Key Points

Prevalence:
- Barnsley’s 2014/15 rate for the diagnosed prevalence of depression (9.6%) is significantly higher than the rate for England (7.3%) (see Figure 1).
- The proportion of adults in Barnsley diagnosed with a severe mental health problem (schizophrenia, bipolar affective disorder and other psychoses) is 0.7%; significantly lower than the rate for England (0.9%) (see Figure 4).

Treatment:
- The rates of IAPT referrals in Barnsley in 2015/16 entering treatment (65.8%) and finishing a course of treatment (24.5%) are significantly lower than the rates for England (68.2% and 38.4% respectively) (see Figures 8 and 9).
- Barnsley had a slightly lower rate in 2015/16 (44.7%) than the England average (45.3%) for IAPT referrals finishing a course of treatment classified as having recovered (see Figure 12).
- The proportion of adults in Barnsley who have had an assessment of severity at the time of being diagnosed with depression (84.8%) is significantly lower than the rate for England (90.6%) (see Figure 13).
- Less than half (48.8%) of adults in Barnsley are reviewed 10-56 days after being diagnosed with depression; this is significantly lower than the rate for England (63.8%) (see Figure 14).
- Only 5.3% of adults in contact with mental health services in Barnsley have a diagnosis recorded; this is significantly lower than the rate for England (15.9%) (see Figure 15).
- The proportion of adults in Barnsley with a severe mental illness who have a comprehensive care plan (68.9%) is significantly lower than the rate for England (77.2%) (see Figure 16).
- Barnsley has a significantly higher rate of adults in contact with mental health services (2,953.3 per 100,000) than the rate for England (2,134.4 per 100,000) (see Figure 17).
- The proportion of mental health service users in Barnsley who are inpatients in a psychiatric hospital (1.7%) is significantly lower than the rate for England (2.6%) (see Figure 18).
- Levels of co-existing mental health problems in the drug and alcohol treatment populations in Barnsley are significantly lower than the rates for England (see Figures 20 and 21).
- Barnsley’s spend on antidepressants per 1,000 weighted population (£7,251) is higher than the England rate of £5,686 (see Figure 22).

Crisis Care:
- Barnsley had a significantly lower rate in 2012/13 for A&E attendances for a psychiatric disorder (42.8 per 100,000) than the rate for England (243.5 per 100,000) (see Figure 24).
- Barnsley’s rates for hospital admissions for mental and behavioural disorders due to use of alcohol are significantly higher than national rates for persons, males and females (see Figures 25 to 27).
- Barnsley’s 2014/15 rate for emergency hospital admissions for intentional self-harm (266.6 per 100,000) is significantly higher than the rate for England (191.4 per 100,000) (see Figure 29).

Employment/Accommodation:
- Barnsley has a slightly lower rate of adults who are receiving secondary mental health services and in employment (5.5%) than the England average (6.7%) (see Figure 34).
- The proportion of adults in Barnsley who are receiving secondary mental health services and living in settled accommodation (61.0%) is slightly higher than the England average of 59.0% (see Figure 36).

Carers:
- Carers of mental health clients in Barnsley have significantly higher rates of completed assessments and services received than the England rates (see Figures 38 and 40).

Mortality:
- Barnsley has a slightly higher rate (1,329.3 per 100,000) for under 75 mortality in adults with serious mental illness than the England rate (1,318.9 per 100,000) (see Figure 42).
Purpose & Context:

- The purpose of this report is to present information relating to mental health in Barnsley, including data on prevalence, treatment, A&E attendances, hospital admissions, employment and accommodation status of adults receiving secondary mental health services, carers of mental health clients and premature mortality in adults with a serious mental illness.

- The data used has been collated from various data sources including Public Health England, NHS England and the Improving Access to Psychological Therapies (IAPT) programme.
# Mental health in Barnsley

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Prevalence

Depression prevalence, as recorded on GP practice disease registers (aged 18+)

Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for patients, their family and carers, multiple morbidity, higher levels of service use and many associated economic costs (Public Health England, 2016).

Figures 1 to 3 illustrate the proportion of patients aged 18 and over, diagnosed on or after 1 April 2006, who have an unresolved record of depression in their patient record.

Figure 1. Prevalence of depression (in people aged 18+): Barnsley CCG, 10 ‘similar’ CCGs and England (2014/15)

- Barnsley’s 2014/15 rate for the prevalence of depression (9.6%) is significantly higher than the rate for England (7.3%).
- Compared to 10 ‘similar’ CCGs, Barnsley’s rate is the second highest.
- Barnsley’s 2014/15 rate of 9.6% represents 18,840 adults living in Barnsley who have been diagnosed with depression.

Figure 2. Prevalence of depression (aged 18+): Barnsley CCG and England (2011/12 to 2014/15)

- Barnsley’s rates for depression prevalence have been significantly higher than the rates for England at each time point during the period 2011/12 to 2014/15.
- Barnsley’s 2014/15 rate of 9.6% is the second highest during the period, although it is significantly lower than the 2011/12 rate of 15.8%; this reflects the national trend.

Figure 3. Proportion of patients aged 18 and over, diagnosed on or after 1 April 2006, who have an unresolved record of depression in their patient record

Produced by the Research and Business Intelligence Team: Research&BusinessIntelligenceTeam@barnsley.gov.uk
Figure 3. Prevalence of depression (aged 18+): Barnsley GP practices and Barnsley CCG (2014/15)

- There is wide variation in depression prevalence rates amongst Barnsley GP practices, ranging from 3.2% in practice C85028 to 19.0% in practice C85624.

- Of the 36 practices, 14 have higher rates, and 22 have lower rates than the Barnsley average of 9.6%.
Prevalence

Diagnosed Mental health prevalence

Serious mental illness covers a range of symptoms and experiences, which can bring distress and reduce the ability to cope with the demands of everyday life. Treatments are available and recovery is possible. However, people with a serious mental illness have mortality rates 2-3 times higher than the total population. This is mainly due to physical disorders, which may be undiagnosed or not treated, due to the focus on the mental illness. This indicator shows the prevalence of schizophrenia, bipolar affective disorder and other psychoses, as recorded on general practice systems (Public Health England, 2016).

Figures 4 to 6 illustrate the proportion of patients (all ages), with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers.

Figure 4. Prevalence of a mental health problem (schizophrenia, bipolar affective disorder and other psychoses), all ages: Barnsley CCG, 10 ‘similar’ CCGs and England (2014/15)

- Barnsley’s 2014/15 rate for the prevalence of mental health problem (0.7%) is significantly lower than the rate for England (0.9%).
- Compared to 10 ‘similar’ CCGs, Barnsley’s rate is the third lowest.
- Barnsley’s 2014/15 rate of 0.7% represents 2,942 adults living in Barnsley who have been diagnosed with a mental health problem (schizophrenia, bipolar affective disorder and other psychoses).

Figure 5. Prevalence of a mental health problem (all ages): Barnsley CCG and England (2012/13 to 2014/15)

- Barnsley’s rates for the prevalence of mental health conditions have been significantly lower than the rates for England at each time point during the period 2012/13 to 2014/15.
- Barnsley’s rates have remained relatively stable during the period, rising slightly from 0.72% in 2012/13 to 0.74% in 2014/15; this reflects the national trend.
Mental health problem:

Figure 6. Prevalence of mental health problem (all ages): Barnsley GP practices and Barnsley CCG (2014/15)

- There is wide variation in the prevalence of diagnosed mental health problems amongst Barnsley GP practices, ranging from 0.3% in practice C85617 to 1.9% in practice Y02644.

- Of the 36 practices, 15 have higher rates, and 21 have lower rates than the Barnsley average.
Long-term mental health problem

Quality and Outcomes Framework data shows that 0.9% of patients in England have a recorded diagnosis of serious mental illness. This indicator examines the percentage of patients (aged 18+) responding to a national GP survey reporting that they had a long-term mental health problem – a much higher prevalence of 5.1%. This may reflect a likelihood for people with mental or physical illnesses to participate in GP surveys, but it could also indicate under-recording of mental illness diagnoses on GP computer systems (Public Health England, 2016).

Likewise, within Barnsley, 0.7% of patients have a recorded diagnosis of serious mental illness (figure 4), compared to 6.3% self-reporting in the GP survey that they had a long-term mental health problem (figure 7).

Figure 7. Percentage of patients (aged 18+) reporting a long-term mental health problem: Barnsley CCG, 10 ‘similar’ CCGs and England (2014/15)

- Barnsley’s 2014/15 rate for the proportion of patients self-reporting that they had a long-term mental health problem (6.3%) is significantly higher than the rate for England (5.1%).
- Compared to 10 ‘similar’ CCGs, Barnsley’s rate is the third highest.
The Improving Access to Psychological Therapies (IAPT) programme supports the frontline NHS in implementing NICE guidelines for people suffering from depression and anxiety disorders. It was created to offer patients a realistic and routine first-line treatment, combined where appropriate with medication which traditionally had been the only treatment available. When the programme was first implemented in 2008, it was targeted at people of working age, but in 2010 was opened to adults of all ages (IAPT 2016).

**IAPT referrals received, entering treatment and finishing a course of treatment**

*Figure 8. Proportion of IAPT referrals entering treatment: Barnsley CCG, 10 ‘similar’ CCGs and England (2015/16)*

- The proportion of IAPT referrals in Barnsley in 2015/16 entering treatment (65.8%) is significantly lower than the rate for England (68.2%).

- Barnsley has the third lowest rate of IAPT referrals entering treatment, when compared to 10 ‘similar’ CCGs.

*Figure 9. Proportion of IAPT referrals finishing a course of treatment: Barnsley CCG, 10 ‘similar’ CCGs and England (2015/16)*

- Less than a quarter of IAPT referrals in Barnsley in 2015/16 finished a course of treatment; this is significantly lower than the rate for England (38.4%).

- Barnsley has the third lowest rate of IAPT referrals finishing treatment, when compared to 10 ‘similar’ CCGs.
Table 1. Number of IAPT referrals, and numbers and proportions of referrals entering and finishing a course of treatment: Barnsley, by age and gender (2015/16)

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th></th>
<th>FEMALE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of IAPT referrals received</td>
<td>Number of referrals entering treatment</td>
<td>% of referrals received entering treatment</td>
<td>Number of referrals finishing a course of treatment</td>
<td>% of referrals received finishing a course of treatment</td>
</tr>
<tr>
<td>16-17</td>
<td>50</td>
<td>20</td>
<td>40.0</td>
<td>*</td>
</tr>
<tr>
<td>18-35</td>
<td>1,210</td>
<td>695</td>
<td>57.4</td>
<td>220</td>
</tr>
<tr>
<td>36-64</td>
<td>1,145</td>
<td>820</td>
<td>71.6</td>
<td>350</td>
</tr>
<tr>
<td>65 &amp; over</td>
<td>85</td>
<td>65</td>
<td>76.5</td>
<td>30</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2,490</td>
<td>1,600</td>
<td>64.3</td>
<td>600</td>
</tr>
</tbody>
</table>

* Numbers less than 5, including zero, have been suppressed in order to protect patient confidentiality.

- More than one and half times more women (4,505) than men (2,490) were referred into IAPT in 2015/16 (see Table 1).
- The rates for men and women entering treatment and finishing treatment are similar.
- The highest rates for entering treatment and finishing treatment are seen in the 65 and over age band for men and the 36-64 age group for women.
- The lowest rates for finishing treatment are seen in the younger age groups, for both men and women.

Table 2. Trend in numbers of IAPT referrals, and numbers and proportions of referrals entering and finishing a course of treatment: Barnsley CCG (2012/13 to 2015/16)

<table>
<thead>
<tr>
<th></th>
<th>Number of IAPT referrals received</th>
<th>Referrals entering treatment</th>
<th>% of referrals received entering treatment</th>
<th>Referrals finishing a course of treatment</th>
<th>% of referrals received finishing a course of treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>5,020</td>
<td>2,977</td>
<td>59.3</td>
<td>540</td>
<td>10.8</td>
</tr>
<tr>
<td>2013/14</td>
<td>5,805</td>
<td>3,680</td>
<td>63.4</td>
<td>1,450</td>
<td>25.0</td>
</tr>
<tr>
<td>2014/15</td>
<td>6,460</td>
<td>3,815</td>
<td>59.1</td>
<td>1,615</td>
<td>25.0</td>
</tr>
<tr>
<td>2015/16</td>
<td>6,995</td>
<td>4,605</td>
<td>65.8</td>
<td>1,715</td>
<td>24.5</td>
</tr>
</tbody>
</table>

- The number of referrals into IAPT in Barnsley has increased by more than a third since 2012/13 (from 5,020 to 6,995) (see Table 2).
- Barnsley’s rates for IAPT referrals entering treatment have fluctuated during the period 2012/13 to 2015/16; the 2015/16 rate of 65.8% is the highest during the period.
- Rates for referrals finishing treatment have increased from 10.8% in 2012/13 to 24.5% in 2015/16.

Produced by the Research and Business Intelligence Team: Research&BusinessIntelligenceTeam@barnsley.gov.uk
Treatment:
Improving Access to Psychological Therapies (IAPT)

**Figure 10. IAPT referrals completing treatment by problem descriptor: Barnsley CCG (2015/16)**

- More than two in five IAPT referrals completing treatment in Barnsley in 2015/16 (42.2%) did not have a problem descriptor allocated. For England overall, the proportion with no problem descriptor allocated was 23.5%.

- Of the referrals that did have a problem descriptor allocated, the largest cause was anxiety and stress related disorders (39.0%).

**IAPT waiting times**

**Figure 11. Waiting times to enter treatment, for IAPT referrals finishing a course of treatment: Barnsley CCG and England (2015/16)**

- The majority of IAPT referrals in Barnsley in 2015/16 (54.2%) had a waiting time of between 29 and 56 days, from the referral received date and the first treatment appointment.

- More than two thirds (71.1%) of referrals in England in 2015/16 had a waiting time of 28 days or less. Within Barnsley, the rate for those waiting 28 days or less before entering treatment was just over a quarter (25.7%).

Produced by the Research and Business Intelligence Team: Research&BusinessIntelligenceTeam@barnsley.gov.uk
Table 3. Trend in waiting times to enter treatment, for IAPT referrals finishing a course of treatment: Barnsley CCG (2013/14 to 2015/16)

<table>
<thead>
<tr>
<th></th>
<th>28 days or less (%)</th>
<th>Between 29 and 56 days (%)</th>
<th>Between 57 and 90 days (%)</th>
<th>More than 90 days (%)</th>
<th>Average waiting time (in days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>72.4</td>
<td>17.5</td>
<td>3.9</td>
<td>6.1</td>
<td>Not available</td>
</tr>
<tr>
<td>2014/15</td>
<td>21.8</td>
<td>58.1</td>
<td>11.8</td>
<td>8.4</td>
<td>49.2</td>
</tr>
<tr>
<td>2015/16</td>
<td>25.7</td>
<td>54.2</td>
<td>12.2</td>
<td>7.9</td>
<td>48.9</td>
</tr>
</tbody>
</table>

- The proportion of referrals in Barnsley entering treatment within 28 days decreased by more than half from 2013/14 (72.4%) to 2015/16 (25.7%).

- Less than one in five referrals in 2013/14 (17.5%) had a waiting time of between 29 and 56 days. This increased to more than one in two in 2015/16 (54.2%).

- The proportion of people waiting more than 57 days and more than 90 days also increased from 2013/14 to 2014/16.

IAPT recovery status

Figure 12. IAPT referrals finishing a course of treatment by recovery status: Barnsley CCG and England (2015/16)

- Over half of referrals finishing a course of treatment, in Barnsley, in 2015/16 (58.5%) were classed as having reliable improvement. This is slightly lower than the England rate of 62.2%.

- Less than half of referrals finishing a course of treatment, in Barnsley, in 2015/16 (44.7%) were classified as having moved to recovery; slightly lower than the England rate of 46.3%.

- Barnsley has a slightly higher rate (35.0%) than the England average (31.6%) for referrals finishing a course of treatment which resulted in no reliable change.
Patients with severity of depression assessed

NICE guidelines state that an assessment of severity in patients with depression is essential to decide on appropriate interventions and improve the quality of care. An assessment of severity as close as possible to the time of diagnosis enables a discussion with the patient about relevant treatment and options ... (Public Health England, 2016).

**Figure 13. Proportion of patients with a new diagnosis of depression, who have had an assessment of severity at the time of diagnosis: Barnsley CCG, 10 ‘similar’ CCGs and England (2012/13)**

- The proportion of patients in Barnsley who have had an assessment of severity at the time of being diagnosed with depression (84.8%) is significantly lower than the rate for England (90.6%).
- Barnsley has the lowest rate when compared to 10 ‘similar’ CCGs.

**Figure 14. New cases of depression which have been reviewed 10-56 days after diagnosis: Barnsley CCG, 10 ‘similar’ CCGs and England (2014/15)**

- Less than half (48.8%) of patients in Barnsley are reviewed 10-56 days after being diagnosed with depression; this is significantly lower than the rate for England (63.8%).
- Barnsley has the lowest rate when compared to 10 ‘similar’ CCGs.
Treatment: serious mental illness

Patients with a diagnosis recorded

Obtaining an accurate diagnosis for a mental illness is not easy. Often a period of time for careful assessment is necessary to ensure a correct and accurate diagnosis is made. A diagnosis can be useful in helping an individual to understand their own condition and access appropriate support, such as social care. It can also be helpful for health professionals to access the appropriate guidance for a particular condition, e.g. National Institute for Health and Clinical Excellence (NICE) guidelines on schizophrenia (Public Health England, 2016).

Figure 15. Percentage of adults in contact with mental health services with a secondary care diagnosis recorded: Barnsley CCG, 10 ‘similar’ CCGs and England (2015/16 Q2)

- The proportion of patients in contact with mental health services in Barnsley, who have a diagnosis recorded (5.3%) is significantly lower than the rate for England (15.9%).

- Barnsley has the lowest rate when compared to 10 ‘similar’ CCGs.

Patients with a comprehensive care plan

This indicator reflects good professional practice and is supported by NICE clinical guidelines. Patients diagnosed with a severe mental illness should have a documented primary care consultation with a plan for care, especially in the event of a relapse. This consultation may include the views of their relatives or carers where appropriate (Public Health England, 2016).

Figure 16. Percentage of patients on the mental health register who have a comprehensive care plan documented: Barnsley CCG, 10 ‘similar’ CCGs and England (2014/15)

- The proportion of patients in Barnsley, on the mental health register, who have a comprehensive care plan (68.9%) is significantly lower than the rate for England (77.2%).

- Compared to 10 ‘similar’ CCGs, Barnsley’s rate is the lowest.
People in contact with mental health services per 100,000 population

This indicator looks at the numbers admitted to NHS funded adult specialist mental health services, regardless of a formal diagnosis. It includes use of community as well as hospital-based services and it can be compared with the levels of health and illness for a CCG to see whether the use of services is relatively high or low, given the recorded prevalence of mental illness. It can also be considered in conjunction with other treatment indicators to show if, for example, the use of inpatient beds is high compared with the use of health services overall (Public Health England, 2016).

Figure 17. People in contact with mental health services per 100,000 population (18+): Barnsley CCG, 10 ‘similar’ CCGs and England (2015/16 Q2)

• Barnsley has a **significantly higher** rate of adults in contact with mental health services (2,953.3 per 100,000) than the rate for England (2,134.4 per 100,000).

• Compared to 10 ‘similar’ CCGs, Barnsley’s rate is the **second highest**.

• Barnsley’s rate of 2,953.3 per 100,000 represents 4,660 adults in Barnsley who are in contact with mental health services.
Mental health service users in a psychiatric hospital

This indicator considers how many clients of mental health services are admitted to hospital, showing what proportion of the population with a mental illness require the most intense services. Looking at results across CCGs may reflect variation in needs in different areas but it may also indicate differences in the way mental health trusts provide their services (Public Health England, 2016).

Figure 18. Proportion of mental health service users who were inpatients in a psychiatric hospital: Barnsley CCG, 10 ‘similar’ CCGs and England (2015/16 Q2)

- The proportion of mental health service users in Barnsley who were inpatients in a psychiatric hospital at Q2 2015/16 (1.7%) is significantly lower than the rate for England (2.6%).
- Barnsley has the fourth lowest rate when compared to 10 ‘similar’ CCGs.
- Barnsley’s rate of 1.7% represents 95 adults in Barnsley who are inpatients in a psychiatric hospital.

People subject to Mental Health Act

In most cases, when people are treated in hospital or another mental health facility, they have agreed or volunteered to be there. However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act (1983) and treated without their agreement. The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others (NHS Choices, 2016).

Figure 19. People (aged 18+) subject to Mental Health Act: Barnsley CCG, 10 ‘similar’ CCGs and England

- The proportion of adults in Barnsley subject to the Mental Health Act at Q2 2014/15 (46 per 100,000) is higher than the rate for England (40 per 100,000).
- Compared to ‘similar’ CCGs, Barnsley’s rate is the third highest.
- Barnsley’s rate of 46 per 100,000 represents 85 adults in Barnsley who are subject to the Mental Health Act.
Direct indicators of dual diagnosis are currently largely unavailable. However, mental health problems are very common among those in treatment for drug and alcohol misuse, and alcohol misuse is common among those with a mental health problem. These indicators show the proportion of people who, when assessed for drug or alcohol treatment, were receiving treatment from mental health services for reasons other than substance misuse. The measure is indicative of levels of co-existing mental health problems in the drug and alcohol treatment populations. However, they should not be regarded as comprehensive measures of dual diagnosis as they only capture whether a person is receiving mental health treatment at a given point in time (Public Health England, 2016).

**Figure 20. Concurrent contact with mental health services and substance misuse services for drug misuse: Barnsley, statistical neighbours and England (2014/15)**

- Barnsley’s 2014/15 rate for people in treatment for drug misuse, who were also in contact with mental health services (9.0%) is **significantly lower** than the rate for England (21.0%).

- Compared to statistical neighbours, Barnsley’s rate is the **second lowest**.

**Figure 21. Concurrent contact with mental health services and substance misuse services for alcohol misuse: Barnsley, statistical neighbours and England (2014/15)**

- Barnsley’s 2014/15 rate for people in treatment for alcohol misuse, who were also in contact with mental health services (8.9%) is **significantly lower** than the rate for England (20.0%).

- Compared to statistical neighbours, Barnsley’s rate is the **second lowest**.
Primary care prescribing — Antidepressants

The volume of prescribing is measured in Average Daily Quantities. For a given drug, the Average Daily Quantity is a value calculated to reflect the daily dose typically prescribed to individual patients within UK General Practices. A STAR-PU (Specific Therapeutic group Age-sex Related Prescribing Unit) is a value calculated to reflect not only the number of patients in a practice, but also the age and sex mix of that group. Because the need for particular drugs within a group of patients is affected by their ages and gender balance, using the number of STAR-Pus, instead of the number of patients, as the basis the indicator, means that comparisons between General Practices better reflect differences in prescribing practice, and are less influenced by differences between the groups of patients being treated (NHS Choices, 2016).

Figure 22. Total cost for all antidepressant prescribing per STAR-PU: Barnsley CCG, 10 ‘similar’ CCGs and England (January to December 2015)

- Barnsley’s total spend on antidepressants per 1,000 weighted population in 2015 (£7,251) is higher than the England rate of £5,686.
- Compared to similar CCGs, Barnsley’s rate for antidepressant prescribing costs is the third highest.
Primary care prescribing for psychoses and related disorders (cost per 1,000 population 18+)

Figure 23. Cost of GP prescribing for psychoses and related disorders: Barnsley CCG, 10 ‘similar’ CCGs and England (2015/16 Q2)

- Barnsley’s prescribing costs for psychoses and related disorders per 1,000 population in 2015/16 Q2 (£663) is **higher** than the England rate of £614.

- Compared to similar CCGs, Barnsley’s rate for is the fourth highest.
Crisis resolution teams treat people with serious mental health conditions when they experience an acute and severe psychiatric crisis. However, many crisis episodes result in contact with police services or attendance at hospital A&E departments. Mental health problems are also associated with physical health problems, which may result in hospital visits. The impact of mental illness upon A&E departments may be significant and the need for liaison psychiatry services substantial (Public Health England, 2016).

Attendances at A&E for a psychiatric disorder

This indicator looks at the total number of attendances at A&E departments where a diagnosis of mental illness has been recorded, per 100,000 resident population. Note: approximately 10% of attendances to A&E do not have a valid diagnosis code. This value is variable across different providers.

**Figure 24. Attendances at A&E for a psychiatric disorder: Barnsley, similar CCGs and England (2012/13)**

- Barnsley’s 2012/13 rate for A&E attendances for a psychiatric disorder (42.8 per 100,000) is **significantly lower** than the rate for England (243.5 per 100,000).
- Compared to 10 ‘similar’ CCGs, Barnsley’s rate is the **lowest**.
- Barnsley’s 2012/13 rate of 42.8 per 100,000 represents 355 attendances at A&E for a psychiatric disorder.
Admissions for mental and behavioural disorders due to use of alcohol condition

Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and society as a whole £21 billion annually.

The Government has said that everyone has a role to play in reducing the harmful use of alcohol - this indicator is one of the key contributions by the Government (and the Department of Health) to promote measurable, evidence based prevention activities at a local level, and supports the national ambitions to reduce harm set out in the Government’s Alcohol Strategy. This ambition is part of the monitoring arrangements for the Responsibility Deal Alcohol Network. Alcohol-related admissions can be reduced through local interventions to reduce alcohol misuse and harm (Public Health England, 2016).

Figure 25. Admissions for mental and behavioural disorders due to use of alcohol condition (persons): Barnsley, statistical neighbours and England (2014/15)

- Barnsley’s 2014/15 rate for hospital admissions for mental and behavioural disorders due to use of alcohol (522.0 per 100,000) is significantly higher than the rate for England (390.1 per 100,000).
- Barnsley’s rate is the fifth highest when compared to statistical neighbours.
- Barnsley’s 2014/15 rate of 522.0 per 100,000 represents 2,015 admissions for mental and behavioural disorders due to use of alcohol.

Figure 26. Admissions for mental and behavioural disorders due to use of alcohol condition (males): Barnsley, statistical neighbours and England (2014/15)

- Men in Barnsley have a significantly higher rate (729.5 per 100,000) than England (572.9 per 100,000) for hospital admissions for mental and behavioural disorders due to use of alcohol.
- Barnsley’s rate is the fifth highest when compared to statistical neighbours.
- Barnsley’s 2014/15 rate for men (729.5 per 100,000) is more than twice the rate for women (325.0 per 100,000) (see figure 27).
• Women in Barnsley have a **significantly higher** rate (325.0 per 100,000) than England (216.9 per 100,000) for hospital admissions for mental and behavioural disorders due to use of alcohol.

• Barnsley’s rate is the fourth highest when compared to statistical neighbours.

**Figure 27. Admissions for mental and behavioural disorders due to use of alcohol condition (females): Barnsley, statistical neighbours and England (2014/15)**

![Figure 27](image)

**Figure 28. Trend in admissions for mental and behavioural disorders due to use of alcohol condition (persons, males and females): Barnsley and England (2008/09 to 2014/15)**

![Figure 28](image)

• Trend data shows that the rates for admissions for mental and behavioural disorders due to use of alcohol for men, women and persons in Barnsley are **significantly higher** in 2014/15 than they were in 2008/09. The 2014/15 rates are the highest during the period.

• Rates for men have been consistently higher than rates for women. During the period 2008/09 to 2011/12, rates for men in Barnsley were more than three times higher than the rates for women. From 2012/13, the rates for men have been more than double the rates for women.

• Rates for women in Barnsley were slightly lower than the rates in England at four time points during the period; however, they are now significantly higher.
Emergency hospital admissions for self-harm

Self-harm results in approximately 110,000 inpatient admissions to hospital each year in England, of which 99% are emergency admissions. 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. (Public Health England, 2016).

Figure 29. Emergency hospital admissions for intentional self-harm (persons): Barnsley, statistical neighbours and England (2014/15)

- Barnsley’s 2014/15 rate for emergency hospital admissions for intentional self-harm (266.6 per 100,000) is significantly higher than the rate for England (191.4 per 100,000).
- Compared to statistical neighbours, Barnsley’s rate is the fifth highest.
- Barnsley’s rate of 266.6 per 100,000 represents 1,217 admissions for intentional self-harm in 2014/15.

Figure 30. Trend in emergency hospital admissions for intentional self-harm (persons): Barnsley and England (2011/12 to 2014/15)

- Barnsley’s rate for emergency hospital admissions for intentional self-harm is significantly higher in 2014/15 than in 2011/12. The 2014/15 rate is the highest during the period.
- Barnsley’s rates have changed from being not significantly different to the England rates in 2011/12 and 2012/13 to being significantly higher in 2013/14 and 2014/15.
- The difference between the Barnsley rate and the England rate has increased considerably during the period (7 more people per 100,000 in Barnsley were admitted to hospital for intentional self-harm in 2011/12, compared to 75 more per 100,000 in 2014/15).
Figure 31. Standardised emergency admission ratio for hospital stays for intentional self-harm (persons): Barnsley electoral wards (2010/11 to 2014/15).

- Figure 31 illustrates standardised emergency admission ratios for hospital stays for intentional self-harm for the wards within Barnsley. A standardised admission ratio is a comparison of the number of observed admissions in an area (in this case, Barnsley wards) with the number of expected admissions if the rates were the same as the standard population (in this case, England). A ratio of 100 indicates that the admission rate is the same as the England rate; a ratio less than 100 indicates an admission rate below the England rate and a ratio more than 100 indicates an admission rate above the England average.

- There are large geographical differences within Barnsley for admissions to hospital for intentional self-harm, ranging from 36.8 in Penistone East to 180.7 in Kingstone.

- Seven wards have rates below the England average (Penistone East, Penistone West, Rockingham, Darton West, Hoyland Milton, Dodworth and Darfield). The remaining wards have rates above the England average.

- The wards showing the highest rates are located in and around the town centre (Kingstone, Worsbrough, Central and Stairfoot) and Dearne North ward.
Emergency hospital admissions for schizophrenia

Schizophrenia is a long-term mental health condition that causes a range of different psychological symptoms, including hallucinations, delusions and changes in behaviour. The exact cause is unknown. However, most experts believe the condition is caused by a combination of genetic and environmental factors. Schizophrenia is one of the most common serious mental health conditions; about one in 100 people will experience schizophrenia in their lifetime. There is no single test for schizophrenia; it is most often diagnosed after an assessment by a mental health care professional. It is important that it is diagnosed as early as possible, as the chances of recovery improve the earlier it is treated (NHS England, 2016).

Figure 28. Emergency hospital admissions for schizophrenia: Barnsley, statistical neighbours and England (2009/10 to 2011/12)

- Barnsley’s rate for emergency hospital admissions for schizophrenia (51.0 per 100,000) is not significantly different to the rate for England (57.0 per 100,000).

- Compared to statistical neighbours, Barnsley’s rate is the fifth lowest.

Figure 29. Trend in emergency hospital admissions for schizophrenia: Barnsley and England (2008/09—10/11 to 2009/10—11/12)

- Barnsley’s rates for emergency hospital admissions for schizophrenia have been lower than the rates for England at each time point.

- However, the rate for Barnsley has increased from 32.8 per 100,000 in 2008/09—10/11 to 51.0 per 100,000 in 2009/10—11/12, and from being significantly lower than the England rate to being not significantly different.
The 2005 evidence review "Is work good for your health and wellbeing" concluded that work was generally good for both physical and mental health and wellbeing. The strategy for public health takes a life course approach and this indicator provides a good indication of the impact of long term illness on employment among those in the 'working well' life stage (Public Health England, 2016).

**Figure 34. Proportion of people aged 18-69 receiving secondary mental health services and on the Care Programme Approach in employment: Barnsley, ‘similar CCGs’ and England (2015/16 Q2)**

- The proportion of adults in Barnsley who are receiving secondary mental health services and in employment (5.5%) is **lower** than the England average of 6.7%, but not significantly lower.

- Compared to similar CCGs, Barnsley’s rate is the fifth lowest.

**Figure 35. Trend in proportion of people aged 18-69 receiving secondary mental health services and on the Care Programme Approach in employment: Barnsley and England (2013/14 Q1 to 2015/16 Q2)**

- Barnsley’s rates for adults receiving secondary mental health services and in employment have been lower than the rates for England at each time point during the period 2013/14 Q1 to 2015/16 Q2.

- However, the rate for Barnsley has doubled from 2.7% in 2013/14 Q1 to 5.5% in 2015/16 Q2, and the gap between Barnsley and England has reduced from 4.4 percentage points to 1.2.
Settled Accommodation

The indicator is intended to improve settled accommodation outcomes for adults with mental health problems – a key group at risk of social exclusion (Public Health England, 2016).

Figure 36. The proportion of adults aged 18-69 in contact with secondary mental health services and are on the Care Programme Approach that are living in settled accommodation: Barnsley, ‘similar’ CCGs and England (2015/16 Q2)

- The proportion of adults in Barnsley who are receiving secondary mental health services and living in settled accommodation (61.0%) is slightly **higher** than the England average of 59.0%, but not significantly higher.

- Compared to similar CCGs, Barnsley’s rate is the third lowest.

Figure 37. Trend in proportion of adults aged 18-69 receiving secondary mental health services and on the Care Programme Approach that are living in settled accommodation: Barnsley and England (2013/14 Q1 to 2015/16 Q2)

- Barnsley’s rates for adults receiving secondary mental health services and in settled accommodation have fluctuated during the period 2013/14 Q1 to 2015/16 Q2. Rates were significantly higher than the England rates in 2013/14 Q4 and 2014/15 Q1 and Q2.

- The rate for Barnsley has moved from being significantly lower than the England rate in 2013/14 Q1 to being slightly higher in 2015/16 Q2.
Carers

A carer is anyone who cares, unpaid for a friend or family member who, due to illness, disability, mental health problem or addiction cannot cope without their support (Carers Trust, 2016). New rights came into effect in April 2015, as a result of The Care Act 2014, which entitle carers and the people they care for to a clear right to an assessment of their needs, regardless of their income and finances, or their level of need. The benefit of having an assessment is that it will identify care and support needs and provide information and advice about services aimed at meeting those needs (CarersUK, 2016).

Figure 38. People who care for an adult with a mental health condition and were assessed during the year per 100,000 population: Barnsley, statistical neighbours and England (2013/14)

- Barnsley’s 2013/14 carer assessment rate for people caring for an adult with a mental health condition (163.7 per 100,000) is significantly higher than the rate for England (64.3 per 100,000)
- Compared to statistical neighbours, Barnsley’s rate is the fifth highest.

Figure 39. Trend in people who care for an adult with a mental health condition and were assessed during the year per 100,000 population: Barnsley and England (2012/13 to 2013/14)

- Barnsley’s rates for carers of mental health clients who received an assessment have been significantly higher than the England rates in 2012/13 and 2013/14.
- However, Barnsley’s rate per 100,000 declined from 197.8 in 2012/13 to 163.7 in 2013/14.
Figure 40. Carers of mental health clients receiving services: Barnsley, statistical neighbours and England (2013/14)

- Just over a quarter of carers of mental health clients in Barnsley in 2013/14 (26.4%) were receiving services; **significantly higher** than the England average of 19.5%.

- Compared to statistical neighbours, Barnsley’s rate is the sixth highest.

Figure 41. Trend in carers of mental health clients receiving services: Barnsley and England (2012/13 to 2013/14)

- Barnsley’s rate for carers of mental health clients who receive services has **increased** from 14.5% in 2012/13 to 26.4% in 2014/15.

- Compared to the rates for England, Barnsley’s rate moved from being significantly lower in 2012/13 to significantly higher in 2013/14.
Mortality

Figure 42. Premature (<75) mortality in adults with serious mental illness: Barnsley, statistical neighbours and England (2012/13)

- Barnsley’s 2012/13 rate for under 75 mortality in adults with serious mental illness (1,329.3 per 100,000) is slightly higher than the England rate (1,318.9 per 100,000), but not significantly higher.

- Compared to statistical neighbours, Barnsley’s rate is the third lowest.

Figure 43. Trend in premature mortality in adults with serious mental illness: Barnsley and England (2009/10 to 2012/13)

- Barnsley’s rate for premature mortality in adults with serious mental illness has fluctuated during the period 2009/10 to 2012/13.

- The 2012/13 rate of 1,329.3 per 100,000 is the highest during the period, and the only time it has been higher than the England rate.
Prevalence of Depression:
The recorded depression prevalence is the number of people (aged 18+) with depression recorded on their practice register within a CCG, as a proportion of the practice list size (aged 18+).

Prevalence of mental health problem:
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers.

Long-term mental health problem:
The percentage of all respondents to the question “Which, if any, of the following medical conditions do you have?” who answered “long-term mental health problem”.

IAPT referrals entering treatment:
In order to enter treatment, a referral must have a first treatment appointment in the year. Referral received date not necessarily in the year.

IAPT referrals finishing a course of treatment:
In order to finish a course of treatment, a referral must have ended in the year with at least two treatment appointments having been attended in the course of the referral. Referral received date and treatment appointment dates not necessarily in the year.

IAPT referrals finishing a course of treatment, by recovery status:
Referrals are classed as having reliably improved if the patient shows a reliable improvement in anxiety or depression score between the first and last measurement, and the other clinical state (depression or anxiety) also shows no reliable decrease.

Referrals are classed as having no reliable change if the patient does not show reliable change on both anxiety and depression measures, or has reliable improvement on one whilst having reliable deterioration on the other.

Referrals are classed as having reliably deteriorated if the patient shows a reliable increase in anxiety or depression score between the first and last measurement, and the other clinical state (depression or anxiety) either also reliably increases or shows no reliable change.

A referral has moved to recovery if they are classified as a clinical case when they enter treatment but no longer classified as a clinical case when they have completed a course of treatment. Recovery is measured in terms of the anxiety and depression scores. For a referral to be considered recovered, the patient needs to score below the clinical threshold on BOTH scores at the end of treatment, to ensure that recovery is measured by looking at the welfare of the individual rather than one specific symptom.

A referral has shown reliable recovery if they have both reliably improved and also recovered. This means that their scores on one or both measures reliably increases whilst the other shows no reliable increase, and also that they have moved from being a clinical case at the start of treatment to not a clinical case at the end of treatment.

Patients with severity of depression assessed:
In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care.
New cases of depression which have been reviewed 10-56 days after diagnosis:
The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis.

Patients with a diagnosis recorded:
The percentage of people in contact with mental health services with a secondary care diagnosis recorded as a percentage of all people in contact with mental health services.

Patients with a comprehensive care plan:
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate.

People in contact with mental health services per 100,000 population:
People with an open Adult Mental Health Care Spell in NHS funded adult specialist mental health services at the end of the Reporting Period expressed as a rate per 100,000 aged 18+

Mental health service users in a psychiatric hospital:
Number of people with an open hospital spell at the end of the quarter, as a proportion of all people in contact with services.

People subject to Mental Health Act
The number of people in NHS funded specialist adult mental health services at the end of the Reporting Period who were subject to the Mental Health Act expressed as a rate per 100,000 population aged 18+

Concurrent contact with mental health services and substance misuse services for drug misuse:
Number of individuals who entered treatment at a specialist drug misuse service and were currently in receipt of treatment from mental health services for a reason other than substance misuse at the time of assessment, as a proportion of all individuals entering specialist drug misuse services.

Concurrent contact with mental health services and substance misuse services for alcohol misuse:
Number of individuals who entered treatment at a specialist alcohol misuse service and were currently in receipt of treatment from mental health services for a reason other than substance misuse at the time of assessment, as a proportion of all individuals entering specialist alcohol misuse services.

Attendances at A&E for a psychiatric disorder
The number of attendances to A&E units for a psychiatric disorder (A&E 2 digit diagnosis code = ‘35’).
Admissions for mental and behavioural disorders due to use of alcohol condition
Admissions to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable mental and behavioural disorders due to use of alcohol code. Children aged less than 16 years were only included for alcohol-specific conditions and for low birth weight. This indicator is based on admission episodes to hospital for alcohol related conditions. This counts the number of admissions, rather than individuals, so repeat admissions by the same individual may be recorded.

Emergency hospital admissions for self-harm:
Emergency hospital admissions for Intentional Self-Harm, directly age-sex standardised rate, all ages, Persons. Self-harm is defined by external cause codes (ICD10 X60-X84) which include: Intentional self poisoning (X60 to X69 inclusive); Intentional self harm by hanging, drowning or jumping (X70, X71 and X80); Intentional self harm by firearm/explosive (X72 to X75 inclusive); Intentional self harm using other implement (X78 and X79); Intentional self harm other (X76, X77 and X81 to X84). This definition does not include events of undetermined intent.

Emergency hospital admissions for schizophrenia:
Admission rate to hospital as a result of schizophrenia and delusions. The rate is directly standardised for age and sex. Count of admissions for diagnosis codes F20 to F29 in the 3 year period for people aged 15 and over. This indicator will be affected by the quality of diagnosis coding and data completeness, which may vary across areas. In particular, some areas have erroneously low numbers due to Trusts not coding their activity.

Proportion of people aged 18-69 on Care Programme Approach in employment:
The percentage of adults aged 18-69 receiving secondary mental health services and on the Care Programme Approach in paid employment at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting.

Proportion of people aged 18-69 on Care Programme Approach in settled accommodation:
People aged 18-69 with an open Care Programme Approach Episode at the end of the quarter whose most recent record of Accommodation Status in the previous 12 months showed they were in settled accommodation expressed as a proportion of all people aged 18-69 on Care Programme Approach.

Carer Assessments:
The number of adult carers of mental health clients aged 18-64 whose needs were assessed during the year (includes those who declined assessments) expressed as a rate per 100,000 population aged 18+.

Carers of mental health clients receiving services:
The number of carers (of mental health clients aged 18-64) whose needs were assessed or reviewed by the council and who received a specific carer’s service or advice and information as a percentage of all mental health clients aged 18-64 receiving community based services in the year.

Premature (<75) mortality in adults with serious mental illness:
Age-standardised mortality rate among people aged 18-74 who had contact with specialist mental health services (data from the mental health minimum data set linked to mortality records).
Confidence Intervals:

Confidence intervals are a statistical method of accounting for variability in data. Variability means that data collected under the same circumstances can yield different results. The confidence interval is therefore used to represent with a confidence of 95% the range in which the true value will lie. Where confidence intervals do not overlap, we say that the difference is statistically significant. Statistically significant differences will indicate that there is a real underlying difference between the proportions.

‘Similar’ CCGs and Statistical Neighbours

‘Similar’ CCGs are deemed to have similar characteristics based on demographic variables. Comparing against ‘similar’ CCGs provides an initial guide as to whether performance is above or below the level that might be expected. The ‘similar’ CCGs used in this briefing are those identified by Public Health England/NHS England in their ‘Commissioning for Value’ packs. [https://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/](https://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/)

These differ slightly to the comparator local authorities, which illustrate the Chartered Institute of Public Finance and Accountancy (CIPFA) statistical neighbours, recommended by Public Health England.
Public Health England (Mental Health, Dementia and Neurology Intelligence Network): http://fingertips.phe.org.uk/profile-group/mental-health

Improving Access to Psychological Therapies: http://www.iapt.nhs.uk/about-iapt/

Public Health England (Local Health): http://www.localhealth.org.uk/