2018/19 Mental Health Joint Strategic Needs Assessment

Swindon Borough Council Public Health

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1. Introduction

1.1 Definitions

Health needs assessment is a systematic method of identifying unmet health needs of a population, with the goal of informing the planning and commissioning of health, well-being and social care services within the local authority area. The overall goals of health needs assessments are to improve health and reduce health inequalities.

A Joint Strategic Needs Assessment (JSNA) is a type of health needs assessment that is commonly co-produced by a number of partners with a focus on longer-term strategic issues. Each Health and Wellbeing Board has a statutory obligation to produce an annual JSNA which must describe the current and future health, wellbeing and social care needs of the local population. In Swindon, an overall JSNA Summary is produced each year, alongside of which a programme of thematic 'deep-dive' JSNAs on specific topics or population groups is carried out, of which the present report is part.

The World Health Organisation (WHO, 2001) has defined mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." Resilience, that is the ability to "cope with the normal stresses of life", is a particularly important element of this definition in terms of prevention of mental ill-health. The Faculty of Public Health (FPH, 2019) has defined mental health as the field which encompasses mental illness/disorder, mental wellbeing and all other states of mental health.

Mental illness is commonly classified into common mental disorders (CMDs) and severe mental illness (SMI). CMDs comprise different types of depression and anxiety, including generalised anxiety disorder, panic disorder, phobias and obsessive compulsive disorder. Symptoms of depression and anxiety often co-occur. CMDs cause emotional distress and may interfere with daily function, but do not usually impair cognition or insight (NHS Digital, 2016). SMI encompasses schizophrenia, other psychoses or bipolar disorder (PHE, 2018a). Psychotic disorders "produce disturbances in thinking and perception that are severe enough to distort perception of reality" (NHS Digital, 2016, pg. 132). Bipolar disorder is a lifelong mental health condition "characterised by recurring episodes of depression (feelings of low mood and lethargy) and of mania (feelings of elation and overactivity)" (NHS Digital, 2016, pg. 222).

Mental wellbeing is conceptualised by the FPH (2019) as the 'positive side of mental health' (i.e. it is more than the absence of mental illness). There is no clear consensus on a definition of mental wellbeing – however, a succinct definition is 'feeling good and functioning well' from the perspective of positive psychology (FPH, 2019).

The FPH clarifies that mental illness and mental wellbeing are not mutually exclusive states – a person can have a mental illness but also experience mental wellbeing (FPH, 2019).

1.2 Policy context

In 2016, NHS England published the Five Year Forward View (FYFV) for Mental Health, which identified that in the last five years public attitudes towards mental health have improved, partly due to the Time to Change Campaign, however the rising demand and challenges in the system have led to worsening outcomes and an increase in suicide rates (NHSE, 2016).

In 2017, Public Health England (PHE) published the Prevention Concordat for Better Mental Health Programme as recommended in the FYFV. The Prevention Concordat looks to

galvanise local action and encourage cross sector working to support the promotion of mental wellness and prevention of mental health problems (PHE, 2017a). It was formally adopted by Swindon Borough Council (SBC) and Swindon Clinical Commissioning Group (CCG) in 2018.

At a national level the key concerns identified in the Prevention Concordat were:

- 1 in 10 children experience mental health problems
- 1 in 5 adults consider taking their own life at some point
- 1 in 6 had a common mental health problem in the last week
- 9 in 10 people with mental health problems experience stigma and discrimination.

There are 5 key themes highlighted in the Concordat and this strategy will look to embed these key themes and support other key areas identified at a local level.

1. Needs Assessment and assets assessment- Using data and intelligence to understand the local need and help inform our strategic direction.

2. Partnership and alignment- Identifying partners across the Public, Private and VSE sector who can work collaboratively and align plans to improve public mental health.

3. Translating need into deliverable commitments- Ensuring high level strategic aims are integrated at an operational level across all relevant organisations.

4. Defining success outcomes- Having a clear understanding of how to measure outcomes in preventing mental health problems and promoting good mental health, and which would be most relevant to the local community.

5. Leadership and accountability- Ensuring that organisations from different sectors are involved in promoting public mental health and are held to account for anything they commit to.

1.3 Background and aims of the 2018/19 Mental Health JSNA

In 2014, an Adults Mental Health and Wellbeing Needs Assessment was published in Swindon and in 2015/16 a Children and Young People's Mental Health Needs Assessment was published. This report provides an updated assessment of mental health and wellbeing need in Swindon for 2018/19.

Community mental health and wellbeing services for adults are due to be re-commissioned in 2019, and hence the main aim of this needs assessment is to inform re-commissioning plans. Community mental health and wellbeing services are those that are provided in the community setting by the voluntary sector for people with CMDs or people managing/recovering from SMI. Providers accept self-referrals as well as referrals from health professionals.

The specific objectives of the 2018/19 mental health needs assessment are as follows:

- To provide an up-to-date epidemiological overview of mental ill health among young people aged 16 years and over and adults in Swindon
- To assess community mental health and wellbeing service provision for children and adults and identify gaps in provision
- To present information gained from engagement with the public, mental health service users and providers

- To identify effective mental health interventions for adults from the literature
- To make recommendations for service provision for the re-commissioning plan

1.4 Structure of the 2018/19 Mental Health JSNA

This report is structured according to the following main themes:

- Factors affecting mental health
- Young people aged 16-25 transitioning from child/adolescent mental health services
- Prevalence of CMDs and SMI in the Swindon adult population aged 16 years and over
- Suicide and self-harm
- Current provision of adult community mental health and wellbeing services in Swindon
- Views of local people and providers on mental health needs and community mental health and wellbeing service gaps in Swindon
- Evidence-based, effective mental health interventions, including:
    - Those recommended by the National Institute for Health and Care Excellence (NICE) for CMDs, SMI and perinatal mental health problems
    - Interventions to improve mental wellbeing and prevent mental ill-health
    - Cost-effective mental health interventions recommended by Public Health England (PHE)

2. Factors affecting mental health

Factors affecting mental health can be divided into place-based (or social) determinants and behavioural factors (PHE, 2017b). Place-based determinants of mental health include;

- Deprivation & inequality
- Financial insecurity
- Housing & homelessness
- Education & lifelong learning
- Employment
- Crime, safety & violence.

Health behaviours that affect mental health include smoking, physical activity and substance misuse. Health behaviours, physical health and mental health are closely linked, with each a cause and consequence of the other. Negative health behaviours, whether a cause or consequence of mental health conditions, contribute to physical health inequalities among those with mental health conditions.

Social media use is attracting increasing focus as a behavioural factor that may impact mental health – however, as yet there is no clear consensus on this issue in the literature. A recent inquiry by the House of Commons Science and Technology Committee highlighted that research on the relationship between young people's social media use and their mental health is lacking in both quantity and quality. Much of the research is correlational, based on cross-sectional surveys, and although some studies have found small associations between social media use and children's mental health, it is not possible to determine at present whether social media use is a cause or consequence of mental health problems (House of Commons Science and Technology Committee, 2019).

Social factors underpin health behaviours and mental health. The prevalence of common mental health problems is double and the prevalence of psychotic disorders is 9 times higher in the lowest quintile of household income compared to the highest (PHE, 2017b). Smoking and obesity are also associated with deprivation.

2.1 Place-based determinants of mental health

Table 1 below presents data from the Index of Multiple Deprivation (IMD), PHE and Official Labour Market Statistics to illustrate Swindon's position nationally on place-based factors affecting mental health. For indicators from the IMD and its constituent domains, Swindon is ranked relative to other upper-tier local authorities in England (London boroughs, county councils, unitary authorities and metropolitan districts). There are 152 upper-tier local authorities in total – a rank of 1 indicates the authority that is the most deprived, and a rank of 152 indicates the authority that is least deprived.

It is clear from the table below that Swindon compares well to England and to other local authorities on place-based determinants of mental health. Swindon is less deprived than average on a number of IMD measures including overall IMD rank, proportion of LSOAs in most deprived decile nationally and proportion of the population living in the most deprived 30% of LSOAs nationally. Swindon is among the top 25% least deprived local authorities on income and employment deprivation. Compared to England, Swindon has a lower long-term unemployment rate and a slightly smaller gap in the employment rate for those in contact with secondary mental health services compared to the overall employment rate.

However, one domain in which Swindon does not compare well nationally is education, skills and training - Swindon is more deprived than average in this domain.

Table 1: Snapshot of place-based determinants of mental health in Swindon, compared to England or other upper-tier local authorities in England

Category of determinant	Indicator	Swindon figure *(England figure if applicable)*	Year
Deprivation & inequality	IMD rank *(Range: 1-152, 1=most deprived)*	113	2015
	Proportion of lower-layer super output areas (LSOAs)[1] in most deprived decile nationally	6.1%	2015
	Rank of proportion of LSOAs in most deprived decile nationally *(Range: 1-152, 1=most deprived)*	86	2015
	Proportion of the population living in the most deprived 30% of LSOAs nationally (weighted by deprivation percentile)	14.6%	2015
	Rank of proportion of the population living in the most deprived 30% of LSOAs nationally *(Range: 1-152, 1=most deprived)*	90	2015
	Life expectancy gap (males) between most and least deprived LSOA deciles	5.9 years *(9.4 years)*	2015-17
	Life expectancy gap (females) between most and least deprived LSOA deciles	5.3 years *(7.4 years)*	2015-17
Financial insecurity	Number of people who are income-deprived[2]	26,335	2015
	Rank on number of people who are income deprived *(Range: 1-152, 1=most deprived)*	120	2015
Housing & homelessness	Rank on barriers to housing and services *(Range: 1-152, 1=most deprived)*	119	2015
	Number of rough sleepers	45	2017

Category of determinant	Indicator	Swindon figure *(England figure if applicable)*	Year
	2017 rough sleeping rate per 1,000 households in Swindon	0.48 *(0.20)*	2017
	Number of people accepted as being homeless and in priority need per 1,000 households	1.20 *(2.41)*	2017/18
Education & lifelong learning	Rank on education, skills and training deprivation *(Range: 1-152, 1=most deprived)*	53	2015
	Proportion of the population aged 16-64 with no qualifications	5.6% *(7.7%)*	2017
Employment	Number of people who are employment-deprived[3]	12,683	2015
	Rank on number of people who are employment-deprived *(Range: 1-152, 1=most deprived)*	122	2015
	Long-term unemployment rate per 1,000 working age population	2.1 *(3.5)*	2017
	Proportion of the population claiming out-of-work benefits as of Oct. 2018	2.3% *(2.3%)*	2018
	Gap in employment rate for those in contact with secondary mental health services and the overall employment rate	64.4 percentage points *(67.4%)*	2016/17
Crime, safety & violence	Rank on crime *(Range: 1-152, 1=most deprived)*	82	2015
	Rate of violent offences per 1,000 population in Swindon	24.5 *(23.7)*	2017/18

[1]Small areas containing on average 1,500 residents

[2]Income-deprived is defined as being on a low income and in receipt of benefits and tax credits.

[3]Employment-deprived is defined as being involuntarily excluded from the labour market due to unemployment, sickness or disability or caring responsibilities.

Sources: English Indices of Deprivation 2015, Public Health England, Official Labour Market Statistics

2.2 Behavioural determinants of mental health

Table 2 below presents a snapshot of Swindon's position nationally on behavioural factors affecting mental health. Swindon is very similar to the England average on all of these factors – smoking prevalence in the general population and among those with mental health conditions, prevalence of physical inactivity and excess weight and rate of opiate and/or crack cocaine use.

Table 2: Snapshot of behavioural factors affecting mental health in Swindon, compared to England

Category of determinant	Indicator	Swindon figure *(England figure)*	Year
Smoking	Smoking prevalence in adults	17.3% *(14.9%)*	2017
	Smoking prevalence among adults with severe mental illness (SMI)	41.0% *(40.5%)*	2014/15
	Smoking prevalence in adults with anxiety or depression	26.3% *(25.8%)*	2016/17
Physical activity	Percentage of physically inactive adults	18.4% *(22.2%)*	2016/17
Excess weight	Percentage of adults who are overweight or obese	64.1% *(61.3%)*	2016/17
Substance misuse	Rate of opiate and/or crack cocaine use per 1,000 population aged 15-64	8.1 *(8.6)*	2014/15

Sources: PHE Co-occurring Substance Misuse and Mental Health Issues profile & PHE Mental Health and Wellbeing JSNA profile

3. Prevalence of common mental disorders and severe mental illness in the adult population aged 16 years and over in Swindon

Common mental disorders (CMDs) comprise different types of depression and anxiety, including generalised anxiety disorder, panic disorder, phobias and obsessive compulsive disorder. Symptoms of depression and anxiety often co-occur. CMDs cause emotional distress and may interfere with daily function, but do not usually impair cognition or insight (NHS Digital, 2016). Severe mental illness (SMI) encompasses schizophrenia, other psychoses or bipolar disorder (PHE, 2018a). Psychotic disorders "produce disturbances in thinking and perception that are severe enough to distort perception of reality" (NHS Digital, 2016, pg. 132). Bipolar disorder is a lifelong mental health condition "characterised by recurring episodes of depression (feelings of low mood and lethargy) and of mania (feelings of elation and overactivity)" (NHS Digital, 2016, pg. 222).

3.1 National prevalence estimates of CMDs and SMI

Every seven years the Adult Psychiatric Morbidity Survey (APMS) provides an assessment of mental health in England – it is the most reliable profile of mental health available, taking a representative sample of over 7,500 adults from across the country (NHS Digital, 2016). It identifies both diagnosed and undiagnosed disorders. National prevalence estimates for CMDs and SMI from the most recent 2014 survey, published in 2016, are outlined in the table below for the population overall, and for each gender. In relation to SMI, the survey assessed bipolar disorder and psychotic disorder separately. The latter category includes schizophrenia and affective psychosis (but not organic psychoses such as those associated with dementia and Alzheimer's disease).

A clear gender gap in relation to prevalence of CMDs is evident in the table below – approximately one in five women, compared to one in eight men, have a CMD. However, rates of psychotic disorder (approximately one adult in 100) and bipolar disorder (approximately one in 50) are similar in men and women. The APMS series has highlighted that the prevalence of severe CMD symptoms has increased in women since 2000, but remained stable among men (NHS Digital, 2016).

Table 3: National prevalence estimates for CMDs and SMI in the adult population from the 2014 Adult Psychiatric Morbidity Survey

Indicator	Population overall	Estimated count for Swindon	Women	Men
Estimated prevalence of any CMD	17.0%	29,820	20.7%	13.2%
Estimated prevalence of severe CMD (warranting intervention)	8.1%	14,208	9.8%	6.4%
Estimated prevalence of generalised anxiety disorder	5.9%	10,349	6.8%	4.9%
Estimated prevalence of depressive episode in the past week	3.3%	5,789	3.7%	2.9%
Estimated prevalence of bipolar disorder	2.0%	3,508	1.8%	2.1%
Estimated prevalence of psychotic disorder	0.5%	877	0.6%	0.5%

Sources: NHS Digital, 2016, ONS 2017 mid-year population estimates

The prevalence of CMDs is higher in the working age population compared to older people – the 2014 APMS estimated the prevalence of CMD among age groups between 16-64 years at 18-19%. This declined to 11.5% for those aged 65-74, and further declined to 8.8%, approximately half the rate in the working age population, for those aged 75 and over. The lower prevalence of CMDs in the older population is somewhat surprising, given the increasing social isolation and declining physical health that ageing often brings (NHS Digital, 2016).

CMD prevalence was assessed in the 2014 APMS by asking participants about symptoms they experienced over the past week. This recent timeframe allowed for the impact of recall bias on estimates to be minimised. The 2014 APMS also provides lifetime prevalence estimates for CMDs – participants were asked whether they thought they had ever had a CMD at some point in their life (self-diagnosed lifetime prevalence) and whether they had ever had a CMD diagnosed by a professional at some point in their life (professional-diagnosed lifetime prevalence). It should be kept in mind that these estimates are based on self-report, and were not checked against health records. These lifetime prevalence estimates, along with prevalence of a diagnosed disorder in the past 12 months, are presented in the table below. Again, the gender gap is evident on all of these measures of CMD prevalence, with higher rates among women on the self-diagnosed and professional-diagnosed measures.

Table 4: National estimates of lifetime prevalence (self-diagnosed and professional-diagnosed) and prevalence over the past 12 months of any CMD, and of depression

Indicator	Population overall	Estimated count for Swindon	Women	Men
Self-diagnosed lifetime prevalence of any CMD[1]	43.4%	76,128	51.2%	35.1%
Professional-diagnosed lifetime prevalence of any CMD[1]	27.4%	48,062	34.5%	20.0%
Professional-diagnosed prevalence of any CMD[1] in the past 12 months	13.7%	24,031	16.9%	10.2%
Self-diagnosed lifetime prevalence of depression	27.8%	48,764	30.9%	24.7%
Professional-diagnosed lifetime prevalence of depression	20.9%	36,661	24.9%	16.6%
Professional-diagnosed prevalence of depression in the past 12 months	10.9%	19,120	13.0%	8.6%

[1] Any of 8 CMDs including depression, postnatal depression, phobias, panic attacks, seasonal affective disorder, posttraumatic stress disorder, nervous breakdown, obsessive compulsive disorder

Sources: NHS Digital 2016, ONS 2017 mid-year population estimates

3.2 Local prevalence estimates of CMDs and SMI

Local prevalence figures for CMDs and SMI in the Swindon adult population are presented in the table below, along with national benchmarks from the same data sources. These figures are derived from primary care patient (or social care user) lists – by comparing them to prevalence estimates from the APMS, which are based on sampling from the general population, inferences about the 'treatment gap' (i.e. the gap between the number of people with a mental disorder who are in treatment, and the number who are not in treatment) and the rate of undiagnosed mental disorders can be made.

Table 5: Prevalence of CMDs and SMI in the Swindon adult population, compared to England

Indicator	Source	Year published	Swindon	England	Swindon (count)
Recorded prevalence of depression in those aged 18+	QOF	2017/18	10.2%	9.9%	17,385
Prevalence of depression and anxiety in those aged 18+*	GP Patient Survey	2016/17	13.8%	13.7%	23,521
Prevalence of depression and anxiety among social care users*	NHS Digital	2017/18	52.1%	54.5%	2,861
Recorded prevalence of SMI (all ages)	QOF	2017/18	0.81%	0.94%	1,785

*Concerns about data quality

Sources: PHE Mental Health and Wellbeing JSNA Profile, ONS 2017 mid-year population estimates, SBC

3.3 Summary of CMD and SMI prevalence data for Swindon

Comparing local CMD prevalence figures to the national estimates from the APMS, it can be concluded that the local figures are likely under-estimates of the true prevalence of CMDs in the population. For instance, estimates from the GP Patient Survey indicate that the prevalence of depression and anxiety in the Swindon adult population is 13.8% - however, the APMS estimates that 17.0% of the population have a CMD.

Recorded prevalence of depression in the Swindon adult population is 10.2% (since April 1st 2006) – however, this figure does not include undiagnosed cases of depression. It is likely that the true lifetime prevalence of depression (including both diagnosed and undiagnosed cases) is almost three times this rate, based on the estimated lifetime prevalence of self-diagnosed depression from the APMS of 27.8%.

Recorded prevalence of SMI in the Swindon population (0.81%) is likely also an under-estimate of the true prevalence. Estimates from the APMS (which include undiagnosed cases) indicate that 2.0% of the population have bipolar disorder and 0.5% have a psychotic disorder. Nearly 60% of those that screened positive for bipolar disorder in the APMS were not currently receiving treatment (psychotropic medication or psychological therapy) (NHS Digital, 2016).

3.4 Vulnerable groups

3.4.1 Women in the perinatal period

During pregnancy and in the year after birth, women can be affected by a range of mental health problems, including anxiety disorders, depression and postnatal psychotic disorders. These are collectively called perinatal mental illnesses. Perinatal mental illnesses affect at least 10% of women and, if untreated, can have a devastating impact on them and their families. Suicide is the leading cause of maternal death over the first year after pregnancy (University of Oxford, 2018).

The incidence of many mental health disorders does not change in the perinatal period: pregnant women and new mothers have the same level of risk as other adults, although the effects of these illnesses are likely to be more significant at this critical period in their lives. However, for those with a history of mental illness and those with lifelong mental illnesses, such as bipolar disorder, the risk of developing or experiencing a recurrence of the illness does increase in the perinatal period (SBC Public Health, 2015).

Depression is the most prevalent mental illness in the perinatal period, with research suggesting that around 10 to 14% of mothers are affected during pregnancy or after the birth of a baby. Depression is the most common major complication of pregnancy. Many cases of

depression are mild, but around 3% of mothers suffer from a severe depressive illness (PHE, 2017c). The 2014 APMS shed some light on the treatment gap with regard to post-natal depression – the survey results suggest that self-diagnosed lifetime prevalence of post-natal depression among women who have had children is 10%, compared to a rate of 7.2% for professional-diagnosed lifetime prevalence of the condition (NHS Digital, 2016). Self-diagnosed prevalence was estimated by asking participants whether they thought they had ever had post-natal depression at some point in their life, and professional-diagnosed prevalence by asking whether they had ever had post-natal depression diagnosed by a professional at some point in their life.

Local data gathered by midwives at the Great Western Hospital indicated that approximately 17% of women who gave birth between January and June 2015 were identified as having mental health concerns at some point during their pregnancy, delivery or early postnatal period (SBC Public Health, 2015). This tallies with the consensus in the literature that, overall, between 10% and 20% of women are affected by mental health problems at some point during pregnancy or the first year after childbirth (PHE, 2017c).

The table below outlines the estimated number of women in Swindon with different perinatal mental illnesses, calculated based on national prevalence estimates.

Table 6: Estimated number of women in Swindon with perinatal mental illnesses, based on national prevalence estimates

Indicator	Year	Swindon	National prevalence estimate
Mild-moderate depressive illness and anxiety in perinatal period: estimated number of women (lower – upper estimate)*	2015/16	275-410	10%-15%
Severe depressive illness in perinatal period: estimated number of women*	2015/16	85	3%
Post-Traumatic Stress Disorder in perinatal period: estimated number of women*	2015/16	85	3%
Adjustment disorders and distress in perinatal period: estimated number of women (lower-upper estimate)*	2015/16	410-815	15%-30%
Chronic Severe Mental Illness in perinatal period: estimated number of women*	2015/16	10	0.2%
Postpartum psychosis: estimated number of women*	2015/16	10	0.2%

* Concerns about data quality

Source: PHE Perinatal Mental Health Profile

3.4.2 Vulnerable groups – national data from the 2014 APMS

There are little to no data available at a local level on mental health issues among high risk groups, however it is likely that Swindon reflects the national picture in this regard. At a national level, the 2014 APMS, the most recent, reliable profile of mental health available in the UK, identified the following high risk groups with regard to CMDs and SMI; women (particularly in the 16-24 year age group), the Afro-Caribbean community, people living alone, unemployed and economically inactive people, smokers and those with chronic physical health conditions (NHS Digital, 2016). The higher risk of mental disorders in these groups is expanded upon in more detail below.

It should be kept in mind that there are other well-recognised high risk groups for mental disorders that were not identified in the APMS, including the below (PHE, 2017b);

- people living with learning disabilities
- prison population and offenders
- LGBT people
- carers
- people with sensory impairment
- homeless people
- refugees, asylum seekers and stateless person
- people living in poverty
- people with debt problems
- people with substance misuse problems.

3.4.2.1 Women, particularly those aged 16-24:

There is a clear gender gap in relation to prevalence of CMDs (although not SMI). The graph below highlights the higher prevalence among women in all age groups, but particularly in the 16-24 group (28.2%). Overall, the results indicated that 20.7% of women had a CMD, compared with 13.2% of men. Applying these prevalence estimates to 2017 mid-year population estimates for Swindon results in the following estimated counts of people in Swindon with any CMD:

- Women aged 16-24: 2,920 with any CMD
- Women aged 16 and over: 18,328 with any CMD
- Men aged 16 and over: 11,467 with any CMD

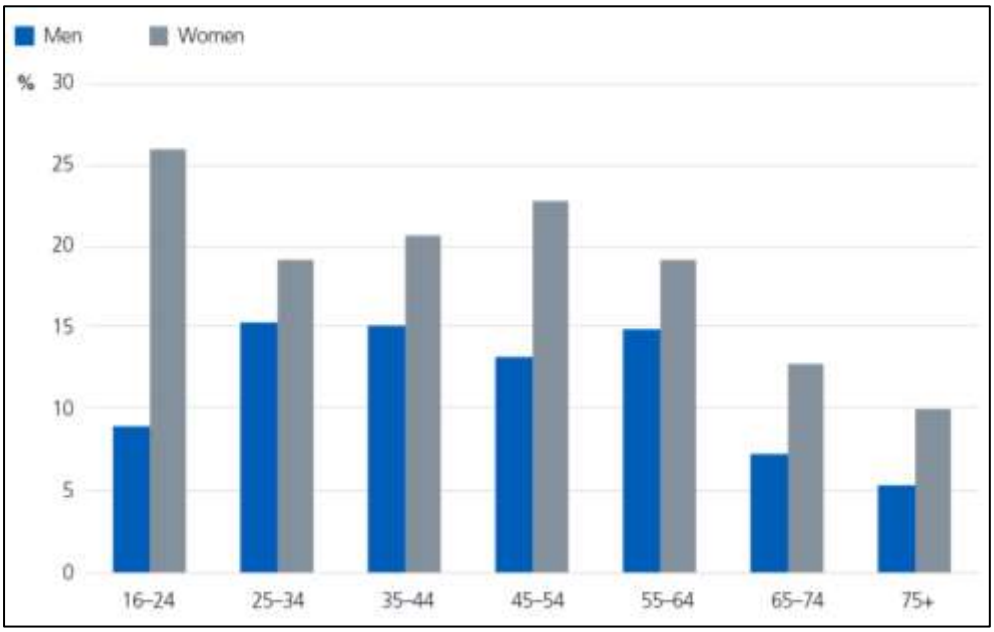

Figure 1: Estimated prevalence of CMDs by age group and sex, as indicated by the 2014 APMS (Source: NHS Digital, 2016)

3.4.2.2 Ethnicity:

The survey found that prevalence of CMDs varied by ethnic group in women, but not men. Prevalence of CMDs is higher among black and black British women (29.3%) compared to white non-British women and white British women (15.6% and 20.9% respectively). (Prevalence of CMDs among men was estimated at 13.2%). Depression and panic disorder

in particular appear to be more prevalent among black than white women – however differences between ethnic groups on specific disorders were not statistically significant.

The trend was reversed when it came to psychotic disorder – prevalence varied by ethnic group among men, but not women. The prevalence of psychotic disorder in the past year was higher among black men (3.2%) than men from other ethnic groups (0.3% of white men and 1.3% in the Asian group).

The 2014 APMS did not find any variation by ethnic group for bipolar disorder.

3.4.2.3 Those living alone:

Adults aged between 16 and 59 who lived alone were significantly more likely to have CMD than people who lived with others. Over a quarter of men (25.5%) and a third of women (35.0%) in this age group who lived alone were identified as having a CMD, compared with 13.2% of all men and 20.7% of all women.

As well as CMDs, prevalence of mental disorders including PTSD, psychotic disorder, personality disorder, and bipolar disorder was higher among people living alone.

3.4.2.4 Unemployed and economically inactive people:

Those defined as 'economically inactive' in the APMS included students, those looking after the home, long term sick or disabled, or retired people, but not unemployed people (NHS Digital, 2016). The survey results indicated that the prevalence of CMDs was double among those who were economically inactive (33.1%) or unemployed (28.8%) respectively, compared to those in employment (approximately 15% for those in either full- or part-time employment).

Consistent with these findings, the survey showed that two thirds of adults aged 16 to 64 in receipt of Employment and Support Allowance (ESA, a disability-related out-of-work benefit) had a CMD (66.1%), compared with one in six adults not in receipt of this benefit (16.9%). It should be noted that while ESA can be claimed because of a mental health problem, most people receive ESA primarily for physical health reasons. Generalised Anxiety Disorder (GAD) (41.1%), phobias (31.2%) and depression (28.5%) were particularly common among female ESA recipients, as were GAD (24.3%) and depression (25.3%) for men.

In Swindon, approximately 5% of the population aged 16-64 claim ESA and incapacity benefits, compared to about 6% nationally (ONS, 2016). Based on 2017 mid-year estimates of the population, this equates to approximately 7,054 people, and based on the APMS findings it is likely that 4,703 (two thirds) have a CMD.

As well as CMD prevalence, the prevalence of psychotic disorder and bipolar disorder is also higher among economically inactive people (2.3% and 4.3% respectively) compared to those in employment (0.1% and 1.9% respectively). The survey results indicated that about one in eight ESA claimants tested positive for psychotic disorder in the past year, and the same proportion for bipolar disorder.

3.4.2.5 Smokers:

Prevalence of CMDs was significantly higher among smokers than non-smokers – prevalence was highest among heavy smokers (15 or more cigarettes a day). In the latter group, age-standardised prevalence (31.3%) was double that among people who had never smoked or were ex-smokers (approximately 15%). It should be noted that smoking is likely a consequence of poor mental health, rather than a cause.

3.4.2.6 Those with chronic physical health conditions:

The 2014 APMS examined co-morbidities between five chronic physical conditions (asthma, high blood pressure, cancer, diabetes and epilepsy) and mental disorders. The results indicated that those with a chronic physical condition were more likely to have at least one CMD compared to those without, as illustrated in the figure below.

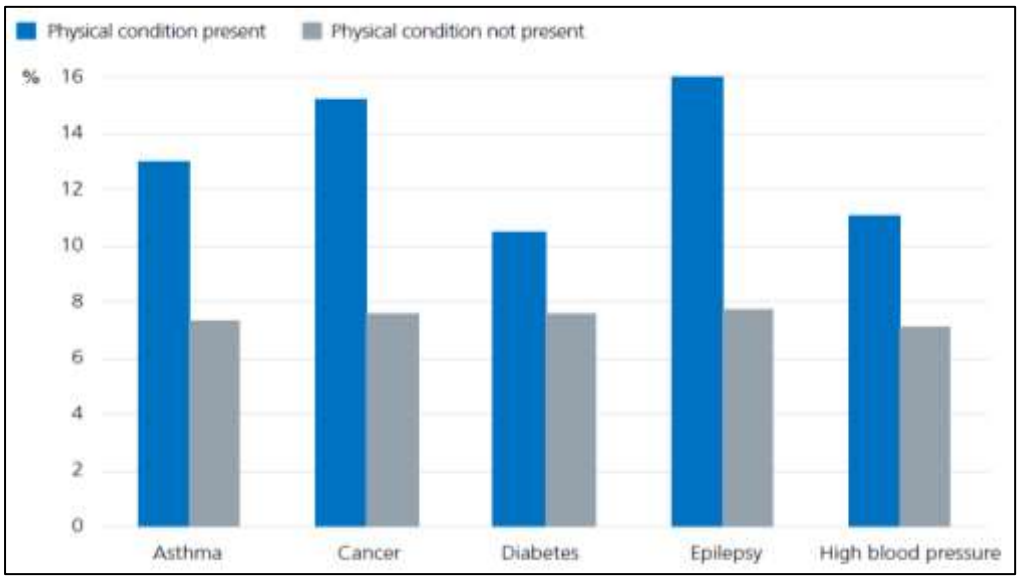

Figure 2: Estimated prevalence of mixed depression/anxiety among those with one of five chronic physical health conditions, compared to those without a chronic physical health condition, as indicated by the 2014 APMS (Source: NHS Digital, 2016)

4. Young people aged 16+, transitioning out of children's mental health services

NHS England (2018, pg. 82) has defined 'transition' or 'transitioning' as "the transfer of young people out of children and young people's mental health services (CYPMHS) to other services (adult mental health services and other relevant CCG-commissioned services), or being discharged, **as a consequence of reaching a certain age.** The age of transition varies locally, with young people in most areas transitioning at 18 years, but others at 16 or 25, or at a needs-based or condition-specific time."

The point of transition from CYPMHS is a time of heightened vulnerability for young people – they may find it difficult to manage their mental health once they no longer have access to support from CYPMHS. For many, adult mental health services are either not available or not appropriate. Adult mental health services (AMHS) are not universally equipped to meet the needs of young people with conditions such as ADHD, or mild to moderate learning difficulties or autistic spectrum disorder. There are significant risks of young people disengaging or being lost in transition despite needing further support, which can result in mental health problems increasing in severity later in life (PHE, 2017, Department of Health and Social Care, 2015). The TRACK study of young people's transitions from CAMHS to AMHS showed that up to a third are lost from care during a transition, and a further third experience an interruption in care (2010, as cited in Joint Commissioning Panel for Mental Health (JCPMH), 2013).

4.1 Service use data for children and young people (CYP) aged 16+ receiving or transitioning from child/adolescent mental health services in Swindon

4.1.1 CYP aged 17+ transitioning from Child and Adolescent Mental Health Services (CAMHS):

The number of patients who, on being discharged from CAMHS are transferred to Adult Mental Health Services in Avon and Wiltshire Mental Health Partnership Trust (AWP) remains consistently low in Swindon. Between January 2017 and December 2018, a total of 372 young people aged 17.5 and over were discharged from CAMHS. From September 2017 to December 2018, 13 young people transitioned to AMHS, 26 were discharged to MIND, nine were recommended to self-refer to Lift Psychology, and 21 were signposted to both MIND and Lift. The remainder were discharged back to primary care. From April 2017-February 2019, 15 CAMHS patients were referred to Mind's Step Down service, which consists of monthly wellbeing appointments.

While the majority of CAMHS patients aged 17 and over are discharged back to primary care, this does not necessarily indicate that they have 'recovered' from their mental health problem. While some of them will have made a full recovery, for many it is not a question of 'recovering' but rather learning to manage and live well with mental health issues, which CAMHS support them to do. Thus, while young people who are discharged back to primary care are considered well enough not to require further secondary mental health services, some of them may still be dealing with a mental health problem and/or remain on medication, which needs to be monitored by their GP.

Based on pre- and post-transition surveys completed by patients between January-October 2018, young people's experience of the transitions process in Swindon seems to be positive on the whole. However, the response rate was very low, with only 13 patients completing the pre-transition survey and 4 completing the post-transition survey.

The pre-transition survey results indicated that 11 of 13 young people felt that they knew where to get support around their mental health if they become unwell in future, and 13 of 13 respondents either felt “very well supported, ready and prepared ”or “supported, ready and prepared” for their transition. However, only 9 of 13 responded “yes” to the question “Has anyone talked to you or given you information that you can understand about the support you can expect to get from AMHS or your GP?”. The 4 young people who did not respond “yes” to this question were all being discharged to their GP.

The post-transition survey results showed that all 4 respondents had an agreed transfer plan with key goals/aims whilst under the care of CAMHS, and were either very satisfied or satisfied with the process of moving to Adult Services.

4.1.2 CYP aged 16-19 receiving Targeted Mental Health Services (TaMHS):

In Swindon, between September 2016 and December 2018, 3,383 CYP aged 16-19 were referred to Targeted Mental Health Services (TaMHS). Almost a third (1,028 children) were referred more than once (437 of these were re-referred for the same primary reason) and thus the total number of referrals was 4,903 for this period and age group. Table 3 below outlines the primary reason for referral for each of the 4,903 referrals. The average length of intervention was 5.5 months.

Anxiety was the most common reason, accounting for over a quarter of all TaMHS referrals in this age group. This is consistent with findings from the most recent major national survey of child mental health, which showed that anxiety disorders are the most common type of mental health disorder among 17-19 year olds, with a prevalence of 13.1% in this age group (NHS Digital, 2018). This survey also showed that girls in this age group are more than twice as likely as boys to have a mental health disorder – it is estimated that 23.9% of girls aged 17-19 have a mental health disorder, compared to 10.3% of boys.

Table 7: Primary involvement reason in the 4,903 referrals to TaMHS for CYP aged 16-19 from Sept. 2016-Dec. 2018

Primary TaMHS Referral Reason	Number of Referrals
Anxiety	1302
Aggression	871
Deliberate Self Harm	611
Behaviour	594
Low Mood	430
Autistic Spectrum Presentation	156
Eating	153
Bereavement / Loss	124
Family Breakdown	122
Low Self Esteem	80
Parenting	62
Hyperkinetic	58
Traumatic Life Event	53

Domestic Abuse/Violence	44
Attachment	40
Learning Needs in School/SPLD	37
Psychotic Presentation	26
Obsessive Compulsive Disorder	25
Development	21
Identity/Gender Issues	21
Sleep	19
Habitual/Ritualistic Behaviour	18
Peer Relationships	10
Young Carer	9
Substance Abuse	8
Phobia/Phobic Presentation	6
Dismorphic	Suppressed due to low numbers
Placement Support	Suppressed due to low numbers
Speech & Language	Suppressed due to low numbers

4.1.3 CYP aged 16-18 receiving services from STEP:

STEP is a registered charity in Swindon providing therapeutic group support to children and young people aged 7-18 years experiencing isolation and exclusion due to a lack of social skills, personal circumstances or poverty. From April 2017-November 2018, 17 out of 379 referrals to STEP were for young people aged 16-18 – 3 referrals came from CAHMS and 5 from TaMHS. Thirteen referrals were for emotional well-being or mental health concerns, nine of which were for an anxiety disorder (the other four were referred for low self-esteem, self-harm or attachment disorder). The 17 young people aged 16-18 who received an intervention from STEP between April 2017 and November 2018 were not subsequently discharged to any other services or interventions.

4.2 National guidance on the transitions process

There is no prescribed best practice service model to meet the needs of young people transitioning out of CYPMHS (JCPMH, 2013). The optimal model for a particular area will depend on local circumstances and need, and the configuration of local services. There are two main transitions service models (JCPMH, 2013);

- A designated stand-alone transitions service: This model involves setting up a multidisciplinary team with the specific purpose of working jointly with CAMHS and AMHS to meet the mental health needs of older adolescents.

- A designated transitions team integrated within an existing CAMHS or AMHS service: This model has been shown to improve transitions for young people with

psychological development disorders, such as autistic spectrum conditions and attention deficit disorders, who are well known to experience discontinuity of care.

Another way of improving joint working between CAMHS, AMHS and other agencies is through Transition Forums, which bring together representatives from CAMHS, AMHS, the voluntary sector and young people's groups to agree, review and monitor transition protocols (JCPMH, 2013).

Whilst there is no one best practice transitions service model, there is agreed best practice with regard to the elements of an effective transitions process, including the following (JCMPH, 2013, Department of Health and Social Care, 2015, Social Care Institute for Excellence, 2011);

- Be flexible around age boundaries of services.
- Take account of the wider context of young people's lives, for instance their family, friends, housing, school, college and work - there is a growing evidence base that helping young people with broader life issues leads to improvements in their mental health.
- Offer young people additional and alternative support to AMHS including support from non-health settings, voluntary sector services, primary health care and other universal services.
- Follow up and monitor outcomes following the discharge from CAMHS, including those young people who don't transfer to AMHS.
- Audit, review and evaluate practice and service models, and include young people, families and carers in the process.
- Work collaboratively across agencies. In order to provide joined-up care, staff should be aware of how each other's services operate.
- Develop and use formally agreed cross-agency transition protocols.

NHS England's model specification for transitions from CAMHS (2015) highlights care planning, involvement of young people in the transitions process and design of the transition pathway, and joint agency working as key elements of an effective transitions process, outlined in further detail below.

4.2.1 Care planning:

NHS England (2015) stipulates that the transitions process between services should be underpinned by care planning that:

- is written, agreed and shared with the young person, and where appropriate with their parent/carer;
- includes information on how to access services routinely and in a crisis;
- is supported by a named professional who acts as a coordinator throughout the transition process;
- is supported by access to peer support, which may be offered individually or in groups, face to face or through social media.

For young people being discharged back to primary care, they should have a written and agreed discharge plan that supports self-management where possible and explains how to access help if this becomes necessary.

NHS England introduced a financial incentive to improve transition planning under the national mandatory Commissioning for Quality and Innovation (CQUIN) scheme 2017 to 2019. The Transitions Out of CYPMHS CQUIN sets out requirements for joint agency

transition planning, including surveys to assess whether young people feel ready for discharge, and whether they are meeting their personal transition goals following transition.

4.2.2 Involvement of young people in the transitions process and design of the transition pathway:

The transition pathway should be co-designed with young people and their families.

The young person, and where appropriate, their family should be fully involved throughout the transitions process. They should be offered a choice of interventions that are appropriate to their needs.

Many studies have been carried out to investigate what makes a good transitions process from the young person's perspective – this research has found that young people want (JCPMH, 2013):

- to be listened to and understood;
- to be taken seriously;
- to experience well planned, smooth transitions;
- to receive flexible services;
- to have information and choice;
- to have continuity of care.

4.2.3 Joint agency working:

CAMHS should follow the Care Programme Approach (CPA) guidance and make a referral 6 months before the transition time so that the young person and their family, and both CAMHS and AMHS, have enough time to ensure an effective transitions process and continuity of care.

At least one joint meeting should take place between the young person and/or family member, the provider and the new service. The new service should provide at least one follow up contact with the young person and, if appropriate, the parent/carer after 6 months to check that the transition has proceeded smoothly.

4.2.4 The transitions process in Swindon:

There is no designated, stand-alone transitions service in Swindon. However, there is a Transitions Panel which meets monthly to review the needs of young people due to be discharged from CAMHS – the meeting provides a multi-agency forum to discuss service user needs and to agree the transition care pathway.

Work is ongoing at the Sustainability and Transformation Partnership (STP) level to monitor progress against transitions standards using the self-assessment tool from the National CAMHS Support Service and the Child and Maternal Health Observatory.

5. Self-harm and suicide

5.1 Self-harm as a public health issue

Self-harm has been described by the National Institute for Health and Care Excellence (NICE) as “any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation. This commonly involves self-poisoning with medication or self-injury by cutting.”[1]

Self-harm is an expression of personal distress and there are varied reasons for a person to harm themselves irrespective of the purpose of the act. Self-harm is poorly understood in society and people who harm themselves are subject to stigma and hostility. There is a significant and persistent risk of future suicide following an episode of self-harm and the risk is higher with increasing age at initial self-harm.

In contrast to the trends in completed suicide, the incidence of self-harm has continued to rise in the UK over the past 20 years and, for young people at least, is said to be among the highest in Europe.

Self-harm is one of the top five causes of acute medical admission and those who self-harm have a 1 in 6 chance of repeat attendance at A&E within the year. Aside from the obvious danger of death, self-harm and suicide attempts can be seriously detrimental to an individual's long-term physical health, if they survive. Paracetamol poisoning is a major cause of acute liver failure. Self-cutting can result in permanent damage to tendons and nerves, not to mention scarring and other disfigurements. The NICE guidelines on self-harm note that people who have survived a medically serious suicide attempt are more likely to have poorer outcomes in terms of life expectancy.

Self-harm often goes unreported and is it thought that hospital statistics underestimate overall rates of self-harm by about 60%. However, there are no comprehensive surveys of self-harm in the community at local level. Accident and emergency (A&E) data is of poor quality and lacks detail and therefore the most robust measure available is hospital admissions. They are used in the Public Health Outcomes Framework and other Public Health England tools to compare rates of self-harm between local authorities.

Those at greater risk of self-harm include women, young people, older people (who are more likely to do so in an attempt to end their life), people who have or are recovering from drug and alcohol problems, people in prison, people who are lesbian, gay, bisexual or gender reassigned, socially deprived people living in urban areas and women of South-Asian ethnicity. Individual elements including personality traits, family experiences, life events, exposure to trauma, cultural beliefs, social isolation and income also heighten the risk of self-harm. Other factors such as education, housing and wider macro-socioeconomic trends such as unemployment rates may also contribute directly, or by influencing a person's susceptibility to mental health problems.

5.1.1 Hospital admission rates

Swindon’s hospital admission rates for self-harm are significantly higher than the England rates for both the all age measure and the young person’s measure for 10 to 24 year olds (see figures 3 and 4).

[1] https://www.nice.org.uk/guidance/qs34

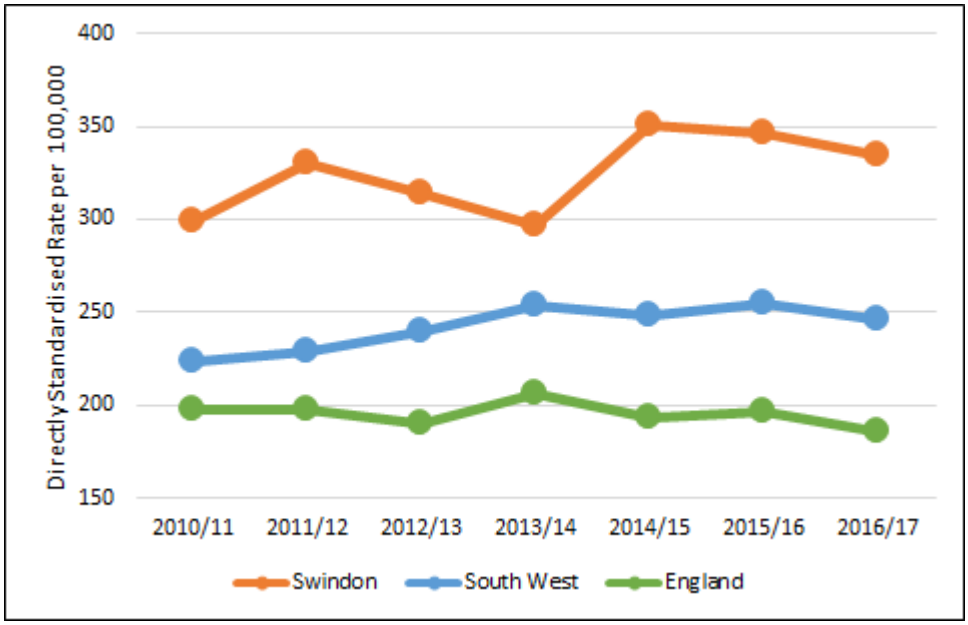

Figure 3: Admissions to hospital for self-harm (all ages) per 100,000 (Source: Hospital Episode Statistics, 2016)

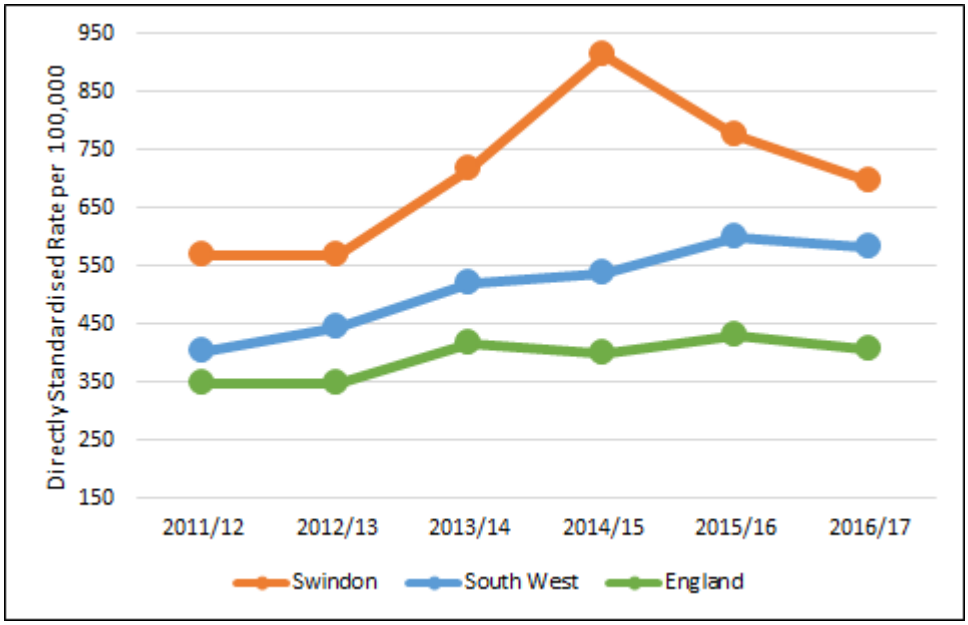

Figure 4: Admissions to hospital for self-harm (10-24 years) per 100,000 (Source: Hospital Episode Statistics, 2016)

The distribution of excess admissions[2] was analysed in Swindon. 23% of all excess admissions were in males aged 25-44 years, 24% in females aged 10-24 years and 20% in females aged 25-44 years. Therefore, in addition to focussing on females in the 10-44 age range, and in particular the 15-19 year-olds, Swindon should also investigate males in the 25-44 age range and in particular, those aged 35-39 years, who accounted for 13% of the excess in 2016/17.

[2] The number of excess admissions is the observed number of admissions minus the expected number of admissions. The percentage of excess admissions is this excess number of admissions compared to the expected number of admissions.

5.1.2 Research into self-harm and hospital admissions

Swindon's high rates are mirrored by most of the South West region. The PHE South West Local Knowledge and Intelligence Service are carrying out a piece of exploratory research into the causes and Swindon have been collaborating in this project.

The project report highlights a number of findings that are relevant in Swindon (Frost, 2019):

- Self-harm can mean many different things. Many people associate the term with cutting and in particular cutting without attempting suicide. Methods of self-harm can be divided into self-poisoning and self-injury. Studies of attendance at emergency departments show that approximately 80% of people have taken an overdose of prescribed or over the counter medication. However, general population studies have shown that for self-harm events that don't result in an admission, self-injury may be more common than self-poisoning.

- There are links between self-harm and other harms, e.g. for alcohol or substance misuse, unintentional injuries or assault, and many areas have high admission rates for more than one type of harm. There is scope for overlap, duplication and mis-recording between these and self-harm.

- There is a lot of confusion around what constitutes a hospital admission as far as data appearing in the hospital episode statistics (HES) dataset and national admissions indicators is concerned. This is especially true where patients are moved from A&E to observation wards or assessment centres, both of which are counted as hospital admissions that appear in HES. The role of assessment centres and observation wards to take pressure off A&E departments, especially in relation to the four-hour A&E waiting time target is not fully understood. Analysis of ward level data in Swindon (and Bristol) shows a very high percentage (over three-quarters of adults) are admitted to the observation ward (and almost all of these go to no other ward).

- Service provision that may be considered best practice may lead to higher admissions rates. For example at GWH, where previously patients who had self-harmed out of hours were invited to return to GWH for an appointment with the psychiatric liaison service they are now seen on attendance. However, this has meant that they are admitted to the observation ward. Similarly close adherence to NICE guidance may also necessitate practices that result in more people, especially under 18s, being admitted.

- The England admission rates for self-harm are heavily influenced by the London region data. London has a large population (around 9 million compared to around 5.5m in the South West) and the lowest admission rates by some margin. When London is removed from the analysis of admission rates, the South West is found to be much more in-line with the remaining English regions. For females the South West has the highest admissions rates out of the regions at each age group but the gap to the England average without London is much reduced. For males, the South West is fairly typical of the English regions apart from London. Removing London from the analysis would also bring Swindon's rates closer to the (non-London) national average.

- Self-harm has increased in the South West in the last five year, especially amongst young people, especially amongst young women and especially due to overdoses

- Self-harm is strongly linked to deprivation and studies which look at small area geographies show this more distinctly. It is also apparent that nationally the admissions gap between the most and least deprived has narrowed in recent years and that admissions may be rising fastest in some of the least deprived deciles.

The interim report detailed what is known about self-harm (in relation to admission rates) and explained what the key areas for further research are. These are being progressed by PHE and a report is expected in summer 2019. In the meantime the findings can be used locally as a 'checklist' of issues that LAs and CCGs can investigate depending on the local circumstances.

The priorities for further research include:

- Detailed analysis of A&E data including age and gender specific rates, repeat attendances and age standardised rates by LA and Trust. Followed by a comparison of A&E data with inpatient data.

- A qualitative study, led by the Care Forum, to explore patient journeys is underway in Swindon, Wiltshire, Bath and North East Somerset, Bristol, North Somerset, Somerset and South Gloucestershire. This is intended to find out more about what happens to people who come to A&E but aren't admitted and why do some people are admitted multiple times.

- Descriptive analysis of the crisis and liaison teams in each area including hours of operation and ages catered for and comparison with attendance and admittance rates.

- It is a strongly held view and one supported by some local analysis that a major problem in the South West is the number of young girls overdosing on analgesics. To explore this admission rates for young people (male and female) from intentional analgesic poisoning will be analysed.

- Conducting more detailed analysis into associated harms using age standardised rates and overlaying the rates for the individual harms over the top of the general harm indicator. Additionally, looking at whether coding in the South West is more comprehensive (either in general or for particular types of harm).

- Investigating coding practices in the South West to show whether coders in the South West are coding differently from other areas.

5.1.3 NICE guidance on self-harm

NICE have produced two Clinical Guidelines on self-harm; Clinical Guideline133 (NICE, 2011a) on the long-term management of self-harm, and Clinical Guideline16 on the short-term management of self-harm and prevention of recurrence. The latter makes recommendations for the physical, psychological and social assessment and treatment of people in primary and secondary care in the first 48 hours after having self-harmed. Given that the main aim of this needs assessment is to inform the commissioning of community mental health and wellbeing services, Clinical Guideline133 was considered more relevant. Some of the key points in each of the five sub-sections of this guideline (general principles of care, primary care, psychosocial assessment in community mental health services and other

specialist mental health settings, longer-term treatment and management of self-harm, treating associated mental health conditions) are outlined in Appendix 1.

One of the recommendations in relation to longer-term treatment and management of self-harm is to (NICE, 2011a);

- Consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm. The intervention should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements.

According to Health Education England's (2018) Self-harm and Suicide Prevention Competence Frameworks for children and adults, the structure of interventions for self-harm should include five components, some of which overlap but which also constitute a sequential treatment process; crisis intervention, clinical management, safety planning, assessment and initial management of self-harm, and interventions for self-harm.

In terms of specific types of intervention for self-harm, the NICE guidance is quite general in recommending cognitive-behavioural, psychodynamic or problem-solving elements. Evidence from randomised controlled trials (RCTs) on interventions for self-harm in CYP is very limited – a 2015 Cochrane systematic review identified only 11 trials worldwide that met inclusion criteria, and the quality of these trials was mostly graded as low (Hawton, Witt, Taylor et al., 2015). The authors concluded that there is little support for group-based psychotherapy, and that further research is needed into the effectiveness of other types of therapy.

A more recent systematic review (Iyengar, Snowden, Asarnow et al., 2018) of interventions for suicide attempts and self-harm in adolescents again found very few studies with a significant treatment effect, and found that CBT (in which category they included dialectical behaviour therapy) is the only type of intervention for which evidence of efficacy has been replicated independently. They noted that all of the CBT interventions with evidence for efficacy have strong family systems-driven components. Dialectical behaviour therapy, or DBT, refers to psychosocial therapies that focus on identification of triggers that lead to reactive behaviours and on providing individuals with emotional coping skills to avoid these reactions (Hawton, Witt, Taylor et al., 2016).

A Cochrane review of psychosocial interventions for self-harm in adults (Hawton, Witt, Taylor et al., 2016) also highlighted CBT-based psychotherapy and DBT as the approaches with the greatest evidence of effectiveness. Nonetheless, the findings of this review on DBT related only to people diagnosed with borderline personality disorder, and highlighted a lack of clear evidence supporting the effectiveness of prolonged exposure to DBT.

5.2 Suicide

In the UK, suicide is defined as deaths given an underlying cause of intentional self-harm or injury/ poisoning of undetermined intent. Suicidal ideation refers to recurring thoughts or preoccupation with suicide. A number of high risk groups for suicide have been identified, including (Department of Health and Social Care, 2017);

- young and middle-aged men;
- people in the care of mental health services, including inpatients;
- people in contact with the criminal justice system;
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers; and

- people with a history of self-harm.

Despite an encouraging reduction in suicide rates amongst men over the past four years both nationally and locally, suicide is the biggest killer of men under the age of 50. Nonetheless, it should be kept in mind that the prevalence of suicide is relatively low – the suicide rate in the general population (both nationally and in Swindon) is less than 10 suicides per 100,000 people, and in men, it is just over 11 per 100,000 (both nationally and locally).

5.2.1 Suicide in Swindon

The graphs below provide information on the numbers, rates, trends and demographic profile of suicides in Swindon. The numbers of suicides in Swindon have fluctuated over time, probably due to the relatively low numbers rather than any particular causal factors in different years.

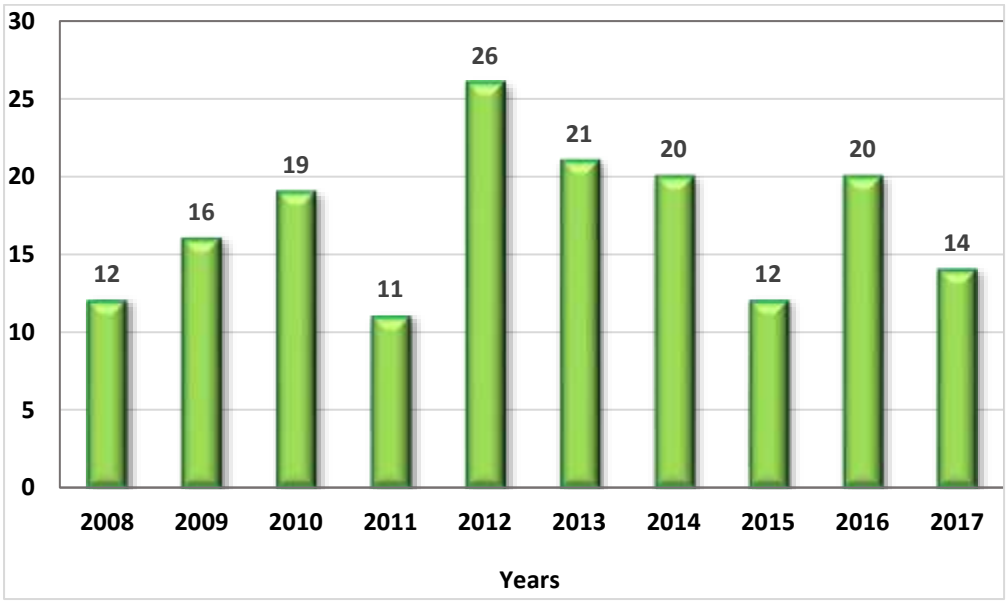

Figure 5: Number of suicides (persons) in Swindon UA by year 2008 to 2017 (Source: ONS)

As illustrated in the figure below, the suicide rate in Swindon per 100,000 people was slightly below the national and regional averages (but not significantly so) for the period 2015-2017. This was the case overall, and for males and females.

Figure 6: Suicide rates for 2015-2017 for Swindon UA, South West and England (directly standardised rates per 100,000 with 95% CIs) (Source: ONS)

As illustrated in the figure below, since 2003, the suicide rates in Swindon have tended to be slightly below the national average although they rose above the national average during the period 2012 -14. Since then they have been decreasing slowly and for the latest period 2015 -17 the rate is 7.8 per 100,000. This is below the national rate of 9.6 per 100,000.

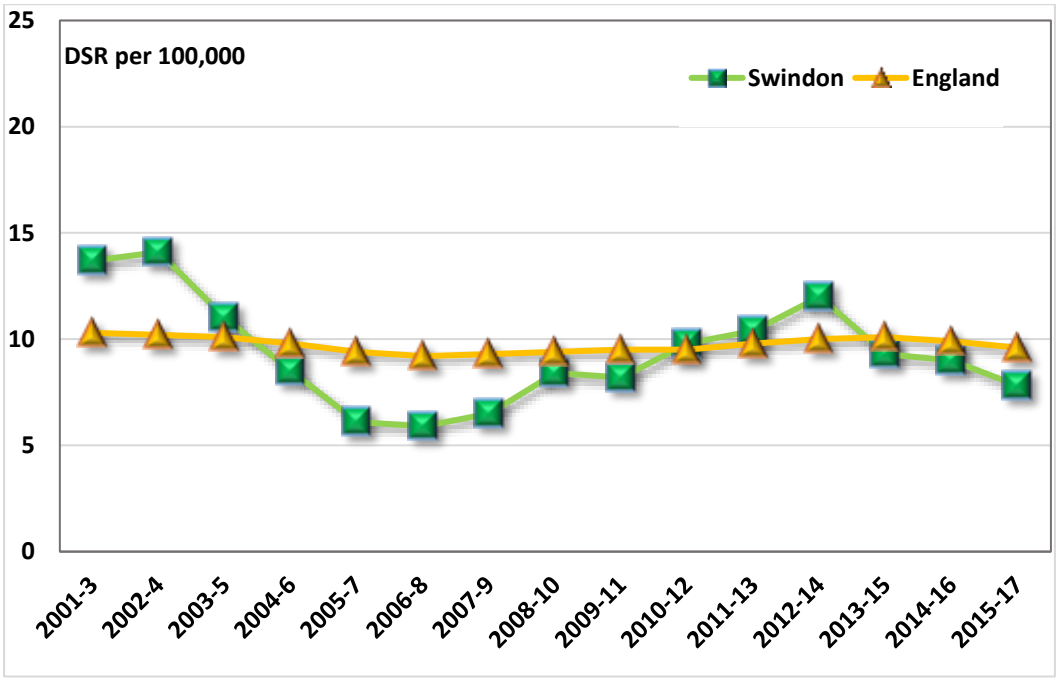

Figure 7: Suicide rate for persons 2001 to 2017 for Swindon UA and England (directly standardised rates per 100,000 for rolling three year periods) (Source: PHOF/ONS)

It can be seen from comparing Figures 8 and 9 below that the suicide rate for males is consistently higher than for females both nationally and locally. The graph below shows a decrease in male suicides in Swindon since 2012 -14. It is currently 11.4 deaths per 100,000 male population. This is below the national rate of 11.7, although the rates are not statistically significantly different.

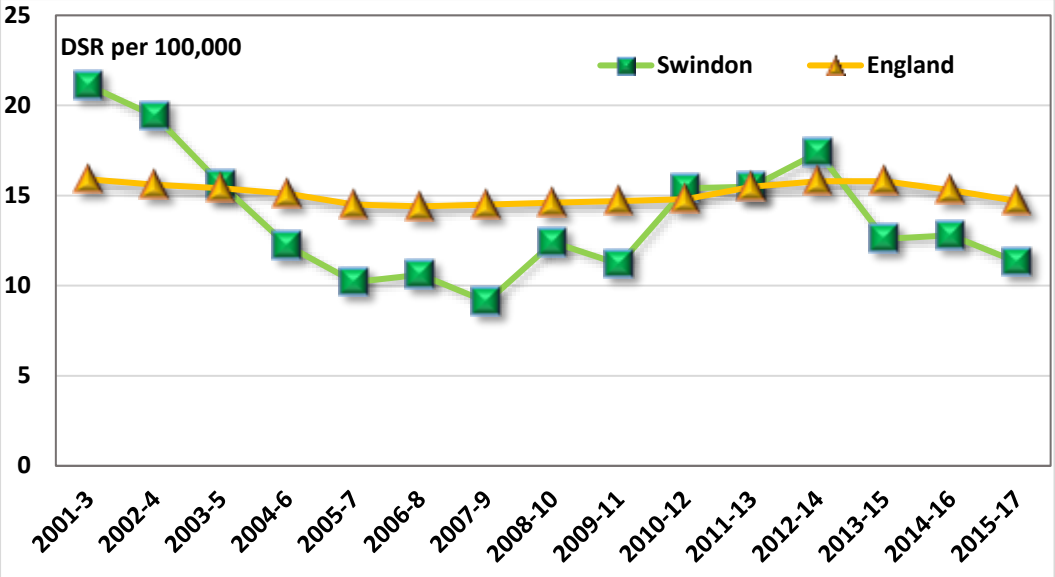

Figure 8: Male suicide rate 2001 to 2017 for Swindon UA and England (directly standardised rates per 100,000 for rolling three year periods) (Source: PHOF/ONS)

Since 2011 the suicide rate for females in Swindon has been above the national average. However, since 2012 -14 the rate has been decreasing and in 2015 -17 the rate is very slightly below the national average at 4.3 per 100,000. The national rate was 4.7 per 100,000.

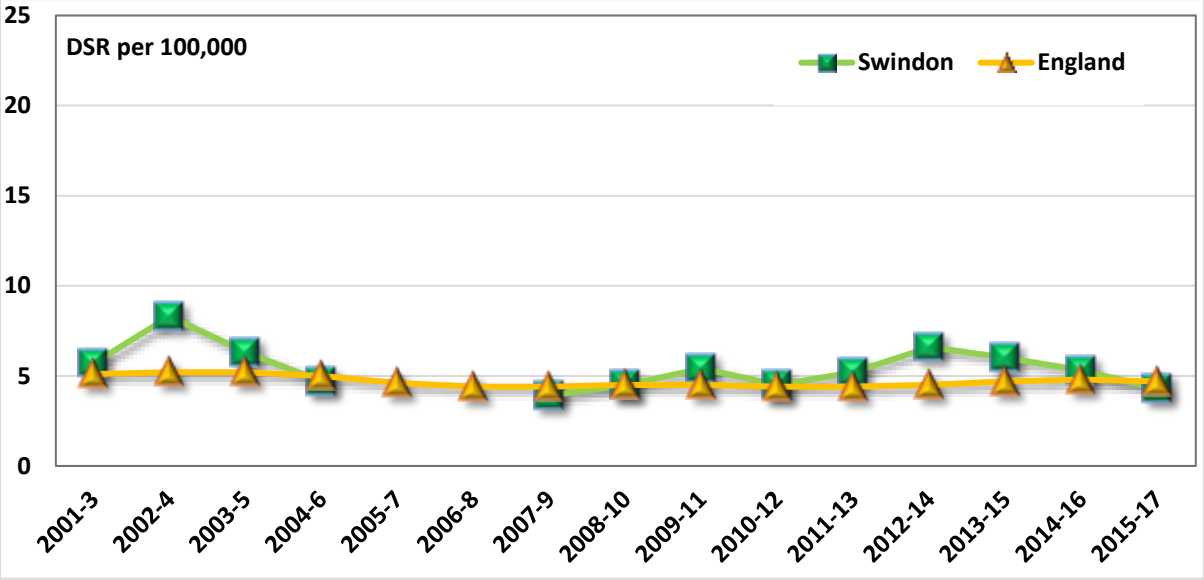

Figure 9: Female suicide rate 2001 to 2017 for Swindon UA and England (directly standardised rates per 100,000 for rolling three year periods) (Source: PHOF/ONS)

The graph below shows a spike in numbers of suicides in Swindon in people in their forties, with men accounting for the majority of these suicides. Suicide is the biggest killer of men under the age of 50.

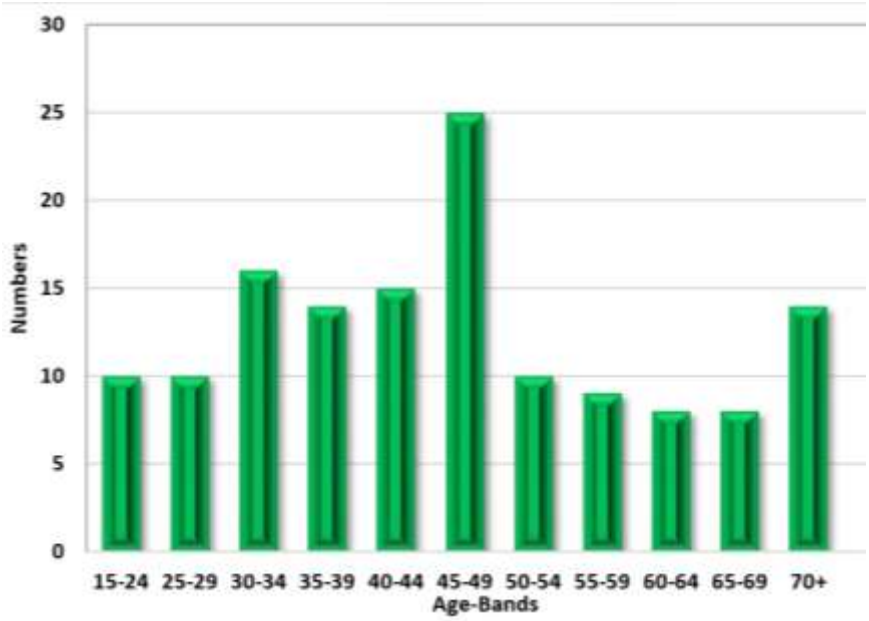

Figure 10: Number of suicide deaths by age-bands in Swindon from 2008-2017 (total=139) (Source: Suicide Audit Database/Wiltshire Coroner)

5.2.2 Suicide bereavement counselling

Providing support for people bereaved by suicide is a key objective of the national suicide prevention strategy for England (Department of Health, 2012). When compared with people bereaved through other causes, those bereaved by suicide are at an increased risk of suicide, psychiatric admission and depression. The risk of friends and relatives of people who die by suicide making a suicide attempt themselves is 1 in 10. Close family members, particularly parents and spouses or partners, are thought to be the most vulnerable groups following a suicide, but there are also risks for extended family, friends and colleagues. Research suggests there is a substantial unmet need for support after suicide (PHE, 2016b).

According to PHE (2016b), there is no standard approach to delivering support services for people bereaved by suicide, and the type of support needed and how long it will be needed for varies from person to person. Thus, PHE recommend that any postvention[3] service is able to offer individuals a wide choice of support tailored to their needs, either directly or through referral to local partner organisations.

The Bereavement Support Triangle below (PHE, 2016b) presents different models of support including information provision, local suicide bereavement support groups, and one-to-one and family support such as psychotherapy. Evidence-based training has also been developed for GPs and mental health professionals to support parents bereaved by suicide.

[3] The term postvention describes activities developed by, with, or for people who have been bereaved by suicide, to support their recovery and to prevent adverse outcomes. (PHE, 2016b)

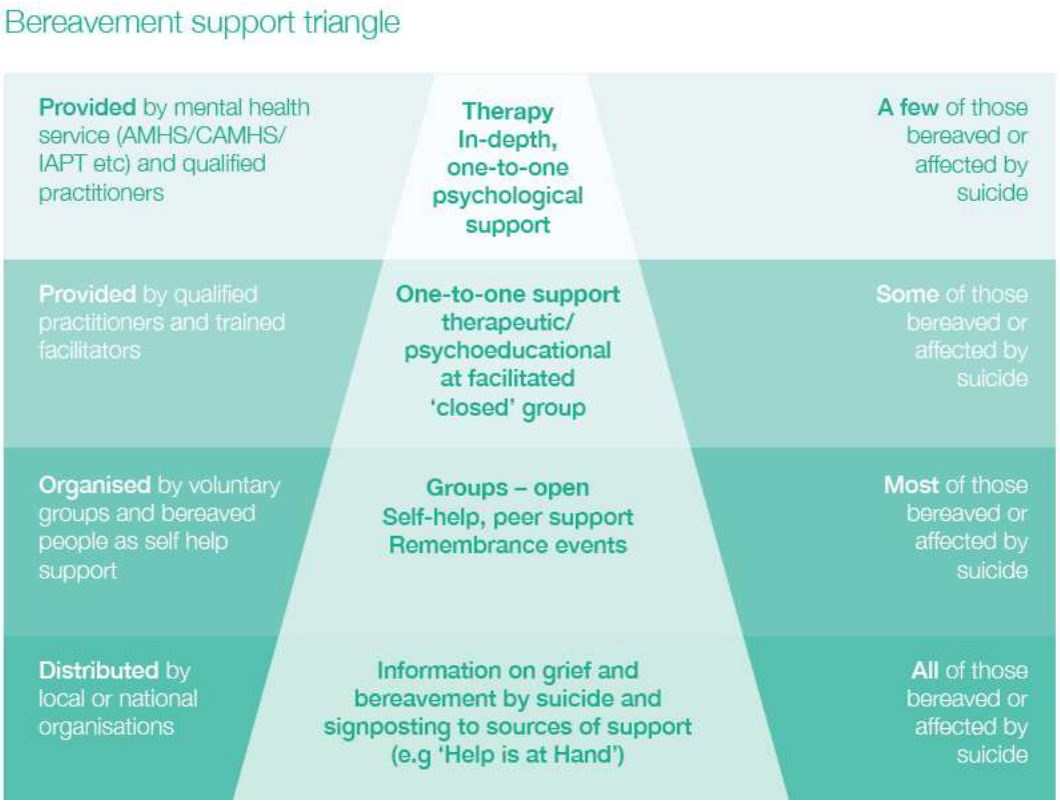

Figure 11: Suicide bereavement support triangle (Source: PHE, 2016b (reproduced with permission from D. Stubbs))

In the guidance they have produced on providing local services to support those bereaved by suicide, PHE (2016b) emphasize the importance of timely identification and referral of people bereaved by suicide to support. Many people bereaved by suicide say they need immediate outreach from a range of voluntary and statutory sector support services, and there may be considerable delays between a suicide occurring and the coroner completing the inquest and issuing a verdict of suicide. In order to offer timely bereavement support, it is important for agencies to work together and share information on suspected suicides. This is known as real-time suicide surveillance – such a system may be coroner-led (in which the coroner allows information on suspected suicides to be transferred securely to public health teams) or police-led (in which the police, who are often the first responders at the scene of a death, asking if the bereaved person would like a referral for support and then sharing this request with public health and other relevant partners).

In providing local suicide bereavement support, PHE (2016b) further highlight the importance of evaluation as a key element of postvention support in order to improve services and demonstrate effectiveness.

Specialist support is needed for children who have been bereaved by suicide – postvention services should recognise the different needs of children and adults (PHE, 2016b). Winston's Wish is the UK's childhood bereavement charity, and provides postvention support for children. Some considerations for providers of postvention support for children include:

- Parents and carers may need support to communicate with children and respond to difficult questions.
- Children need honest information about how someone died, appropriate to their age.

- Because information enters the public domain quickly, it is important for children to learn the truth from a trusted carer.

An example pathway developed by PHE for providing care and support locally to those bereaved by suicide is shown below. A more detailed version of this pathway can be found in the publication, "Support after a suicide: Developing and delivering local bereavement support services", by the National Suicide Prevention Alliance.

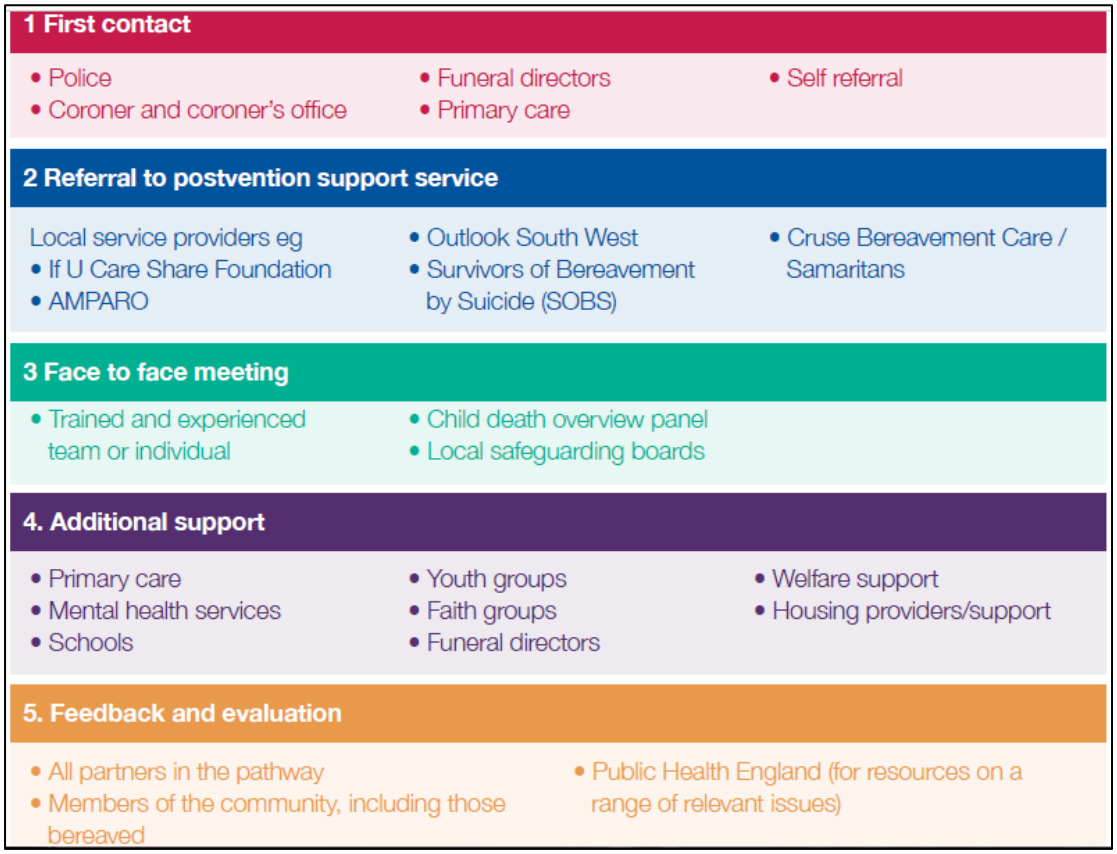

Figure 12: PHE example pathway of care and support for those bereaved by suicide (Source: PHE, 2016b)

6. Adult community mental health and wellbeing service provision in Swindon

6.1 Current provision of adult community mental health and wellbeing services

Information on current provision of adult community mental health and wellbeing services, commissioned by the Voluntary Sector Commissioning team at SBC, was drawn from providers' 2017/18 annual reports. As at time of publication, the Voluntary Sector Commissioning team commissions the following four voluntary sector providers of services in this category;

- Cruse: a bereavement care service for people having difficulty coping with bereavement which provides support through one-to-one sessions, group sessions and over the phone.

- Twigs: a community gardens project for people with mental health problems.

- Mind: a national charity providing advice and support to people with mental health problems. The five ways to wellbeing underpin many of the services offered by Swindon Mind, which include one-to-one counselling for self-harm, a physical activity intervention, one-to-one employment support, one-to-one and group wellbeing support, and transitions services for both adults and children being discharged from mental health services,

- Phoenix: an independent social enterprise which supports people with mental health problems to access training and employment opportunities.

The table below summarises information on service use and performance, as reported by these providers for 2017/18.

Table 8: Information on service use and performance for adult community mental health and wellbeing services in Swindon in 2017/18

Provider	Total number of service users	Key successes	Key challenges
Cruse	223	- Increase in number of clients offered a service and seen by a bereavement volunteer over the previous year - Client assessment forms show that clients made progress in areas of emotional health and wellbeing following support from bereavement volunteers - Initiated evening groups so that more clients can be seen	- Managing the waiting list - Retaining volunteers - Receiving more complex referrals from clients with mental health issues/drug and alcohol problems
Twigs	124	- Piloting the service for people with dementia - Chosen as one of three Mayor's charities for the year along with The Harbour project and 105.5FM	- Keeping the service running effectively on minimal staffing - Obtaining sustainable funding
Mind	762 members registered to use the service *(Apr. 2017-Feb. 2019: 155 referrals from AWP and 15 from CAMHS)*	- Delivered Mental Health First Aid training courses and Applied Suicide Intervention Skills Training (ASIST) courses - Supported individuals to access a community programme/activity	- Increasing demand for services
Phoenix	62	- Funding secured for a Fundraising Manager - Becoming a work experience partner with the Swindon job centre	- Building commercial business and obtaining non-seasonal work

Given that it is estimated that 29,820 people in Swindon have a CMD, and that just under half of those (14,208) have a severe CMD warranting intervention (based on prevalence estimates from the 2014 APMS and 2017 mid-year population estimates), it is clear from the figures for total annual service users that these service providers are reaching only a tiny proportion of those with mental health needs in the community.

6.2 Gaps in provision of adult community mental health and wellbeing services

Currently, there are no services commissioned by the Voluntary Sector Commissioning team for women in the perinatal period. Between 10% and 20% of women are affected by mental health problems at some point during pregnancy or the first year after childbirth (PHE, 2017c). In Swindon, based on live births data for 2015/16, this likely totals more than 1,000 women annually according to upper estimates.

The only provider for which demographic information on service users was available in their 2017/18 annual report was Mind – they reported that 89% of service users were White British and 56% were female. Ages ranged from 16-77, with an average of 47 years. It is clear from these figures that the BME community is under-represented among service users of Mind, especially given that prevalence of CMDs is higher among black and black British women (29.3%) compared to white non-British women and white British women (15.6% and 20.9% respectively) (NHS Digital 2016).

A number of other well-recognised high-risk groups for mental health problems are currently not explicitly targeted by voluntary sector community mental health and wellbeing services in Swindon:

- people with chronic physical health conditions
- people living with learning disabilities
- prison population and offenders
- LGBT people
- carers
- people with sensory impairment
- homeless people
- refugees, asylum seekers and stateless person
- people living in poverty
- people with debt problems.

7. Views of local people and providers

7.1 Community mental health and wellbeing service aims

The main purpose of the present needs assessment is to inform re-commissioning plans for community mental health and wellbeing services (i.e. those that are provided in the community setting by the voluntary sector for people with CMDs or people managing/recovering from SMI). The needs assessment aims to provide guidance on how to achieve the following aims of the new community mental health and wellbeing service;

- Improve mental health and wellbeing in Swindon
- Tackle stigma and discrimination and inequalities associated with mental health, promoting inclusion
- Raise awareness of mental health and wellbeing
- Improve collaborative working in the mental health and wellbeing sector to achieve better outcomes
- Reduce hospital admissions for self-harm
- Reduce suicide rate in Swindon
- Reduce demand on health care services
- Improve employment, volunteering, and mainstream integration of those with poor mental health.

As part of the re-commissioning process for the new service, the views of members of the public and of service providers were sought on mental health needs and service gaps in Swindon through an online survey, focus groups, consultations with representatives of vulnerable groups and an engagement event with providers. The findings of this research are summarized below.

7.2 Views of local people

An online survey was conducted from November-December 2018 and received 436 responses, and four focus groups were conducted in December 2018 and January 2019. The survey and three of the focus groups were open to all members of the public; one of the focus groups was for AWP service user representatives. The majority of survey respondents were White British (93%), female (79%), heterosexual (83%), had experienced a mental health problem (75%) and had accessed mental health support (68%).

A number of key themes emerged from consultation with local people, highlighted below.

1. **Popular activity types for improving mental health and wellbeing**

Local people identified a number of activities as being particularly helpful to them in managing their mental health and improving mental wellbeing, including:

- Talking to someone, such as a friend, family member or colleague
- Mindfulness
- Art based activities such as; photography, poetry, singing, arts and crafts
- Physical activities such as; gentle exercise, social walking, social media activities (beat the street), team sports (football) and dance
- Green Space activities such as; gardening, use of existing green spaces, contributing to green spaces in Swindon and nature/ wildlife based projects

2. **Peer groups**

Peer groups are popular with local people as a mode of support – they said that, in these groups, others understand your experiences and you can help other people in a similar position to you. People said that the focus of such groups should be shifted away from mental illness – rather they should be based around activities, and they should take place in community settings. People said that it should be made clear whether groups are peer-led or supported by staff, and that they should offer an assessment based on individual needs.

3. **Stigma around mental health**

Stigma around mental health problems was an important theme that emerged – it was discussed extensively in focus groups, and a majority of survey respondents (65%) reported having experienced or witnessed stigma or discrimination due to mental health.

Local people said that a town wide approach to reducing stigma and increasing awareness of mental health is needed to change the culture around mental health.

Further, people said that it's important for services to be mindful of the language they use – language relating to mental illness and mental health can be stigmatising so using the term 'wellbeing' instead may encourage more people to engage with services.

4. **Support for mental health from mainstream services in the community**

The general feedback from local people was that if mainstream services in the community (i.e. those that are not specific to mental health such as leisure centres, sports or cultural groups) were better equipped to support mental wellbeing, there would be much more on offer. Further, integration back into community life (after receiving mental health services) would be easier. Some people may need one-to-one or peer support to engage in community life when 'stepping down' from mental health services.

7.3 Consultations with vulnerable groups on providing an inclusive service

Members of vulnerable groups and staff working with these groups were consulted on what needs to be considered in order to provide an inclusive community health and wellbeing service. The following groups were consulted between December 2018 and February 2019;

- Swindon Carers Centre staff
- The Learning Disability Forum (staff from local service providers)
- Swindon Disability Sport group (staff from local service providers)
- Adult LGBTQ community (staff from local service providers as well as 30 responses to a public survey)
- The local Goan Community (26 participants at a focus group event)
- The CEO of Gloucestershire Deaf Association

The Activity Alliance and Healthwatch Swindon findings in their Quality Checkers reports were also considered.

Feedback from these groups was collated and the below key trends identified.

1. **Training in communication skills**

All services reported that there is a distinct lack in education/ training for professionals when dealing with customers both written and verbally.

Training around communicating with someone who is transgender (e.g. on the use of pronouns) was seen as a big gap in Swindon. Training in how to communicate effectively with

someone who has a learning disability and in understanding the barriers to communication was also seen as a need for staff. Training is needed to increase the confidence of staff to ask people with physical disabilities or long-term conditions directly about the kind of support they need.

Such training is needed for staff on reception, right through to staff working one-to-one with individuals.

2. **Training for faith leaders in the community**

Consultation with the Goan community highlighted that faith was a huge factor in supporting mental health, so training for key faith leaders may be an important way of improving mental health support in this community. This may also be the case for other ethnic and faith groups.

3. **Clear information about the service to improve accessibility**

Members of vulnerable groups and staff working with them highlighted the importance of ensuring that people have a clear understanding of the service offer, and of practical details such as what the venue looks like (e.g. by including photos on the website), toilets, parking and transport links. Such information would allow people to plan ahead around parking and accessing the building.

Information about services should be provided in a number of formats to make it accessible to different groups, for example easy read formats for people with learning disabilities or pictorial formats for people for whom English is not their first language. Information about local services that offer interpreters or translation would also be a helpful step towards being inclusive.

4. **Service user involvement**

All groups highlighted service user involvement and consulting a wide group of service users as an important part of being an inclusive service.

5. **Promoting awareness and reducing stigma around mental health**

As in the consultation with members of the wider public, the importance of raising awareness around mental health and reducing stigma and discrimination again emerged as a key theme. Staff said that it's important to raise awareness among carers about looking after their own mental health. The Goan community reported that there was a lack of awareness of how family members could support each other's mental health. Members of the LGBTQ community emphasized the importance of continuing to raise awareness among the public about the effect that stigma and discrimination due to their sexuality can have on mental health.

7.4 Views of local mental health and wellbeing service providers

As part of the re-commissioning cycle, community mental health and wellbeing service providers were invited to give their feedback on initial re-commissioning plans at a Market Engagement Event that took place on February 18th 2019. Twenty people attended, representing 14 community mental health organisations;

- Age UK
- Wiltshire Wildlife Trust
- Homegroup
- Rethink
- SOBS (Survivors of Bereavement by Suicide)
- Twiggs
- Swindon and Gloucestershire Mind

- GDA (Gloucestershire Deaf Association)
- Ipsum
- Together for Mental Health
- Disability Experts
- Service users from AWP
- AWP
- Swindon Town Football in the Community Trust

The main points of feedback from providers are summarised below.

1. **Partnership working**

Providers appreciated the focus on partnership working and collaboration in the commissioning plans. They said this would help to address the current gap in awareness among providers of other work going on in Swindon, and would help to facilitate transitions between services.

2. **Co-producing plans with service users**

Providers emphasized the importance of co-producing plans with service users in order to address demand from repeat users and to;

- Establish their needs early on
- Address causes of their mental ill-health
- Specify timeframes of service use

It was recommended that plans focus on mental wellbeing as well as mental ill-health.

3. **Healthy lifestyle promotion**

Providers were asked about how healthy lifestyle promotion could be embedded into the new community mental health and wellbeing service. They suggested embedding healthy lifestyle planning in personal planning, and to promote and encourage engagement with existing healthy lifestyle provision in Swindon.

Providers cautioned that healthy lifestyle planning needs to be led by the individual as healthy lifestyle changes are typically not a top priority for people experiencing mental ill-health – hence it would be important to focus on the causes of mental ill-health first, and then on healthy lifestyle changes.

8. Review of evidence for effective mental health interventions

This section presents an overview of evidence-based mental health interventions in the following categories:

- Interventions recommended by NICE for mild to moderate CMDs, SMI and perinatal mental health problems respectively;
- Interventions to improve mental wellbeing and prevent mental ill-health, with a particular focus on physical activity, access to green space and arts-based interventions, in line with the re-commissioning priorities for community mental health and wellbeing services;
- Cost-effective interventions, including those recommended by PHE and online counselling interventions.

8.1 Effective interventions for mild to moderate CMDs recommended by NICE guidance

NICE guidance stipulates that the below interventions should be available for people with mild to moderate CMDs (PHE, 2017b, NICE, 2018):

- individual facilitated self-help based on the principles of cognitive behavioural therapy (CBT)
- computerised CBT
- structured group physical activity programmes
- group-based peer support (self-help) programmes (for those who also have a chronic physical health problem).

Individual facilitated self-help programmes based on CBT principles should (NICE, 2018):

- include the provision of written materials of an appropriate reading age (or alternative media to support access)
- be supported by a trained practitioner, who typically facilitates the self‑help programme and reviews progress and outcome
- consist of up to six to eight sessions (face-to-face and via telephone) normally taking place over 9 to 12 weeks, including follow-up.

Computerised CBT should (NICE, 2018):

- be supported by a trained practitioner, who typically provides limited facilitation of the programme and reviews progress and outcome
- typically take place over 9 to 12 weeks, including follow-up.

Structured group physical activity programmes should (NICE, 2018):

- be delivered in groups with support from a competent practitioner
- consist typically of three sessions per week of moderate duration (45 minutes to 1 hour) over 10 to 14 weeks (average 12 weeks).

For those who have a chronic physical health condition, group-based peer support (self-help) programmes should (NICE, 2009):

- be delivered to groups of patients with a shared chronic physical health problem
- focus on sharing experiences and feelings associated with having a chronic physical health problem
- consist typically of one session per week delivered over a period of 8 to 12 weeks.

- be supported by practitioners who should:
    - facilitate attendance at the meetings
    - have knowledge of the patients' chronic physical health problem and its relationship to depression
    - review the outcomes of the intervention with the individual patients.

For each of these NICE-recommended interventions, the table below outlines details of the corresponding local provision.

Table 9: Interventions for mild to moderate CMDs recommended by NICE guidance, and details of corresponding local provision

NICE-recommended intervention	Local provider(s)	Further details on local provision
Individual facilitated self-help based on CBT principles	1. Books on Prescription scheme running in Swindon 2. Living Life to the Full https://llttf.com/ 3. NHS Self Help Leaflets https://web.ntw.nhs.uk/selfhelp/ 4. NHS Moodzone https://www.nhs.uk/Conditions/stress-anxiety-depression/	1. Books are supported by the NHS and GP can refer to this scheme but it is not facilitated by professionals. 2. National scheme, not facilitated but supported by NHS. 3. National scheme, not facilitated but supported by NHS.
Computerised CBT	Lift Psychology Silvercloud https://liftpsychology.silvercloudhealth.com/signup/	Non facilitated support but clinically tested
Structured group physical activity programmes	Mind Be Active Sessions include sports such as Boxing, Swimming, Football, Running, Gym.	Sessions are open to all for as long as they want to attend – a fee is charged. Session are weekly and range from 1- 3 hours. Sessions are also open to people with LD, and physical disabilities including hearing impairments.
Group-based peer support (self-help) programmes (for those who also have a chronic physical health problem)	Lift Psychology run a range of course for long-term health conditions (LTHC) including 'living well with long term pain' and specific LTHC such as Diabetes, COPD and Chronic Pain. All courses are delivered with CBT techniques to manage emotional health around the pain.	Courses are run by facilitators and are self-referral or GP referral. Courses range from 1 day to 6 weeks long. Customers may not always be known to the LIFT service and the facilitators may only have information from their referral form to refer to.

8.2 Effective interventions for SMI recommended by NICE guidance and PHE

Due to advances in care and drugs, and greater emphasis on human rights, the model of mental health care for people with SMI has transformed from a hospital-centred specialty to one where 90% of contacts take place in the community (NHSE, 2016). Recommendations from the National Institute of Health and Care Excellence (NICE) for community-based mental health services include the following (PHE, 2017b):

- a person-centred and co- produced approach to the formulation, delivery and review of care planning;
- psychosocial and psychological therapy interventions for individuals and their families;
- optimisation of medication and regular medication review;
- physical health assessment and required interventions, including dental and ophthalmologic and healthy lifestyle promotion;
- effective recovery and rehabilitation in home and community settings including support with finding and maintaining stable housing, employment, financial wellbeing and social networks.

The NHS Five Year Forward View (FYFV) for Mental Health (NHSE, 2016) also highlights the importance of focussing on the physical health needs of people with SMI. People with SMI are at risk of dying on average 15-20 years earlier than other people – this is one of the greatest health inequalities in England. Two thirds of these deaths are due to preventable physical illnesses, including heart disease and cancer (NHSE, 2016). Smoking is a significant cause of poorer physical health among people with SMI – approximately 40% of this group smoke, compared to 15% of the general population (PHE, 2018c). There is low take up among people with SMI of health information, tests and interventions relating to physical activity, smoking, alcohol problems, obesity, diabetes, heart disease and cancer (NHSE, 2016).

The FYFV for Mental Health recommends that people with SMI be offered screening and secondary prevention for physical health problems, particularly smoking cessation interventions (NHSE, 2016).

Also in line with the NICE recommendations for community-based mental health services, the FYFV for Mental Health emphasizes the importance of supporting people with mental health problems to find or stay in work, stating that “employment is vital to health and should be recognised as a health outcome” (NHSE, 2016, pg. 17). In Swindon, there is a 64% gap between the employment rates of those in contact with secondary mental health services and the general population.

Regarding recovery and rehabilitation for people with SMI, the FYFV for Mental Health recommends the provision of more community-based ‘step-down’ help from secure care such as residential rehabilitation, supported housing and forensic or assertive outreach teams, and trialling new co-commissioning funding and service models in doing this.

Many of the recommendations made in the FYFV regarding care for people with SMI have been taken forward for action in the NHS Long Term Plan (NHS, 2019). It sets out plans for new and integrated models of primary and community mental health care to support adults and older adults with severe mental illnesses, stating that, “a new community-based offer will include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use,” (NHS, 2019, pg. 69). The plan also states that, “local areas will be supported to redesign and reorganise core community mental health

teams to move towards a new place-based, multidisciplinary service across health and social care aligned with primary care networks," (NHS, 2019, pg. 69).

8.3 Effective interventions for perinatal mental health problems recommended by NICE guidance

Routine antenatal and postnatal appointments with maternity, GP and health visiting services are good opportunities for health professionals to identify potential mental health problems (PHE, 2017b). The FYFV for Mental Health recommends that women with perinatal mental health problems should have access to psychological therapies and specialist perinatal community or inpatient mental health care (NHSE, 2016).

Depression is the most common perinatal mental health problem, affecting 10-15% of women in the perinatal period (SBC Public Health, 2015). For women with persistent sub-threshold depressive symptoms, or mild to moderate depression, NICE recommends non-directive counselling delivered at home (listening visits) (NICE, 2011b).

For pregnant women who have sub-threshold symptoms of depression and/or anxiety that significantly interfere with personal and social functioning, NICE recommends the below interventions (NICE, 2011b):

- individual brief psychological treatment (four to six sessions), such as interpersonal therapy (IPT) or CBT for women who have had a previous episode of depression or anxiety
- social support during pregnancy and the postnatal period for women who have not had a previous episode of depression or anxiety; such support may consist of regular informal individual or group-based support.

8.4 Interventions to improve mental wellbeing and prevent mental ill-health

The Faculty of Public Health's (FPH) definition of mental health encompasses "mental illness/disorder, mental wellbeing and all other states of mental health" (FPH, 2019). Thus, mental wellbeing can be conceived of as the "positive side of mental health" (i.e. it is more than the absence of mental illness). There is no clear consensus on a definition of mental wellbeing – however, a succinct definition is 'feeling good and functioning well' from the perspective of positive psychology (FPH, 2019). According to the FPH (2019), mental wellbeing includes the capacity to:

- realise our abilities, live a life with purpose and meaning, and make a positive contribution to our communities
- form positive relationships with others, and feel connected and supported
- experience peace of mind, contentment, happiness and joy
- cope with life's ups and downs and be confident and resilient
- take responsibility for oneself and for others as appropriate.

The Foresight Mental Wellbeing and Capital project (Government Office for Science, 2008, pg. 61) found that, "people with a low level of wellbeing, even if they do not have a mental disorder, function far less well and have poorer health and life expectancy. This latter group is unlikely to come to the attention of specialist mental health services, but constitutes a large part of the population who are neither flourishing nor disordered, yet could benefit greatly from having access to interventions to improve their wellbeing. They are frequently seen in GP surgeries, primary care settings, social work departments and many other front-line public services."

It is clear that, from a health promotion perspective, there is a need to improve wellbeing at a population level and to provide universally accessible interventions to reach the 'large part of the population that are neither flourishing nor disordered'.

To improve mental wellbeing and prevent mental ill-health, PHE (2017a, 2018d) recommends developing social capital through community engagement, promoting healthier lifestyle choices, tackling stigma and discrimination around mental health problems and taking action to address the wider determinants of mental health such as reducing poverty, and improving housing and employment. For working age adults, low educational attainment, poverty and unemployment are particularly strong factors affecting mental health and wellbeing (PHE, 2017b).

Tackling the wider determinants of mental health is also a priority from the perspective of people with experience of mental health problems, as highlighted by the findings of a public consultation with over 20,000 people undertaken for the FYFV for Mental Health report. Specific themes discussed included good quality housing, debt, poverty, employment, education, access to green space and tough life experiences such as abuse, bullying and bereavement (NHSE, 2016).

In line with local commissioning priorities regarding community mental health and wellbeing services, a brief overview of the evidence for interventions to improve mental wellbeing through physical activity, access to green space and engagement with the arts respectively is presented below.

8.4.1 Physical activity interventions

'Be active' is one of the five evidence-based ways to wellbeing identified by the New Economics Foundation as part of the Foresight project, and is a local and national public health priority. The Get Swindon Active Strategy sets out a vision for Swindon of having 'everybody active, every day', and highlights the importance of cross-sector collaboration and of continuing to develop and promote the existing range of opportunities for physical activity available in Swindon to deliver this vision (SBC, 2015).

Physical activity can benefit mental health and wellbeing in a number of ways including through (PHE, 2016a);

- a sense of purpose and value
- better quality of life
- improved sleep
- reduced stress.

There is a well-established link between physical activity and depression – regular physical activity can reduce the risk of depression by up to 30%, and inactive people have 3 times the rate of moderate to severe depression compared to active people (PHE, 2016a). NICE recommends the use of structured group physical activity as a treatment for mild to moderate depression (NICE, 2018).

PHE (2014b) has reviewed evidence of effectiveness for over 950 local physical activity interventions in England – the largest study of its kind. From all the interventions reviewed, two were identified as having the strongest evidence of effectiveness; Project ACE (Active, Connected, Engaged neighbourhoods) and Les Mills UK.

Project ACE is an intervention being rolled out in Bristol by the charity LinkAge in which retired volunteers (activators) promote physical activity among older adults by supporting them to 'get out and about' more and engage with their local communities. Evaluation of the

programme demonstrated significant improvements in participants' confidence, social support and knowledge of local initiatives, as well as improvements in life satisfaction, feeling that life is worthwhile and social wellbeing compared to the control group (PHE, 2014b). Les Mills UK is an international franchise operation delivering 30,000 group fitness classes per week in fitness clubs across the UK – evaluation of these classes focussed on physical health benefits, showing reduced cardiovascular risk in participants compared to controls.

8.4.2 Access to green space

Green space can be defined as areas of greenery - the terms 'public spaces', 'urban spaces', 'open spaces' and 'green spaces' are often used interchangeably. There are different types of green space including parks, public gardens and playing fields, but also 'spaces' such as streets or cycle ways where there are trees planted (PHE, 2014a).

There is strong and consistent evidence linking access to green space with improved mental health and wellbeing, with indications of a causal relationship (PHE, 2014a, DEFRA, 2017). Research has shown that green space exposure is associated with reduced stress, fatigue, anxiety and depression (DEFRA, 2017). Green space exposure is linked with a number of other health outcomes, including greater physical activity levels. Studies have shown that users of green space and those living close to green space are more likely to engage in physical activity, and to achieve recommended levels of physical activity (PHE, 2014a). Increased physical activity is linked with improved mental wellbeing, and engaging in physical activity outdoors in the natural environment is associated with additional benefits to mental wellbeing compared to doing the same amount of exercise indoors (PHE, 2014a, PHE, 2016a).

There are inequalities in access to green space across England: less deprived areas have more green spaces than more deprived areas; he most affluent 20% of wards in England have five times the amount of green space compared with the most deprived 10% of wards (PHE, 2014a). Given the strong links between access to green space and a range of physical and mental health outcomes, inequalities in access to green space are likely to contribute to health inequalities.

PHE (2014, pg. 26) has stated that "public health teams in local areas have a clear role in prioritising, designing and commissioning interventions to improve access to green spaces and in working with local authorities to influence delivery. Interventions that improve access to green spaces are likely to help local areas reduce health inequalities and help level up the social gradient in health." Central government has also set itself a mandate to "help people improve their health and wellbeing by using green spaces including through mental health services", as part of the 25 Year Environment Plan (DEFRA, 2018).

PHE (2014) further recommends that, in order to reduce inequalities in access to green space and health outcomes, interventions to improve access to green spaces should be universally available to the local population, while also being targeted to vulnerable groups with a scale and intensity proportionate to their needs (in line with the Marmot principle of proportionate universalism).

PHE (2014) have identified a number of effective interventions for improving access to and engagement with green space, including the following:

- Creating new green spaces;

- Protecting and improving the quality of existing green spaces by, for instance, improving infrastructure such as paths, outdoor gyms, car parks, cafés, toilets, play areas and recreational facilities such as tennis courts;
- Improving access/transport links to green spaces;
- Health walk programmes;
- The Green Gyms scheme run by the Conservation Volunteers, in which guides assist and support participants in engaging in physical, outdoor activities in local green spaces;
- Natural England's Green Exercise programme which engaged hard to reach groups, including people with mental health problems, in green exercise activities including conservation tasks, outdoor activity programmes (including cycling), walking programmes and woodland games.

8.4.3 Arts-based interventions

The term 'the arts' encompasses the visual and performing arts, including crafts, dance, film, literature, music and singing, as well as the culinary arts and gardening. Arts engagement may take place in a variety of settings including concert halls, galleries, heritage sites, libraries, museums, theatres, health and social care environments and community settings (All-Party Parliamentary Group on Arts, Health and Wellbeing, 2017).

An All-Party Parliamentary Group on Arts, Health and Wellbeing (APPGAHW) was formed in 2014 to examine research and practice with regard to the impact of arts engagement on health and wellbeing. Following a two year Inquiry, the APPGAHW published a report in which they concluded that, "the time has come to recognise the powerful contribution the arts can make to our health and wellbeing," and called for "an informed and open-minded willingness to accept that the arts can make a significant contribution to addressing a number of the pressing issues faced by our health and social care systems," (APPGAHW, 2017, pg. 1). Engaging with the arts is a way of addressing the social determinants of health, as illustrated in the below quote from Professor Sir Michael Marmot (APPGAHW, 2017, pg. 4):

"The mind is the gateway through which the social determinants impact upon health, and this report is about the life of the mind. It provides a substantial body of evidence showing how the arts, enriching the mind through creative and cultural activity, can mitigate the negative effects of social disadvantage."

Although engaging with the arts can mitigate the health impacts of social disadvantage, engagement with the publicly funded arts is relatively low among socio-economically disadvantaged people. Thus, to reduce health inequalities, programmes to improve access to and engagement with the arts should target this group (APPGAHW, 2017).

The APPGAHW's report found that a number of different arts-based interventions are supported by evidence of beneficial impacts on health and wellbeing, including;

- Arts in health and care environments, including GP surgeries, hospitals, hospices and care homes.

- Participatory arts programmes (defined as individual and group arts activities intended to improve and maintain health and wellbeing in health and social care settings and community locations).

- Arts therapies (defined as drama, music and visual arts activities offered to individuals, usually in clinical settings, by any of 3,600 practitioners accredited by the Health and Care Professions Council).

- Arts on prescription (a type of social prescribing in which people experiencing psychological or physical distress are referred (or refer themselves) to engage with the arts in the community including galleries, museums and libraries).

- Inclusion of the arts in the training and professional development of health and social care professionals.

- Everyday creativity (people engaging in the arts as a hobby, as part of daily life).

- Attendance at cultural venues and events including at concert halls, galleries, heritage sites, libraries, museums and theatres.

- Improving the quality of the built and natural environments.

The APPGAHW made ten recommendations to work towards changing thinking and practice in order to realise the potential of the arts to improve health and wellbeing. Three of these recommendations are applicable at a local level (APPGAHW, 2017, pg. 10);

- We recommend that, at board or strategic level, in NHS England, Public Health England and each clinical commissioning group, NHS trust, local authority and health and wellbeing board, an individual is designated to take responsibility for the pursuit of institutional policy for arts, health and wellbeing.

- We recommend that those responsible for NHS New Models of Care and Sustainability and Transformation Partnerships ensure that arts and cultural organisations are involved in the delivery of health and wellbeing at regional and local level.

- We recommend that NHS England and the Social Prescribing Network support clinical commissioning groups, NHS provider trusts and local authorities to incorporate arts on prescription into their commissioning plans and to redesign care pathways where appropriate.

It is apparent from the latter recommendation that, of the range of evidence-based arts interventions highlighted in the APPGAHW's report, arts on prescription should be prioritised by local commissioners. As mentioned above, arts on prescription is a type of social prescribing, which is defined as "a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services," (King's Fund, 2017). Social prescribing is consistent with the emphasis of NHS England's Five Year Forward View (2014) on community-based, non-medical responses to physical and mental health and wellbeing needs. There are many different models for social prescribing, but most involve a link worker or navigator to help people access local services and activities (King's Fund, 2017).

The APPGAHW's report highlights the example of Gloucestershire CCG's arts on prescription scheme, delivered by a charity called Artlift, for patients with a range of conditions, including chronic pain, stroke, anxiety and depression. The intervention consists of a weekly two-hour session over the course of eight weeks, led by a professional artist

working in poetry, ceramics, drawing, mosaic or painting. An evaluation of the programme between 2009 and 2012 demonstrated a 37% drop in GP appointments and a 27% drop in hospital admissions among participants, equating to a return on investment of £216 per patient.

Another example of an arts on prescription scheme is “Inspiring Minds”, commissioned by Salford CCG in Greater Manchester, which focusses on people with mental health problems (APPGAHW, 2017). People with mild to severe mental health problems are referred to the service via primary or secondary mental health services. The intervention consists of weekly two-hour studio-based creative workshops led by professional artists over the course of 6-18 months, along with a personalised support and recovery package. On completion of the programme, a community integration worker works with participants to explore other opportunities for community involvement.

Recommendations for ensuring the success of arts on prescription schemes include raising awareness of such schemes among health professionals and developing local champions in arts and culture (King’s Fund, 2017, APPGAHW, 2017).

8.5 Cost-effective mental health interventions

8.5.1 Key definitions in health economics

In health economics, cost-effectiveness is measured using the incremental cost-effectiveness ratio (ICER) – this represents the extra cost per extra quality-adjusted life-year (QALY) gained by the intervention compared to the alternative against which it is being compared (often usual care). The ICER is then compared to a cost-effectiveness threshold (the threshold used by NICE is £20,000-£30,000 per QALY gained), and if the ICER is below this threshold, the intervention is considered cost-effective. A QALY is a summary outcome measure that takes into account gains in both health-related quality of life and quantity of life due to an intervention – one QALY represents one year of life in full health (PHE, 2018b).

Return-on-investment (ROI) contrasts the cost savings achieved by an intervention compared to the alternative/usual care with the cost of implementing the intervention. If the return (i.e. the cost savings) is greater than the cost of implementation, the intervention provides a net gain – however, if the return is lower than the cost of implementation, the intervention results in a net loss (PHE, 2018b).

8.5.2 Cost-effective mental health interventions recommended by PHE

There are two key evidence reviews on cost-effective mental health interventions that have been commissioned and published by the Department of Health and Social Care and PHE respectively – *Mental health promotion and mental illness prevention: The economic case* (Knapp, McDaid & Parsonage, 2011), and *Commissioning cost-effective services for promotion of mental health and wellbeing and prevention of mental ill-health* (McDaid, Park & Knapp, 2017).

For the 2011 report, a literature review was carried out to identify effective mental health interventions. Subsequently, economic analysis of the costs and benefits associated with 15 interventions identified in the literature review was carried out, the results of which were estimates of the ROI for these interventions. It should be kept in mind that these ROI estimates are conservative, and that they were calculated by discounting prices to 2009/10 values (present value at the time of publication) (Knapp, McDaid & Parsonage, 2011). These estimates did not include monetised health gains (i.e. conversion of QALY gains from interventions into monetary values) in the calculation of return on investment, and thus any net gains are in addition to improvements in mental health achieved by the interventions.

The 2017 report builds on the findings of the 2011 report – it examined the economic evidence for effective mental health interventions that emerged since the publication of the 2011 report. Economic analysis of eight interventions for which new evidence had emerged was carried out. The ROI estimates were calculated by discounting prices to 2015 values, and again, did not include monetised health gains.

Tables 11 and 12 below present the ROI estimates, and the perspective from which they are calculated, for the interventions examined in the 2011 and in the 2017 report respectively.

Table 10: Cumulative ROI estimates for 15 effective mental health interventions (Knapp, McDaid & Parsonage, 2011)

Intervention	Cumulative ROI estimate (NHS & other public sector perspective)	Timeframe for public sector ROI to be realised	Total cumulative ROI estimate (societal perspective - public & non-public sectors)
Early identification and intervention			
Early intervention for conduct disorder	£2.86 : £1.00	Long-term horizon (year 6 onwards)	£7.89 : £1.00
Health visitor interventions to reduce postnatal depression	£0.40 : £1.00	Short-term horizon (year 1)	£0.80 : £1.00
Early intervention for depression in diabetes	£0.19 : £1.00	Medium-term horizon (years 2-5)	£0.33 : £1.00
Early intervention for medically unexplained symptoms (physical symptoms likely caused by mental or emotional factors)	£1.01 : £1.00	Medium-term horizon (years 2-5)	£1.75 : £1.00
Early diagnosis and treatment of depression at work	£0.51 : £1.00	Medium-term horizon (years 2-5)	£5.03 : £1.00
Early detection of psychosis	£3.41 : £1.00	Long-term horizon (year 6 onwards)	£10.27 : £1.00
Early intervention in psychosis	£9.95 : £1.00	Long-term horizon (year 6 onwards)	£17.97 : £1.00
Screening for alcohol misuse	£3.17 : £1.00	Long-term horizon (year 6 onwards)	£11.75 : £1.00
Suicide training courses provided to all GPs	£0.13: £1.00	Long-term horizon (year 6 onwards)	£43.99 : £1.00
Suicide prevention through bridge safety barriers	£3.06 : £1.00	Long-term horizon (year 6 onwards)	£54.45 : £1.00
Promotion of mental health and prevention of mental disorder			
Prevention of conduct disorder through social and emotional learning programmes	£26.44 : £1.00	Long-term horizon (year 6 onwards)	£83.73 : £1.00
School-based interventions to reduce bullying	£0.00: £1.00	Long-term horizon (year 6 onwards)	£14.35 : £1.00
Workplace health promotion programmes	£9.69 : £1.00 *(employer, not public sector, perspective)*	Short-term horizon (year 1)	£9.69 : £1.00

Intervention	Cumulative ROI estimate (NHS & other public sector perspective)	Timeframe for public sector ROI to be realised	Total cumulative ROI estimate (societal perspective - public & non-public sectors)
Addressing social determinants and consequences of mental disorder			
Debt advice services	£0.92 : £1.00	Medium-term horizon (years 2-5)	£3.55 : £1.00
Befriending for older adults	£0.44 : £1.00	Short-term horizon (year 1)	£0.44 : £1.00

Table 11: Cumulative ROI estimates for 8 effective mental health interventions (McDaid, Park & Knapp, 2017)

Intervention	Cumulative ROI estimate (NHS & local authority perspective)	Timeframe for NHS & LA ROI to be realised	Total cumulative ROI estimate (societal perspective – public & non-public sectors)
School-based anti-bullying programme	£0.68 : £1.00	Medium-term horizon (year 4)	£1.58 : £1.00
School-based social and emotional learning programme	£0.36 : £1.00	Medium-term horizon (year 2)	£5.08 : £1.00
Workplace wellbeing	£2.31 : £1.00 *(from employer, not NHS & local authority, perspective)*	Short-term horizon (year 1)	£2.37 : £1.00
Workplace stress prevention	£1.52 : £1.00 *(from employer, not NHS & local authority, perspective)*	Medium-term horizon (year 2)	£2.00 : £1.00
Protecting the mental health of people with physical health problems	£0.26 : £1.00	Medium-term horizon (year 2)	£1.52 : £1.00
Tackling loneliness	£0.95 : £1.00	Medium-term horizon (year 5)	£1.26 : £1.00
Support for people in debt	£0.22 : £1.00	Medium-term horizon (year 5)	£2.60 : £1.00
Suicide and self-harm prevention	£2.52 : £1.00	Long-term horizon (year 10)	£39.11 : £1.00

8.5.2.1 Implications for commissioning in Swindon

The findings of the reports into cost-effective mental health interventions by Knapp, McDaid and Parsonage (2011) and McDaid, Park and Knapp (2017) indicate that the below interventions provide a net gain in terms of cost savings from a NHS and other public sector, NHS and local authority, or employer perspective (in the case of workplace interventions):

- Early intervention for conduct disorder
- Early intervention for medically unexplained symptoms (somatoform conditions in which physical symptoms with no identifiable physical cause are believed to be caused by mental or emotional factors)
- Early detection of psychosis
- Early intervention in psychosis
- Screening for alcohol misuse
- Suicide prevention through bridge safety barriers
- Prevention of conduct disorder through social and emotional learning programmes
- Workplace health promotion programmes
- Workplace wellbeing
- Workplace stress prevention
- Suicide and self-harm prevention

From this list, the interventions that are relevant to current local commissioning priorities are those relating to suicide and self-harm prevention, and workplace health promotion. Further details on these intervention models, as examined in the above mentioned reports, are outlined below.

Suicide and self-harm prevention interventions:

Knapp, McDaid and Parsonage (2011) found that installing bridge safety barriers to prevent suicides provides an estimated ROI of £3.06 for every £1.00 invested, from a public sector perspective, in the long-term. Jumping from a height accounts for around 3% of completed suicides. The construction of safety barriers on bridges has been shown to successfully reduce suicides - it appears that these averted suicides are not simply displaced to other, unsecured jumping sites, but it is unclear whether suicide occurs by another method in such cases. Knapp, McDaid and Parsonage's (2011) economic analysis was based on a case study of the Clifton Suspension Bridge in Bristol. Following the installation of a safety barrier in 1998, at a cost of £300,000 (in 2009 prices), the number of suicides reduced from an average of 8.2 per annum in the five years before the barrier, to 4 per annum in the five years after it was installed. The model assumes that a bridge safety barrier would prevent around half of suicide attempts. It takes into account the consideration that individuals may instead attempt suicide using other methods – however, it is assumed that this displacement still leads to a lower number of suicides, as the mortality rate assumed in the model from jumping from a bridge is 95%, compared with around 9% for other suicide methods combined.

The report by McDaid, Park and Knapp (2017) highlighted an estimated ROI, from a NHS and local authority perspective, for suicide and self-harm prevention of £2.52 per £1.00 invested in the long-term. The intervention modelled in the report was the increased use of psychosocial assessment when individuals present to hospital accident and emergency departments due to deliberate self-harm. Increased use of psychosocial assessment has been associated with a lower rate of future self-harm events (due to an increased likelihood of receiving appropriate psychological therapies) and reduced risk of subsequent suicidal

events through the use of cognitive behavioural therapy following assessment (McDaid, Park and Knapp, 2017).

Workplace health promotion interventions:

Knapp, McDaid and Parsonage (2011) estimated that workplace health promotion interventions provide a ROI of nearly £10 for every £1 invested, from an employer perspective, in the first year of implementation. One such programme examined was workplace-based enhanced depression care, which involves the use of a screening questionnaire to be completed by employees and subsequently offering those identified as having, or being at risk of depression and/or anxiety disorders, a course of 6 CBT sessions over 12 weeks. The model assumes that the employer will bear all costs of the intervention, and shows that these costs are outweighed by improved productivity (through reduced absenteeism and presenteeism).

The 2011 report also examined a universal, multi-component workplace wellbeing intervention consisting of personalised health and wellbeing information and advice; a health risk appraisal questionnaire; access to a tailored health improvement web portal; wellness literature; and seminars and workshops focused on identified wellness issues. This type of intervention is estimated to have a significant ROI, from an employer perspective, due to reduced stress levels, reduced absenteeism and reduced presenteeism.

The economic model for this workplace wellbeing intervention was updated by McDaid, Park and Knapp in 2017 – they estimate a ROI of over £2 per £1 (from an employer perspective) invested in a universal mental health promotion intervention which includes a health risk appraisal questionnaire, unlimited access to a personalised web portal to encourage healthy lifestyle behaviours including interactive behavioural changes via online, fortnightly e-mail communications to provide practical tips for self-care (in addition to paper-based information packs) on stress management, sleep, nutritional advice, and physical activity, and four off-line seminars touching on the most common wellness issues over a 12- month period. The model assumed that 10% of employees would take up the intervention.

Return for the business is expected to be over double the costs of implementation within a year, due to a reduction in sickness absence of more than four days per annum and in presenteeism of more than six hours every four weeks, per employee. These productivity gains are based on the results of a controlled trial evaluation of this intervention in a white collar branch of a multinational company in the UK.

McDaid, Park and Knapp (2017) also found evidence of a positive ROI for employers of £1.52 per £1 invested in a workplace stress prevention intervention over a two year timeframe. The intervention modelled was the universal provision of a workplace CBT service of up to 12 one-hour sessions offered to all employees who are identified by occupation health services as being stressed, based on observed experience of a workplace CBT programme available to the 11,000 employees of Cardiff City Council. The model makes the conservative assumption that CBT reduces the risk of stress by 13% relative to no intervention. Observed experience of the service at Cardiff City Council suggested that significant positive impacts on mental health were seen in nearly half of those who received CBT.

8.5.3 Cost-effective interventions: online counselling for adults

As a mode of delivery for mental health interventions, the Internet has significant advantages over other more traditional delivery modes, including greater cost-effectiveness, ease and anonymity of access, and scalability (Harrer, Adam, Baumeister et al., 2018). These advantages may contribute to narrowing the treatment gap for depression in particular.

Research suggests that the general public is open to the use of online mental health interventions, and that those that have used such services tend to be satisfied with them (Kerst, Zielasek & Gaebel, 2019, Meurk, Leung & Whiteford, 2016). However, satisfaction and preferences are higher for guided, as opposed to unguided, online interventions (Apolinário-Hagen, Kemper & Stürmer, 2017). Guidance in this context refers to human support which may vary in intensity and may take the form of personalized feedback, contact with coaches online or via telephone, or peer support (Hennemann, Farnsteiner & Sander, 2018). Some studies have suggested that the public perceives online mental health interventions as less helpful than traditional face-to-face interventions (Apolinário-Hagen, Kemper & Stürmer, 2017).

Systematic reviews and meta-analyses have found small effects of Internet-based psychological interventions on depression and anxiety (Harrer, Adam, Baumeister et al., 2018, Hennemann, Farnsteiner & Sander, 2018).

The authors of one study suggested that the small effect size of Internet-based interventions on depression calls into question "the clinical usefulness of treating depressive symptoms in students using Internet-based approaches," (Harrer, Adam, Baumeister et al., 2018, pg. 15).

However, there is greater support in the literature for Internet-based interventions based on CBT principles – such interventions are more common than other types of Internet-based therapeutic interventions and have been shown to have bigger effect sizes in relation to depression outcomes (Harrer, Adam, Baumeister et al., 2018, Hennemann, Farnsteiner & Sander, 2018). They have also been shown to be effective in increasing functionality and decreasing symptoms across a range of other mental health problems (Kumar, Sattar, Bseiso et al., 2017). Further, research has supported the role of Internet-based CBT in preventing suicide – given the stigma associated with suicide, people with suicidal thoughts find it harder to seek help and hence the anonymity provided by Internet-based CBT is a major advantage in this context (Kumar, Sattar, Bseiso et al., 2017).

It should be taken into account that Internet-based CBT interventions often include some form of guidance. Research has shown that guidance has beneficial effects on adherence and effectiveness in Internet-based mental health interventions (Hennemann, Farnsteiner & Sander, 2018).

It should be kept in mind that the methodological quality of many studies of Internet-based psychological interventions for mental health problems is sub-optimal – for instance, many studies suffer from high drop-out rates and fail to assess co-interventions received by participants (e.g. outpatient therapy) (Hennemann, Farnsteiner & Sander, 2018). Further, the purpose of online counselling interventions is often unclear in the literature – i.e. whether they are intended to provide only a brief intervention, or constitute an alternative to face-to-face treatment.

To summarise, the literature suggests that Internet-based CBT programmes are superior to other types of Internet-delivered mental health interventions. This isn't surprising when one takes into account the strong evidence base for CBT - it is recommended by NICE for the treatment of mild to moderate depression and for perinatal mental health problems. Computerised CBT is currently recommended by NICE for the treatment of mild to moderate depression (NICE, 2018).

9. Recommendations for the 2019 re-commissioning of community mental health and wellbeing services

9.1 Recommendations for re-commissioning based on data and literature

Based on the epidemiological and service data and the literature reviewed as part of this needs assessment, the below recommendations are made for the re-commissioning of community mental health and wellbeing services in Swindon in 2019.

- **Follow CBT principles:** Based on NICE guidelines for the treatment of mild to moderate CMDs, provision should be delivered using CBT principles.

- **Promote mental health in the workplace:** Based on evidence of cost-effectiveness for workplace mental health promotion interventions, continue to work with local employers to promote the mental health of the workforce.

- **Support women with perinatal mental health problems:** Based on NICE guidance for pregnant women who have sub-threshold symptoms of depression and/or anxiety, ensure that a community-based social support offer is available during pregnancy and the postnatal period, and raise awareness among the public and health and social care professionals of the risk of perinatal mental health problems and how to recognise and identify such problems.

- **Increase community self-harm support:** Based on high rates of self-harm admissions in Swindon, increase community self-harm support, ensuring that:

    - Young people are specifically targeted;

    - Provision complies with Health Education England's Self-Harm and Suicide Prevention Competence Framework for Community & Public Health;

    - Provision complies with NICE Clinical Guideline 133 on the long-term management of self-harm in people aged over 8 years old (see Appendix 1 for key points from this guideline).
        - This guideline emphasizes the importance of ensuring community mental health services offer an integrated and comprehensive psychosocial assessment of needs, including skills, coping strategies, mental health problems and physical health problems, and risks to understand and engage people who self-harm and to initiate a therapeutic relationship. Needs assessments for children and young people should include a full assessment of the child's family, social situation, and child protection issues.

        - The guideline also recommends that mental health services, including community services, consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm. The intervention should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements.

        - In considering the above, priority should be given to CBT-based interventions based on the available evidence. CBT-based interventions for adolescents should have strong family-systems driven components (Iyengar, Snowden, Asarnow et al., 2018).

- **Offer suicide bereavement counselling:** Based on national suicide prevention policy and recommended best practice, offer bereavement counselling tailored for those bereaved by suicide.

- **Raise public awareness of community mental health and wellbeing services:** It is clear from the figures for total annual service users of community mental health and wellbeing services in Swindon that these service providers are reaching only a tiny proportion of those with mental health needs in the community (for instance, it is estimated that nearly 15,000 people in Swindon have a severe CMD warranting intervention). Hence, based on current limited reach of community mental health and wellbeing services in Swindon, it is recommended to raise awareness among the public of services available, for instance through a website.

- **Address inequalities of vulnerable groups:** Services should explicitly focus on groups who experience higher rates of poor mental health but may not access treatment. The needs of the vulnerable groups below should be addressed as a priority, based on current limited provision for them;

    - Young people, particularly women, aged 16-24 (women in this age group have the highest prevalence of CMDs in the population)
    - Young and middle-aged men (particularly in relation to suicide)
    - LGBT people
    - The black community
    - The prison population and offenders
    - Homeless people
    - Refugees, asylum seekers and stateless person
    - People with debt problems
    - People with substance misuse problems

- **Support people with financial problems:** All services should be aware of the importance of benefit, gambling and debt services and intervening early, and signpost to the Citizen's Advice Bureau where appropriate.

- **Up-skill mainstream community services around mental health issues:** Based on national policy guidelines, adopt the principle of proportionate universalism in provision, by ensuring that the service is universally available, but with additional targeting of high risk groups as outlined above. To ensure universal mental health provision, it is recommended to work on up-skilling mainstream community services (i.e. those outside the field of mental health) to be more inclusive and more aware of mental health issues and supporting people with mental health problems.

- **Adopt a social prescribing model:** Based on national policy guidelines (most recently the NHS Long Term Plan), provision should be delivered using a social prescribing model.

    - It will be important to raise awareness among GPs of available services and ensure they can easily refer to them, for instance through having a single point of access for self-referrals such as a website.
    - Providers should develop their evaluation skills and measure the impact of social prescribing interventions in a quantitative way if possible.

- **Focus on promoting mental wellbeing:** To truly adopt a public mental health approach, it is recommended that promotion of mental wellbeing be at the heart of service provision in order to reach the 'large part of the population that are neither flourishing nor disordered' (Government Office for Science, 2008, pg. 61). Provision should comprise evidence-based approaches to improving population mental wellbeing, including;
    - Tackling stigma and discrimination
    - Promoting healthy lifestyle choices, particularly with regard to physical activity, smoking cessation and safer drinking levels.
        - Promotion of physical activity and smoking cessation should be in line with the Get Swindon Active Strategy and the Swindon Tobacco Control Strategy respectively.
        - All services should be aware of and signpost to existing healthy lifestyle services including Stop Smoking services, Health Checks, screening programmes, substance misuse treatment services and the Lift Back To Work programme.
    - Addressing wider determinants of mental health, such as improving access to green space, and increasing engagement with the arts.

9.2 Recommendations for re-commissioning based on stakeholders' perspectives

Based on feedback gathered from service providers, the below recommendations are made.

- **Promote partnership working:** Promote collaboration and partnership working between different providers of the service, and awareness among providers of other mental health-related work going on in Swindon.

- **Focus on wellbeing in care planning:** Ensure mental wellbeing is a focus of care planning with service users, and create a service-wide wellbeing plan template for use by all services.

Based on feedback gathered from local people including representatives of vulnerable groups, the following recommendations are made with a view to ensuring that the new service is as inclusive as possible.

- **Tackle stigma and raise awareness around mental health:** To tackle stigma around mental health, raise awareness among the public and vulnerable groups, including carers and the LGBTQ community, about mental health. Consider training and raising awareness among faith leaders on mental health in BME communities, such as the Goan community. Ensure the workforce is upskilled to enable them to communicate in an inclusive manner with vulnerable groups, such as transgender people and people with learning or physical disabilities.

- **Provide clear and accessible information on the service offer:** As well as information about the service, provide information about practical details such as what the venue looks like (e.g. by including photos on the website), toilets, parking and transport links to allow people to plan ahead around accessing the building.

Information about services should be provided in a number of formats to make it accessible to different groups, for example easy read formats for people with learning disabilities or pictorial formats for people for whom English is not their first language. Consider also providing information about local services that offer interpreters or translation.

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11. Appendix 1: Key points from NICE Clinical Guideline 133 'Self-harm in over 8's: Long-term management'

1. **General principles of care**

- Health and social care professionals who work with people who self-harm should ensure that people are fully involved in decision-making about their treatment and care and aim to foster people's autonomy and independence wherever possible.
- Health and social care professionals should be educated about the stigma and discrimination usually associated with self-harm and the need to avoid judgemental attitudes.
- Health and social care professionals should be trained to understand when and how the Mental Health Act (1983; amended 1995 and 2007) can be used to treat the physical consequences of self-harm.
- Children and young people who self-harm should have access to the full range of treatments and services recommended in the guideline within CAMHS.
- Ensure equitable access to services for children and adults from BME communities, and for people for whom English presents a language barrier by providing information and interventions in their preferred language, and an independent interpreter.
- Manage the endings of services, treatments or relationships and support transitions between services, through a process of planning with the service user.

2. **Primary care**

- If a person presents in primary care with a history of self-harm and a risk of repetition, consider referring them to community mental health services for assessment. If they are under 18 years, consider referring them to CAMHS for assessment.
- Primary care professionals should monitor the physical health of people who self-harm. Pay attention to the physical consequences of self-harm as well as other physical healthcare needs.

3. **Psychosocial assessment in community mental health services and other specialist mental health settings**

- Offer an integrated and comprehensive psychosocial assessment of needs, including skills, coping strategies, mental health problems and physical health problems, and risks to understand and engage people who self-harm and to initiate a therapeutic relationship.
- During assessment, explore the meaning of self-harm for the person and take into account that each person who self-harms does so for individual reasons, and each episode of self-harm should be treated in its own right and a person's reasons for self-harm may vary from episode to episode.
- Needs assessments for children and young people should include a full assessment of the child's family, social situation, and child protection issues.
- The psychosocial assessment should be used to develop a care plan and a risk management plan in conjunction with the person who self-harms and their family, carers or significant others if this is agreed with the person.

4. **Longer-term treatment and management of self-harm**

- In terms of the provision of care, mental health services (including community mental health teams and liaison psychiatry teams) should generally be responsible for the routine assessment and the longer-term treatment and management of self-harm. In children and young people this should be the responsibility of tier 2 and 3 CAMHS.
- Care plans, including risk management plans, should be a central component in the care and long-term management of self-harm, and should be jointly developed with the person who self-harms, and reviewed on a regular basis.
- Consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm. The intervention should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements.
- Do not offer drug treatment as a specific intervention to reduce self-harm.

5. Treating associated mental health conditions

- Provide psychological, pharmacological and psychosocial interventions for any associated conditions.
- When prescribing drugs for associated mental health conditions to people who self-harm, take into account the toxicity of the prescribed drugs in overdose.