locally is lacking.

There is a lack of information in this Needs Assessment about the numbers of 16-18 year olds with mental health problems in Plymouth. This needs assessment has only touched upon the period of transition for young people between child and adolescent mental health services and adult services. This is both in terms of their needs and of the services currently provided. Transition from Child and Adolescent Mental Health Services to adult services is a critical time when many young people are vulnerable and need appropriate pathways and support.

A significant gap, which was necessary due to limited time, is the views of professionals. Given the importance and volume of mental health problems treated in primary care – the views of primary care professionals on the need, unmet need and services they would like to see is markedly lacking.

Due to the rapid nature of this needs assessment, and the fact that the MINI-2000 index has not been updated, there is no detailed analysis of need by neighbourhood and sub locality. This Needs Assessment contains some useful information that, along with the 2009 Mental Health Atlas, provides a starting point for such analysis.

A suicide audit is usually completed annually, and the most recent is now close to completion after a gap. On-going suicide audit to identify at-risk groups and inform suicide prevention remains a priority.

**Gaps in Services**

There is a considerable need identified for physical health improvement amongst people with mental health problems, and severe and enduring problems in particular, who experience significant health inequalities. Equity in access to good-quality physical healthcare and health promotion opportunities is likely to be lacking.
The growing numbers of people with dementia in Plymouth means that there will be increasing need in this group, which may result in a gap in capacity. A large proportion of dementia goes undiagnosed, as does a high percentage of depression in older people. As well as specific services, staff working in all branches of healthcare will need to have an awareness of dementia and may require training and specialist liaison support. Around 30% of people over 60 will die with dementia, so having appropriate end-of-life care is also a necessity, which may also constitute a future gap.

This Needs Assessment has not considered in detail the mental health services and resources available within primary care. However, due to the high prevalence of common mental health problems seen in primary care, there are likely to be opportunities to optimise best practice at primary care level.

Medically unexplained symptoms (MUS) are physical symptoms which doctors are unable to explain by finding any pathology in the body. They may be due to a physical problem, but often have a psychological origin or may be related to a mental health problem. Medically unexplained symptoms are common, associated with significant distress, and can lead to unnecessary investigations or treatments which can carry risks and use many resources. MUS are not covered in this Needs Assessment and therefore constitute a potential gap. However, in 2009 a project team in Plymouth working across services and with the Sentinel CIC Referral Management Centre, produced guidance on MUS management in primary and secondary care, along with a whole systems pathway and further actions.

Recommendations

**Recommendation:** Further work is necessary to fully understand the mental health and well-being needs and service supply and requirements for the following groups as a priority:

- Women during pregnancy and in the postnatal period;
- Service families and ex-service personnel;
- People who are lesbian, gay, bisexual or transgender;
- Offenders and ex-offenders;
- BME groups, refugees and asylum seekers.

**Recommendation:** The scale of the mental health need in young people aged 16-18 is not well understood; and more analysis may be required in this area. In addition, services should act to reinforce and support the
implementation of the Child and Adolescent Mental Health Services Transition Protocol and standards in Plymouth.

**Recommendation:** Scope current work and opportunities to engage with and ascertain the views of professionals (especially in primary care) on need and gaps in services.

**Recommendation:** Along with the Mental Health Atlas, this Needs Assessment should provide a starting point for further and on-going analysis of need, supply and spend at neighbourhood and sub locality level to inform service planning on an annual basis.

**Recommendation:** On-going Suicide Audit (in progress) is needed to identify at-risk groups within the City and to monitor and inform suicide prevention measures.

**Recommendation:** A holistic approach should be taken by mental health services and resources in promoting good physical health and healthy lifestyles, targeted at those with severe and mental illness, alongside the work done in specific areas such as health checks for people taking medication such as antipsychotics, in line with the NICE guidance.

**Recommendation:** A number of services exist and are being developed with dementia care and support. It is important that capacity continues to be reviewed and expanded to meet the needs of people with dementia and their carers both now and in the future, informed by the Joint Dementia Strategy.

**Recommendation:** Service developments and commissioning decisions should reinforce/improve mental health within primary care:

- Primary care should be supported to implement the NICE Guidance on Common Mental Health Disorders Identification and Pathways to Care (May 2011);

- Primary care access to and support from A & E Mental Health Liaison and Secondary Mental Health Services.

**Recommendation:** Guidance and pathways for managing Medically Unexplained Symptoms should be supported throughout primary and secondary care, and the recommended commissioning options explored.
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4. Mental Health and Well-being Services and Resources (Supply)

4.1 Introduction

This section provides an overview of the mental health and well-being services and resources currently available in Plymouth. This is sometimes known as the ‘supply’ of services. This is important as it can show the range and emphasis of services and resources currently available and indicates where there may be duplication or under-provision in relation to the needs identified in the preceding sections of this assessment.

Not all the information on mental health and well-being services was available, and where there are gaps in what is known, these have been indicated.

4.2 Collection of Information on Services and Resources

A database was compiled to provide a picture of the full spectrum of mental health and well-being and related services and resources provided for Plymouth residents aged 18 and over.¹ Service and resource information was collected in four key areas:

1. Core Information

   - Age Criteria
   - Charge/Fee
   - Contact details
   - Geographical Area Covered
   - Length of Service Offered
   - Opening Times
   - Provider Types
   - Referral Criteria
   - Referral Process
   - Service or Resource Detail
   - Waiting Times

2. Services and Resources Categories

- Universal Services
- Targeted Community Based Services
- Specialist Mental Health Services
- Services relating to People with Lived Experience
- Commissioning and Procurement Provision
The five service and resource categories (detail below) were developed by referring to other mental health needs assessments undertaken across the UK and ensuring that the service and resource categories reflected current national and local health and social commissioning definitions.²

### Services and Resources Categories

**Universal Services**
Provision aimed at the whole population with promotion of mental health and well-being, building resilience and social capital as core components and access is open irrespective of Fair Access to Care (FACs) Criteria/Diagnosis

**Targeted Community Based Services**
Community based services targeted at vulnerable groups at risk of mental ill health including those with protected characteristics and across the full spectrum of mental of problems (mild, moderate, severe and enduring). These services are based on principles of choice, control, recovery and inclusion with prevention, early detection and intervention, and evidence based interventions as core components

**Specialist Mental Health Services**
Provision aimed at people with acute and complex mental health needs and provision aimed at people with specialist needs not ordinarily supported and within secondary care

**Services relating to People with Lived Experience**
Individual and collective service user experience and expertise including peer support and service development

**Commissioning & Procurement Services and Resources**
Key commissioning and procurement services and organisational/individual enablers

In all, a total of 238 mental health and well-being services and resources were identified, grouped and recorded.³

Data relating to the quality of the service provision and accessibility to those whose first language is not English was not included. Nor was there investigation of service provider operational policies and service specifications as part of health and social care contracts or non-general
medical services (NGMS i.e. GP services, QOF (Quality Outcome Framework) and LES (Local Enhanced Services) mental health related services).

4.3 Sources of information on Services and Resources

Services and resources information was obtained from the following sources:

- Plymouth Online Directory (POD) and Website, Plymouth County Council
- Voluntary Service Directory (2009) NHS Plymouth
- Community and Social Action Plymouth (CASAP) Directory
- Mental Health Joint Commissioning Intentions (2010/11) NHS Plymouth and Plymouth City Council
- Plymouth Mental Health Strategic Quality Improvement Partnership (SQIP) Financial Mapping Reports (2010/11)
- Community Public Health Team Annual Report, NHS Plymouth (2009/10)
- Service Provider Websites
- ‘Word of mouth’

Financial information was identified by the main commissioners of mental health and well-being services and resources and included:

- NHS Plymouth Mental Health Commissioning Team
- NHS Plymouth Public Health Commissioning Programme
- DAAT Commissioning Team (NHS Plymouth Public Health)
- Plymouth City Council Adult Services Commissioning Team

Those not included:

- Non General Medical Services (GPs)
Non-Statutory Funders

NHS Plymouth children and young people’s mental health services (16-18)

Plymouth City Council children and young people’s emotional health and well-being services (16-18)

4.3.1 Completing the Database

Most information was electronically accessed. Where services were listed on ‘advice/information directories’ links to individual provider websites often provided further and more detailed information.

Figure 19: Number of Services and Resources by Information Source (2011)

The majority of the information on services and resources was obtained from the Plymouth Online Directory (POD) and individual provider websites, however, these ‘sources’ only covered just over half of the total of services and resources identified. Information was also obtained from reports and leaflets. Although these formats seem to be used primarily to support electronic information sources, the use of hard copies as the only readily accessible information source was not uncommon, particularly in relation to health improvement and some community-based activities.
Time constraints limited the opportunity to identify the extent of duplication of information across the information sources, although this is extensively indicated, particularly in relation to voluntary and third sector services and resources.

Further, the core services and resources information was not consistently or comprehensively provided in any one information source (see Figure 20), thus requiring investigation across a number of sources and even then much of the core information was not available. However, as contact details were provided by three quarters of service and resource providers full information in all eleven areas could be obtained by contacting the providers by telephone.

There was minimal availability of information relating to specialist and secondary community based mental services and specific GP mental health interventions (e.g. assessment, QOF (Quality Outcome Framework) and LES (Local Enhanced Services) related services).

Figure 20: Core Services and Resources Information (2011)

4.4 Analysis of Plymouth Mental Health and Well-being Services and Resources

Figure 21 provides an overview of how mental health and well-being services and resources are apportioned to each of the five main service and resource categories.
Targeted community based services account for 61% of mental health and well-being services and resources. Approximately a quarter of services and resources are universal and the remaining 12% cover services and resources relating to specialist, commissioning and procurement and people with lived experience.

This overview may reflect a positive shift in the balance of service provision that is in line with national and local intentions and developments to focus on promoting mental health and well-being and meeting the needs of people with common mental health problems, as well as preventing mental ill-health.

Figure 21: Overview of Plymouth Mental Health and Well-being Services and Resources (2011)

Table 9 provides an overview of the primary functions of the services and resources identified. Information, advice and practical support make up 24% of the total services and resources identified and cross cut all five areas. Whilst it is crucial to have consistent and accessible information about all the services and resources to understand what is available and how it may help, duplication can serve to complicate and confuse as well as preventing best use of finite resources.

Access, assessment and treatment are the primary function for 10% of services and resources. These functions exist across universal, targeted community based services and specialist mental health services.
15% of services and resources focus primarily on providing emotional or practical support and counselling across the full spectrum of mental health problems (mild, moderate, severe and enduring) and vulnerable groups at risk of mental ill health, including those with protected characteristics.

17% of the services and resources identified focus on meaningful occupation (including education, training and volunteering), employment and employment related support and 15% focus on needs and support in relation to accommodation.

The majority of the ‘healthy lifestyles’ services and resources identified promote physical activity, which indicates a positive move towards promoting an integrated approach to physical and mental health and well-being.

Community and public health interventions are targeted on key neighbourhoods within Plymouth that require significant investment in order to address some of the health and social inequalities. These include: Ernsettle, Stonehouse, Barne Barton, Devonport, North Prospect and Efford. Analysis also highlighted Plymouth City Council regeneration and development priorities covering: Devonport, Millbay, North Prospect, Derriford, Central Park, City Centre, Sutton Harbour, North Plymstock and Sherford.

Table 9 shows that there are few services and resources relating to mental health and well-being promotion, literacy and education; organisational support and resilience; mentoring and coaching opportunities; and utilising the experience of people with lived experience.
Table 9: Primary Functions of the Services and Resources

<table>
<thead>
<tr>
<th>Function</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access, Assessment, Treatment</td>
<td>24</td>
</tr>
<tr>
<td>Community Resource</td>
<td>11</td>
</tr>
<tr>
<td>Meaningful Occupation (Education Training, Volunteering)</td>
<td>17</td>
</tr>
<tr>
<td>Emotional &amp; Practical Support</td>
<td>22</td>
</tr>
<tr>
<td>Information, Advice</td>
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<tr>
<td>Promoting Healthy Lifestyles</td>
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<tr>
<td>Counselling</td>
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<td>Employment</td>
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<tr>
<td>Community Resource</td>
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<td>Enabling &amp; Floating Support</td>
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<td>Housing &amp; Supported Living</td>
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<td>Development Priorities</td>
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<td>Secure &amp; High Dependency</td>
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<td>Self Help, Enabling</td>
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<td>Day Care</td>
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<td>Awareness &amp; Anti-stigma</td>
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<td>Continuing Care</td>
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<td>Advocacy</td>
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<td>Coaching</td>
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<tr>
<td>Counselling &amp; Organisational Resilience</td>
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<td>Crime Reduction</td>
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<td>Domiciliary Care</td>
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<td>Grants</td>
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<td>Mental Health &amp; Well-being Literacy &amp; Education</td>
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<td>Practical Support &amp; Enabling</td>
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<td>Rehabilitation</td>
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<td>Service User Feedback</td>
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<td>Support &amp; Enabling</td>
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</table>
4.4.1 Universal Services

Universal services are sub-divided into seven key service and resource function areas.

<table>
<thead>
<tr>
<th>Table 10: Universal Services (2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advice &amp; Information</strong></td>
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<tr>
<td>Access, Triage &amp; Referral</td>
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<td>Information Directory</td>
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<tr>
<td>Information, Advice, Practical Support</td>
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<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Community Resilience</strong></td>
</tr>
<tr>
<td>Community Resource</td>
</tr>
<tr>
<td>Grants</td>
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<tr>
<td>Information, Advice, Practical Support</td>
</tr>
<tr>
<td>Meaningful Occupation</td>
</tr>
<tr>
<td>Regeneration (covering 9 priority neighbourhoods)</td>
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<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>MH &amp; WB Literacy &amp; Education</strong></td>
</tr>
<tr>
<td>Awareness &amp; Anti-stigma</td>
</tr>
<tr>
<td>Information, Advice, Enabling</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>MH &amp; WB Promotion</strong></td>
</tr>
<tr>
<td>Healthy Lifestyles</td>
</tr>
<tr>
<td>Healthy Eating</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Organisational Support &amp; Resilience</strong></td>
</tr>
<tr>
<td>Information, Advice, Practical Support</td>
</tr>
<tr>
<td>Workforce</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Support</strong></td>
</tr>
<tr>
<td>Coaching</td>
</tr>
<tr>
<td>Counselling</td>
</tr>
<tr>
<td>Self Help, Enabling</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Promotion of Protective Factors/Individual Resilience</strong></td>
</tr>
<tr>
<td>Alternative Therapies</td>
</tr>
<tr>
<td>Community Resource</td>
</tr>
<tr>
<td>Counselling</td>
</tr>
<tr>
<td>Day Care</td>
</tr>
<tr>
<td>Employment</td>
</tr>
<tr>
<td>Healthy Lifestyles</td>
</tr>
<tr>
<td>Information, Advice, Practical Support</td>
</tr>
<tr>
<td>Meaningful Occupation</td>
</tr>
<tr>
<td>Self Help, Enabling</td>
</tr>
<tr>
<td>Support &amp; Enabling</td>
</tr>
<tr>
<td>Volunteering</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
</tr>
</tbody>
</table>

Table 10 shows that 52% of the universal services and resources identified focus on the promotion of protective factors and individual resilience. Information and advice services and resources account for over a quarter of universal services and resources, with 6 specifically on information.
directories. 11% of universal services and resources focus on promoting community resilience.

Table 10 again indicates that there are limited services and resources relating to mental health and well-being promotion, literacy and education that reinforced an integrated ‘whole lifestyle’ approach and were targeted at individual, organisational and community levels and awareness across the life course, and organisational support and resilience that are universally accessible.

And whilst 63% of the universal services identified promoted protective factors and community resilience, their connection with mental health and well-being promotion and targeted community based services and consequential uptake and impact were not known.

There were no established social prescribing services or ‘time banks’ identified although there were pilots in each being set up within Plymouth.

### 4.4.2 Targeted Community Based Services

Table 11 shows the range of targeted community based services and resources currently available and indicates that 70% of targeted community based services are targeted at vulnerable groups at risk of mental ill health including those with protected characteristics and approximately 28% targeted at people with a range of mental health problems (e.g. common, moderate and serious mental health problems).
<table>
<thead>
<tr>
<th>MH Advocacy</th>
<th>Information, Advice, Practical Support</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td><strong>Community Based Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH Advocacy</td>
<td>Information, Advice, Practical Support</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td><strong>Community Based</strong></td>
<td>Access, Assessment, Treatment</td>
<td>11</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>Access, Triage &amp; Referral</td>
<td>1</td>
</tr>
<tr>
<td>Assessment &amp; Treatment</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Continuing Care</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Education, Leisure, Meaningful Occupation, Healthy Lifestyles, Social</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Emotional &amp; Practical Support, Enabling, Social</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Enabling &amp; Floating Support</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Health Promotion</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Housing &amp; Supported Living</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Information, Advice, Emotional Support</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Information, Advice, Practical Support</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Meaningful Occupation</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Mentoring</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Residential Care</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Training, Education, Volunteering, Employment</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Volunteering</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>41</td>
</tr>
<tr>
<td><strong>Community High Risk/Protected Characteristics</strong></td>
<td>Advocacy</td>
<td>1</td>
</tr>
<tr>
<td><strong>Focused Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Resource</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Counselling</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Counselling &amp; Organisational Resilience</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Crime Reduction</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Day Care</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Domiciliary Care</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Education, Leisure, Meaningful Occupation, Healthy Lifestyles, Social</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Education, Training, Volunteering</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Emotional &amp; Practical Support, Enabling</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Emotional &amp; Practical Support, Enabling, Social</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Emotional &amp; Practical Support, Enabling, Social, Employment</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Enabling &amp; Floating Support</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Health Promotion</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Housing &amp; Supported Living</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Individual &amp; Community Resilience</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Information, Advice, Advocacy</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Information, Advice, Practical Support</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>Information, Advice, Practical Support, Counselling</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Information, Advice, Practical Support, Volunteering</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>MH &amp; WB Literacy &amp; Education</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Physical Activity</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Practical Support &amp; Enabling</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Residential Care</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Social</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>103</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td></td>
<td>147</td>
</tr>
</tbody>
</table>
Table 12 provides an overview of the five primary functions provided within targeted community services. The figures broadly mirror the primary function distribution across all five services and resources categories as highlighted above.

<table>
<thead>
<tr>
<th>Table 12: Key Functions within targeted community based services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>% of Targeted High-Risk groups</strong></td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Information and Advice</td>
</tr>
<tr>
<td>Access, Assessment, Treatment⁸</td>
</tr>
<tr>
<td>Emotional/ practical support and counselling</td>
</tr>
<tr>
<td>Meaningful Occupation</td>
</tr>
<tr>
<td>Accommodation</td>
</tr>
</tbody>
</table>

There appears to be a range of targeted opportunities relating to education, training, volunteering and employment both within universal and targeted community based services in Plymouth. Duplication was evident particularly in relation to volunteering and employment support (employment related support - work based interventions and programmes, support for people to stay in work, return to work and/or gain employment). However, the extent of duplication, overlap and/or integration with other services and resources is unclear.

Also, the opportunities in relation to education and training for people using targeted mental health services seemed to be variable and disconnected, with uptake appearing to be a reflection of individual knowledge rather than a wider shared knowledge and understanding of what is available. As indicated within Universal Services, there are few opportunities within targeted community base services relating to integrated mental and physical health and well-being promotion, literacy and education.

Social and befriending opportunities also appear very limited and there is significant scope to develop coaching, mentoring and community navigation services to support individuals’ access and use of universal services and resources promoting protective factors and individual resilience.
4.4.3 Specialist Mental Health Services

Specialist mental health service provision covers services aimed at people with acute and complex mental health needs and provision aimed at people with specialist needs not ordinarily supported and within secondary care.

Specialist mental health services account for 6% of the total of services and resources identified. Within this 46% of services and resources identified were inpatient services, 39% community crisis services and 15% tertiary services, as shown in Table 13.

<table>
<thead>
<tr>
<th>Table 13: Specialist Mental Health Services (2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Crisis Services</td>
</tr>
<tr>
<td>A&amp;E Mental Health Liaison Service</td>
</tr>
<tr>
<td>ASW Service</td>
</tr>
<tr>
<td>Crisis Accommodation</td>
</tr>
<tr>
<td>Crisis Resolution Home Treatment Team</td>
</tr>
<tr>
<td>Emergency Duty Team</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>Inpatient</td>
</tr>
<tr>
<td>Acute Inpatient Unit/Ward</td>
</tr>
<tr>
<td>Inpatient care - Older Adult Acute Assessment</td>
</tr>
<tr>
<td>Local Low Secure Service</td>
</tr>
<tr>
<td>Local Medium Secure Service</td>
</tr>
<tr>
<td>Local Psychiatric Intensive Care Unit</td>
</tr>
<tr>
<td>Regional Medium Secure Service</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>Tertiary</td>
</tr>
<tr>
<td>Community Forensic Service</td>
</tr>
<tr>
<td>Eating Disorders Service</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
</tr>
</tbody>
</table>

Table 14 shows the key functions within specialist mental health services.

<table>
<thead>
<tr>
<th>Table 14: Key Functions within Specialist Mental Health Services (2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
</tr>
<tr>
<td>Assessment &amp; Treatment</td>
</tr>
<tr>
<td>Secure &amp; High Dependency</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>Tertiary</td>
</tr>
<tr>
<td>Assessment &amp; Treatment</td>
</tr>
<tr>
<td>Information, Advice, Practical Support</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>Community Crisis Services</td>
</tr>
<tr>
<td>Access, Assessment, Treatment</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
</tr>
</tbody>
</table>
Findings from the analysis of universal and targeted community based services are applicable to individuals accessing specialist mental health services as it is assumed they are part of the pathway of care, support and recovery. It is unclear, however, how well individuals using specialist mental health services access targeted community based and universal services.

### 4.4.4 Services relating to People with Lived Experience

<table>
<thead>
<tr>
<th>Peer Support Services</th>
<th>Emotional &amp; Practical Support, Enabling, Social</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employment</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Information, Advice, Practical Support</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Service User Involvement</td>
<td>Service Improvement</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Service User Feedback</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>8</td>
</tr>
</tbody>
</table>

Table 15 indicates a limited use of the experiences and expertise of people with lived experience of mental health problems.

The six peer support services were specific to particular mental health problems and provide support relating to high risk factors (unemployment and abuse). There were two services and resources relating to service user involvement and feedback (Plymouth Involvement and Participation Service (PIPs) and the Local Involvement Network (LINK)) and none identified in relation of whole population surveys.

Overall there are significant opportunities to further scope and develop and use the expertise and knowledge of people with lived experience of mental health problems.

### 4.4.5 Commissioning and Procurement Services and Resources

Commissioning and procurement services accounted for the smallest proportion of services and resources identified.

Currently the Plymouth Mental Health Strategic Quality Improvement Partnership (MH SQIP) has commissioning, procurement and investment responsibilities for adult and older adult mental health and social care and related services and resources in Plymouth, as shown in Table 16.
However, analysis highlighted that the MH SQIP ‘remit’ does not include all mental health commissioning and procurement services and resources. For example, Drug and Alcohol Assessment and Treatment Services (DAAT) and Public Health Programmes are not included. Nor are non-statutory funding sources (Big Lottery, charitable grants etc.), top-end (i.e. 16 to 18 years) children and adolescent mental health services (CAMHS), and non-general medical services (NGMS).

| Table 16: Commissioning and Procurement Services and Key Functions (2011) |
|---------------------------------|---------------------------|
| Infrastructure                  | Community and Social Action Plymouth (CASAP) | 1 |
|                                 | Plymouth Asylum Seeker and Refugee Consortium | 1 |
|                                 | Sustainable Routes          | 1 |
|                                 | The Zebra Collective        | 1 |
| Total                           |                           | 4 |
| Strategy and Funding Source     | NHS Plymouth Mental Health Commissioning Team | 1 |
|                                 | NHS Plymouth Public Health Commissioning Team | 1 |
|                                 | Plymouth Drug and Alcohol Team (DAAT) | 1 |
|                                 | Strategic Commissioning Team, Adult Social Care | 1 |
| Total                           |                           | 4 |
| Grand Total                     |                           | 8 |

The four infrastructure services and resources identified relate to the voluntary and third sector (e.g. Community and Social Action Plymouth (CASAP), Plymouth Asylum Seeker and Refugee Consortium) and would appear very limited in light of the number and range of third voluntary and third sector service providers.

During the process of the needs assessment it became clear that there were varying levels of understanding and knowledge of the role of the Mental Health Strategic Quality Improvement Partnership (SQIP) and of key strategies, documents and processes, such as The Plymouth Mental Health and Well-being Promotion Strategy and local commissioning and governance processes.

A comprehensive search of brokerage services to support the use and uptake of direct payments was not undertaken.

4.4.6 Mental Health and Well-being Resources and Services and Client Group

Figure 22 shows the range of client groups that the mental health and well-being services and resources are primarily targeted at. Services and resources targeted at several client groups were generally included in the ‘Multiple Disabilities’ group, and whilst there were 10 bespoke gender based
services and resources, only 4 were recorded as such as the other 6 were grouped under the primary client group (homeless, substance misuse and abuse).

Figure 22: Plymouth Mental Health and Well-being Resources and Services – Client Group (2011)
It would appear that services and resources cover a wide range of vulnerable groups considered to be at risk of poor mental health (including those with protected characteristics) and exist across the full spectrum of mental health problems.

The extent of overlap and/or integration of bespoke client based services with other services and resources was unclear, particularly in relation to universal and recovery based community services (e.g. substance misuse services accessing meaningful occupation services or IAPT services etc.). There also appear to be limited discrete universal services and resources for people who have been affected by self-harm and suicide unless they can access targeted community based mental health services.

4.4.7 Services and Resources Expenditure

Knowledge of individual service costs and uptake detail did not appear to be widespread or shared consistently across mental health and well-being providers and commissioners.

The Mental Health Strategic Quality Improvement Partnership (SQIP) Financial Mapping Report and Plymouth City Council’s Market Position Statement cover NHS Plymouth and Plymouth City Council mental health investment for adult and older adult mental health and social care and related services and resources in Plymouth.\textsuperscript{9} Neither includes Drug and Alcohol Assessment and Treatment Services (DAAT) and Public Health Programmes. Nor are non-statutory funding sources (Big Lottery, charitable grants etc.), top-end (i.e. 16 to 18 years) children and adolescent mental health services (CAMHS), and non-general medical services (NGMS).

Financial information was taken from the following sources:

- Adult Mental Health Service
- Older Adult Mental Health Services
- Adult Social Care Service
- Public Health Programme
- DAAT Services

Table 17 shows the MH SQIP’s direct services investment for adults and older peoples mental health services over three main types of provider – NHS, local authorities and the non-statutory sector.\textsuperscript{10}

It shows who physically provides the service – not who commissions and pays for it. For example if a PCT or Local authority commissions a service
from a private (that is non-statutory) provider, that part of its investment will be shown under the ‘Non-statutory’ provider column. Non General medical Services (NGMs) refers to those services provided by Primary Care (GMS) but funded from the PCT’s mainstream revenue allocations.

The PCT and PCC investment in adult mental health services in 2010/11 was 79% and 19% respectively. The total combined PCT and PCC investment was £35,939,000 (including out of area investments). 30% of this investment was in non-statutory providers (including out of area treatments) and 55% on in-house PCC and PCT provision. 21% of the total investment was on out of area placements.

Just under a quarter of adult services investment is on secure and high dependency, with 15%, 14% and 9% on accommodation, clinical and access and crisis services. The PCT and PCC investment in adult mental health services in 2010/11 was 79% and 19% respectively. The total combined PCT and PCC investment was £35,939,000 (including out of area investments). 30% of this investment was in non-statutory providers (including out of area treatments) and 55% on in-house PCC and PCT provision. 21% of the total investment was on out of area placements.

Just under a quarter of adult services investment is on secure and high dependency, with 15%, 14% and 9% on accommodation, clinical and access and crisis services.

The total PCT and PCC investment in older adult mental health services in 2010/11 was £13,995,000 (including out of area investments). Half of the total investment (£7,245,000) was on residential care, 33% on specialist services (e.g. memory clinics, dementia services) and 5% on homecare.

There was no investment in mental health promotion services for either adult or older adult’s mental health services.

The total PCT and PCC investment in older adult mental health services in 2010/11 was £13,995,000 (including out of area investments). Half of the total investment (£7,245,000) was on residential care, 33% on specialist services (e.g. memory clinics, dementia services) and 5% on homecare.

There was no investment in mental health promotion services for either adult or older adult’s mental health services.
<table>
<thead>
<tr>
<th>Description</th>
<th>2010 (£000's)</th>
<th>2011 (£000's)</th>
<th>Total PCT spend</th>
<th>Total PCC spend</th>
<th>Total Out of area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Community Mental Health Team</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Access &amp; Crisis Services</td>
<td>388</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Clinical Services</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Secure and High Dependency Provision</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Continuing Care</td>
<td>349</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Services for Mentally Disordered Offenders</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total other community and hospital professional teams/specialists</td>
<td>35</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Psychological Therapy Services (non IAPT)</td>
<td>170</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Total Psychological Therapy Services (IAPT)</td>
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<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Total Home Support Services</td>
<td>46</td>
<td>487</td>
<td>0</td>
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<tr>
<td>Total Day Services</td>
<td>0</td>
<td>310</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Support Services</td>
<td>124</td>
<td>183</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Carers' Services</td>
<td>0</td>
<td>4</td>
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<td>0</td>
</tr>
<tr>
<td>Total Accommodation</td>
<td>291</td>
<td>1731</td>
<td>916</td>
<td>1225</td>
<td>0</td>
</tr>
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<td>Total Personality disorder service</td>
<td>443</td>
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<td>0</td>
<td>0</td>
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<td>Total Direct Payments</td>
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<td>212</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL WORKING AGE ADULT DIRECT COSTS</td>
<td>1846</td>
<td>2927</td>
<td>2290</td>
<td>1225</td>
<td>991</td>
</tr>
<tr>
<td>TOTAL INVESTMENT IN ADULT MENTAL HEALTH SERVICES</td>
<td>1846</td>
<td>3220</td>
<td>2290</td>
<td>1237</td>
<td>991</td>
</tr>
<tr>
<td>Total CARE FOR PEOPLE IN GENERAL HOSPITAL (OPMH)</td>
<td>0</td>
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<td>Total PRIMARY AND COMMUNITY CARE -PCS (OPMH)</td>
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<td>Total Investment in Adult</td>
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Table 18 shows the key area for potential saving opportunities and service investment for 2011/12 - as a result of the MH SQIP QIPP (Quality Innovation Productivity and Performance) Review.\textsuperscript{11}

<table>
<thead>
<tr>
<th>Service area</th>
<th>Potential Savings (£)</th>
<th>Potential Savings (%)</th>
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</thead>
<tbody>
<tr>
<td>Anti-psychotics</td>
<td>240,000</td>
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<tr>
<td>Maximise Early Intervention, Assertive Outreach and Home Treatment Services</td>
<td>9,000</td>
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<tr>
<td>Out of Area Placements</td>
<td>2.01m</td>
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<tr>
<td>Prevention, promotion and early Intervention in Primary, Community and Prison Services*</td>
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<tr>
<td>Treatment of mental health problems in the acute sector</td>
<td>210,000</td>
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<tr>
<td>Improving efficiency of secondary care to best practice levels including LOS, delayed transfers of care, skill mix, sickness</td>
<td>300,000</td>
<td>10</td>
</tr>
</tbody>
</table>

* It was noted that the review highlighted opportunities to provide the economic case for promotion, early intervention and prevention across all the QIPP recommendations.

An overview of Public health programme identified that there were no discrete mental health programme investments.

There is a Plymouth DAAT budget of £4 million for drug and alcohol treatment services. Within this there is some resource for support for the DAAT service users who have a dual diagnosis and also have mental health problems (between 30 and 70% of service users) but the amount of resource is not clearly identifiable as a separate area of expenditure.
4.5 Summary

Mental Health and Well-being Database

- Almost half of the information on services and resources was obtained from the Plymouth Online Directory (POD) and individual provider websites

- Data relating to quality of the service and accessibility to those whose first language is not English and non-general medical services (NGMS i.e. GP services, QOF (Quality Outcome Framework) and LES (Local Enhanced Services) mental health related services) was not included

- There was minimal availability of information relating to specialist and secondary community based mental services and specific GP mental health interventions

Plymouth Mental Health and Well-being Services and Resources

- Information, advice and practical support account for 24% of the total services and resources identified and cross cut all five areas

- Access, assessment and treatment are the primary functions for 10% of services and resources

- 15% of all services and resources have a primary focus on providing emotional/ practical support and counselling across the full spectrum of mental health problems and vulnerable groups at risk of mental ill health including those with protected characteristics

- 17% of all services and resources focus on meaningful occupation (including education, training and volunteering), employment and employment related support

- 15% of the services and resources focus on needs and support in relation to accommodation

- The majority of the ‘healthy lifestyles’ services and resources identified promote physical activity

- There is evidence that community resources and public health interventions are being targeted at key neighbourhoods within Plymouth to address health and social inequalities
Universal Mental Health and Well-being Services and Resources

- A quarter of mental health and well-being services and resources are universal
- Just over half of universal services and resources focus on the promotion of protective factors and individual resilience
- Information and advice services and resources accounted for over a quarter of universal services and resources with 6 specifically on information directories
- 11% of universal services and resources focus on promoting community resilience

Targeted Community Based Services

- Targeted community based services account for 61% of mental health and well-being services and resources
- 70% of targeted community based services are targeted at vulnerable groups at risk of mental ill health including those with protected characteristics
- 28% targeted community based services are targeted at people with a range of mental health problems

Specialist Mental Health Services

- Specialist mental health services account for 6% of the total of services and resources
- 46% of specialist mental health services and resources were inpatient services, 39% community crisis services and 15% tertiary services

Services relating to People with Lived Experience

- There are 6 peer support services specific to particular mental health problems and support
- There are 2 services and resources relating to service user involvement and feedback

Commissioning and Procurement Services and Resources

- The Plymouth Mental Health Strategic Quality Improvement Partnership (SQIP) has commissioning, procurement and investment responsibilities for adult and older adult mental health and social care and related services and resources in Plymouth.
• There were 4 infrastructure services and resources identified which would appear very limited in light of the number and range of third voluntary and third sector service providers

**Mental Health and Well-being Resources and Services and Client Group**

• Mental health services and resources cover a wide range of vulnerable groups considered to be at risk of poor mental health (including those with protected characteristics) and across the full spectrum of mental health problems

**Plymouth Mental Health and Well-being Services and Resources**

**Expenditure**

• The PCT and PCC investment in adult mental health services in 2010/11 was 79% and 19% respectively. The total combined PCT and PCC investment was £35,939,000 (including out of area investments). 30% of this investment was in non-statutory providers (including out of area treatments) and 55% on in-house PCC and PCT provision. 21% of the total investment was on out of area placements

• Just under a quarter of adult services investment is on secure and high dependency, with 15%, 14% and 9% on accommodation, clinical and access and crisis services

• The total PCT and PCC investment in older adult mental health services in 2010/11 was £13,995,000 (including out of area investments). Half of the total investment (£7,245,000) was on residential care, 33% on specialist services (e.g. memory clinics, dementia services) and 5% on homecare

• There is a Plymouth DAAT budget of £4 million for drug and alcohol treatment services. Within this there is some resource for support for the DAAT service users who have a dual diagnosis and also have mental health problems (between 30 and 70% of service users) but the amount of resource is not clearly identifiable as a separate area of expenditure
Supply: Gaps and Recommendations

Gaps in Information and Intelligence

- A comprehensive search of brokerage services to support the use and uptake of services was not undertaken and represents a gap in knowledge.

- Core information relating to mental health and well-being services and resources was not consistently or comprehensively provided in any one of the information sources. There was extensive duplication of information across the sources, particularly in relation to voluntary and third sector services and resources. The use of hard copies as the only readily accessible information source was not uncommon (particularly in relation to health improvement and some community-based activities).

Gaps in Services and Resources

- The supply analysis identified that there were limited services and resources relating to mental health and well-being promotion, literacy and education that reinforced an integrated ‘whole lifestyle’ approach and were targeted at individual, organisational and community levels and awareness across the life course.

- 63% of the universal services identified promoted protective factors and community resilience. The uptake of these universal services by those using targeted community based and specialist mental health services was not known.

In many practices, the level of prescribing of antidepressants, anxiolytics and hypnotics was higher than the national average. Social prescribing links people with non-medical sources of support within the community. It may be used for clinical populations to reduce symptoms and for at risk groups to promote well-being or prevent mental illness (e.g. books on prescription, arts and creativity, reading groups, befriending, mutual aid and self-help).

- The supply analysis indicated that there is a range of targeted opportunities relating to education, training, volunteering and employment both within universal and targeted community based services in Plymouth. Duplication was evident particularly in relation to volunteering, employment support and employment related support. This includes work based interventions and programmes, support for people to stay in work, return to work and/or gain employment. However, the extent of duplication, overlap and/or integration with other services and resources is unclear.

Also, the opportunities in relation to education and training for people using targeted mental health services seemed to be variable and
disconnected, with uptake appearing to be related to personal recommendation or word of mouth rather than a wider shared knowledge and understanding of what is available.

- The supply analysis identified that there is significant scope to develop community navigators, coaching and mentoring services to support individuals’ access and use of universal services and resources promoting protective factors and individual resilience and achievement of life goals.

- Social and befriending opportunities for working age adults appear very limited, across the spectrum of services but particularly for people with serious mental health problems.

- There are particular issues for consideration in relation to specialist mental health services that have not been fully addressed within this needs assessment. These relate to the following questions:
  - Are inpatient services and resources adequate and proportionate to the need, and are specialist services and resources available for groups such as adults with Autistic Spectrum Disorders and adult ADHD?
  - Have all alternatives to inpatient services and resources been considered (e.g. peer supported community crisis accommodation)?
  - Are inpatient services recovery focused and do they reflect a recovery-based approach?
  - Is the balance of investment in services and resources out-of-city proportionate to the need for City based services and resources?

- There is a need to fully understand the range of older people’s liaison psychiatry services offered in the general hospital and to primary care, given the rising prevalence of dementia in Plymouth; and the extent of undiagnosed dementia and depression in this population.

- There are significant opportunities to further scope and develop approaches and increase the utilization of the expertise and knowledge of people with lived experience of mental health problems

- Understanding of the Plymouth mental health and well-being strategy, commissioning and governance processes, Plymouth need and current evidence base, the role/support of the Mental Health Strategic Quality
Improvement Partnership and the Plymouth Mental Health Provider Network appeared to be inconsistent across providers.

- The extent of overlap and/or integration of bespoke client based services with other services and resources was unclear, particularly in relation to universal and recovery based community services (e.g. substance misuse service users accessing meaningful occupation services or IAPT services etc.)

- There appears to be limited targeted services and resources for people who have been affected by self-harm and suicide. The targeted services need to be in areas where there is the greatest need.

- A comprehensive mental health and well-being commissioning and investment ‘picture’ was not captured. Currently, Drug and Alcohol Assessment and Treatment Services (DAAT) and Public Health Programmes are not included. Nor were non-statutory funding sources (Big Lottery, charitable grants etc.), top-end (i.e. 16 to 18 years) children and adolescent mental health services (CAMHS), and non-general medical services (NGMS). Further, knowledge of individual service costs and uptake detail did not appear to be known and shared consistently across mental health and well-being providers and commissioners.

- An opportunity to develop and provide the economic case for prioritised mental health promotion across the life course that is supported by adequate resource investment was identified. Currently there is no investment in mental health promotion services for either adult or older adult’s mental health services nor are there any discrete public mental health programme investments.

In addition, there were no locally determined mental health promotion and suicide prevention metrics or whole population mental health and well-being surveys identified to monitor the impact of investment.

**Recommendations**

**Recommendation:** Map and identify gaps and ensure brokerage services and support are proportionate to the needs of people with mental health problems on direct payments. Plymouth City Council aims to ensure the uptake of direct payments by all adult mental health service users by 2014. Therefore appropriate (and where necessary bespoke) support services will need to be in place.
**Recommendation:** One Plymouth health and well-being service/resource directory that includes key information (as identified in this assessment) on all mental health and well-being services and resources. It is recommended that the Plymouth Online Directory (POD) be developed and extended to deliver this. It is further recommended that key information include:

- Core information areas (including the eleven used in this assessment, clarity about whether the service is accessed by assessment and options for potential service users to be accompanied by carers etc… at assessment);
- Downloadable leaflets (available in relevant English and non-English speaking languages);
- A Plymouth health/social care recognized/shared ‘quality’ mark;
- Options to rate the directory and provide a review of the services;
- A discrete mental health and well-being service ‘navigation’ diagram and a ‘who’s who and who does what’ in developing, commissioning, procuring and providing mental health and well-being services;
- Key local and national strategy documents

**Recommendation:** Develop a Plymouth-wide mental health and well-being marketing approach (including the use of social media/website) to optimise mental health and well-being knowledge and understanding as well as relevant use of services and resources. This would help to pool best practice and local expertise as well as limited resources.

**Recommendation:** Develop a Plymouth Mental Health and Well-being Promotion and Recovery Campaign that is integrated with national promotional programmes and existing local initiatives (e.g. Time to change, Five Ways to Well-being, Mind Apples, population level suicide awareness training and intervention, school based awareness, education and interventions). It also should be integrated with physical health improvement outcomes (diet, exercise, alcohol, and smoking) and targeted at high risk groups and neighbourhoods, as identified in this needs assessment.

**Recommendation:** Mental health and lifestyle advice should be routinely and opportunistically offered in primary care and other health and well-being settings, with a focus on diet, exercise, alcohol, smoking and strengthening individual resilience (Five Ways to Well-being).

**Recommendation:** Target and deliver mental health and well-being and recovery awareness sessions e.g. Mental Health First Aid (MHFA) and
Wellness and Recovery Action Plan (WRAP) to key organisations/‘gatekeepers’ of services and high risk/priority groups.

**Recommendation:** Reinforce and expand the range of support and treatment offered (directly and via referral) to individuals presenting at primary care:
- Signposting to universal and targeted community services for social support (housing, financial management, bereavement, relationship difficulties, employment and volunteering and legal support);
- Develop a social prescribing approach across Plymouth (building on current pilot in North Prospect);
- Optimizing the use of IAPT services.

**Recommendation:** Reinforce individual and community resilience through the development of a co-ordinated network of Time banks.

**Recommendation:** Support the development of a co-ordinated local evidence base to demonstrate the impact and outcomes of services and resources that promote individual and community resilience.

**Recommendation:** Scope and develop a Plymouth mental health and well-being employment/meaningful occupation and employment support pathway to join up, co-ordinate and streamline services and resources and so improve access and uptake. The pathways should aim to:

Map & identify gaps in current provision & best practice that helps to promote & manage people’s MHWB at work & those with health conditions & disabilities stay in work &/or return to work;

Map, identify gaps & develop current provision & best practice that helps to promote & support people with mental health problems to gain & sustain employment;

Involve education, training, volunteering and employment and work based support (including workplace screening for depression and anxiety disorders; professional workplace champions to support workforce and negotiation of workplace systems)

**Recommendation:** Scope and develop ways to formally join up and co-ordinate community based recovery services and resources (to include brief therapeutic and psycho/social interventions and employment/meaningful
occupation opportunities) either literally (Plymouth Recovery college) and/or virtually (Recovery Curriculum).

**Recommendation:** Develop and pilot the role and use of community navigators, mentors and coaches for people with mental health problems to support recovery.

**Recommendation:** Scope and develop a co-ordinated mental health befriending programme across the age range.

**Recommendation:** Further analysis to provide a more comprehensive understanding of specialist mental health services and their response to local need is required. This should be in conjunction with current service development and QIPP work streams.

**Recommendation:** The provision of liaison services for older people offering diagnosis, assessment and management should be expanded and supported in line with current national and local guidelines. This should be supplemented by appropriate staff training and development.

**Recommendation:** Expand and develop sustainable and systematic Plymouth wide user involvement service development networks to promote mental health and well-being, improve practice (including transitions between services) & develop recovery focused services and monitor and measure impact of involvement

**Recommendation:** Develop workplace mental health support groups (and ‘buddying’ system) for people who have experience of mental ill health or having supported people with mental ill health.

**Recommendation:** Develop sustainable & systematic opportunities to use employees with lived experience expertise to improve workplace practice and develop recovery focused workplace environments.

**Recommendation:** Increase opportunities for accessible self-help and peer support programmes.

**Recommendation:** Best practice discussions should take place amongst mental health stakeholders – an appropriate forum may be the Mental Health Provider Network. It is recommended that this include:

- Information on Plymouth MH strategic and governance structures across commissioning, procurement and provision;
- Support to develop mental health and well-being evidence based business cases;
- Provide legitimate commissioning context for setting priorities, using data, metrics, comparative, cost effective, evidenced based information.

**Recommendation:** Support the MH SQIP QIPP programme in the development of clinical pathways across spectrum of mental health and well-being.

**Recommendation:** Map and identify gaps and develop services and resources to support people who have been affected by self-harm and suicide or attempted suicide (including people who self-harm and carers).

**Recommendation:** Increase knowledge and awareness of interventions and approaches for working with people who self-harm or are affected by self-harm within universal and targeted community services.

**Recommendation:** Establish a comprehensive picture and understanding of Plymouth mental health and well-being investment across all services and resources areas through reviewing current MH SQIP investment alongside key areas identified as omissions.

**Recommendation:** Develop a business case for mental health promotion in Plymouth to support discrete investment.

**Recommendation:** Develop mental health and well-being and recovery metrics at individual, community, organisational and city-wide levels.

**Recommendation:** Consider the feasibility of undertaking a Plymouth wide (WEMWBS) survey in line with current national direction developments.
References

1. Key services covering young people from age 16 were included


3. See Appendix 5 to view full database

4. See Appendix 5 to view full database

5. Search Categories: mental health, service user, health and well-being, disabilities

6. For purposes of this table analysis only, Plymouth development priority areas are divided into the seven giving a revised services and resources total of 244

7. These groups include survivors of childhood sexual abuse; domestic violence; homeless people; unemployed; carers; people with long term conditions (LTC) including serious mental illnesses; minority ethnic groups (BME); asylum seekers and refugees; gypsies and travellers; lesbian, gay, bisexual and trans gender people (LGBT); people with disabilities; age and gender

8. Targeted high-risk groups would use the access, assessment and treatment services and resources housed within universal and targeted community base and specialist mental health services


11. The Quality, Innovation, Productivity and Prevention programme is a national Department of Health strategy involving all NHS staff, patients, clinicians and the voluntary sector. It aims to improve the quality and delivery of NHS care while reducing costs to make £20bn efficiency savings by 2014/15. These savings will be reinvested to support the front line
5. Mental Health Service Activity and Uptake

5.1 Introduction

This section of the needs assessment aims to describe the current activity within mental health and well-being services and resources within Plymouth, in terms of how many people are using services and what type of people these are, where possible. For example, prescriptions for antidepressants or number of contacts with mental health services are included in this section. This is sometimes known as ‘demand’. Some of this section contains updated data from the 2009 Mental Health Atlas; where any differences in the updated data are significant these will be discussed.

As with other sections, not all the information on activity was available for a rapid assessment, and where there are gaps in what is known, these have been indicated. Activity has also been mapped where practicable to the domains below:

- Universal services
- Targeted Community based services
- Specialist mental health services
- People with lived experience

The particular areas where activity information has been gathered are:

- Activity in private and third sector providers
- Improving Access to Psychological Therapies Programme (IAPT)
- Mental Health Prescribing
- Quality and Outcomes Framework Mental Health Indicators in Primary Care
- The Mental Health Minimum Dataset
- Provider Performance Book
- Emergency Mental Health Admissions

Gaps

There is a particular gap regarding what information has been gathered for this needs assessment on activity in some universal and targeted community services. This is partly due to the very large and diverse provision in this area – i.e. there are many different agencies providing universal services which are
to do with mental health and well-being, and gathering activity data from each of these would constitute a long piece of work.

5.2 Activity in non-statutory providers

- Includes: Universal and targeted community based services

There remains a gap in terms of information about activity of private and third sector providers; although some numbers from services commissioned by Adult Social Care have been given below. Activity in terms of services users per year for some examples is given below, the rest of which is given in the Appendix:

- Peace of Mind run by MIND (Universal provider offering advice and information): 1249 enquiries
- Plymouth Guild Mental Health and Well-being Advocacy Service (Targeted community service providing advice and information): 105
- The Spring Resettlement Service (Targeted community based providing housing and supported living): 59
- Disability and Carers Advice and Support (DIAC – targeted community based service): 1,153 services users with a mental health problem.

5.3 Improving Access to Psychological Therapies (IAPT)

- Includes: Targeted community based services

The IAPT programme was established to improve access to NICE compliant psychological interventions to people with common mental health problems, principally depression and anxiety disorders. The activity of the IAPT programme in Plymouth for 2010/2011 is described below; a full evaluation of the IAPT programme in Plymouth is under way.

- 5362 people referred for psychological therapies
- 3202 people entered psychological therapies
- 1396 completed treatment
- 106 people moving off sick pay and benefits (who were on benefits/sick pay at start but not at the end)
- 486 ‘moving to recovery’ (this indicator is defined as: of those who
completed treatment, the numbers of those who at initial assessment achieved "caseness", i.e. had significant symptoms and at final session did not)

As of November 2011, the average wait for treatment in the Plymouth IAPT programme was 6.6 weeks, with almost 600 people on the waiting list.

5.4 Mental Health Prescribing

- Includes: Targeted community based services and specialist mental health services

This section describes the prescribing of mental health medication across NHS Plymouth. The prescribing amounts are weighted to allow comparison with national averages and between GP practices. The specific terms used in the graphs are explained below:

**ADQ (Average Daily Quantities)**
This is a volume indicator measuring 'treatment activity' using the assumed average maintenance dose for a drug used for its main indication in adults.

**STAR-PU (Specific Therapeutic group Age-sex Related Prescribing Units)**
This is a measure of the number of prescribing units in a cohort of patients reflecting 'prescribing need' and based on age, sex and number of temporary residents with adjustment for differences in prescribing in a particular therapeutic group.

**ADQ per STAR-PU (ADQ/STAR-PU)**
This is a nationally developed indicator for weighted prescribing volume in a specific therapeutic area. It is independent of the cost of the drugs prescribed

5.4.1 Antidepressant prescribing

Antidepressant prescribing includes all drugs classified this way by the British National Formulary (BNF), such as Fluoxetine (Prozac). Antidepressant drugs are used to treat depression, anxiety and other mental health conditions.

**Trends**
Figure 23 displays trends in antidepressant prescribing over time, compared with the national average. Whilst prescribing nationally and in NHS Plymouth has risen over time, the weighted volume prescribed is greater in Plymouth, which may reflect greater need, different prescribing practices or lack of
access to alternatives such as psychological therapies. It can be seen that weighted volume prescribed in Plymouth continues to rise from the previous figures given in the 2009 Atlas.

**Figure 23: Antidepressant prescribing over time for NHS Plymouth compared to national average**

![Comparison of weighted volume (ADQ/STAR-PU) Antidepressants for NHS Plymouth and National](chart)

**Prescribing by practice**

Figure 24 displays the volume of antidepressants prescribed by practice in NHS Plymouth, grouped by sub-locality, compared with the PCT average (shown by the pink line) and the national average (shown by the black line) for 2010/2011. Generally, practices in the North West and South West of the City, which contain some of the most deprived neighbourhoods, appear to prescribe more antidepressants than average. One practice, Freedom Health Centre, provides shared care support for people with problematic drug and alcohol use, which may account for the high prescribing seen in the following charts.
Figure 24: Prescribing by practice in Plymouth compared to PCT and national average

Comparison of weighted volume (ADQ/STAR-PU) of antidepressants NHS Plymouth GP practices 2010/2011

### 5.4.2 Anxiolytic prescribing

This includes prescriptions from section 4.1.2 of the BNF, referred to as anxiolytic or anti-anxiety medications. An example of these drugs are the benzodiazepines, which are used for treating anxiety but also carry a risk of dependence.

**Trends**

As with antidepressant prescribing, NHS Plymouth prescribes more than the national average. However, as can be seen in Figure 25, prescription of these drugs has remained steadier over time.
Figure 25: Anxiolytic prescribing over time for NHS Plymouth compared to national average

Prescribing by practice

Figure 26 displays anxiolytic prescribing by GP practice, compared to PCT (pink line) and national (black line) averages. Again, more anxiolytics appear to be prescribed by practices in the deprived South West of the City, although one practice in the South East appears to prescribe the most.
Figure 26: Prescribing by practice in Plymouth compared to PCT and national average

Comparison of weighted volume (ADQ/STAR-PU) of anxiolytics prescribed across NHS Plymouth GP practices 2010/2011

5.4.3 Hypnotic prescribing

Hypnotics are drugs used to treat insomnia, for example, Zopiclone, and certain benzodiazepines. They should also be used with caution as dependence and tolerance can occur. Insomnia can occur with different mental health and non-mental health conditions.

More hypnotics are prescribed in NHS Plymouth than the national average, but the trend in prescribing is downward.

Prescribing by practice

Figure 27 is similar to the charts for antidepressant and anxiolytic use. It can again be seen that the South West sub-locality has relatively high levels of hypnotic prescribing, although there are a number of practices elsewhere where hypnotic prescribing is well above the local and national weighted average.
5.5 Primary Care for people with Mental Health problems: 
Quality and Outcomes Framework Indicators

- Includes: targeted community based services

The Quality and Outcomes Framework, also known as QOF, contains groups of indicators, against which practices score points according to their level of achievement. QOF contains a number of indicators which relate to how practices look after the physical health of their patients with mental health conditions, and whether they have care plans and regular reviews. The performance of practices in NHS Plymouth against three of these indicators is discussed below.

**MH 6**: The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate.
• All NHS practices achieved at least 70% on this indicator, with 9 out of 42 scoring 100%
• The PCT total was 88.65%

**MH 4:** The percentage of patients on lithium therapy with a record of serum creatinine and Thyroid Stimulating Hormone (TSH) in the preceding 15 months.

• 40 out of 42 practices scored 100% on this indicator
• The PCT total was 99.24%

**MH 9:** The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the preceding 15 months. In the review there should be evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status.

• 12 practices scored 100% on this indicator
• All achieved at least 62%
• The PCT average was 92%

### 5.6 The Mental Health Minimum Dataset

• Includes targeted community based services and specialist mental health services

#### 5.6.1 Background

The mental health minimum data set (MHMDS) is designed to show the detailed patterns of care received by individuals looked after by specialist mental health care providers in England. Each mental health provider trust makes quarterly and annual returns documenting the care they have provided to individual patients. The MHMDS is intended to provide a comprehensive overview of all the types of staff contact, assessment and care received by individuals and is designed to draw together data from all available sources.

The information in this section is based on an analysis of activity relating to the 7197 individual patients who came into contact with NHS Plymouth's mental health services in the financial year 2010/2011. The more detailed analysis is based on the 6451 of them who were Plymouth residents. The 2009 Mental Health Atlas examined the 2008/2009 Mental Health Dataset. Since then, a new deprivation grouping has been introduced, making
comparison difficult; however where there are interesting differences from
2008/2009 these will be highlighted.

5.6.2 Patients by deprivation group and gender

Table 19 shows the number of patients by deprivation group within the City, using the new IMD 2010 groupings. The highest percentages of patients using mental health services were from the middle and most deprived groups.

Table 19: Patients by IMD 2010 deprivation grouping

<table>
<thead>
<tr>
<th>IMD 2010 groupings</th>
<th>Male</th>
<th>Female</th>
<th>Persons</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most deprived (8)</td>
<td>814</td>
<td>788</td>
<td>1,602</td>
<td>24.8</td>
</tr>
<tr>
<td>Upper middle (9)</td>
<td>576</td>
<td>787</td>
<td>1,363</td>
<td>21.1</td>
</tr>
<tr>
<td>Middle group (9)</td>
<td>759</td>
<td>887</td>
<td>1,646</td>
<td>25.5</td>
</tr>
<tr>
<td>Lower middle (9)</td>
<td>331</td>
<td>530</td>
<td>861</td>
<td>13.3</td>
</tr>
<tr>
<td>Least deprived (8)</td>
<td>394</td>
<td>585</td>
<td>979</td>
<td>15.2</td>
</tr>
<tr>
<td>Plymouth City</td>
<td>2,874</td>
<td>3,577</td>
<td>6,451</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 20 displays the percentage of patients by gender from each deprivation group. Overall, a higher percentage of patients were women, 55.4%; and this difference was most marked in the lower middle and least deprived areas of the City, where women were 61.6% and 59.8% of patients respectively. In contrast, in the most deprived grouping, the genders were more evenly balanced, with only 49.2% of patients being female.

Table 20: Patients by deprivation group and gender

<table>
<thead>
<tr>
<th>IMD2010 Groupings</th>
<th>Male (%)</th>
<th>Female (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most deprived (8)</td>
<td>50.8</td>
<td>49.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Upper middle (9)</td>
<td>42.3</td>
<td>57.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Middle group (9)</td>
<td>46.1</td>
<td>53.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Lower middle (9)</td>
<td>38.4</td>
<td>61.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Least deprived (8)</td>
<td>40.2</td>
<td>59.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Plymouth City</td>
<td>44.6</td>
<td>55.4</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 21 shows the number of patients per 10,000 resident population aged 16+ years of age by deprivation group. The highest rates appear to be from the most deprived areas of the City. The overall rate of patients per 10,000 population was lower than in 2008/2009 at 237.5 per 10,000 compared to 263.4 per 10,000 in 2008/2009. Interesting, the rate for patients in the least deprived third in 2008/2009 was the lowest of all groups at 224.6 per 10,000. In the table below where deprivation is divided into fifths, it can be seen that the least deprived fifth in 2010/2011, have a higher rate than the middle and lower middle deprivation groups at 260.7 per 10,000.

Table 21: Patients (crude rate per 10,000) by deprivation group

<table>
<thead>
<tr>
<th>IMD 2010 groupings</th>
<th>Patients</th>
<th>Pop 16+</th>
<th>Crude rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most deprived (8)</td>
<td>1,452</td>
<td>41,909</td>
<td>346.5</td>
</tr>
<tr>
<td>Upper middle (9)</td>
<td>1,368</td>
<td>41,828</td>
<td>327.1</td>
</tr>
<tr>
<td>Middle group (9)</td>
<td>1,489</td>
<td>58,156</td>
<td>256.0</td>
</tr>
<tr>
<td>Lower middle (9)</td>
<td>5,063</td>
<td>256,438</td>
<td>197.4</td>
</tr>
<tr>
<td>Least deprived (8)</td>
<td>975</td>
<td>37,403</td>
<td>260.7</td>
</tr>
<tr>
<td>Plymouth City</td>
<td>10,347</td>
<td>435,735</td>
<td>237.5</td>
</tr>
</tbody>
</table>

5.6.3 Patients by neighbourhood

Figure 28 shows the number of patients per 10,000 resident population aged 16+ years of age by neighbourhood.
- The highest rate was in Morice Town, where there were 539.7 per 10,000
- The lowest was in Egguckland, with 164.7 patients per 10,000
- In 2008/2009 the highest rate was in Stonehouse at 474.4 per 100,000, and the lowest in Widewell at 85.5 per 10,000.
Figure 28: Patients (crude rate) by neighbourhood of residence

5.6.4 Patients by sub-locality and gender

Table 22 shows the numbers of patients from each of the Plymouth sub-locality, also by gender. 28% of all patients were from the South West of the City, contrasting with only 8.4% from Plymstock. In each locality, there are more women than men as patients, the gender balance is least pronounced in the South West.

Table 22: Patients by sub-locality and gender

<table>
<thead>
<tr>
<th>Sub-locality</th>
<th>Male</th>
<th>Female</th>
<th>Persons</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central/North East</td>
<td>459</td>
<td>645</td>
<td>1,104</td>
<td>17.1</td>
</tr>
<tr>
<td>North West</td>
<td>488</td>
<td>666</td>
<td>1,154</td>
<td>17.9</td>
</tr>
<tr>
<td>Plympton</td>
<td>230</td>
<td>415</td>
<td>645</td>
<td>10.0</td>
</tr>
<tr>
<td>Plymstock</td>
<td>233</td>
<td>310</td>
<td>543</td>
<td>8.4</td>
</tr>
<tr>
<td>South East</td>
<td>553</td>
<td>619</td>
<td>1,172</td>
<td>18.2</td>
</tr>
<tr>
<td>South West</td>
<td>911</td>
<td>922</td>
<td>1,833</td>
<td>28.4</td>
</tr>
<tr>
<td><strong>Plymouth City</strong></td>
<td><strong>2,874</strong></td>
<td><strong>3,577</strong></td>
<td><strong>6,451</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

5.6.5 Patients by age group

Table 23 shows the percentage of patients in each age group for the five deprivation groups. Overall the highest percentage of patients was in the 35-44 year old age group (15.8%). This age group also accounted for the most patients in both the most deprived and upper middle group of neighbourhoods. However in the least deprived areas of the city, it is the 75-
84 year olds who represented the greatest amount of patients, showing the relative burden of mental health problems in older people in the least deprived areas of the city. In the most deprived areas this age group represent only 6.3% of patients in contrast to 25.2% in the most affluent areas.

**Table 23: – Patients (%) by age group and deprivation group**

<table>
<thead>
<tr>
<th>IMD 2010 groupings</th>
<th>&lt;16</th>
<th>16-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65-74</th>
<th>75-84</th>
<th>85+</th>
<th>All ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most deprived (8)</td>
<td>0.0</td>
<td>18.1</td>
<td>18.5</td>
<td>20.3</td>
<td>16.3</td>
<td>10.1</td>
<td>4.7</td>
<td>6.3</td>
<td>5.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Upper middle (9)</td>
<td>0.1</td>
<td>14.2</td>
<td>16.0</td>
<td>17.0</td>
<td>15.1</td>
<td>7.7</td>
<td>8.3</td>
<td>13.6</td>
<td>8.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Middle group (9)</td>
<td>0.0</td>
<td>13.7</td>
<td>16.2</td>
<td>15.4</td>
<td>12.8</td>
<td>8.6</td>
<td>7.9</td>
<td>12.9</td>
<td>12.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Lower middle (9)</td>
<td>0.0</td>
<td>7.9</td>
<td>8.2</td>
<td>12.0</td>
<td>9.2</td>
<td>7.9</td>
<td>12.1</td>
<td>23.7</td>
<td>19.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Least deprived (8)</td>
<td>0.1</td>
<td>5.9</td>
<td>9.2</td>
<td>10.8</td>
<td>10.2</td>
<td>5.9</td>
<td>14.4</td>
<td>25.2</td>
<td>18.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Plymouth City</td>
<td>0.0</td>
<td>12.9</td>
<td>14.6</td>
<td>15.8</td>
<td>13.3</td>
<td>8.3</td>
<td>8.7</td>
<td>14.7</td>
<td>11.6</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Figure 29 shows the number of patients in each age group by sub-locality. The highest absolute numbers of patients in the younger adult age groups are in the South West locality; with the highest absolute number of over-85s in Central/North East Plymouth and Plympton.

Figure 29: Patients by sub-locality and age group – absolute numbers
5.6.6 Patient contacts by deprivation and sub-locality

In total there were over 76,000 contacts with services in 2010/2011. This is less than the 90,851 total contacts in 2008/2009. The greatest proportion of contacts was with Community Psychiatric Nurses. As Table 24 shows, the highest number of contacts were from the middle and most deprived groups, with a lower proportion from the less deprived areas of the City.

Table 24: Total contacts and type of contacts by IMD-2010 Deprivation groupings

<table>
<thead>
<tr>
<th>IMD 2010 groupings</th>
<th>Community Psychiatric Nurse</th>
<th>Clinical Psychologist</th>
<th>Occupational Therapist</th>
<th>Physiotherapist</th>
<th>Consultant Psychotherapy</th>
<th>Social Worker</th>
<th>Consultant outpatient attendances</th>
<th>Total contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most deprived (8)</td>
<td>8,068</td>
<td>1,491</td>
<td>5,742</td>
<td>219</td>
<td>339</td>
<td>378</td>
<td>2,710</td>
<td>16,947</td>
</tr>
<tr>
<td>Upper middle (9)</td>
<td>6,567</td>
<td>1,572</td>
<td>5,271</td>
<td>429</td>
<td>190</td>
<td>206</td>
<td>2,292</td>
<td>16,519</td>
</tr>
<tr>
<td>Middle group (9)</td>
<td>6,790</td>
<td>1,463</td>
<td>6,948</td>
<td>808</td>
<td>146</td>
<td>250</td>
<td>2,708</td>
<td>19,113</td>
</tr>
<tr>
<td>Lower middle (9)</td>
<td>3,149</td>
<td>879</td>
<td>4,216</td>
<td>930</td>
<td>86</td>
<td>88</td>
<td>1,462</td>
<td>10,809</td>
</tr>
<tr>
<td>Least deprived (8)</td>
<td>3,017</td>
<td>1,005</td>
<td>5,077</td>
<td>670</td>
<td>26</td>
<td>86</td>
<td>1,381</td>
<td>11,262</td>
</tr>
<tr>
<td>Plymouth City</td>
<td>27,591</td>
<td>6,410</td>
<td>27,254</td>
<td>3,056</td>
<td>776</td>
<td>1,010</td>
<td>10,553</td>
<td>76,650</td>
</tr>
</tbody>
</table>

Table 25 shows that the greatest total contacts were from the South West and South East localities, with over 22,000 and 15,000 contacts respectively. The tables also display the types of contact recorded.

Table 25: Total contacts and type of contacts by sub-locality

<table>
<thead>
<tr>
<th>Sub-locality</th>
<th>Community Psychiatric Nurse</th>
<th>Clinical Psychologist</th>
<th>Occupational Therapist</th>
<th>Physiotherapist</th>
<th>Consultant Psychotherapy</th>
<th>Social Worker</th>
<th>Consultant outpatient attendances</th>
<th>Total contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central/North East</td>
<td>4,729</td>
<td>1,145</td>
<td>4,172</td>
<td>645</td>
<td>37</td>
<td>121</td>
<td>1,673</td>
<td>12,522</td>
</tr>
<tr>
<td>North West</td>
<td>4,401</td>
<td>1,295</td>
<td>2,772</td>
<td>410</td>
<td>85</td>
<td>166</td>
<td>1,865</td>
<td>10,794</td>
</tr>
<tr>
<td>Plympton</td>
<td>1,763</td>
<td>676</td>
<td>3,877</td>
<td>654</td>
<td>63</td>
<td>46</td>
<td>1,130</td>
<td>8,209</td>
</tr>
<tr>
<td>Plymstock</td>
<td>1,892</td>
<td>474</td>
<td>2,936</td>
<td>422</td>
<td>24</td>
<td>63</td>
<td>746</td>
<td>6,357</td>
</tr>
<tr>
<td>South East</td>
<td>5,729</td>
<td>1,148</td>
<td>5,819</td>
<td>466</td>
<td>381</td>
<td>252</td>
<td>2,164</td>
<td>15,959</td>
</tr>
<tr>
<td>South West</td>
<td>9,277</td>
<td>1,672</td>
<td>7,678</td>
<td>459</td>
<td>186</td>
<td>362</td>
<td>3,175</td>
<td>22,809</td>
</tr>
<tr>
<td>Plymouth City</td>
<td>27,591</td>
<td>6,410</td>
<td>27,254</td>
<td>3,056</td>
<td>776</td>
<td>1,010</td>
<td>10,553</td>
<td>76,650</td>
</tr>
</tbody>
</table>
5.6.7 Types of contact by deprivation group

Contacts from the most deprived areas were more likely to be with CPNs, psychiatrists, psychotherapists and social workers than contacts from the least deprived. 42.6% of contacts from the most deprived areas were with a CPN, as compared to only 26.8% from the least deprived. However, contacts from the least deprived areas were more likely to be with physiotherapists and occupational therapists, suggesting that these patients might be from an older age group and suffering with more physical problems.

Table 26: Percentage of contacts from each deprivation group with each type of service/professional

<table>
<thead>
<tr>
<th>IMD 2010 groupings</th>
<th>Community Psychiatric Nurse</th>
<th>Clinical Psychologist</th>
<th>Occupational Therapist</th>
<th>Physiotherapist</th>
<th>Consultant Psychotherapy</th>
<th>Social Worker</th>
<th>Consultant outpatient attendances</th>
<th>Total contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most deprived (8)</td>
<td>42.6</td>
<td>7.9</td>
<td>30.3</td>
<td>1.2</td>
<td>1.8</td>
<td>2.0</td>
<td>14.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Upper middle (9)</td>
<td>39.8</td>
<td>9.5</td>
<td>31.9</td>
<td>2.6</td>
<td>1.1</td>
<td>1.3</td>
<td>13.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Middle group (9)</td>
<td>35.5</td>
<td>7.7</td>
<td>36.4</td>
<td>4.2</td>
<td>0.8</td>
<td>1.3</td>
<td>14.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Lower middle (9)</td>
<td>29.1</td>
<td>8.1</td>
<td>39.0</td>
<td>8.6</td>
<td>0.8</td>
<td>0.8</td>
<td>13.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Least deprived (8)</td>
<td>26.8</td>
<td>8.9</td>
<td>45.1</td>
<td>5.9</td>
<td>0.2</td>
<td>0.8</td>
<td>12.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Plymouth City</td>
<td>36.0</td>
<td>8.4</td>
<td>35.6</td>
<td>4.0</td>
<td>1.0</td>
<td>1.3</td>
<td>13.8</td>
<td>100.0</td>
</tr>
</tbody>
</table>

5.6.8 Types of contact by sub-locality

Table 27 shows a number of differences between in the localities in the types of contact. More contacts from Plymstock and Plympton were with occupational therapists, and fewer contacts from these areas were with CPNs. The greatest percentage of psychology contacts was in the North West locality compared to 7.2% from the South East, and 2.4% of contacts from the South East were with a psychotherapist, compared to only 0.3% from the Central/North East sublocality. These differences may reflect different underlying presenting problems, or differences in access, or may not in all cases be statistically significant – i.e. they could be due to chance and random variation.
Table 27: Percentage of contacts from each sub-locality with each type of service/professional

<table>
<thead>
<tr>
<th>Sub-locality</th>
<th>Community Psychiatric Nurse</th>
<th>Clinical Psychologist</th>
<th>Occupational Therapist</th>
<th>Physiotherapist</th>
<th>Consultant Psychotherapy</th>
<th>Social Worker</th>
<th>Consultant outpatient attendances</th>
<th>Total contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central/North East</td>
<td>37.8</td>
<td>9.1</td>
<td>33.3</td>
<td>5.2</td>
<td>0.3</td>
<td>1.0</td>
<td>13.4</td>
<td>100.0</td>
</tr>
<tr>
<td>North West</td>
<td>40.8</td>
<td>12.0</td>
<td>25.7</td>
<td>3.8</td>
<td>0.8</td>
<td>1.5</td>
<td>15.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Plympton</td>
<td>21.5</td>
<td>8.2</td>
<td>47.2</td>
<td>8.0</td>
<td>0.8</td>
<td>0.6</td>
<td>13.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Plymstock</td>
<td>26.6</td>
<td>7.5</td>
<td>46.2</td>
<td>6.6</td>
<td>0.4</td>
<td>1.0</td>
<td>11.7</td>
<td>100.0</td>
</tr>
<tr>
<td>South East</td>
<td>35.9</td>
<td>7.2</td>
<td>36.5</td>
<td>2.9</td>
<td>2.4</td>
<td>1.6</td>
<td>13.6</td>
<td>100.0</td>
</tr>
<tr>
<td>South West</td>
<td>40.7</td>
<td>7.3</td>
<td>33.7</td>
<td>2.0</td>
<td>0.8</td>
<td>1.6</td>
<td>13.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Plymouth City</td>
<td>36.0</td>
<td>8.4</td>
<td>35.6</td>
<td>4.0</td>
<td>1.0</td>
<td>1.3</td>
<td>13.8</td>
<td>100.0</td>
</tr>
</tbody>
</table>

5.6.9 Types of patient contacts

This data is from the NHS Information Centre and includes all contacts with NHS Plymouth adult and elderly mental health services, not just those patients resident in the City.

Contacts were as follows: 13.6% psychiatrist contacts, 34.4% CPN contacts, 7.9% psychologist contacts, 37.1% OT contacts, 4.8% physio contacts, 1.0% psychotherapist contacts, 1.2% social worker contacts.

For comparison, the average for all providers is approximately 13.1% psychiatrist contacts, 54.1% CPN contacts, 7.1% psychologist contacts, 10.6% OT contacts, 1.4% physio contacts, 2.2% psychotherapist contacts, 11.5% social worker contacts.

- Plymouth mental health services appear to have a greater proportion of OT and physiotherapy contacts than the national average, and a lower proportion of psychotherapy, social worker and CPN contacts.
5.6.10 Admissions by deprivation and sub-locality

There were a total of 394 people admitted on one or more occasions in 2010/2011. The highest proportion (26.4%) was from the middle deprivation group, and the lowest (14.2%) from the least deprived, shown in Table 28. In 2008/2009 there were 425 people admitted; and here the highest proportion was from the most deprived third that made up 48.2% of all admissions.

Table 28: Number and percentage of admissions by IMD-2010 deprivation grouping

<table>
<thead>
<tr>
<th>IMD 2010 groupings</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Total</th>
<th>1+</th>
<th>% 1+ (of total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most deprived (8)</td>
<td>1,510</td>
<td>67</td>
<td>19</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1,602</td>
<td>92</td>
<td>23.4</td>
</tr>
<tr>
<td>Upper middle (9)</td>
<td>1,279</td>
<td>60</td>
<td>19</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>1,363</td>
<td>84</td>
<td>21.3</td>
</tr>
<tr>
<td>Middle group (9)</td>
<td>1,542</td>
<td>79</td>
<td>18</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1,646</td>
<td>104</td>
<td>26.4</td>
</tr>
<tr>
<td>Lower middle (9)</td>
<td>803</td>
<td>45</td>
<td>11</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>861</td>
<td>58</td>
<td>14.7</td>
</tr>
<tr>
<td>Least deprived (8)</td>
<td>923</td>
<td>44</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>979</td>
<td>56</td>
<td>14.2</td>
</tr>
<tr>
<td>Plymouth City</td>
<td>6,057</td>
<td>295</td>
<td>73</td>
<td>17</td>
<td>4</td>
<td>5</td>
<td>6,451</td>
<td>394</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Similarly, in terms of admissions from the different sub-localities, the highest percentage of admissions came from the South West of the City (30.2%), and the lowest from Plymstock (8.1%) as shown in table 29.
Table 29: Number and percentage of admissions by sub-locality

<table>
<thead>
<tr>
<th>Sub-locality</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Total</th>
<th>1+</th>
<th>% 1+ (of total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central/North East</td>
<td>1,041</td>
<td>48</td>
<td>13</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1,104</td>
<td>63</td>
<td>16.0</td>
</tr>
<tr>
<td>North West</td>
<td>1,101</td>
<td>42</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1,154</td>
<td>53</td>
<td>13.5</td>
</tr>
<tr>
<td>Plympton</td>
<td>601</td>
<td>37</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>645</td>
<td>44</td>
<td>11.2</td>
</tr>
<tr>
<td>Plymstock</td>
<td>511</td>
<td>24</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>543</td>
<td>32</td>
<td>8.1</td>
</tr>
<tr>
<td>South East</td>
<td>1,089</td>
<td>59</td>
<td>16</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>1,172</td>
<td>83</td>
<td>21.1</td>
</tr>
<tr>
<td>South West</td>
<td>1,714</td>
<td>85</td>
<td>27</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>1,833</td>
<td>119</td>
<td>30.2</td>
</tr>
<tr>
<td>Plymouth City</td>
<td>6,057</td>
<td>295</td>
<td>73</td>
<td>17</td>
<td>4</td>
<td>5</td>
<td>6,451</td>
<td>394</td>
<td>100.0</td>
</tr>
</tbody>
</table>

5.7 Provider Performance Book 2010/2011

- Includes targeted community based and specialist services

This is based on information from Plymouth Community Healthcare’s Adult Mental Health services. Looking at national data from the Mental Health Minimum Dataset, Plymouth’s performance is broadly similar to its comparators on many of these indicators. For example, local mental health services have a total bed-days per year figure of 43,919 – this is compared to 41,184 in Southampton and 45, 798 in Sheffield. A bed-day is one person occupying a bed for one day.

Inpatient hospital admissions

Figure 31 shows the number of admissions per month to adult mental health units in 2010/2011, which is in the region of 50-80 on average.

Figure 31: Inpatient Hospital Admissions to any wards
Average length of stay

Figure 32 displays the average length of stay in days in adult mental health inpatient units in Plymouth for 2010/2011

**Figure 32: Average Length of Stay**

![Average Length of Stay Chart](chart)

Emergency readmissions

Figure 33 shows the number of emergency readmissions to mental health wards for each month. An emergency readmission would be defined as a patient being readmitted within a month of their discharge from an inpatient unit.

**Figure 33: Emergency Readmissions**

![Emergency Readmissions Chart](chart)

New community referrals

Figure 34 shows the number of new mental health referrals per month on the EPEX system.

**Figure 34: New Community Referrals**

![New Community Referrals Chart](chart)
Closed community referrals
This is a count of closed community referrals per month on EPEX.

Figure 35: Closed Community Referrals

Patients on active caseload
Figure 36 displays the number of patients on active mental health caseloads by month.

Figure 36: Patients on Active Referrals

5.8 Admissions under the Mental Health Act – Plymouth Teaching PCT

Under the Mental Health Act, people with a mental disorder can be admitted to hospital and treated without their consent, if their health and safety is at risk; or if it is required for the protection of others.

In 2010/2011, 276 inpatients were formally detained under the Mental Health Act in Plymouth Teaching PCT (now Plymouth Community Health), constituting 51.5% of all inpatients. This is higher than the national average for all providers, which was 40.9% of inpatients detained under the Act. However, it is more similar to some of Plymouth’s comparators; for example in Southampton 48.2% of inpatients were detained under the Mental Health Act in 2010/11; in Sheffield the figure was 54.4%
5.9 Emergency Mental Health Admissions to Plymouth Hospitals NHS Trust

- Includes specialist mental health services

This information shows how many admissions there were, where a mental health problem was the primary or secondary diagnosis.

Figure 37 displays the emergency admissions rates by neighbourhood. Here it is possible to see that Devonport had the highest emergency admission rate, followed by Stonehouse.

Figure 37: Emergency Admissions with Primary or Secondary Diagnosis (2010/11)
5.9.1 Emergency mental health admissions by age group, deprivation group and sub-locality

- The highest admission rate is from the over-75 age group, with almost 7000 admissions per 100,000 people, as compared to 1,603 per 100,000 for all ages
- Emergency admission rates vary greatly by deprivation group and sub-locality

Table 30 shows that the highest admission rates for all ages was from the most deprived fifth, with a clear gradient down to the lowest admission rate from the least deprived. This is most marked for the under-65s. In the over-75 age group, the highest admission rates are from the middle and lower middle group, with the lowest rate in the most deprived.

Table 30: Directly age standardised emergency admission rates per 100,000 by deprivation group

<table>
<thead>
<tr>
<th>IMD 2010 groupings</th>
<th>All Ages</th>
<th>under 65s</th>
<th>Under 75s</th>
<th>Over 75s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most deprived (8)</td>
<td>2,313.6</td>
<td>2,046.3</td>
<td>2,164.8</td>
<td>5,885.3</td>
</tr>
<tr>
<td>Upper middle (9)</td>
<td>1,920.3</td>
<td>1,677.6</td>
<td>1,748.2</td>
<td>6,049.4</td>
</tr>
<tr>
<td>Middle group (9)</td>
<td>1,586.1</td>
<td>1,167.2</td>
<td>1,313.5</td>
<td>8,128.7</td>
</tr>
<tr>
<td>Lower middle (9)</td>
<td>1,099.8</td>
<td>785.1</td>
<td>847.0</td>
<td>7,166.3</td>
</tr>
<tr>
<td>Least deprived (8)</td>
<td>1,088.7</td>
<td>811.5</td>
<td>853.8</td>
<td>6,728.1</td>
</tr>
<tr>
<td>Plymouth City</td>
<td>1,603.1</td>
<td>1,300.5</td>
<td>1,382.7</td>
<td>6,892.5</td>
</tr>
</tbody>
</table>

Looking at rates by sub-locality, the highest all-age admission rate is from the South West of the City, whereas the highest for the over-75s is for Plympton.

Table 31: Directly age standardised emergency admission rates per 100,000 by sub-locality

<table>
<thead>
<tr>
<th>Sub-locality</th>
<th>All Ages</th>
<th>under 65s</th>
<th>Under 75s</th>
<th>Over 75s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central/North East</td>
<td>1,188.9</td>
<td>934.5</td>
<td>992.1</td>
<td>5,912.3</td>
</tr>
<tr>
<td>North West</td>
<td>1,691.6</td>
<td>1,465.5</td>
<td>1,540.2</td>
<td>5,324.8</td>
</tr>
<tr>
<td>Plympton</td>
<td>1,268.9</td>
<td>877.7</td>
<td>926.5</td>
<td>9,485.9</td>
</tr>
<tr>
<td>Plymstock</td>
<td>1,014.4</td>
<td>770.1</td>
<td>833.9</td>
<td>5,345.8</td>
</tr>
<tr>
<td>South East</td>
<td>1,907.9</td>
<td>1,476.1</td>
<td>1,618.9</td>
<td>8,845.7</td>
</tr>
<tr>
<td>South West</td>
<td>2,402.0</td>
<td>2,007.9</td>
<td>2,170.2</td>
<td>7,963.7</td>
</tr>
<tr>
<td>Plymouth City</td>
<td>1,603.1</td>
<td>1,300.5</td>
<td>1,382.7</td>
<td>6,892.5</td>
</tr>
</tbody>
</table>
5.10 Adult Social Care in Plymouth

Social care services provided for mental health services users or other vulnerable people in the community play an important part in promoting mental health and well-being and recovery. These services are responsible for:

- Rehabilitation, intermediate care and residential care
- Provision of direct payments and individual budgets for those managing their own social care – this is set to increase to give users more control and autonomy
- Carer assessment and support
- Other support such as employment, befriending etc…

5.10.1 Adult Social Care in Plymouth Activity and Indicators

According to the National Adult Social Care Intelligence Services (NASCIS), in Plymouth in 2010/2011, there were:

- 4230 mental health clients using social care services
- 1365 using community based services
- 725 using residential care services
- Where age was reported, 240 clients were aged 18-64 and 1745 aged 65 or over.

NASCIS publishes a number of indicators describing the performance and activity of adult social care services. A number of these are outlined below for Plymouth in 2010/2011.

NI125 (VSC04) - Achieving independence for older people through rehabilitation/intermediate care

This indicator measures the benefit to individuals from intermediate care and rehabilitation following a hospital episode. It captures the joint work of social services and health staff and services commissioned by joint teams

- Score for Plymouth: 90.9%
- This is higher than the national average and Plymouth’s comparators
NI130 (VSC17) - Social care clients receiving self-directed support (direct payments and individual budgets) 2009-2010 definition

This indicator measures the degree to which clients are receiving self-directed support to design the support or care arrangements that best suit their specific needs.

- Score for Plymouth: 30.3%
- This is higher than the national average and Plymouth’s comparators

NI135 (VSC18) - Carers receiving needs assessment or review and a specific carer’s service or advice or information (percentage)

This measure provides a measurement of engagement with, and support to, carers

- Score for Plymouth: 29.9%
- This is higher than the national average and Plymouth’s comparators

NI149 (VSC06) - Adults receiving secondary mental health services in settled accommodation (percentage)

This is a measure of accommodation outcomes for those adults in touch with secondary mental health services whose complex needs are being managed using the Care Programme Approach (‘new CPA’).

- Score for Plymouth: 52%
- This is lower than the national average and Plymouth’s comparators

NI150 (VSC08) - Adults receiving secondary mental health services in employment (percentage)

This indicator measures employment outcomes for those adults in touch with secondary mental health services whose complex needs are being managed using the Care Programme Approach (‘new CPA’).

- Score for Plymouth: 8.3%
- This is lower than the national average and Plymouth’s comparator group.
5.11 SUMMARY

IAPT in 2010/11
- 3202 people entered psychological therapies through IAPT
- 1396 completed treatment

Prescribing in NHS Plymouth
- Weighted prescribing for antidepressants, anxiolytics and hypnotics is above the national average
- Weighted prescribing of antidepressants is increasing over time
- There is a large amount of variation between practices and sub-localities in the City in terms of volume of drugs prescribed

Primary care for People with Mental Health Problems
- Practices in Plymouth scored well on physical health care of people with mental health disorders

Mental Health Minimum Dataset
- There were over 7000 individual contacts with mental health services in Plymouth in 2010/11
- 37% of contacts were with physiotherapy, and 34.4% with Community Psychiatric Nurses, 7.9% with psychologists and 13.6% with psychiatrists
- Plymouth mental health services appear to have a greater proportion of OT and physiotherapy contacts than the national average, and a lower proportion of psychotherapy, social worker and CPN contacts
- The highest percentages of patients using mental health services were from the middle and most deprived groups, and from the South West locality
- Overall, a higher percentage of patients were women, 55.4%; and this difference was most marked in the lower middle and least deprived areas of the City
- 394 people were admitted to mental health inpatient units – the lowest proportion of people admitted was from the least deprived population group

Emergency Admissions to Plymouth Hospitals NHS Trust – where a mental health diagnosis was the primary or secondary diagnosis
- Devonport had the highest emergency admission rate, followed by Stonehouse
• The highest admission rate is from the over-75 age group, with almost 7000 admissions per 100,000 people, as compared to 1,603 per 100,000 for all ages

• The highest admission rates for all ages was from the most deprived fifth, with a clear gradient down to the lowest admission rate from the least deprived

Adult Social Care

• 4230 mental health clients used social care services in Plymouth in 2010/11

• Most were older adults

• Scores for carer assessments, self-directed support and independent living were higher than the national average; although scores for mental health clients in employment and settled accommodation were lower

Demand: Gaps and Recommendations

Gaps in Information and Intelligence

• Some information is included in this document on the IAPT programme in Plymouth; however more detail is required in terms of age and socio-economic profile of those accessing services to determine which groups within the City the programme is reaching and whether it is addressing mental health inequalities. There are likely to be people who are not eligible for IAPT due to the nature or complexity of their mental health problems who may not be able to access appropriate psychological therapies.

• This needs assessment has included information on prescribing rates of psychotropic drugs such as antidepressants and anxiolytics in GP practices across Plymouth. However, it has been beyond the scope of this piece of work to examine and explain any variation in prescribing, which constitutes a gap in understanding.

Recommendations

Recommendation: The IAPT programme in Plymouth is currently being evaluated – the results of this should be awaited and considered in light of the issues raised.

Recommendation: Further work is needed to gain a better understanding of psychotropic prescribing in practices across Plymouth and the variation that exists; as part of QIPP or through other work streams.
References


6. Summary of Gaps

6.1 Gaps relating to Information and Intelligence

1. Information relating to the needs of the key at-risk groups is not as comprehensive as desired. Without detailing every gap, there are some specific areas where more information is required as a priority:

   a. Information on the mental health needs of women during pregnancy and after childbirth is lacking in this Needs Assessment. There are no specific figures on the numbers with mental health problems, or the number accessing services in Plymouth. There is also a lack of knowledge about the range of City and out-of-City services available for this group.

   b. The mental health needs of service families and ex-service personnel have not been fully assessed, due to a need for more information about the numbers of both groups resident in the Plymouth area. There is also an opportunity to confirm exactly what services and resources exist for this group to see if this meets the need identified.

   c. Further information is required on the numbers of people who are lesbian, gay, bisexual and/or transgender in Plymouth; and whether they are accessing services equitably.

   d. Information is also needed on the size of the offender and ex-offender population in Plymouth to confirm whether the services identified are adequate to meet the needs of this group.

   e. Whereas a range of services available for BME groups, refugees and asylum seekers have been identified, information about the specific needs of these groups locally is lacking.

2. A comprehensive search of brokerage services to support the use and uptake of services was not undertaken and represents a gap in knowledge.

3. Some information is included in this document on the IAPT programme in Plymouth; however more detail is required in terms of age and socio-economic profile of those accessing services to determine which groups within the City the programme is reaching and whether it is addressing mental health inequalities. There are likely to be people who are not eligible for IAPT due to the nature or complexity of their mental health problems who may not be able to access appropriate psychological therapies.
4. A significant gap, which was necessary due to limited time, is the views of professionals. Given the importance and volume of mental health problems treated in primary care – the views of primary care professionals on the need, unmet need and services they would like to see is markedly lacking.

5. There is a lack of information in this Needs Assessment about the numbers of 16-18 year olds with mental health problems in Plymouth. This needs assessment has only touched upon the period of transition for young people between child and adolescent mental health services and adult services. This is both in terms of their needs and of the services currently provided. Transition from Child and Adolescent Mental Health Services to adult services is a critical time when many young people are vulnerable and need appropriate pathways and support.

6. Core information relating to mental health and well-being services and resources was not consistently or comprehensively provided in any one of the information sources. There was extensive duplication of information across the sources, particularly in relation to voluntary and third sector services and resources. The use of hard copies as the only readily accessible information source was not uncommon (particularly in relation to health improvement and some community-based activities).

Accessible, accurate and relevant information and marketing of services/resources is a critical component to optimising uptake and mental health and well-being promotion, improvement and recovery.

7. This needs assessment has included information on prescribing rates of psychotropic drugs such as antidepressants and anxiolytics in GP practices across Plymouth. However, it has been beyond the scope of this piece of work to examine and explain any variation in prescribing, which constitutes a gap in understanding.

8. Due to the rapid nature of this needs assessment, and the fact that the MINI-2000 index has not been updated, there is no detailed analysis of need by neighbourhood and sub locality. This Needs Assessment contains some useful information that, along with the 2009 Mental Health Atlas, provides a starting point for such analysis.

9. A suicide audit is usually completed annually, and the most recent is now being completed after a gap. On-going suicide audit to identify at-risk groups and inform suicide prevention remains a priority.
6.2 Gaps relating to Mental Health and Well-being Services

6.2.1 Gaps relating to Universal Services

10. The supply analysis identified that there were limited services and resources relating to mental health and well-being promotion, literacy and education that reinforced an integrated ‘whole lifestyle’ approach and were targeted at individual, organisational and community levels and awareness across the life course.

Achieving change in relation to diet, exercise, alcohol and smoking has potentially large mental health benefits with relatively low cost interventions, particularly in primary care.

Interventions that promote collective opportunities for healthy lifestyles (green gyms, walking groups, self-help groups) may have additional benefits and are sometimes offered via social prescribing through primary care/community referrals for people at risk of mental health problems.

There is widespread ignorance of mental ill health in the general population and an associated stigma too. For some the stigma can lead to delays in people seeking help and support. There is also a lack of confidence in what to do if someone is distressed or in a crisis situation. Mental health first aid (MHFA) is a response to this with the aim of improving mental health literacy throughout communities, with the belief that mental health crises, such as suicidal and self-harming actions, can sometimes be avoided with early intervention.

11. 63% of the universal services identified promoted protective factors and community resilience. The uptake of these universal services by those using targeted community based and specialist mental health services was not known.

In many practices, the level of prescribing of antidepressants, anxiolytics and hypnotics was higher than the national average. Social prescribing links people with non-medical sources of support within the community. It may be used for clinical populations to reduce symptoms and for at risk groups to promote well-being or prevent mental illness (e.g. books on prescription, arts and creativity, reading groups, befriending, mutual aid and self-help).
Time Banks are a mutual volunteering scheme using time as a currency. Time bank activities can be very wide ranging, including DIY, befriending, learning new skills, such as languages or word processing, sewing, cooking, giving lifts, shopping, and gardening. Time Banks have been widely used to reduce isolation and strengthen social support. They may also be used to build social cohesion, acknowledging and rewarding people who take an active part in community activities, such as organizing social events, offering advice, street cleaning, environmental improvements and graffiti removal.

6.2.2 Gaps relating to Targeted Community Based Services

12. The supply analysis indicated that there is a range of targeted opportunities relating to education, training, volunteering and employment both within universal and targeted community based services in Plymouth. Duplication was evident particularly in relation to volunteering, employment support and employment related support. This includes work based interventions and programmes, support for people to stay in work, return to work and/or gain employment. However, the extent of duplication, overlap and/or integration with other services and resources is unclear.

Also, the opportunities in relation to education and training for people using targeted mental health services seemed to be variable and disconnected, with uptake appearing to be related to personal recommendation or word of mouth rather than a wider shared knowledge and understanding of what is available.

13. The supply analysis identified that there is significant scope to develop community navigators, coaching and mentoring services to support individuals’ access and use of universal services and resources promoting protective factors and individual resilience and achievement of life goals.

The benefits of community navigator services stem from helping people to follow more appropriate pathways through local service and related systems, thus helping them to meet their needs. For example, navigators might help to identify people with debt or benefits problems, help them to access the right information about emotional and practical support that is available locally, and signpost or encourage them to seek specialist advice where needed. Among the advantages could be a reduction in employment disruption (as a result of mental health problems, for example) or job loss, fewer GP visits (once an
individual's health needs have been assessed and treated), better health and generally greater well-being.

Mentoring is a long established and well regarded technique for supporting the personal and professional development of individuals' careers. Mentoring involves a more experienced person (the mentor) who shares their knowledge and experience with someone who is less experienced (the mentee), in a relationship based on mutual trust.

Coaching is a shorter term role than mentoring; it tends to be task/project focused with the line manager coaching a member of staff towards achieving a specific outcome. Coaching helps individuals improve their performance and skills development, for example, helping staff with learning needs related to a task.

Both can help those with a wide range of mental health difficulties to better focus on life skills which can help them overcome certain obstacles in their day to day life and say on target with goals. They are popular among those who may not want to use a therapist and who may not even require one, but who need help with motivation, organization and life skills. It deals more with the what’s, where’s, when and how questions, while therapy delves more into the whys.

14. Social and befriending opportunities for working age adults appear very limited, across the spectrum of services but particularly for people with serious mental health problems.

Befriending is a social support intervention provided by an individual ‘befriender’ through the development of an affirming, emotion-focused relationship over time. Befriending services – many of which are run by voluntary and community organizations and which tend to be heavily reliant on volunteers – have the aim of alleviating social isolation, as well as preventing or reducing loneliness and depression, particularly among older people.

15. This Needs Assessment has not considered in detail the mental health services and resources available within primary care. However, due to the high prevalence of common mental health problems seen in primary care, there are likely to be opportunities to optimise best practice at primary care level.

16. The growing numbers of people with dementia in Plymouth means that there will be increasing need in this group, which may result in a gap in
capacity. A large proportion of dementia goes undiagnosed, as does a high percentage of depression in older people. As well as specific services, staff working in all branches of healthcare will need to have an awareness of dementia and may require training and specialist liaison support. Around 30% of people over 60 will die with dementia, so having appropriate end-of-life care is also a necessity, which may also constitute a future gap in services.

17. Medically unexplained symptoms (MUS) are physical symptoms which doctors are unable to explain by finding any pathology in the body. They may be due to a physical problem, but often have a psychological origin or may be related to a mental health problem. Medically unexplained symptoms are common, associated with significant distress, and can lead to unnecessary investigations or treatments which can carry risks and use many resources. MUS are not covered in this Needs Assessment and therefore constitute a potential gap. However, in 2009 a project team in Plymouth working across services and with the Sentinel CIC Referral Management Centre, produced guidance on MUS management in primary and secondary care, along with a whole systems pathway and further actions.

6.2.3 Gaps relating to Specialist Mental Health Services

The supply analysis identified that it was unclear how well individuals using specialist mental health services access targeted community based and universal services (see above). The recommendations relating to community navigators, mentors and coaches would help address some of these issues, with particular focus on access to meaningful occupation across spectrum of mental ill health and dual diagnosis.

18. There are particular issues for consideration in relation to specialist mental health services that have not been fully addressed within this needs assessment. These relate to the following questions:

- Are inpatient services and resources adequate and proportionate to the need, and are specialist services and resources available for groups such as adults with Autistic Spectrum Disorders and adult ADHD?
- Have all alternatives to inpatient services and resources been considered (e.g. peer supported community crisis accommodation)?
- Are inpatient services recovery focused and do they reflect a recovery-based approach?
• Is the balance of investment in services and resources out-of-city proportionate to the need for City based services and resources?

19. There is a need to fully understand the range of older people’s liaison psychiatry services offered in the general hospital and to primary care, given the rising prevalence of dementia in Plymouth; and the extent of undiagnosed dementia and depression in this population.

6.2.4 Gaps identified in services relating to People with Lived Experience

20. There are significant opportunities to further scope and develop approaches and increase the utilization of the expertise and knowledge of people with lived experience of mental health problems

6.2.5 Gaps relating to Commissioning and Procurement Services and Resources

21. Understanding of the Plymouth mental health and well-being strategy, commissioning and governance processes, Plymouth need and current evidence base, the role/support of the Mental Health Local Implementation Team and the Plymouth Mental Health Provider Network appeared to be inconsistent across providers.

Best practice and service provision is enhanced through sound and shared knowledge and understanding of the subject and processes that surround it.

6.2.6 Gaps relating to Mental Health and Well-being Resources and Services and Client Group

22. The extent of overlap and/or integration of bespoke client based services with other services and resources was unclear, particularly in relation to universal and recovery based community services (e.g. substance misuse service users accessing meaningful occupation services or IAPT services etc.)

23. There appears to be limited targeted services and resources for people who have been affected by self-harm and suicide. The targeted services need to be in areas where there is the greatest need.
24. There is a considerable need identified for physical health improvement amongst people with mental health problems, and severe and enduring problems in particular, who experience significant health inequalities. Equity in access to good-quality physical healthcare and health promotion opportunities is likely to be lacking.

6.2.7 Gaps relating to Plymouth Mental Health and Well-being Services and Resources Investment

25. A comprehensive mental health and well-being commissioning and investment ‘picture’ was not captured. Currently, Drug and Alcohol Assessment and Treatment Services (DAAT) and Public Health Programmes are not included. Nor were non-statutory funding sources (Big Lottery, charitable grants etc.), top-end (i.e. 16 to 18 years) children and adolescent mental health services (CAMHS), and non-general medical services (NGMS). Further, knowledge of individual service costs and uptake detail did not appear to be known and shared consistently across mental health and well-being providers and commissioners.

As a consequence, the mental health and well-being service/need ‘pathway’ may not be fully reflected in current mental health commissioning forums and transitions between service provision not fully or adequately joined up.

26. An opportunity to develop and provide the economic case for prioritised mental health promotion across the life course that is supported by adequate resource investment was identified. Currently there is no investment in mental health promotion services for either adult or older adult’s mental health services, nor are there any discrete public mental health programme investments. In addition, there were no locally determined mental health promotion and suicide prevention metrics or whole population mental health and well-being surveys identified to monitor the impact of investment.

Making the case for promoting positive mental health is crucial to improving mental health and well-being of people living in Plymouth to ensure targeted evidence based services are adequately resourced and proportional to the level of need identified. This involves demonstrating outcomes that are not just about the absence of mental illness, but are also about key aspects of positive mental health. The use of scales that measure different elements of well-being will make it
easier to assess the relationship between positive mental health and improvements in areas such as physical health, greater education achievement, greater productivity, reduced crime and higher levels of participation in community life (e.g. those included in Warwick and Edinburgh Mental Health and Well-being Scale (WEMWBS)).

7. Summary of Recommendations

7.1 Information and Intelligence

**Recommendation 1:** Further work is necessary to fully understand the mental health and well-being needs and service supply and requirements for the following groups as a priority:

- Women during pregnancy and in the postnatal period;
- Service families and ex-service personnel;
- People who are lesbian, gay, bisexual or transgender;
- Offenders and ex-offenders;
- BME groups, refugees and asylum seekers.

**Recommendation 2:** Map and identify gaps and ensure brokerage services and support are proportionate to the needs of people with mental health problems on direct payments. Plymouth City Council aims to ensure the uptake of direct payments by all adult mental health service users by 2014. Therefore appropriate (and where necessary bespoke) support services will need to be in place.

**Recommendation 3:** The IAPT programme in Plymouth is currently being evaluated – the results of this should be awaited and considered in light of the issues raised.

**Recommendation 4:** Scope current work and opportunities to engage with and ascertain the views of professionals (especially in primary care) on need and gaps in services.

**Recommendation 5:** The scale of the mental health need in young people aged 16-18 is not well understood; and more analysis may be required in this area. In addition, services should act to reinforce and support the implementation of the Child and Adolescent Mental Health Services Transition Protocol and standards in Plymouth.

**Recommendation 6a:** One Plymouth health and well-being service/resource directory that includes key information on all mental health and well-being services and resources. It is recommended that the Plymouth Online Directory (POD) be developed and extended to deliver this. This should include:
Core information areas (including the eleven used in this assessment, clarity about whether the service is accessed by assessment and options for potential service users to be accompanied by carers etc. at assessment);

- Downloadable leaflets (available in relevant English and non-English speaking languages);
- A Plymouth health/social care recognized/shared ‘quality’ mark;
- Options to rate the directory and provide a review of the services;
- A discrete mental health and well-being service ‘navigation’ diagram and a ‘who’s who and who does what’ in developing, commissioning, procuring and providing mental health and well-being services;
- Key local and national strategy documents

The directory should aim to be accessible and used by Plymouth citizens, service users and personal budget holders, carers, service providers, practitioners and mental health service commissioners

**Recommendation 6b:** Develop a Plymouth-wide mental health and well-being marketing approach (including the use of social media/website) to optimise mental health and well-being knowledge and understanding as well as relevant use of services and resources. This would help to pool best practice and local expertise as well as limited resources.

**Recommendation 7:** Further work is needed to gain a better understanding of psychotropic prescribing in practices across Plymouth and the variation that exists; as part of QIPP or through other work streams.

**Recommendation 8:** Along with the Mental Health Atlas, this Needs Assessment should provide a starting point for further and on-going analysis of need, supply and spend at neighbourhood and sub locality level to inform service planning on annual basis.

**Recommendation 9:** On-going Suicide Audit (in progress) is needed to identify at-risk groups within the City and to monitor and inform suicide prevention measures.

### 7.2 Universal Services

**Recommendation 10a:** Develop a Plymouth Mental Health and Well-being Promotion and Recovery Campaign that is integrated with national promotional programmes and existing local initiatives (e.g. Time to change, Five Ways to Mental Well-being, Mind Apples, population level suicide awareness training and intervention, school based awareness, education and interventions). It also should be integrated with physical health improvement
outcomes (diet, exercise, alcohol, and smoking) and targeted at high risk groups and neighbourhoods, as identified in this needs assessment.

**Recommendation 10b**: Mental health and lifestyle advice should be routinely and opportunistically offered in primary care and other health and well-being settings, with a focus on diet, exercise, alcohol, smoking and strengthening individual resilience (Five Ways to Well-being).

**Recommendation 10c**: Target and deliver mental health and well-being and recovery awareness sessions e.g. Mental Health First Aid (MHFA) and Wellness and Recovery Action Plan (WRAP) to key organisations/‘gatekeepers’ of services and high risk/priority groups.

**Recommendation 11a**: Reinforce and expand the range of support and treatment offered (directly and via referral) to individuals presenting at primary care:
- Signposting to universal and targeted community services for social support (housing, financial management, bereavement, relationship difficulties, employment and volunteering and legal support);
- Develop a co-ordinated social prescribing approach across Plymouth (building on current pilot in North Prospect);
- Optimizing the use of IAPT services.

**Recommendation 11b**: Reinforce individual and community resilience through the development of a co-ordinated network of Time banks.

**Recommendation 11c**: Support the development of a co-ordinated local evidence base to demonstrate the impact and outcomes of services and resources that promote individual and community resilience.

### 7.3 Targeted Community Based Services

**Recommendation 12a**: Scope and develop a Plymouth mental health and well-being employment/meaningful occupation and employment support pathway to join up, co-ordinate and streamline services and resources and so improve access and uptake. The pathways should aim to:

Map & identify gaps in current provision & best practice that helps to promote & manage people’s MHWB at work & those with health conditions & disabilities stay in work &/or return to work;
Map, identify gaps & develop current provision & best practice that helps to promote & support people with mental health problems to gain & sustain employment;

Involve education, training, volunteering and employment and work based support (including workplace screening for depression and anxiety disorders; professional workplace champions to support workforce and negotiation of workplace systems)

**Recommendation 12b:** Scope and develop ways to formally join up and co-ordinate community based recovery services and resources (to include brief therapeutic and psycho/social interventions and employment/meaningful occupation opportunities) either literally (Plymouth Recovery college) and/or virtually (Recovery Curriculum).

**Recommendation 13:** Develop and pilot the role and use of community navigators, mentors and coaches for people with mental health problems to support recovery.

**Recommendation 14:** Scope and develop a co-ordinated mental health befriending programme across the age range.

**Recommendation 15:** Service developments and commissioning decisions should reinforce/improve mental health within primary care:

- Primary care should be supported to implement the NICE Guidance on Common Mental Health Disorders Identification and Pathways to Care (May 2011);
- Primary care access to and support from A & E Mental Health Liaison and Secondary Mental Health Services.

**Recommendation 16:** A number of services exist and are being developed with dementia care and support. It is important that capacity continues to be reviewed and expanded to meet the needs of people with dementia and their carers both now and in the future, informed by the Joint Dementia Strategy.

**Recommendation 17:** Guidance and pathways for managing Medically Unexplained Symptoms should be supported throughout primary and secondary care, and the recommended commissioning options explored.

### 7.4 Specialist Mental Health Services

**Recommendation 18:** Further analysis to provide a more comprehensive understanding of specialist mental health services and their response to local
need is required. This should be in conjunction with current service development and QIPP work streams.

**Recommendation 19:** The provision of liaison services for older people offering diagnosis, assessment and management should be expanded and supported in line with current national and local guidelines. This should be supplemented by appropriate staff training and development.

**7.5 Services relating to People with Lived Experience**

**Recommendation 20a:** Expand and develop sustainable and systematic Plymouth wide user involvement service development networks to promote mental health and well-being, improve practice (including transitions between services) & develop recovery focused services and monitor and measure impact of involvement

**Recommendation 20b:** Develop workplace mental health support groups (and ‘buddying’ system) for people who have experience of mental ill health or having supported people with mental ill health.

**Recommendation 20c:** Develop sustainable & systematic opportunities to use employees with lived experience expertise to improve workplace practice and develop recovery focused workplace environments.

**Recommendation 20d:** Increase opportunities for accessible self-help and peer support programmes.

**7.6 Commissioning and Procurement Services and Resources**

**Recommendation 21:** Best practice discussions should take place amongst mental health stakeholders – an appropriate forum may be the Mental Health Provider Network. This may include:

- Information on Plymouth MH strategic and governance structures across commissioning, procurement and provision;
- Support to develop mental health and well-being evidence based business case;
- Provide legitimate commissioning context for setting priorities, using data, metrics, comparative, cost effective, evidenced based information.
7.7 Mental Health and Well-being Resources and Services and Client Group

**Recommendation 22**: Support the MH SQIP QIPP programme in the development of clinical pathways across spectrum of mental health and well-being.

**Recommendation 23a**: Map and identify gaps and develop services and resources to support people who have been affected by self-harm and suicide or attempted suicide (including people who self-harm and carers).

**Recommendation 23b**: Increase knowledge and awareness of interventions and approaches for working with people who self-harm or are affected by self-harm within universal and targeted community services.

**Recommendation 24**: A holistic approach should be taken by mental health services and resources in promoting good physical health and healthy lifestyles, targeted at those with severe and mental illness, alongside the work done in specific areas such as health checks for people taking medication such as antipsychotics, in line with the NICE guidance.

7.8 Plymouth Mental Health and Well-being Services and Resources Investment

**Recommendation 25**: Establish a comprehensive picture and understanding of Plymouth mental health and well-being investment across all services and resources areas through reviewing current MH SQIP investment alongside key areas identified as omissions.

**Recommendation 26a**: Develop a business case for mental health promotion in Plymouth.

**Recommendation 26b**: Develop mental health and well-being and recovery metrics at individual, community, organisational and city-wide levels.

**Recommendation 26c**: Consider the feasibility of undertaking a Plymouth-wide (WEMWBS) survey in line with current national direction developments.
7.9 Updating the Mental Health Needs Assessment

**Recommendation 27:** Where relevant and feasible, aspects of the Needs Assessment should be updated on an annual basis to support the Joint Strategic Needs Assessment and the commissioning and planning of Mental Health and Wellbeing services and resources in Plymouth. This process should involve stakeholder groups in identifying priorities for updating and highlighting any new information and intelligence.
Appendix 1: Glossary

**Acute**
Acute, in medicine, refers to an intense illness or an illness of sudden onset.

**Advocate**
An advocate is a person who can support a service user or carer through their contact with health services. Advocates will attend meetings with patients and help service users or carers to express concerns or wishes to health care professionals. Although many people can act as an advocate (friend, relative, member of staff) there are advocacy services available that can be accessed through the Trust. These advocates are trained and independent.

**Benchmarking**
A way of comparing a particular process and outcomes in one organisation with another organisation. Each organisation can then examine and change their own processes to achieve better outcomes.

**Care Co-ordinator**
A care co-ordinator is the person responsible for making sure that a patient gets the care that they need. Patients and carers should be able to contact their care co-ordinator (or on-call service) at any reasonable time. Once a patient has been assessed as needing care under the Care Programme Approach they will be told who their care co-ordinator is. The care co-ordinator is likely to be community mental health nurse, social worker or occupational therapist.

**Care plan**
A care plan is a written plan that describes the care and support staff will give a service user. Service users should be fully involved in developing and agreeing the care plan, sign it and keep a copy. (see Care Programme Approach)

**Care Programme Approach (CPA)**
The Care Programme Approach is standardised way of planning a person's care. It is a multidisciplinary (see definition) approach that includes the service user, and where appropriate, their carer, to develop an appropriate package of care that is acceptable to health professionals, social services and the service user. The care plan and care co-ordinator are important parts of this (see Care Plan and Care Co-ordinator)

**Commissioning**
This is a process where organisations such as Adult Social Care, a Primary Care Trust or a group of GPs (GP consortia) develop understanding of the needs of their populations and commission or 'buy' the right services to meet these needs -i.e. by securing high-quality services.

**CPN - Community psychiatric nurse**
A specialist nurse who works within a local community to assess needs as well as plan and evaluate programmes of care.
Co-morbidity/ Co-morbid
The presence of two or more disorders at the same time. For example, a person with depression may also have co-morbid obsessive compulsive disorder.

Dual diagnosis
Dual diagnosis refers to two or more disorders affecting one person. For example, mental illness and learning disability. It is also used to indicate that a person who has been diagnosed with a mental health problem also misuses substances, such as illegal drugs, legal drugs or alcohol.

Mental Health Act (1983) (MHA)
The Mental Health Act (1983) is a law that allows the compulsory detention of people in hospital for assessment and/or treatment for mental disorder. People who are detained under the mental health act must show signs of mental disorder and need assessment and/or treatment because they are a risk to themselves or a risk to others. People who are detained have rights to appeal against their detention.

Mental Health Strategic Quality Improvement Partnership (SQIP)
The SQIP brings together a wide group of stakeholders in mental health, including service users and carers, to plan and oversee the development of mental health services in their local area. In future they will work closely with primary care, which is responsible for commissioning mental health services.

National Institute for Clinical Excellence (NICE)
It provides clinical staff and the public in England and Wales with guidance on current treatments. It coordinates the National Collaborating Centres from whom it commissions the development of clinical practice guidelines.

Primary Care
Primary care is the care that you will receive when you first come into contact with health services about a problem. These include family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

Psychotherapy
The treatment of mental health, emotional and personality problems through talking with a therapist. There are many different types of psychotherapy.

Secondary care
Secondary care is specialist care, usually provided in hospital, after a referral from a GP or health professional. Mental Health Services are included in secondary care (see also tertiary care).

Service user
This is someone who uses health services. Other common terms are patient, service survivor and client. Different people prefer different terms.
## Appendix 2: Table of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Definition</th>
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<tbody>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<tr>
<td>LD</td>
<td>Learning disabilities</td>
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<tr>
<td>MHWB</td>
<td>Mental Health and Well-being</td>
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<td>MHFA</td>
<td>Mental Health First Aid</td>
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<tr>
<td>ONS</td>
<td>Office for National Statistics</td>
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<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
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<tr>
<td>PANSI</td>
<td>Projecting Adult Needs and Service Information System</td>
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<tr>
<td>POPPI</td>
<td>Projecting Older People Population Information System</td>
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Appendix 3: Mental Health and Well-being Evidence Base

“Evidence-based interventions highlight the health and associated economic savings of intervening early as soon as mental illness has arisen, preventing mental illness and promoting mental health. The resulting savings occur in health and across other areas in the short, medium and longer term. Alongside the range of measures, which can be taken to develop the resilience of whole communities, there is also significant scope for the imaginative re-design of services that support people who live with a mental illness. Services can be safer, timelier, more personalized and increasingly cost effective.

There are further opportunities to improve patient experience, health outcomes and the use of resources by addressing unmet psychological needs, which present as medically unexplained symptoms or as a co-morbidity within long-term conditions.

The benefits to be realized...in tandem with the clinical evidence for good mental health and with what people say they want. It makes financial sense to invest in building and maintaining good mental health and resilience for communities, families and individuals and to provide the most effective and affordable services at times when they are needed.”

All sectors have a role to play in improving mental health and the need for interventions that involve individuals and communities, but also those that address structural barriers to mental health and well-being.

The following overview (which is not a definitive list) presents evidence of what works in terms of outcomes for mental health and well-being, suicidal and self-harming behaviours and ideation and is largely adapted from the Scottish Systematic Review and current mental health policy.

1. Early identification and intervention as soon as mental health problems emerge

- Improve parental health - interventions to reduce maternal depression, home visiting programmes, reduce maternal smoking, and increase breast feeding
- Early detection and early intervention in psychosis
- Screening and brief intervention in primary care for alcohol misuse
• Health visitor interventions to reduce postnatal depression
• Workplace screening and early diagnosis and treatment of depression at work
• Early interventions for dementia

2. Promotion of positive mental health and prevention of mental disorder in childhood and adolescence

• Supporting parents and early years with parenting skills training, preschool education and home learning environment

• The most effective programmes focus on promoting mental health rather than preventing mental health problems; involve social competence and cognitive approaches – broadly described as life skills training (i.e. improving emotional, social and cognitive skills/attributes, including resilience/problem solving and peer support); adopt a whole school approach: involving teachers, pupils, parents and the wider community is more effective than curriculum based projects and; peer tutoring and cross age tutoring are effective for children with emotional and behavioural difficulties.  

6. Parenting interventions for the prevention of persistent conduct disorders

• School based social and emotional learning programmes to prevent conduct problems in childhood

• School-based violence prevention programmes

• School-based interventions to reduce bullying

• Nurse home visiting programme

• Family Intervention Projects

• Multi-dimensional treatment foster care

3. Promotion of positive mental health and prevention of mental disorder in adulthood

• Lifelong learning and continuing education

• Time banks and community navigators

• Promoting well-being in the work-place

• Employment/workplace based interventions where there is:

  • Recognition by employers that work is on the whole very good for mental health, as it is for physical health
- Prevention of mental health problems that is directly work-related.
- Awareness training for line managers, to increase their knowledge and understanding of mental health issues and their ability to respond confidently and in a timely fashion to employees in distress
- Better access to help, particularly access to evidence-based psychological help which wherever possible enables people to carry on working at the same time as receiving support

- Effective rehabilitation for those who need to take time off work, including regular contact with the employee during periods of absence
- Time banks and community navigators
- Support the effectiveness of lifestyle messages for the promotion of positive mental health, including exercise, diet, moderating alcohol intake, smoking cessation, learning new skills, creative pursuits and social participation
- A healthy diet has a wide range of positive outcomes and some specific mental health benefits. The cost of harmful eating patterns associated with anorexia, obesity and other eating disorders is high.
- Physical activity is effective in treating and improving symptoms for a wide range of mental health problems including depression, anxiety, phobias, panic attacks, stress disorders and schizophrenia; Improving mental well-being including self-esteem, motivation, self-efficacy, mood, self-perception, quality and quantity of sleep; Improving cognitive function in children and maintaining cognitive function in adults; and preventing depression, although there is insufficient data to determine the optimal level of exercise needed to reduce risk
- Green exercise (physical exercise in a natural environment) is associated with increases in self-esteem, positive mood and self-efficacy
- There is limited evidence on the effectiveness of exercise referral schemes and community walking/cycling schemes although NICE recommends that all efforts to increase physical activity should continue
- Promoting a healthy lifestyle in people with mental illness – smoking cessation, healthy diet, physical activity
- Social prescribing for mental health may be used both for clinical populations, to reduce symptoms e.g. of anxiety or depression and for at risk groups, to promote well-being or prevent mental illness. Examples include exercise on prescription, books on prescription and bibliotherapy,
prescription for learning, arts and creativity, ‘green gyms’, volunteering, mutual aid, befriending and self-help, as well as support with, for example, employment, benefits, housing, debt, legal advice, or parenting problems.

- Promoting recovery from mental ill-health – education/learning and occupational/volunteering opportunities, psychological therapies, spirituality, leisure activities, art, social inclusion and participation

- Maintaining mental health in later years

- Social Networks and support and befriending

- Practical and psychological preparation for military discharge and encouraging appropriate help-seeking behaviour once individuals have left the services

- Peer and Carer Support Groups

- Promotion of positive mental health and prevention of mental health problems in adults (support to get back to work, support for people in work, range of psycho-social primary preventative programmes for older people

- Active labour market programmes

- Control of alcohol prices and availability

4. **Addressing social determinants and consequences of mental health problems**

- Debt advice

- Befriending for older people

- Reducing stigma and discrimination

- Targeted employment support for those recovering from mental health problems

- Housing support services

- Warm housing

- There is limited data on effective interventions in relation to environmental improvements and almost no available data on cost effectiveness, there is growing public and policy concern about the environment and its impact on well-being. While it is not possible to provide any definitive statements on the cost benefits, investing in environmental improvements may not necessarily involve high cost interventions (e.g. addressing street level incivilities) and will help to ensure a balance between interventions that focus on individuals and
those that address the wider determinants of mental health and well-being. 7

5. Preventing suicide in high risk groups

Completed suicide

- Restriction of access to means
- Ongoing support for suicidal people following discharge from hospital

Attempted suicide

- Provision of informal support
- Restriction of access to means
- Clinical approaches such as Dialectic Behavioural Therapy (DBT) and possibly Cognitive Behavioural Therapy (CBT)
- Self-harm - DBT may be of value
- Ongoing contact
- Referral from A&E for specialist support

Suicidal ideation

- Use of moclobemide, fluvoxamine and sertraline in people with depression
- Telephone-based support over very short follow-up periods
- Telephone-based support with non-interventionalist/non-directive styles of communication particularly with first time callers

Reduction of the availability and lethality of suicide methods

- Contact based initiatives and initiatives to pre-empt suicide in high-risk locations (signs offering telephone support)
- Reducing access to means
- Providing physical barriers to restrict access
- Removing ligature points from inpatient wards/regular audits
- Reduce amount of paracetamol sold per packet
- Restricting the availability of Coproxamol
Improving the reporting of suicidal behaviour in the media

- There is inconclusive evidence to show the impact of positive media reporting. However, interventions aimed at those reporting suicides to use caution and sensitivity and limit the use of explicit details, as well as providing and signposting for help suggest that media portrayal and website management can influence suicidal behaviour.

Older people
- Telephone support to older people with and without other interventions

Children and young people
- Psychotherapeutic or similar ‘personal development’ initiatives

People with mental health problems
- Depression – selective serotonin reuptake inhibitors (SSRIs) to prevent suicide and attempted suicide, maintaining on-going contact and providing support, possibly psychotherapeutic interventions
- Personality disorder/borderline personality disorder – DBT
- Schizophrenia/schizoaffective disorders – treatment with clozapine is promising
- Bipolar disorder – some support for treatment with lithium

Ethnic minority populations
- Culturally tailored programmes
- Video-based educational and training initiatives
- Educational public health programmes
- Culturally aware and competent workforce

Rural populations
- Support to rural communities (community based programmes targeted at older people, psycho-educational interventions, depression screening with psychiatric or other health care and health education)

Other suicide prevention interventions
- Individualized restriction of access to ‘preferred’ means of self-harm in stopping self-harming behaviour
- Awareness-raising and encouraging help-seeking
- Population-level suicide awareness training and intervention
• School-based programmes:
• SOS programme teaching young people to recognise signs of suicidal behaviour or ideation in themselves or in peers
• Training initiative for school personnel
• Crisis intervention and management
• Training of health staff
• Video-based training of A&E staff
• Broad based GP and nurse training initiatives based on encouraging staff to follow a care management approach
• Green card/token for readmission to hospital for those who have attempted suicide
• Engagement and involvement with young men 8
• Mental Health First Aid (MHFA) and Applied Suicide Intervention and Support Training (ASIST) training interventions for staff 9,10
• Identifying and supporting young LBGT people
• Specific specialist social and emotional support for high risk groups

6. Improving the quality and efficiency of current mental health services

Improvements to the acute care pathway
• Managing ‘out of area’ placements in acute and secure services more efficiently
• Reducing unplanned ‘out of area’ placements
• Reducing Out of Area placements in medium secure services
• Reducing physical and mental co-morbidity
• Collaborative care for depression in individuals with Type 11 diabetes
• Cognitive behavioural programmes for medically unexplained symptoms
• Strengthen mental health service provision through universal mental health care and sound financial incentives
References


4. HM Government (February 2011) No health without mental health: Delivering better outcomes for people of all ages.

5. Friedli L, Parsonage M. Promoting mental health and preventing mental illness: the economic case for investment in Wales Mental Health Promotion Network (Oct 2009).


## Appendix 4: Summary of Recommendations

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<tr>
<th>Information and Intelligence</th>
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  - People who are lesbian, gay, bisexual or transgender;  
  - Offenders and ex-offenders;  
  - BME groups, refugees and asylum seekers | Public Health and Plymouth City Council and NHS Plymouth |
|                              | MHNA 2    | Map, identify gaps and ensure brokerage services and support are proportionate to the needs of people with mental health problems on direct payments. Plymouth City Council aims to ensure the uptake of direct payments by all adult mental health service users by 2014. Therefore appropriate (and where necessary bespoke) support services will need to be in place | Public Health and Plymouth City Council |
|                              | MHNA 3    | The IAPT programme in Plymouth is currently being evaluated – the results of this should be awaited and considered in light of the issues raised | NHS Plymouth Commissioning and Plymouth Community Healthcare |
|                              | MHNA 4    | Scope current work and opportunities to engage with and ascertain the views of professionals (especially in primary care) on need and gaps in services | Mental Health Strategic Quality Improvement Partnership |
|                              | MHNA 5    | To reinforce and support the implementation of the Child and Adolescent Mental Health Services Transition Protocol and standards in Plymouth | CAMHS, NHS Plymouth and Plymouth City Council |
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  - Downloadable leaflets (available in relevant English and non-English speaking languages);  
  - A Plymouth health/social care recognised/shared ‘quality’ mark;  
  - Options to rate the directory and provide a review of the services;  
  - A discrete mental health and well-being service ‘navigation’ diagram and a ‘who’s who and who does what’ in developing, commissioning, procuring and providing mental health and well-being services;  
  - Key local and national strategy documents  

The directory should aim to be accessible and used by Plymouth citizens, service users and personal budget holders, carers, service providers, practitioners and mental health service commissioners | Plymouth City Council and Public Health |
| MHNA 6b   | Develop a Plymouth-wide mental health and well-being marketing approach (including the use of social media/website) to optimize mental health and well-being knowledge and understanding as well as relevant use of services and resources. This would help to pool best practice and local expertise as well as limited resources | Public Health and Mental Health Strategic Quality Improvement Partnership |
| MHNA 7    | Further work is needed to gain a better understanding of psychotropic prescribing in practices across Plymouth and the variation that exists, as part of QIPP or through other workstreams. | NHS Plymouth and Primary Care |
### Universal Services

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<tr>
<td>MHNA 10b</td>
<td>Mental health and lifestyle advice should be routinely and opportunistically offered in primary care and other health and well-being settings, with a focus on diet, exercise, alcohol, smoking and strengthening individual resilience (Five Ways to Well-being)</td>
<td>Primary Care and Public Health</td>
</tr>
<tr>
<td>MHNA 10c</td>
<td>Target and deliver mental health and well-being and recovery awareness sessions e.g. Mental Health First Aid (MHFA) and Wellness and Recovery Action Plan (WRAP) to key organizations’/gatekeepers’ of services and high risk/priority groups</td>
<td>Public Health and Mental Health and Well-being Promotion Steering Group</td>
</tr>
</tbody>
</table>
| MHNA 11a  | Reinforce and expand the range of support and treatment offered (directly and via referral) to individuals presenting at primary care:  
  - Signposting to universal and targeted community services for social support (housing, financial management, bereavement, relationship difficulties, employment and volunteering and legal support);  
  - Develop a social prescribing approach across Plymouth (building on current pilot in North Prospect);  
  - Optimizing the use of IAPT services                                                                 | NHS Plymouth and Primary Care                                                           |
<table>
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<tr>
<th>Reference</th>
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<tbody>
<tr>
<td>MHNA 11b</td>
<td>Reinforce individual and community resilience through the development of a co-ordinated network of Time banks</td>
<td>Public Health and NHS Plymouth</td>
</tr>
<tr>
<td>MHNA 11c</td>
<td>Support the development of a co-ordinated local evidence base to demonstrate the impact and outcomes of services and resources that promoted individual and community resilience</td>
<td>Public Health, Plymouth Universities and Mental Health and Well-being Promotion Steering Group</td>
</tr>
</tbody>
</table>
| MHNA 12a | Scope and develop a Plymouth mental health and well-being employment/meaningful occupation and employment support pathway to join up, co-ordinate and streamline services and resources and so improve access and uptake. The pathways should aim to:  
Map & identify gaps in current provision & best practice that helps to promote & manage people’s MHWB at work & those with health conditions & disabilities stay in work &/or return to work;  
Map, identify gaps & develop current provision & best practice that helps to promote & support people with mental health problems to gain & sustain employment  
Involve education, training, volunteering and employment and work based support (including workplace screening for depression and anxiety disorders; professional workplace champions to support workforce and negotiation of workplace systems) | Mental Health and Well-being Promotion Steering Group and Public Health |
| MHNA 12b | Scope and develop ways to formally join up and co-ordinate community based recovery services and resources (to include brief therapeutic and psycho/social interventions and employment/meaningful occupation opportunities) either literally (Plymouth Recovery college) and/or virtually (Recovery Curriculum) | Public Health and Mental Health and Well-being Promotion Steering Group |
| MHNA 13 | Develop and pilot the role and use of community navigators, mentors and coaches for people with mental health problems to support recovery | Public Health, Mental Health and Well-being Promotion Steering Group and Mental Health Strategic Quality Improvement Partnership |
### Targeted Community Based Services

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<tbody>
<tr>
<td>MHNA 14</td>
<td>Scope and develop a co-ordinated mental health befriending programme across the age range</td>
<td>Mental Health Strategic Quality Improvement Partnership</td>
</tr>
</tbody>
</table>
| MHNA 15   | Service developments and commissioning decisions should reinforce/improve mental health within primary care:  
- Primary care should be supported to implement the NICE Guidance on Common Mental Health Disorders Identification and Pathways to Care (May 2011);  
- Primary care access to and support from A & E Mental Health Liaison and Secondary Mental Health Services | Mental Health Strategic Quality Improvement Partnership and Primary Care |
| MHNA 16   | A number of services exist and are being developed with dementia care and support. It is important that capacity continues to be reviewed and expanded to meet the needs of people with dementia and their carers both now and in the future, informed by the Joint Dementia Strategy | Plymouth Dementia Strategy Group and Mental Health Strategic Quality Improvement Partnership |
| MHNA 17   | Guidance and pathways for managing Medically Unexplained Symptoms should be supported throughout primary and secondary care, and the recommended commissioning options explored | Mental Health Strategic Quality Improvement Partnership |

### Specialist Mental Health Services

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<tbody>
<tr>
<td>MHNA 18</td>
<td>Further analysis to provide a more comprehensive understanding of specialist mental health services and their response to local need is required. This should be in conjunction with current service development and QIPP work streams</td>
<td>Public Health and Plymouth City Council and NHS Plymouth</td>
</tr>
<tr>
<td>MHNA 19</td>
<td>The provision of liaison services for older people offering diagnosis, assessment and management should be expanded and supported in line with current national and local guidelines. This should be supplemented by appropriate staff training and development</td>
<td>Plymouth Dementia Strategy Group and Mental Health Strategic Quality Improvement Partnership</td>
</tr>
</tbody>
</table>
## Services relating to People with Lived Experience

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<tbody>
<tr>
<td>MHNA 20a</td>
<td>Expand and develop sustainable and systematic Plymouth wide user involvement service development networks to promote mental health and well-being, improve practice (including transitions between services) &amp; develop recovery focused services and monitor and measure impact of involvement</td>
<td>Public Health and Mental Health and Well-being Promotion Steering Group and PIPs</td>
</tr>
<tr>
<td>MHNA 20b</td>
<td>Develop workplace mental health support groups (and ‘buddying’ system) for people who have experience of mental ill health or having supported people with mental ill health</td>
<td>Public Health and Mental Health and Well-being Promotion Steering Group and PIPs</td>
</tr>
<tr>
<td>MHNA 20c</td>
<td>Develop sustainable &amp; systematic opportunities to use employees with lived experience expertise to improve workplace practice and develop recovery focused workplace environments</td>
<td>Public Health and Mental Health and Well-being Promotion Steering Group and PIPs</td>
</tr>
<tr>
<td>MHNA 20d</td>
<td>Increase opportunities for accessible self-help and peer support programmes</td>
<td>Public Health and Mental Health and Well-being Promotion Steering Group and PIPs</td>
</tr>
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## Commissioning and Procurement Services and Resources

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</table>
| MHNA 21   | Best practice discussions should take place amongst mental health stakeholders – an appropriate forum may be the Mental Health Provider Network – this may include:  
- Information on Plymouth MH strategic and governance structures across commissioning, procurement and provision;  
- Support to develop mental health and well-being evidence based business case;  
- Provide legitimate commissioning context for setting priorities, using data, metrics, comparative, cost effective, evidenced based information | Plymouth Mental Health Provider Network and Mental Health and Well-being Promotion Steering Group |
# Mental Health and Well-being Resources and Services and Client Group

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>MHNA 22</td>
<td>Support the MH SQIP QIPP programme in the development of clinical pathways across spectrum of mental health and well-being</td>
<td>Public Health</td>
</tr>
<tr>
<td>MHNA 23a</td>
<td>Map, identify gaps and develop services and resources to support people who have been affected by self-harm and suicide or attempted suicide (including people who self-harm and carers)</td>
<td>Public Health, Plymouth City Council, NHS Plymouth and Mental Health Providers</td>
</tr>
<tr>
<td>MHNA 23b</td>
<td>Increase knowledge and awareness of interventions and approaches for working with people who self-harm or are affected by self-harm within universal and targeted community services</td>
<td>Public Health, Plymouth City Council, NHS Plymouth and Mental Health Providers</td>
</tr>
<tr>
<td>MHNA 24</td>
<td>A holistic approach should be taken by mental health services and resources in promoting good physical health and healthy lifestyles, targeted at those with severe and mental illness, alongside the work done in specific areas such as health checks for people taking medication such as antipsychotics, in line with the NICE guidance.</td>
<td>Primary Care, Mental Health Providers and Public Health</td>
</tr>
</tbody>
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### Plymouth Mental Health and Well-being Services and Resources Investment

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<tr>
<td>MHNA 25</td>
<td>Establish a comprehensive picture and understanding of Plymouth mental health and well-being investment across all services and resources areas through reviewing current MH SQIP investment alongside key areas identified as omissions</td>
<td>Mental Health Strategic Quality Improvement Partnership</td>
</tr>
<tr>
<td>MHNA 26a</td>
<td>Develop business case for mental health promotion in Plymouth</td>
<td>Mental Health and Well-being Promotion Steering Group and Plymouth Mental Health Provider Network</td>
</tr>
<tr>
<td>MHNA 26b</td>
<td>Develop mental health and well-being and recovery metrics at individual, community, organisational and city-wide levels</td>
<td>Public Health</td>
</tr>
<tr>
<td>MHNA 26c</td>
<td>Consider the feasibility of undertaking a Plymouth-wide (WEMWBS) survey in line with current national direction developments</td>
<td>Mental Health and Well-being Promotion Steering Group and Public Health</td>
</tr>
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### Updating the Mental Health Needs Assessment

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<tr>
<td>MHNA 27</td>
<td>Where relevant and feasible, aspects of the Needs Assessment should be updated on an annual basis to support the Joint Strategic Needs Assessment and the commissioning and planning of Mental Health and Well-being services and resources in Plymouth. This process should involve stakeholder groups in identifying priorities for updating and highlighting any new information and intelligence.</td>
<td>Public Health and Mental Health Strategic Quality Improvement Partnership</td>
</tr>
</tbody>
</table>
Appendix 5: Mental Health and Well-being Services and Resources Database

See separate Excel document