Northamptonshire
Health & Wellbeing Board

JSNA Report 2013

Mental Health and Wellbeing

Delivering meaningful, healthier, longer lives for the people of Northamptonshire

This needs assessment was prepared by the Public Health Action Support Team on behalf of Northamptonshire County Council.

Introduction

- Mental health is not just the absence of mental disorder; it is a state of well-being. Therefore mental health promotion is crucial.
- Nearly a quarter (23%) of the total burden of disease in the Northamptonshire is attributable to mental disorder.

Key Points

- This report provides evidence on mental health need in Northamptonshire.
- The aim of the report and its linked resources is to support the development of the evolving mental health commissioning strategies in Northamptonshire. It provides data, resources analyses and commentaries.
- The overall population of Northamptonshire is projected to increase from about 710,400 people in 2013 to 775,000 in 2021, about 1.2% per year. The estimated number of people aged 16+ meeting defined criteria for any psychiatric disorder is estimated at about 128,000 for 2012 rising to 133,500 by 2018, as a result of changes in the number of people in various age groups and overall increase in population.
- Some age groups are projected to rise much faster, e.g., the 75+ group, than others. This has implications for the need for mental health care for disorders which have relatively high prevalence in specific age groups, e.g., dementia in the 75+ group. Some Northamptonshire Districts' populations, e.g. Northampton, will increase faster than others, such as Daventry.
- Suicides rates in Northamptonshire are similar to the England average and have generally fallen between 1993 and 2010. Corby had generally higher rates than the Northamptonshire average.
- There are risk factors for poor mental health, such as under- and over-weight, low levels of physical activity, drug abuse, tobacco and alcohol consumption, and homelessness. Northamptonshire is about average or better except for homelessness, which is higher than the England average.
- Various interventions exist for which there is evidence of effectiveness for promoting mental health and wellbeing and managing mental illness. In particular, there is authoritative evidence that educational sessions by occupational therapists, exercise and other activities, are positively associated with mood, emotion and psychological well-being in adults and older adults. There is also evidence that mass media health promoting campaigns can have a beneficial effect on attitudes to and knowledge of, mental health.
- Only nationally-sourced data on mental health service use in Northamptonshire could be obtained. Such data did not allow analysis of appropriate and inappropriate service use. Further data are required for commissioning strategy development: individual person-based local service activity data (essentially anonymised) and data on clinical severity thresholds of referral and entry to a service, to estimate inappropriate service use.
- From IAPT key performance indicator data from 2012-13 year end, 12.4% of those estimated to have anxiety or depression were counted as having accessed the Improving Access to Psychological Therapies (IAPT) programme with a diagnosis of depression. It is likely that some general practices refer relatively many more patients to IAPT than others.

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- General Practice Quality and Outcomes Framework (QOF) data are not valid estimates of prevalence and should not be used for this purpose. They are, however, very useful in comparing general practices for access to general practice mental health care. Analysis showed a very wide variation between general practices in the proportion of cases of depression diagnosed, compared to the number expected from epidemiological estimates. Out of 74 general practices from Corby and Nene CCGs, 34 had diagnosed at least 70% of the expected number of cases, but 18 practices had diagnosed 40% or less.
- From Spend and Outcome Toolkit data, Northamptonshire had a greater spend per head on mental health services than many other areas (£224 per head), compared to the England average of £212, ranking the County in the top third in England. No sub-Northamptonshire analyses were possible. Nationally compiled Commissioning for Value (CfV) packs for Nene and Corby CCGs indicate that it might well be possible to obtain better value for money from some mental health services, but there are limitations to the CfV analyses.
- This review contributes various original analyses using specially developed mental health service commissioning support tools. These provide investment and service reconfiguration option appraisals for geographical and clinical pathways between primary-care based, specialist community, and specialist secondary mental health services.

Recommendations

1. *Prevent mental ill-health by developing mental health and well-being promotion interventions*
   - Implement the effective and cost effective mental health promoting interventions noted in the section the evidence-base for interventions.
   - Assess the cost effectiveness of carrying out a mental wellbeing impact assessment (MWIA), using the tool kit for MWIA so as to decide whether to carry out such an assessment.
   - Invest in community development work in mental health by training community development workers who would also reduce barriers to accessing services.
   - A suicide prevention strategy should be part of an evolving mental health commissioning strategy, especially for the 16 24 age group, and suicide rates should be monitored.

2. *Use PHAST tools and analyses to support the development of commissioning strategies*
   - Collect individual person-based local service activity data from local mental health service providers.
   - Use the unique PHAST-NHS conceptual framework for health service commissioning when developing commissioning strategies.
   - Survey levels of clinical severity thresholds of referral, entry and admissions, to mental health services
   - Use the Northamptonshire commissioning support tool developed for this report, to support mental health commissioning strategy development.
   - Investigate differences in geographical access to services

- After assembling local programme budgeting data, marginal analysis should be carried out, which should be based on the cost effectiveness principles and economic evaluations set out in these commissioning and ethical-legal frameworks.
- Develop and use for community and inpatient mental health services, the service use and costing and other tools which were developed previously for acute hospital planning.

3. *Support the further development of the existing Northamptonshire mental health commissioning strategy for developing expert primary mental health services*
   - The present Northamptonshire mental health commissioning strategy aims to promote an expert integrated primary mental health service including single point-of-access to services. Therefore use the analysis developed for this report, which indicates the likely intensity of engagement with mental health services for each general practice, to work with those practices where greater involvement is needed.
   - Take part in the local development of the general structure and organisation of general practice, including by initiating a programme to train GPs in mental health specialisation. Where general practices are not large enough to have GPs specialising in various specialties, including mental health care, facilitate co-ordination between smaller general practices to achieve this.
   - As part of a commissioning strategy for acute care, develop a proposal to the Northampton General Hospital NHS Trust to initiate a psychiatric liaison service at the hospital.

Key early priorities are:

- Work with general practices to increase the number of patients in need who access general practice based and specialised mental health services with the already existing Northamptonshire mental health commissioning strategy.
- Collect and analyse detailed data on local mental health service use.
- Collect and analyse data on clinical severity thresholds of referral, entry and admissions, to mental health services.

This needs assessment should be read in conjunction with the report on alcohol.

Why is mental health important in Northamptonshire?

There cannot be good health in Northamptonshire without good mental health.[1] This section gives evidence of the importance of mental health for Northamptonshire. The size of the problem of mental illness in Northamptonshire is shown in the next section 'What is the local picture?'.

[1] Prince M, et al. No health without mental health *Lancet* 2007; 370: 859–77

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Mental health in a community

The World Health Organisation (WHO) noted that "Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community." WHO further noted that "Mental Health refers to a broad array of activities" directly or indirectly related to the mental well-being component included in the WHO's definition of health: 'A state of complete physical, mental and social well-being, and not merely the absence of disease'. It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders."

The importance of mental health

The WHO has further recognised, in the 2005 Mental Health Action Plan for Europe, that "Mental health and well being are fundamental to quality of life, enabling people to experience life as meaningful and to be creative and active citizens. Mental health is an essential component of social cohesion, productivity and peace and stability in the living environment, contributing to social capital and economic development in societies."

Public Mental Health

As the Joint Commissioning Panel for Mental Health note in their Guidance for commissioning public mental health services, "Public health is about improving the health of the population through preventing disease, prolonging life and promoting health."

Nearly a quarter (23%) of the total burden of disease in the UK is attributable to mental disorder. This compares to 16% for cardiovascular disease and 16% for cancer. Mental disorders are very common: a guide to commissioning public mental health services notes:[2]

- 10% of 5 to 16 year-olds have a mental disorder.
- 18% of adults have a common mental disorder, 6% alcohol dependence and 3% drug dependence.
- 25% of older adults have depression requiring intervention.
- Dementia affects 20% of people aged over 80.

What is the local picture?

Jonathan Campion's 2013 report *Mental disorder and wellbeing: Information in Northamptonshire and suggested priorities*[3] noted the general importance of mental health and

[2] http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf p 9

[3] Campion J. Mental disorder and wellbeing: Information in Northamptonshire and suggested priorities Northamptonshire draft 13, Sept 2013

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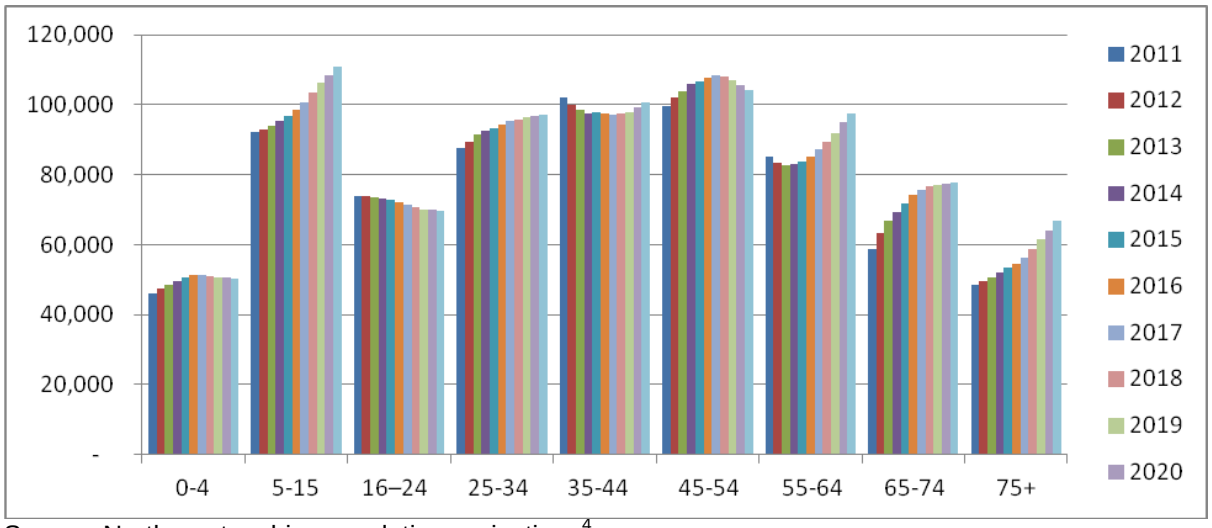
wellbeing and gave much relevant information on the importance of mental health and mental disorders in Northamptonshire.

Population projections and their implications for mental health

The Northamptonshire population projections for 2011 to 2021, by age group, are shown in Figure 1. Details by District are given in the Northamptonshire grouped population projections 2011 to 2021.[4] The total Northamptonshire population is projected to increase from about 710,400 in 2013 to 775,000 in 2021; this is an increase of about 8,000, or 1.2% per year. The rate of increase is projected to reduce slightly after 2018. These population projections are important to mental health service planning because:

- The overall increases in population will produce an increase in need for mental health services.
- Rates of various mental disorders differ in various age groups. In Northamptonshire the projected changes in population differ in various age groups. For example, the 75+ age group is projected to increase greatly, and therefore the numbers of people with dementia is likely to increase pro rata. In contrast, the number in the 16 to 24 age group is projected to fall, with possible less need for specialised services for obsessive compulsive disorder, which has a higher age-specific prevalence rate in this age group compared to older age groups.

Figure 1: Projected populations by age groups, Northamptonshire, 2011 to 2021



Source: Northamptonshire population projections[4].

Prevalence of mental illness in Northamptonshire

Data on how prevalent various mental disorders are for each age group in the Local Authority Districts in Northamptonshire are essential evidence for developing commissioning strategies.

[4] Northamptonshire popln projections 2011 to 2021 .xlsx

Table 1: Number of people 16+ in Northamptonshire estimated to meet defined criteria for diagnosis of any psychiatric disorder

	2012	2014	2016	2018	Increase 2012 to 2018
Corby	11,550	11,780	11,970	12,110	5%
Daventry	14,140	14,230	14,340	14,450	2%
East Northamptonshire	15,550	15,620	15,730	15,830	2%
Kettering	17,160	17,440	17,730	17,990	5%
Northampton	40,580	41,610	42,430	43,110	6%
South Northamptonshire	15,280	15,490	15,720	15,910	4%
Wellingborough	13,710	13,870	14,000	14,090	3%
Total Northamptonshire	**127,970**	**130,040**	**131,920**	**133,490**	**4%**

Source: mental health service commissioning tool.[5] Prevalence data from the ONS 2007 psychiatric survey, chapter 12. Rounded to nearest 10 people for planning purposes.

The data in Table 1 are the estimates of the number of people aged 16+ in each District in Northamptonshire **with any psychiatric disorder**, now and in future years, due to population changes. Table 2 similarly shows estimates for people with **any common mental disorder** (mixed anxiety/depressive disorder, generalised anxiety disorder, depressive episode, all phobias, obsessive compulsive disorder and panic disorder). Table 3 shows estimates for people with a **psychotic disorder** (which consist of two main types: schizophrenia and affective psychosis, such as bi-polar disorder).

These data are indicators of the numbers of people who are likely to have, now and projected into the future, a need for mental health services, either general practice-based, psychological therapy provided by the Increasing Access to Psychological Therapies (IAPT) programme, or provided mainly by the Northamptonshire Healthcare Foundation Trust specialist mental health services. They are adjusted for age and population change, but not for ethnicity and deprivation. These estimates use more accurate population estimates and projections than available in former years.

The projections show that change in need due to population changes will vary by District. For example, the need for services for common mental disorders will increase by about 7% in Northampton City, by 6% in Corby, but only by 3% in Daventry and East Northamptonshire.

[5] Northamptonshire mh commissioning tool 3 -1 dl Nov 2013.xlsx

Table 2: Number of people age 16+ in Northamptonshire estimated for common mental disorders in Northamptonshire Districts

	2012	2014	2016	2018	Increase 2012 to 2018
Corby	8,110	8,300	8,460	8,570	6%
Daventry	10,160	10,270	10,380	10,480	3%
East Northamptonshire	11,170	11,270	11,400	11,500	3%
Kettering	12,200	12,440	12,670	12,890	6%
Northampton	28,230	28,950	29,590	30,130	7%
South Northamptonshire	11,090	11,260	11,430	11,600	5%
Wellingborough	9,770	9,910	10,000	10,100	3%
Total Northamptonshire	**90,730**	**92,400**	**93,930**	**95,270**	**5%**

Source: mental health service commissioning tool.[5] Prevalence data from the ONS 2007 psychiatric survey, chr 2. The reference period for prevalence was one week. Rounded to nearest 10 people for planning purposes.

For the much smaller number with psychotic disorders, Table 3, the numbers are projected to rise in Corby and Northampton, but fall in Daventry and East Northamptonshire, again due to population changes.

Table 3: Number of people age 16+ in Northamptonshire estimated to have a psychosis in Northamptonshire Districts (to nearest 5)

	2012	2014	2016	2018	Percent change 2012 to 2018
Corby	195	200	200	205	5%
Daventry	240	240	235	235	-2%
East Northamptonshire	265	265	265	260	-2%
Kettering	295	295	300	300	2%
Northampton	675	685	700	710	5%
South Northamptonshire	270	265	265	265	-1%
Wellingborough	230	230	230	235	2%
Total Northamptonshire	**2170**	**2180**	**2195**	**2210**	**2%**

Source: mental health service commissioning tool.[5] Prevalence data from the ONS 2007 psychiatric survey, chr 5. The reference period for prevalence was one week. Rounded to nearest 5 people for planning purposes.

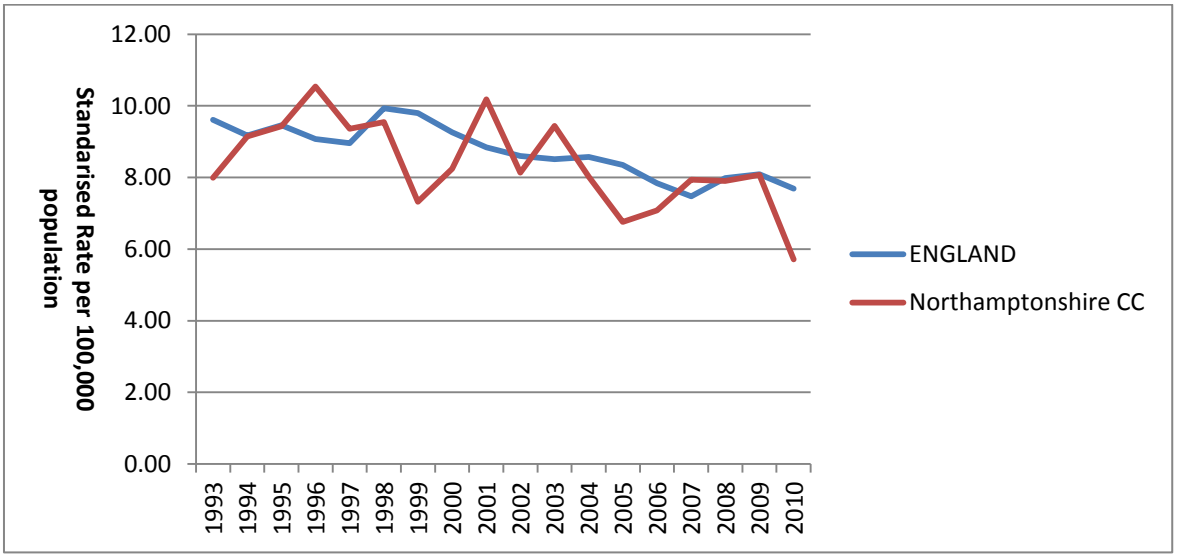
Suicide rates as an indicator of the mental health of the community

Suicides rates in Northamptonshire generally showed a downward trend between 1993 and 2010 (Figure 2), the latest data available. Corby had generally higher rates than the Northamptonshire average. Figure 3 shows that during that period, there were usually between 45 to 65 suicides per year, but with large variation in number from year to year. The number of

suicides in each Northamptonshire District was small and in some Districts there were very few or no suicides in some years.

The projected fall in population numbers in the age groups most at risk of suicide, the 16-24 age group (Figure 1), suggests that numbers and overall rates of suicide might fall due to this population factor. However, risk of suicide also depends on socioeconomic factors; possible increases in the number of young people unemployed in the next few years is likely to increase their suicide risk.

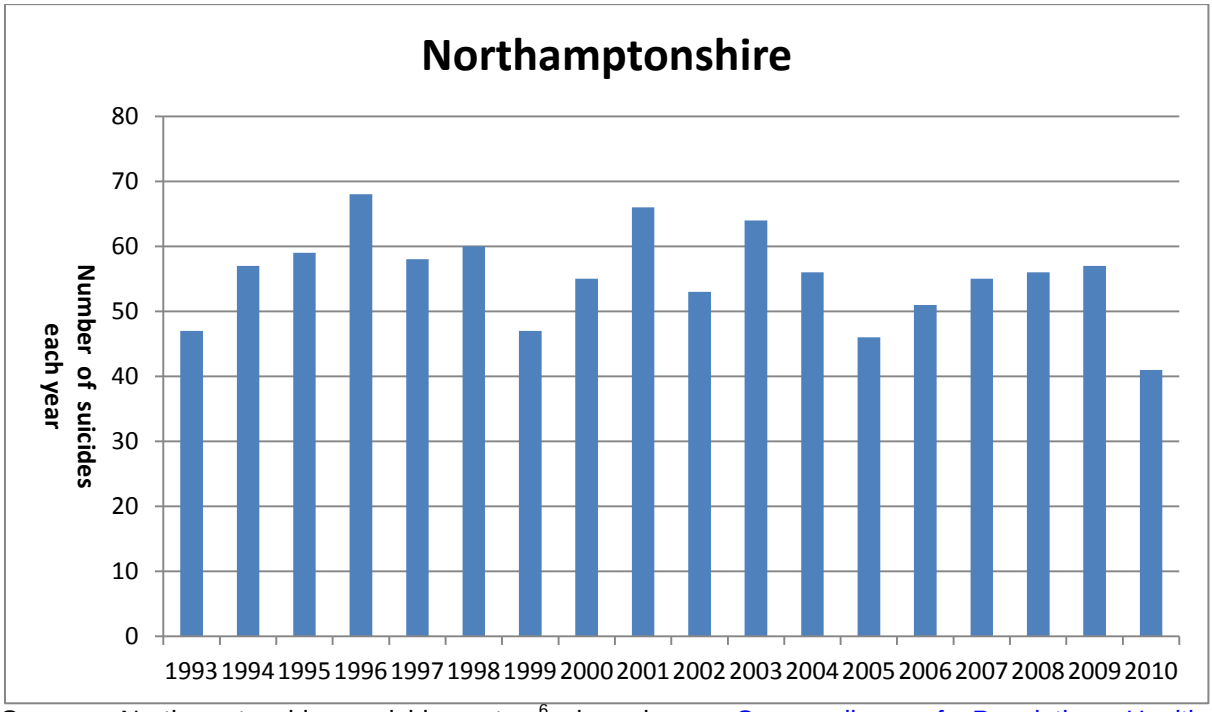
Figure 2: Trends in suicide rates, Northamptonshire and England, 1993 to 2010



Source: Northamptonshire suicide rates,[6] based on Compendium of Population Health Indicators (indicator.ic.nhs.uk or nww.indicators.ic.nhs.uk) Directly age-standardised rates per 100,000 European Standard population All ages.

[6] Northamptonshire Suicides 1993 -2010 issue Jan 2012.xlsx

Figure 3: Number of suicides, persons, Northamptonshire, 1993 to 2010



Source: Northamptonshire suicide rates,[6] based on Compendium of Population Health Indicators (indicator.ic.nhs.uk or nww.indicators.ic.nhs.uk) Directly age-standardised rates per 100,000 European Standard Population. All ages

Risk factors for poor mental health

The Northamptonshire Community Mental Health Profile for 2013[7] noted various risk factors for poor mental health. It said *"A risk factor is any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease, injury or mental health problem. Some examples of the more important risk factors in mental health are under and over-weight, low levels of physical activity, drug abuse, tobacco and alcohol consumption, and homelessness"*. But the Profile only reported on four indicators of such risk: Statutory homeless households, Percentage of the population with a limiting long term illness, First time entrants into the youth justice system and Percentage of adults (16+) participating in recommended level of physical activity. Northamptonshire was higher risk than the England average for homelessness, but better than average for the other three indicators.

Unfortunately, the Profile's 'Levels of mental health and illness Indicators' are not likely to be valid indicators of prevalence of mental illness. This is because 'Percentage of adults (18+) with depression, 2011/12', and 'Percentage of adults (18+) with dementia, 2011/12' are based on data from the GP Quality and Outcome Framework registers, and for many general practices these QOF registers have been shown to be likely under-estimates of true depression levels.

Indeed, the Profile indicator number 12 ('Ratio of recorded to expected prevalence of dementia') shows the level of likely under-ascertainment of levels of dementia.

[7] Northamptonshire Community MH Profile 2013.pdf

Northamptonshire general practices, with a ratio of 0.43 for observed figures compared to epidemiologically estimated prevalence, is about average for England and this is likely to be a good indicator of the quality of general practice care. There is further discussion of this issue in the section 'What inequalities are there in mental health status and access to services?'. The only way to obtain a valid direct measure of levels of mental illness is to carry out a local community survey using a validated questionnaire. This is not likely to be cost effective, as there is likely generally to be unmet need anyway, but more useful is an indicator of unmet access to mental health services of those in need across Districts and general practices. This can be obtained from the proportion diagnosed, compared to expected need, of patents on GP lists, as also described in the section 'What inequalities are there in mental health status and access to services?'.

The Profile's 'Outcomes' indicators: 'People with mental illness and or disability in settled accommodation', 'Directly standardised rate for emergency hospital admissions for self harm', and 'Hospital admissions caused by unintentional and deliberate injuries in <18s', cannot be used as 'outcome' indicators for mental health services, because they are dependent on the clinical severity thresholds for mental health service admission and discharge, which vary, both within Northamptonshire and between Northamptonshire and other places, and also not useful outcomes for mental health services. The Profile outcome indicators: 'Indirectly standardised mortality rate for suicide and undetermined injury' and 'Excess under-75 mortality rate in adults with serious mental illness', are possibly useful as 'need' indicators.

What is the evidence-base for interventions? What is best practice?

There are various interventions for promoting mental health and wellbeing and interventions for mental illness for which there is authoritative evidence.[8]

- There is evidence that educational sessions by occupational therapists, exercise and other activities is positively associated with mood, emotion and psychological well being in adults and older adults.

- For mass media health promoting campaigns, there is evidence that these can have a beneficial effect on attitudes to, and knowledge of, mental health.

Evidence of the cost effectiveness of mental health promotion interventions is essential to policy making in Northamptonshire. The overall conclusion is that there is some, limited, evidence of cost effectiveness of some mental health promoting interventions, such as an exercise programme for older adults, which may be applicable to younger age groups. This situation is partly due to lack of research trials with economic evaluations.[9]

There is review-level evidence derived from the UK, Norway and the USA to suggest that mass media campaigns, particularly those that include community activities, can have a beneficial effect on knowledge of and attitudes towards mental health issues. They can also impact on an individual's behavioural intentions and support enhancing behaviours to improve their own mental wellbeing. These media campaigns were on TV or radio or in newspapers. These studies were before-and-after with controls, and were not all randomised.

[8] P 127 Final report MId Essex PCT mental health Needs assessment v final DL 30 3 09.pdf

[9] Evidence and sources for mental health promoting interventions.docx

There are NICE guidelines and quality standards relevant to mental health services, for example for depression in adults which covers the assessment and clinical management of persistent sub-threshold depressive symptoms, or mild, moderate or severe depression in adults (including people with a chronic physical health problem). The guidance notes that "The quality standard for depression in adults requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole depression care pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to people with depression. It is also noted that patient preference and choice need to be taken into account, and practitioners should offer appropriate evidence-based interventions in their consultations with individual service users. Reflecting patient choice will be particularly important when measuring achievement against statements using the process measures."

NICE's clinical guideline on Common mental disorders offers best practice advice on the care of adults with a common mental health disorder.

What is the pattern of mental health service use in Northamptonshire?

The national mental health minimum data set was the only service-use data set available to us. It does not have local data of the level of detail to be of use in developing commissioning and planning. There are two essential data components of commissioning and demand management strategies which have the aim of developing more cost effective, value for money, services, especially their geographical comparisons:

1. Individual person-based local service activity data, routinely collected by service providers, with patient identification altered in a way that allows data linkage but not patient identification (called pseudonymisation). (These are available for general hospital inpatients, but are less comprehensive for outpatient and A&E). Such data are probably collected locally by mental health providers in Northamptonshire. Typically they should contain a separate data record for each patient, which includes a data field for the general practice of patient, age, diagnosis, and other data such as ethnic group.

2. Data on the clinical severity at which patients are 'admitted' (accepted into) to specialist community and inpatient mental health services. This can be collected using special assessment instruments where available. Where not, such instruments can be developed locally. These data usually have to be collected by special surveys. Admission severity threshold surveys have been carried out for acute care pathways.[10]

Improving access to Psychological Therapies (IAPT) Programme

IAPT is a programme to increase the availability and use of psychological treatments which have authoritative evidence for their effectiveness. The main form of treatment through IAPT is cognitive behavioural therapy (CBT), for which there is good evidence of effectiveness for

[10] Text is provided in Lawrence D et al Over the threshold HSJ 11 Feb 1999.docx

treating non-psychotic common mental illnesses, such as anxiety and depression. The national IAPT data sets were obtained, but did not give sub-Northamptonshire level data. As noted in other sections, mental health commissioning analysis and strategy development require data by at least District level. However, no local IAPT data could be obtained for individual general practices, and the four local provider IAPT clusters.

Nationally the vision for the IAPT programme over the current spending review cycle (April 2011 – March 2015) was set out in 'Talking Therapies: A four-year plan of action'. The expectation is that NHS organisations will contribute to the delivery of 15% access rate (against identified need), and 50% recovery rate for those discharged from services, both by March 2015. Table four shows that the 2012/13 access rate of 12.4% is a strong step towards achieving the expected 15% by 2015. Nevertheless rates of referral of individual vary greatly due to individual patients having different 'referral thresholds', i.e., the level of severity at which a patient will self refer. Many patients in need do not present to general practices, because they have to have high clinical severity before reaching their self-referral threshold. This is especially so for some ethnic minorities.

Because in Northamptonshire referrals to IAPT are from GPs, the number of people referred to IAPT (labelled here as the 'observed' number) will depend on how developed general practice mental health care, including IAPT, is. It is likely that some general practices refer relatively more patients to IAPT than others, based on the large variation between general practices in the number of patients with depression known to practices ('observed' number) compared to the estimated need ('expected' number). The evidence for this is given in the next section 'What inequalities are there in mental health status and access to services'. There also might be service constraints on IAPT facing some general practices, which could be due to lack of trained IAPT practitioners.

Table 4: Percent of people in Northamptonshire estimated to have anxiety or depression who have received psychological treatment under the Increasing Access to Psychological Therapies' (IAPT) initiative 2012/13

	2012-13 Quarter 1	2012-13 Quarter 2	2012-13 Quarter 3	2012-13 Quarter 4
People who have received IAPT in Quarter (KPI 4)	1,927	2,072	2,157	2,133
Number of people estimated to need IAPT (KPI 1)	66,846	66,846	66,846	66,846
% of people in need who have received IAPT	2.9	3.1	3.2	3.2

Source: IAPT Operating Framework indicator PHQ13_05 KPI = Key Performance Indicator
KPI 4 (Key Performance Indicator) is number of people accepted into (entering or receiving) IAPT in the quarter. KPI 1 is an estimate of prevalence of anxiety/depression, taken from the same source as used in our estimate of prevalence of all common mental disorders. Data thanks to Northamptonshire Public Health Department based on National IAPT data.

What inequalities are there in mental health status and access to services?

Ethnic group inequalities

There are some differences in estimated prevalences of mental disorders between ethnic groups in England, as found in the latest most authoritative, psychiatric morbidity survey, the ONS 2007 survey referred to in the section above 'What is the local picture?'. The survey report noted, p 31 "Rates of having at least one CMD were higher for white, black and South Asian women than for white, black and South Asian men respectively. The greatest difference was among South Asian adults where the age-standardised rate among women (34.3% of South Asian women) was three times that of men (10.3% of South Asian men). After age-standardisation of the data, there was little variation between white, black and South Asian men in the rates of any CMD. However, among women rates of all CMDs (except phobias) were higher in the South Asian group. The number of South Asian women in the sample was small, so while the differences were pronounced they were only significant for CMD as a whole, and generalised anxiety disorder and panic disorder." That is, expected prevalence is expected to be half as much again in women of South Asian origin as it is in other gender and ethnic groups.

However, African and Caribbean men are under-represented as users of enabling mental health services and over-represented in the population of patients who are admitted to, or compulsorily detained in, and treated by mental health services. For example, the NHS Information Centre in 2011 showed that between 10 to 12% of patients detained in hospital under the Mental Health Act are of black Caribbean or black African origin. Also in terms of ethnicity, the higher rates of Irish people in hospital admissions in relation to mental health issues.

Research also shows that lesbian, gay, bisexual and transgender (LGB&T) people are more likely to attempt suicide compared to the wider population, and the Department of Health's Suicide Prevention Strategy (2012) identified LGB&T people as a high-risk group. Also, there is some evidence about a link between some disabilities and increased prevalence of mental health issues, such as for those with Learning Disabilities.

The main barriers for ethnic minority groups are (Keynejad R. Barriers to seeking help):

Barriers to acknowledging mental health problems

"The various minority ethnic communities' social, cultural and religious responses to mental health problems posed a number of key obstacles for individuals from such communities in acknowledging their mental health problems. Gossip, negative stereotypes, social rejection and lack of understanding all made it harder for people to identify symptoms as a problem. These were exacerbated by a lack of positive media portrayals of people living well with mental ill-health. Spiritual and faith leaders were identified as key figures who are currently not involved at all with statutory mental health services."

Barriers to seeking help

"Although South Asian groups said a medical professional would be the first person they sought help from, many people suffer in silence. A number of people from South Asian communities felt it would be better to forget their problems than to talk to somebody else about them. Having family support was identified as critical to help seeking. Young Black African

men, by contrast, saw psychotic symptoms as spiritual and identified faith leaders as the appropriate person to seek help from. They were quite suspicious of mental health services and were unconvinced that medication would be of any use. Not everyone is aware of the services and help available but those who did find services sometimes found them to be far better than they had anticipated."

Perceived causes of mental health problems

"Ethnic minority groups' causal explanatory models of mental health problems jarred conspicuously with the Eurocentric bio-medical model adopted by NHS services. Rarely was any biological cause discussed, with social problems, family difficulties, isolation, life in a different culture or a new country, stress generally, substance misuse, psychological problems, spirits and indeed psychiatric medication itself cited as more likely explanations. This of course represents significant challenges for services to engage ethnic minority groups with their own model of mental ill-health."

Barriers to using primary care
"A number of concerns deterred people from ethnic minority groups from seeking help at the primary care level, and they often waited until their symptoms become severe before seeking primary care support. People said they expected primary care practitioners not to have enough time to listen to them, to prescribe anti-depressants as a default solution, to be dismissive or tell them 'there is nothing wrong with you'. Many people felt their problems to be social rather than medical while others did not feel primary care workers had any expertise in mental health. Some people really struggled with a new clinician because they felt they would not know about their previous history and others felt any waiting list they would be put on would be so long that it would not be worth seeking help. People asked for talking therapies delivered by someone based at the general practice of the type supported by the Improving Access to Psychological Therapies agenda."

Barriers to accessing services
"Ethnic minority groups wanted services to be delivered more holistically. Some people wanted complementary and alternative therapies to be available. Although this is a somewhat contentious issue, the NHS does currently provide some of these therapies and they may be a crucial way of engaging ethnic minority groups by illustrating that services go beyond the Eurocentric medical model. Many service users struggled to get their physical health needs taken seriously and ethnic minorities with multiple needs felt they were always being referred from one agency to another. The heritage of relations between White communities and ethnic minorities mean there are profound reasons why some people will be suspicious of what is seen to be a White-dominated service. Ethnic minority groups felt medication needs to be complemented by a range of talking therapies. Those not using services wanted more information in their own languages about the help available; those using services wanted more information available translated about their medication and treatment. Ethnic minority service users felt their views were rarely consulted and wanted more support during the discharge process from inpatient units."

Geographic and service inequalities
General practice Quality and Outcomes Framework (QOF) data are invalid estimates of prevalence and should not be used for this purpose. This is because the numbers of patients with mental disorders known to general practices is likely to be substantially fewer than the numbers estimated by epidemiologically valid estimates of prevalence.

However, these figures are useful for comparing general practices with regard to patient access to mental health care. This is because the numbers of general practice patients on a QOF mental health or depression register is an indicator of both the self-referral threshold of patients on the list and the GP ascertainment rate for those patients who do consult a GP for any reason.

To compare the general practices for the level of patient access to mental health services, the following steps are taken. First, for each general practice, the actual number of patients with depression in the last year from QOF[11] is taken as the 'observed' number of people with depression. Second, the 'expected' number of patients in the general practice is calculated using the age-specific prevalence of depression taken from surveys, and multiplying it by the age specific numbers of patients in each general practice. Third, the 'observed' number with depression for each practice is compared with the number of patients in the same general practice who are expected to have depression, where the higher the proportion of 'observed' to 'expected', is an indicator that the general practice has nearer the number expected.

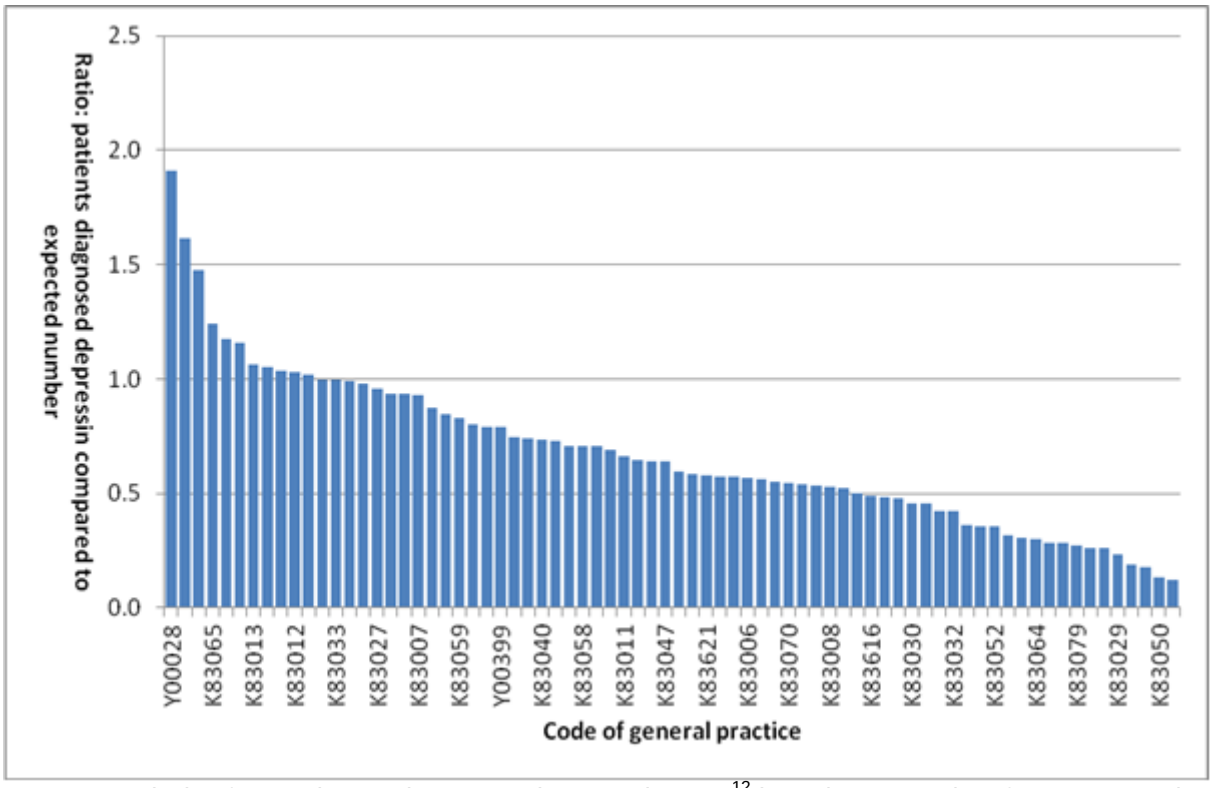
Figure 4 shows the comparison for individual general practices in Northamptonshire. In the Figure, the proportion is called the 'ratio' of observed to expected. Great variation between practices is found, which indicates that some practices are diagnosing far fewer patients with depression than expected compared to other general practices. This could be for a number of reasons, but is a useful indicator which general practices might need support (those identified with a lower observed to expected proportions, say below 0.5). Out of 74 general practices from Corby and Nene CCGs, 34 had a proportion of 0.7 or higher, but 18 practices had a proportion of 0.4 or lower. Those practices are identified in the data used to calculate Figure 4 and these data are available to Northamptonshire commissioners and the general practices concerned.

There are some technical issues:

- The highest and lowest group of general practices' data might be due to problems with the data.
- The 'observed' and expected' values in this depression case are not entirely comparable because the QOF observed number is for patients with a **new** diagnosis of depression within the preceding year, whereas the 'expected' number is based on the 'number of people with depression recorded in the last week', in the 2007 ONS psychiatric morbidity survey, i.e., **all** cases, not just new cases. However, the **comparison** between general practices are likely to be valid for identifying practices with higher and lower intensities of engagement with mental health needs of their patient lists.

Figure 4: Ratio of 'observed' number of patients with depression diagnosed within the preceding year to the 'expected' number with depression by general practice, Northamptonshire, 2012

[11] as part of one of the QOF depression indicators the denominator in the QOF indicator DEP06, p 9 and p 20,



Source: Analysis of QOF data and MH prevalence estimates,[12] based on QOF data from Nene and Corby CCGs, 2012-3 and GP list populations 2012[13]

What is the cost of current services?

The Spend and Outcomes Factsheets and Tool (SPOT) data are available by various categories of mental health spend and give more detail and analysis potential for programme budget and investment/disinvestment analysis than other sources of data. Table 5 shows that for 2011-12 Northamptonshire had a greater spend per head on mental health services, £224, than many other areas, ranking in the top third in England and much higher than Northamptonshire's ONS comparison group prospering smaller towns, where the average spend per head was £185.

Table 5: Mental health expenditure, Northamptonshire, ONS prospering small towns cluster and England, 2011-12

	All Mental Health Disorders	Substance Misuse	Organic Mental Disorders	Psychotic Disorders	Child and Adolescent Mental Health Disorders	Other Mental Health Disorders
	£ per head	£ per Head	£ per head	£ per head	£ per head	£ per head
England	£212	£23	£29	£41	£14	£105
Northamptonshi	£224	£17	£28	£75	£17	£88

[12] Northamptonshire QOF-12-13-Obs Exp v2 G prac-depr v 1-1.xlsx

[13] GP Practice Population 2012.xlsx

re PCT						
ONS group (Prospering Smaller Towns) average	£185	£18	£33	£36	£14	£86

Source: SPOT for Northamptonshire[14]

What investments and changes in funding for services should be made?

Commissioning/planning and ethical-legal frameworks for health services, including prevention and health and wellbeing, commissioning investment and disinvestment have been developed for the NHS.[15] These are useful as conceptual frameworks for commissioning strategies, including for mental health.

While the Northamptonshire Health and Wellbeing Board strategic priorities for 2013 (p 8) do not mention mental health (except for alcohol and drug issues), the *Commissioning for Value* packs for Nene and Corby CCGs indicate that mental health appears as be one of five areas to offer the greatest opportunity for quality-related improvements and spending, with opportunity for financial saving in Nene CCG (Table 6).

Table 6: Potential Northamptonshire Mental Health Improvement and saving opportunities

	Potential savings		**Potential savings**		**Potential savings:**
Family Health Service prescribing	Nene £2,835,000 Corby £157,000	Total bed-days in hospital for patients >74 years with a secondary diagnosis of dementia	Bed days: Nene 5,783 Corby 782	Emergency hospital admissions for self harm	Admissions: Nene 783 Corby 33
		Rate of admissions to hospital for patients >74 years with a secondary diagnosis of dementia	Numbers of patients: Nene 190 Corby 34	Improving access to psychological therapies - recovered patients	Patients Nene 407 Corby 36

Table 6 shows the main areas where the comparisons with a group of similar CCGs indicate potential for cost savings. These include Family Health Service (i.e., GP) prescribing, and using fewer general hospital beddays for patients with a secondary diagnosis of dementia.

[14] Spend and Outcome Tool Northamptonshire 2011-2.xlsx

[15] Lawrence D Framework for NHS commissioning PHAST 2013.doc

However, the mental health indicators used in *Commissioning for Value* are all minor and indirect indicators of value for money in mental health services. They cover only a small part of the use and outcomes per unit of spend on the totality of mental health services. Most of mental health service spend is on use of community mental health teams and inpatient activity of specialised mental health services, not covered in the CfV indicators. Moreover, present actual use of IAPT only covers a small fraction of the potential need for IAPT and that use is most probably very unequally distributed by general practice, since all IAPT services in Northamptonshire are by referral from general practices and this report describes very unequal numbers by general practice of patients with depression.

Further, the amount of potential saving suggested in the CfV Packs depends on which CCGs were used as comparators: these might be lower spenders than the England average. For Nene CCG, the comparator CCGs are mainly in the ONS cluster 'prospering smaller towns', as is Nene itself. All but two of this comparator group have lower overall spends per head on mental health than Nene CCG, which has £224 spend per head, or the England average, £212, as can be seen in the analyses we carried out for the SPOT for Northamptonshire.14[4] Some ONS comparison groups, such as London Centre, London Cosmopolitan and Regional Centres, have higher overall spend than Nene CCG, but many other ONS groups have lower spends. Northamptonshire is not much higher than the England average, but there are probably opportunities for better value for money.

In general, therefore, the *Commissioning for Value* analyses are less useful for Northamptonshire than the SPOT data. For instance, the Northamptonshire spend per head in the SPOT data, on psychotic disorders, is much higher than for England and most of the comparators. That does not mean that the higher psychotic service spend is inappropriate, just that this needs to be investigated. In order to determine appropriateness and potential for savings and re-investment patterns, the following analyses are useful:

- The utilisation of community and inpatient admissions for the relevant diagnoses over time in relation to the numbers of beds and staff supporting these services, in relation to the community service and hospital catchment populations and the actual costs of the services, as has been done previously for acute hospitals using a unique service use and costing tool.[16]

- Assessment of the appropriateness of acceptance to community services and admission to inpatient mental health care is necessary. As noted,[10] carrying out such severity threshold assessments is documented for admission to acute hospitals.

No data were available on the relative spend and value for money for primary care based services for mental health.

Mental health commissioning strategy support

We had very useful discussions with mental health commissioners in Northamptonshire. They indicated that the emerging Northamptonshire mental health commissioning strategy has

[16] Lawrence D Capacity planning MODEL incl rapid rep V 2-1 5 July 2010.xls

primary mental health as an important priority. We have concentrated on the following to support the present Northamptonshire mental health strategy:

- Investment and service reconfiguration options appraisals for geographical and clinical pathways services between primary care based community specialist and secondary specialist mental health services are important. The Northamptonshire mental health commissioning tool[5] has been developed to help this. This tool is a spreadsheet model. It uses the projected expected prevalence of various mental disorders for each District in Northamptonshire, together with various user-input access and admission thresholds (see next paragraph), so as to output the number of people expected to use mental health services for the individual Districts of Northamptonshire. These modelled numbers of service users are then compared with the number of people actually using mental health services, obtained from local service use data and the number of people estimated to need mental health services from the prevalence estimates in the commissioning tool. We would not expect these two to correspond exactly, as the *diagnostic criteria* producing the prevalence estimates of the number of people who have various mental disorders will be different from the *clinical diagnosis thresholds* for referral and admission for actual patients in Northamptonshire. This does not detract from the usefulness of the commissioning tool, as the tool shows the numbers expected comparatively for the Districts in Northamptonshire, which can be compared with actual numbers, and the tool also gives an estimation of how far there need to be changes in clinical severity thresholds and the structure and functioning of the primary care based and specialist, mental health services.

Five user-input access and admission threshold factors used in the commissioning tool are:

- Extent of publicity about mental health services. This will raise awareness of service availability in those with a mental health service need and change the severity thresholds at which patients seek help.

- Relative GP threshold of referral for each general practice, obtained directly from data on numbers of GP referrals.

- Geographical access factors: how available are IAPT services, specialist community mental health and inpatient mental health services in different geographical areas?

- Organisational access and threshold of supply, e.g., recruitment level for IAPT and other mental health services; appropriate up-to-date information.

- Discharge and 'non adherence' thresholds: how many therapy attendances per case or length of inpatient stay and clinical severity level at discharge.

The size of these threshold factors are gathered for each District or, e.g. IAPT programme area, using consensus conferences and focus groups with patients. Special efforts will be necessary to lower barriers to access, especially those which affect thresholds at which many people from ethic groups access services, as indicated in the section ‘What inequalities are there in mental health status and access to services?’.

- Any mental health commissioning strategy could usefully be co-ordinated with general health and social care commissioning strategies. Part of general health care strategies should be the development of more integrated primary care in Northamptonshire, centred on re-developed general practice. According to a recently published research study Securing the future of general practice: new models of primary care, the way in which general practice is organised and functions could be extensively developed in order to be fit for the future. This would enhance the ability of general practice based-mental health services to provide both mental health promotion and prevention and mental illness services. Such a strategy would contain the following components:

    - Developing the general structure and organisation of general practice, such that practices are both big enough to have GPs specialising in various specialties, including mental health and also have sufficient attached mental health staff. These staff would include, community development workers to encourage community mental health and well-being practises, as well as to increase access to and uptake of appropriate mental health services (reference: Barriers to care), psychiatric social workers, and clinical mental health therapists.
    - For general practices too small for such a structure, work with these practices to co-ordinate their development to share such specialised roles.

- There is evidence of the value of psychiatric liaison services in general hospitals, including in A&E.

What more do we need to know?

More local need and use data are necessary, to use with planning models, including data on service catchment populations by Northamptonshire districts and sub districts for Northampton. These are discussed in more detail in other sections.

There are mental health outcomes measures which are in development nationally, not only for IAPT, but more generally, for example, HONOS, which in future can be incorporated in a commissioning decision support model which will incorporate costs, service use, severity thresholds and outcomes. Nationally much further work is required, but without validated and reliable clinical and patient reported outcome measures, evidenced-based, real value-for-money commissioning will be impossible.

Recommendations to improve and support commissioning and forward planning to ensure quality of care and value for money

1. *Prevent mental ill health by developing mental health and well-being promotion interventions*
    - Implement the effective and cost effective mental health promoting interventions noted in the section 'What is the evidence-base for interventions'.
    - Assess the cost-effectiveness of carrying out a mental wellbeing impact assessment (MWIA), using the tool kit for MWIA, so as to decide whether to carry out such an assessment.
    - Enhance community development work in mental health by training volunteer and paid community development workers, who would also reduce barriers to accessing mental health services.

- A suicide prevention strategy should be part of an evolving mental health commissioning strategy and suicide rates should be monitored. The strategy should be especially concerned with the 16-24 age group.

2. *Use PHAST tools and analyses to support the emerging Northamptonshire mental health commissioning strategy*
   - Collect individual person-based local service activity data, appropriately pseudonymised.
   - Use the unique PHAST-NHS conceptual framework for health service commissioning when developing commissioning strategies.
   - Survey levels of clinical severity thresholds of referral, entry and admissions, to mental health services. The severity thresholds for specialist community and inpatient mental health survey questionnaire is developed by:
     - Developing scales for clinical criteria for accessing/admission to a mental health service, with for example five severity levels, with severity criteria for each level on scale (Reference Lawrence D. et al., HSJ 'Over the threshold' article[10] for details of the concept).
     - Surveying a random sample of patients, at the District area level, to measure the actual severity levels for referral, admission and discharge experienced by patients, thus producing 'observed' thresholds.
     - Developing local appropriate admission criteria for community and secondary care mental health services using, in the first instance, consensus methods, based on local discussions with managers, clinicians and patients, this producing 'expected thresholds'.
     - The 'observed' thresholds are then compared to the 'expected thresholds' and be used as part of a mental health commissioning strategy to change severity thresholds for both patients and clinicians to be appropriate and optimal for each District in Northamptonshire.

   - Use the Northamptonshire commissioning support tool developed for this report, to support mental health commissioning strategy development. The data in this tool need to be combined with local financial costs data to model value-for-money strategy options. Use the part of the tool which models threshold factors which affect access to services, so as to develop actions to lower barriers to appropriate access, especially for minority ethnic groups. These thresholds should be ascertained using consensus conferences and focus groups with patients (considered in the section 'What is the pattern of mental health service use in Northamptonshire?').
   - Investigate differences in geographical access to services.
   - Develop and use for community and inpatient mental health services, the service use and costing and other tools mentioned in this report, which were developed previously for acute hospital planning.

3. *Support the further development of the existing Northamptonshire mental health commissioning strategy for developing expert primary mental health services*
   - In the short term the present Northamptonshire mental health commissioning strategy aims to get a single point of access to services, including the IAPT programme. In the medium term, with a tender now being prepared, the strategy aims to deliver an expert integrated primary mental health service. Therefore use the analysis developed for this report, which indicates the likely intensity of engagement with mental health services for each general practice, to work with those practices where greater involvement is needed. The data on which Figure 4 is based should be used.

- Take part in the local development of the general structure and organisation of general practice, including by initiating a programme to train GPs in mental health specialisation. Where general practices are not big enough to have GPs specialising in various specialties, including mental health care, facilitate co-ordination between smaller general practices to achieve this.

- As part of a commissioning strategy for acute care, develop a proposal to the Northampton General Hospital NHS Trust to initiate a psychiatric liaison service at the hospital.