Leeds in Mind 2017
Mental Health Needs Assessment

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Public Health

Foreword

'The difficulty lies, not in the new ideas, but in escaping from the old ones'

John Maynard Keynes

Improving people's mental health is the challenge of our age. The World Health Organisation predicts that, globally, depression will be the greatest cause of disability by 2030, and the Adult Psychiatric Morbidity Survey, published every seven years, suggests that the percentage of people experiencing mental health problems like anxiety and depression has increased significantly in England over the last decade.

Recent years have seen an increased focus upon mental health at a national level – from the work of the royal family and well-known celebrities, to national policy commitments that set out the need to achieve greater parity between mental and physical health. There have also been improvements in the accessibility and effectiveness of mental health treatments; recovery from periods of mental illness, like physical health, is very possible.

However, there remains much to be done - within a context of increasing financial pressures on the NHS, local authority and third sector services. Being able to make best use of our resources to reduce risks associated with mental ill health, increase protective factors, intervene early and improve access to effective and evidence-based care is imperative. *Leeds in Mind* will help us to do this - by illuminating the areas where we need to take action and grounding that action in evidence.

There are a number of challenges for our city which are set out in this report. These include changes in our population, which result in new patterns of mental illness and increased pressure on mental health services. It also shows us that despite significant efforts, there are groups of people in Leeds who continue to struggle to access appropriate mental healthcare in a timely way and who have less chance of recovering from mental health problems when they do. Finally, the report highlights that there many people in Leeds who experience identifiable risk factors for poor mental health and, importantly, many of these are amenable to change. More positively, the city has many mental health assets and this report details the protective factors that exist in Leeds and how these are being strengthened and bolstered.

Leeds in Mind holds a mirror up to the health and care system in our city so that we can continue to develop our understanding of the mental health needs of local communities and to challenge how we improve mental health outcomes and reduce inequalities in mental health between different parts of the city, and between communities. The report builds on the work on the 2011 Leeds Mental Health Needs Assessment (http://observatory.leeds.gov.uk/Leeds_Needs_Assessment/) and a range of innovative citywide work; it is part of on an ongoing process which highlights new emerging needs and explores how well we are addressing some of the more persistent inequalities in our city.

The challenge for us all is to use the key messages and analysis of mental health need set out here, to stimulate collaboration across organisational boundaries and to re-assess how we think about mental health outcomes. Basing our actions on assessment of need will help us to improve the health of people with the poorest health the fastest whilst ensuring that everyone's needs are met.

As Keynes recognised, new ideas are often appealing but the resonance of old ones are often difficult to escape. This needs assessment is published during a time when we are being asked to fundamentally re-think how we organise health and care services and make difficult decisions around ever limited resources. I hope organisations are able to use the content of this report as a helpful tool to inform future shared thinking and joined-up decisions around the mental health and care system for the people of Leeds - to achieve better population health, and to truly be able to integrate how we think about people, their lives and their wellbeing.

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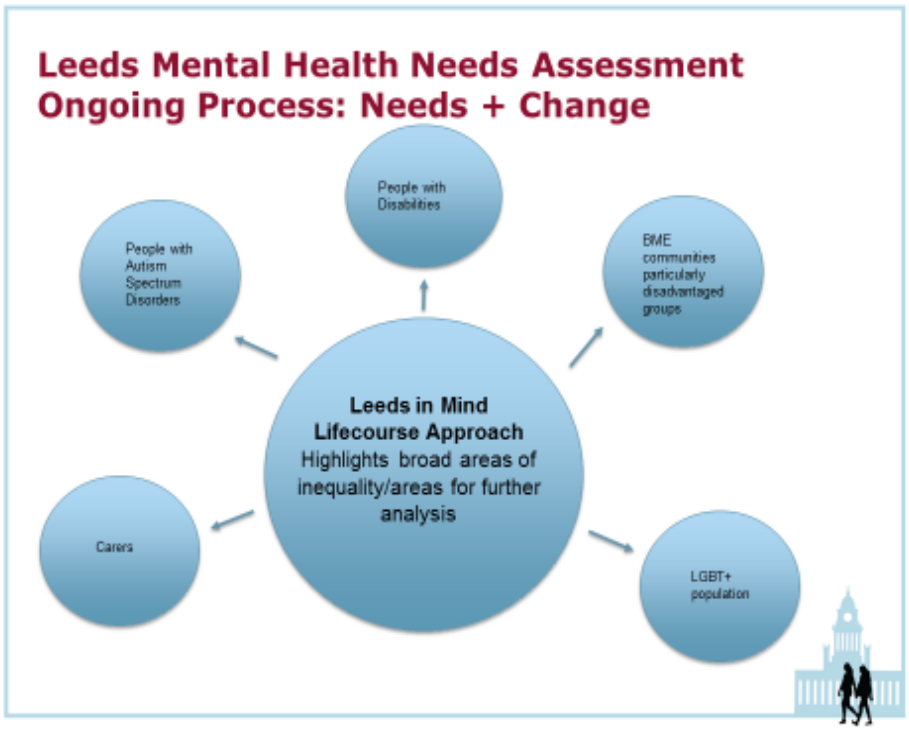
Executive Summary

Mental Health is central to all health. It has a significant impact, not only on individuals, families and communities, but also on the economy. Estimates for Leeds suggest that mental ill-health costs over £500 million every year through lost economic output, benefits payments, and its effects on the health and social care system.

This report assesses the mental health needs of the adult Leeds population, identifies where gaps in provision exist and makes recommendations to address inequity in access to healthcare and unequal health outcomes.

It reviews Common Mental Health Disorders (which range from mild to severe) and Serious Mental Illnesses. It also assesses the needs of people who have both mental and physical health problems and people who have mental health problems that may be complex or less easily defined. Separate pieces of work, developed as part of *Leeds in Mind*, will cover the mental health needs of pregnant women and women with young children, young people (16 – 24 years) and older people (65+ years).

Such a wide scope means that the needs assessment highlights only broad areas of inequality and inequity; there are gaps in what it covers. The report does not fully capture the experience of all groups who experience poor mental health outcomes, and some communities or populations are not adequately represented in mental health data sources. More work is needed to make visible and address the mental health needs of key groups – through improvements in data collection but importantly, through further analysis clearly linked to system change. Priority populations identified include (but are not restricted to): people from Black and Minority Ethnic communities - particularly disadvantaged groups such as Gypsy and Travellers and Asylum Seekers; the LGBT community, people with disabilities, carers, and people with comorbid Autistic Spectrum Disorder. The needs of these groups will be addressed in future pieces of work, linked to recommendations in this report.



Key Findings

Risk and Protective Factors

Mental Health is affected by many factors. It is useful to think about these in terms of those that increase the risk of mental ill health and those that afford some protection. Responses to particular circumstances or events will vary from person to person, but at a population level, there is good evidence regarding the negative and positive effects of particular factors on mental health.

Mental health has a social gradient. This is because risk factors for mental ill health cluster in areas where people have fewer resources. These risks may be 'current' - such as debt or poor housing; however, there is also research to suggest that factors such as domestic violence or past trauma also have long-lasting effects that can reach across generations.

Risk and protective factors often therefore have immediate, but also long term, impact. Investing in protective factors in particular is not only central to improving the health of people in Leeds, but it also makes sound economic sense.

Very recent research undertaken by Public Health England sets out the Return on Investment from delivering against some of these protective factors at a national level.

There are many aspects to living in Leeds which are protective of good mental health. Some of these mental health assets are included below:

Top level summary of key protective factors as experienced in Leeds
Support to develop healthy relationships - the Leeds Best Start Programme
Celebration of positive role models - events such as Leeds Pride and Leeds West Indian Carnival
Resilience programmes that support young people - MindMate in schools
Community resources, social capital and social networks - Leeds has a strong and vibrant Third Sector
Access to green spaces across the city across the whole city
Employment support and anti-poverty programmes

However, there are also clearly identified risk factors. Shown below are estimated numbers of people in the city who are at increased risk of poor mental health/illness. Other factors are important but less easily quantified - these include experiencing discrimination, being homeless/poorly housed and crucially having experienced inadequate care-giving as a child which has a negative impact on future emotional and mental wellbeing. It is important to note that very often people will experience multiple risk factors at the same time - this increases their vulnerability to mental health problems

Top level summary of key risk factors as experienced in Leeds	
Debt and financial strain	100,000
Unemployment	40,000
Adverse experiences such as trauma and abuse	45,000
Caring responsibilities	70,000
Long term health conditions	200,000
Social Isolation	40,000

Finally, mental health stigma can be seen as a risk factor for mental ill health – in that it operates as a significant barrier to people developing an understanding of mental health and illness and to accessing treatment. In underpins all aspects of mental health – from emotional wellbeing to serious mental illness and may be experienced differently by different population groups or communities.

Common Mental Health Disorders

- There are an estimated 106,000 people who, every year in Leeds experience a Common Mental Health Disorder (CMHD) such as anxiety and depression. This estimate is not adjusted for socio-economic status and it may be that the 'true' number is much higher.
- It is estimated that around half of all CMHD is 'moderate - severe'. This equates to over 50,000 people in the city. The needs of people with CMHD are met across a range of services including Improving Access to Psychological Therapies (IAPT), and by Third Sector services – including Social Prescribing.
- GPs report that a significant proportion of workload carried out in Primary Care is associated with mental ill health – possibly up to 40% of all consultations. There were nearly 94,000 single prescriptions for anti-depressants and anxiolytics in 2015/16 which suggests that a significant proportion of estimated CMHD need is being addressed in Primary Care.
- There is good evidence that CMHDs have a social gradient and that they are strongly linked to risk factors associated with having limited resources - such as an adequate income and stable housing. With this in mind, there appears to be under recording of CMHD in Primary Care in the most deprived parts (poorest quintile) of the city. This is particularly noticeable in the case of depression.
- Recent analysis of CMHD in Primary Care suggests that there were 130,000 people recorded as having a CMHD in 2016 (this includes all new cases in a year and past cases and so is higher than annual estimated figures). Anxiety was the largest single mental health condition recorded (n= 75,000) followed by Depression (n = 46,000). There were 27,000 people recorded as having both Anxiety & Depression.
- The mental health service commissioned to support people with CMHD is Improving Access to Psychological Therapies (IAPT). However, IAPT is designed, nationally, to meet only 15% of 'need' - 15,000 people in Leeds. Around 6,000 people finished a course of treatment in 2015/16.
- Setting estimated rates of CMHD against IAPT service use suggests that much CMHD in the city goes untreated
- A recent national study found that young people (16 – 24 years) and black and minority ethnic communities were two groups least likely to receive treatment for CMHD. These two groups are under-represented in primary care CMHD registers in Leeds.
- IAPT is effective for those people who finish a course of treatment. Recovery is measured very crudely, but even so, in Leeds nearly 50% of people, who complete their course of treatment, do recover and around 60% of people 'reliably improve'. This means that their mental health needs may have been quite severe when they started treatment; and whilst they may not leave the service symptom-free, their mental health will be significantly better.
- The benefits of IAPT have not been realised equally across the city. 'Recovery' rates are lowest in the South of the city (where deprivation is greatest), older people do not access the service to the same rates as the working age population and rates of 'finishing a course of treatment' are low for some ethnic groups (compared to White British Groups). This suggests that IAPT has not historically been able to meet the needs of the whole Leeds population and, despite significant efforts from the service; there is inequality of both access and outcomes
- However, recent steps taken by the service offer some promise. These include not discharging people when they drop out of Step 2 treatment and offering top up treatment or step up to Step 3. The service report this is improving recovery rates, however, demand for Step 3 is increasing significantly.
- Nationally, the mental health of young women is of concern. However, locally, whilst there are twice as many women as men in Leeds who are recorded has having a CMHD, only 9% of young women are recorded as having a CMHD in primary care, compared to 20% of all women over 18 years.
- Men are under-represented in both Primary Care data on CMHD and IAPT numbers finishing treatment. This may reflect women's poor mental health but also may signal the fact that men may

not seek support for this type of mental distress. However, it is notable that when men do access IAPT, their recovery rates are similar to those of women.

- Qualitative surveys recently undertaken in Leeds suggest that certain communities experience a range of factors that put them at increased risk of CMHD. These include people from some BME communities (including refugees and asylum seekers) and LGBT+ populations.
- Finally, there are groups whose needs have not been reviewed as part of this needs assessment and who may not always be 'visible' in available data on mental health - but who are known to have high rates of mental health disorder. These groups include people with Learning Disabilities, Autism, ADHD and/or physical disabilities, including the deaf community. More work is needed to explore the particular mental health needs of these groups locally.

Serious Mental Illness

- Many people with Serious Mental Illnesses such as psychosis and bipolar disorder maintain employment and relationships, and have fulfilling lives. For other people, these conditions bring with them significant disability and may be complicated by poor physical health and significant socio-economic disadvantage.
- There are nearly 8,000 people recorded as having a SMI in Primary Care in Leeds. These registers show a significant association with deprivation - with rates highest in the inner part of the city.
- Leeds has higher rates of people experiencing First Episode Psychosis than both the England average, and locally modelled estimates that use adapted methodologies. There is a need to explore the impact of this high level of need on Early Intervention in Psychosis services along with the needs of people who experience 'At Risk Mental States' (which may precede a first psychotic episode).
- There is a significant gap between locally modelled estimates of prevalence rates for psychotic disorder and bipolar disorder and LYPFT cluster data. This may be due to the fact that some services provided by LYPFT do not cluster and/or it may indicate unmet mental health need in the population.
- There is a relationship between having a SMI and being out of work. However, there is a strong evidence base for the positive effects of employment-support programmes. Applying national economic modelling to Leeds employment support programme suggests that the service may be saving the city in excess of £1 million a year.
- At a population level, people from Black or Mixed ethnic groups in Leeds are twice as likely to be admitted to a mental health ward having accessed a crisis service as people from White ethnic groups. This may represent higher levels of need in some population groups and/or limitations across mental health and social care pathways to meet the needs of these groups before crisis occurs.
- Crisis services in the community offer well-evidenced alternative to inpatient stays. Such services provided in Leeds are meeting significant mental health needs of diverse groups– including people from LGBT+ communities and people from a range of minority ethnic groups.
- People with a diagnosis of psychosis who live in the South and East of the city are more likely to be admitted to hospital in an emergency/through A&E than England averages.
- Leeds has higher rates of people subject to the mental health act when compared to the England average – rates are particularly high in the South and East of the city. It is not clear whether this is due to higher need in Leeds or if it reflects that there limitations on community services to be able to support people before crisis occurs.

Physical Health and Mental Health

- There is a significant and complex relationship between physical and mental health, which much current service provision does not adequately address.
- More than 1 in 3 people on the CMHD primary care register in Leeds have at least 1 long term condition – around 48,000 people. There is also a clear relationship between having a serious mental illness and a long term condition. This is notable in the case of Diabetes, COPD and Hypertension.
- Referrals to IAPT for people with LTC do not appear to reflect local estimated prevalence and it is not clear how new national drivers for IAPT provision to target people with LTC will be developed locally.
- Despite efforts being made to improve the holistic care provided in both mental health and physical healthcare services, stakeholders report that there are challenges associated with communication across provider organisations and development of appropriate skills
- New models of care provide a significant opportunity to support people's physical and mental health needs. However, there is separation between Primary Care/New models of care driven by mental health commissioners and citywide approaches focusing upon long term conditions and/or frailty.
- Health coaching approaches, as holistic models, provide a significant opportunity to meet the needs of the population with both LTC and CMHD
- Medically unexplained symptoms (MUS) and somatoform disorders are estimated to constitute a significant proportion of primary care appointments. In Leeds, the Liaison Psychiatry service provides specialist support for people with very complex problems of this nature. It is not currently clear whether the expansion of IAPT to support people with MUS will be successful nationally (pilots are underway) and no plans are in place locally to address the needs of this group through the existing IAPT service.
- The rate of premature mortality in people who have a serious mental illness in Leeds (<75s) is 1,405/100,000 (2012/13) - four times greater than the general population. This is symptomatic of significant health inequalities – associated with deprivation, poor physical health (due in part to anti-psychotic medications and health behaviour) and barriers to health promotion messages and healthcare services.
- There are systemic barriers to screening and improving the health of this population group. There is a shared care protocol in place but communication between acute services, and general practice is a barrier to effective care.
- There is good evidence that smoking cessation is effective with this population group, and that people with SMI have the same desire to stop smoking as the rest of the population.
- Incentives to complete physical health checks have been removed in Primary Care. Whilst rates of checks for people with SMI in Leeds are comparable with the rest of the country - these are low across the whole of England.

Complex Mental Health Problems

- Local stakeholders identify that there are a group of people whose needs are not well met by current service provision (structured around common mental health disorders or serious mental illness). This group is heterogeneous but includes people who may have psychological needs related to unresolved trauma, complex social problems and/or enduring depression.
- 'Complexity' is differently defined and experienced. Being able to meet this wide range of mental health needs suggests requires that responses should be culturally appropriate, evidence-based and adaptable to meet the need of the individual.
- More work is needed to understand the burden of illness that is attributable to 'complex needs' in the city, however numbers of people screened out;' from IAPT and CMHTs provides an initial starting point.
- A new partnership, funded until 2019 is now in place in the city - the visible project aims to raise the profile of child sexual abuse and improve responses across the mental health system.
- Personality Disorder is a complex diagnosis often associated with previous trauma and abuse. Developing accurate estimates of numbers of people affected is challenging given the disagreement over terms and complexities of screening for these conditions. However, it is probable that there are a significant number of people in Leeds who struggle with forming healthy relationships and experience high levels of risk
- Leeds has a greater number of people accessing drug/alcohol services who have a comorbid mental health problem than modelled estimates predict. It also has higher rates of service use contacts (for alcohol/drug services) from people with mental health problems. This suggests high levels of need in the Leeds population.
- Drug and alcohol use is a significant predictor of mental ill health. Dual diagnosis services in the city are meeting needs that exceed modelled estimates. 22% of people accessing Forward Leeds in 2016/17 had a mental health diagnosis. More men accessed the service than women. However, women were more likely to have a formal mental health diagnosis (28% of women, compared to 21% of men).
- There is clear evidence that trauma is associated with a full range of mental illnesses. If rates from national surveys are applied to the Leeds population this suggests that around 45,000 people in the city may have experienced some kind of trauma and abuse.
- New pilot ways of working – bringing mental health services closer to primary care (mental health 'test beds') have to date, developed separately to emerging 'new models of care'
- Early findings suggest that the Primary Care /Mental Health test beds developed as part of the Leeds Mental Health Framework are meeting a range of mental health needs and the impact on primary care workload appears promising.
- The models show the potential of system change/integration. Early results suggest that bringing mental health staff 'closer' to Primary Care appears to improve the appropriateness of referral and a reduction in GP contact time for some people.
- It will be important, going forward to assess the 'net effect' of all three models on the wider health and social care economy - and in particular on their ability to respond flexibly to need.

Recommendations

1. Mental Health is everyone's business. Strategic partners in Leeds to prioritise programmes of work that increase protective factors and reduce risk factors for poor mental health - particularly focussing on those that are linked to poverty. Ensure all commissioned service and programmes of work have an explicit focus on mental health.

2. Commissioners/providers of mental health services to ensure that service provision reflects the levels of mental health needs in the population and includes additional tailored support for identified groups to ensure they are able to access and complete mental health treatment.

3. Mental health commissioners and service providers, LCC Public Health and The Third Sector to ensure further needs analysis and development work in the city addresses the needs of people with increased risk of poor mental health, particularly those groups who may not be easily identified in mental health data sources. These groups to include:

- Homeless people, carers, asylum seekers and refugees and LGBT+ communities (particularly trans and non-binary people)

- People with complex comorbidities: people with Learning Disabilities, Autism Spectrum Disorder and Physical Disabilities (including the deaf community).

- People who have mental health and substance use problems.

4. Commissioners/providers of mental health services to address inequity in identification and treatment of common mental health disorders. In particular:

a) IAPT to take steps to further address the following issues:

- Improve access to the service from older people and increase the number of men finishing treatment
- Improve the proportion of people from minority ethnic backgrounds who finish a course of treatment
- Improve recovery rates in the most deprived parts of Leeds (particularly Inner South and Inner East Leeds)
- Explore further the access rates and outcomes for people with long-term conditions

b) Primary Care services to specifically consider under-recording of depression in low income areas and to further explore how best to support the mental health needs of their practice populations.

c) Mental health commissioners to increase IAPT capacity at Step 3 in order to meet local demand and to support people with moderate- severe common mental health disorders

5. Mental health commissioners/providers of mental health service to address the current gap in provision between CMHTs and IAPT services, by developing community based mental health provision that meets the bio-psycho-social needs of people including those with complex psychological or social needs.

6 .Providers of physical healthcare pathways for long-term conditions and Primary Care, to pro-actively screen people with long term conditions for mental health problems as part of wider psychological informed conversations. Also, to ensure appropriate support and onward referral

7. Mindwell to co-produce bespoke online resources for people with comorbid mental and physical health problems

8. Mental Health service providers, Primary Care and Public Health to urgently address the premature mortality of people with SMI through:

- Ensuring the effective implementation of the Leeds Shared Care protocol
- Urgently addressing issues with communication between LYPFT and Primary Care by improving IT systems
- Increasing the proportion of eligible people receiving the full list of annual physical health checks in Primary care
- Providing support for service users with SMI to access appropriate physical healthcare services
- Developing better health improvement messages that meet the needs of people with SMI and ensuring that healthy living service for this group are tailored to meet needs.

9. Mental health commissioners and service providers to review the impact of high rates of First Episode Psychosis in the population on Early Intervention in Psychosis services, along with the needs of people who experience 'At Risk Mental States'

10. Mental health service providers, LCC Public Health and the Third Sector to review mental health provision for people from Black and Minority Ethnic communities across the whole (mental) healthcare system, in order to better meet needs and reduce identified mental health inequalities. In particular address the unmet needs of vulnerable migrants and disadvantaged groups.

11. Mental health service providers, in partnership with Third Sector, Social Care and LCC Public Health to review use of the MH Act (particularly in Leeds South) and make recommendations across the health and social care system.

12**.** Commissioners/mental health providers to consider how best to deliver trauma informed services that meet the needs of people with mental health problems that have their roots in adverse experiences such as trauma and/or physical, psychological and sexual abuse. Build on the work of the Visible project to ensure sustainability and effectiveness of new approaches to addressing mental health and abuse.

13. Leeds City Council and NHS Leeds CCGs to increase commissioned employment support services for people with mental health problems in order to build on existing good practice

14. LCC Public Health, mental health service providers and NHS Leeds CCGs to ensure that new models of care/population health management approaches are supported through regular provision of good quality mental health data at practice level. This to include information on: mental healthcare service usage, co-morbid long-term conditions and mental illnesses, and SMI annual physical health checks

For further information about *Leeds in Mind* please contact sarah.erskine@leeds.gov.uk

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1. Introduction

1.1 Introduction

Health Needs Assessment (HNA) can be defined as a systematic method of identifying the unmet health and healthcare needs of a population, and making changes to meet those unmet needs.

This Mental Health Needs Assessment (MHNA) assesses the mental health and wellbeing needs of the Leeds population, identifies where gaps in provision exist and makes recommendations to address inequity in access to healthcare and unequal health outcomes. It aims to support both commissioning and service planning and informs the Joint Strategic Needs Assessment process led by the Leeds Health and Wellbeing Board.

The report builds on the approach adopted as part of the Leeds MHNA published in 2011, whilst seeking to provide new analysis that can inform development of mental health services in the current landscape of health and social care services.

Recent years have seen significant changes in the social and economic policy context in England – with a prolonged economic downturn, economic austerity, welfare reform and more latterly Brexit. Observable associations from previous recessions suggest that such changes are likely to have an effect upon the mental wellbeing of the population (PHE, 2015)

Monitoring and assessing the impact of these changes, particularly on those individuals and groups who may be more vulnerable to developing or worsening mental health problems, is central to being able to take effective steps to ameliorate the negative consequences of such wider socio-economic shifts. More broadly, ongoing population analysis supports Leeds commitment to reduce health inequalities and improve the health of the whole population.

1.2 Why Mental Health?

Mental health is central to the wellbeing of individuals and communities.

A definition of good or positive mental health is explained more than in the absence or management of mental health problems; it is the foundation for wellbeing and effective functioning both for individuals and for their communities (WHO, 2013). Mental capital is the entirety of a person's cognitive and emotional resources. It includes their cognitive ability, how flexible and efficient they are at learning, and their 'emotional intelligence', such as their social skills and resilience in the face of stress. It therefore conditions how well an individual is able to contribute effectively to society, as well as their ability to enjoy a high quality of life.

Poor mental health is not only distressing to individuals and families, but is associated with significant costs to society as whole - through the impact that it has upon public services such as health, social care and education, along with the wider economy. People with mental health problems are more likely to experience poorer physical health, be unemployed, fall into poverty and be over-represented in the criminal justice system. Overall costs to the English economy associated with mental health problems are estimated as being £70billion a year (WHO, 2013). The World Health Organisation (WHO) estimates that mental health problems account for more disability adjusted life years lost (23%) than Cardiovascular Disease (16%) or Cancer (16%).

The Five Year Forward View for Mental Health (2014) cites the importance of '*moving beyond moral imperative and individual benefits and recognising the financial necessity of intervening earlier, investing in effective, evidenced based care and integrating physical and mental health'*. Indeed, more than 11% of the NHS budget is spent on treating mental illness – but the indirect costs from unemployment, absenteeism and presenteeism (being at work longer than contracted hour – possibly due to a reduced capacity to 'cope') can be higher. These indirect costs totalled £30.3 billion in England in 2009/10 across all mental illnesses, compared with direct health and social care costs of £21.3 billion (Centre for Mental Health, 2010). **The evidence is now very strong that intervening in mental illness reduces cost across the whole health and social care economy** (Centre for Mental Health, 2016)

Finally, the Early Intervention Foundation estimate that in England and Wales £17bn per year is spent upon late intervention – in addressing problems that could have been prevented through better support for parents and infants. There is strong evidence that the bedrock of good mental health begins in infancy, through the development of healthy attachment relationships with care givers. There is therefore a clear case for investing early in the life course and supporting families to future proof the health of our population (Mental Health Foundation, 2015)

1.3 Scope

The original scope for the Leeds MHNA was developed in agreement with a multi-agency reference group and is therefore based upon expert/stakeholder opinion regarding likely areas of need. This was amended throughout the process as new local priorities emerged.

The report takes a life course approach to mental health. It recognises the centrality of early experiences, key stages and transitions upon mental health. There are therefore important interdependences between this need assessments and other work in the city that seeks to address physical health and the mental health needs of children.

The needs assessment specifically focuses upon adults (defined as 16+), and pays close attention to how both risk and protective factors can influence the development of mental health and illness. Further health needs assessments (HNAs) will be published during 2017/18 that will assess mental health needs during the perinatal period and the mental health of both young people and older people.

Analysis of suicide and self-harm is not included in significant detail. Whilst these are important population metal health indicators - local assessment can be found in The Leeds Suicide Audit 2016. Self-harm is covered in detail in an accompanying HNA on young people's mental health (noted above)

This needs assessment defines 'adult' to be '16 years and over'- rather than 18. This recognises the important developmental changes that take place between 16 and 24 years. The specific needs of older people (64+) are also included within analyses of adult mental health but organic mental health disorders, (eg. Dementia) are not covered and as noted above, a separate mental health needs assessment is under development.

The geographic population under consideration are those people living within the Leeds Local Authority boundary and/or those people who are registered with a Leeds GP.

Key mental health disorders are analysed in this report, by demographic factors (including gender, ethnicity, disability and sexuality). **However, available data does not always allow in-depth assessment of the needs and experiences of specific groups and themes. Further work will be carried out in greater detail as part of ongoing needs analysis.**

Whilst people with mental health problems are over represented in the criminal justice system [9] the needs of the Leeds based prison population is not included in this report. Commissioning and responsibility for Leeds prisons healthcare lies with NHS England.

- Chapter 1 outlines the current national and local mental health policy context
- Chapter 2 highlights factors which increase the likelihood of developing mental illnesses (exploring the intersectionality between socio-economic circumstances and individual attributes such as gender and disability) and those which may afford some 'protection'. This informs the analysis of mental health needs further in the report.
- Chapter 3 uses available demographic data to give an overview of the population of Leeds – at citywide, CCG and neighbourhood level. It highlights key areas that may impact upon the mental health of the population.

Stevens et al (2007) describe three approaches to HNA: *epidemiological* which considers the epidemiology of the condition and current service provision; *comparative* which compares service provision between different populations and *corporate* which is based on eliciting the views of stakeholders (including professionals, patients and service-users, the public and politicians) regarding which services are needed. These approaches are used to structure Chapters 4 - 7

- Chapter 4 reviews Common Mental Health Disorders such as anxiety and depression
- Chapter 5 assesses Serious Mental Illnesses – primarily psychotic disrders and bi-polar disorder
- Chapter 6 covers the complex area of comorbid mental health and physical health conditions
- Chapter 7 outlines some of the very early findings from mental health service re-design in the city (as part of new models of care) that aims to meet current unmet need as well as bringing together available data and intelligence about personality disorder, trauma and people with complex mental health problems.

1.4 Methodology and Sources of Data

The report uses data and intelligence that is already available, including national prevalence/incidence modelling, local service and activity data, and findings from qualitative reports. This is then combined with stakeholder perspectives gathered from 1:1 interviews and events/meetings and through ongoing presentation of emergent areas to groups and networks to sense check findings.

Overall, the process undertaken has been to combine public health population analysis with a collaborative approach to understanding and interpreting the data and to develop recommendations in partnership.

Due to the complex nature of the mental health and wellbeing agenda, and the inter-relationships with other programmes and services, key links to related programmes and documents are made throughout the report.

1.5 Policy Context

This assessment of mental health needs occurs within a global and national policy context – economic recession and austerity measures, widening health inequalities and political policies that have de-stabilised the NHS and significantly reduced core funding to local authorities and the Third Sector. Of note, is the welfare reform policy agenda, which has had an impact upon those with mental health problems and upon the mental health and wellbeing of claimants in general (Addenburg 2009, APMS, 2016) such an agenda sits at odds with wider rhetoric and investment into mental health services.

National Mental Health Strategy

The mental health strategy '*No Health without Mental Health'* (2011) set out a clear position regarding the response needed across governmental departments to address mental health. This was followed in 2014 by *'Closing the gap: Priorities for essential change'* (2014) which set renewed strategic direction to achieve the goals set out in policy.

More recently, broader changes across the NHS have significant implications for mental health. The new structures that are being developed within the NHS under 'New models of care' (as set out in the NHS 5 Year Forward View) have the potential to remove barriers to timely and appropriate care - between physical and mental health services, between health and social care, and by bringing secondary care closer to primary care. However, they are no guarantee of more equitable access to services.

The '*Mental Health Taskforce Five Year Forward View for MH*' (2016) set out some of the key drivers for this NHS service change from the perspective of mental health:

- Addressing the needs of Children and Young People
- Perinatal Mental Health
- The inequalities experienced by people with SMI and the mental health of people with LTC
- The specific needs of veterans, older people and marginalised groups (including the prison population)
- The rising suicide rate

Developing a number of key priorities for delivery by 2020/21

1. A 7 day NHS – right care, right time, right quality
2. An integrated mental and physical health approach
3. Promoting good mental health and preventing poor mental health helping people lead better lives as equal citizens – including support for people at key points in the lifecourse.
4. Creating mentally healthy communities – including local Mental Health Prevention Plans, and anti-stigma
5. Building a better future – including improving benchmarking data to provide transparency about mental health spending and performance.

Direction for local areas on how best to achieve these priorities and detail regarding the support available has now been set out in the implementation plan (https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf) with Sustainability and Transformation Plans viewed as the vehicle for strategic planning implementation at scale and for collaboration between partners.

The Crisis Care Concordat is national programme that runs in parallel with policy changes above to deliver better crisis care. The Concordat focuses on four main areas:

- Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.

- Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment
- Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

Outcome Frameworks

The Health and Social Care Act of 2014 set out responsibility for delivering outcomes related to mental health. These are now included in the NHS, Public Health and Social Care outcomes frameworks which monitor, at local levels, performance against a number of criteria. A number of the indicators are shared across frameworks – signalling the need to work across sectors to improve mental health. Social work and social workers are seen as central to be able to address many complex mental health and social needs. Recent policy document 'Social work for better mental health: a strategic direction' (DH, 2016).

The Public Health Approach to Mental Health

The Public Mental Health policy agenda foregrounds, in particular, addressing the wider determinants of mental health and involves: Mental Health Promotion, Mental Illness and Suicide Prevention and Improving Lives – recovery and inclusion (– with action to address mental health at a population level crucially shown to reduce risks of mental illness [15]

Figure 1 Public mental health: a conceptual model derived from the WHO Public Mental Health framework (2013)

Specific indicators included in the Public Health Outcomes Framework for mental health are: excess mortality <75 years for adults with SMI, local suicide rates and emergency hospital admissions for intentional self-harm. Within the Five Year Forward View for Mental Health (2016) there are also recommendations specific to Public Health - to ensure that mainstream or physical health interventions target people with mental health problems and that Public Health will lead a national mental health Prevention Concordat programme that will: '*support all Health and Wellbeing Boards (along with CCGs) to put in place updated JSNA and joint prevention plans that include mental health and comorbid alcohol and drug misuse, parenting programmes, and housing, by no later than 2017*'. (Department of Health, 2016).

Underpinning much of the Public Mental Health agenda is broad understanding regarding: the central importance of ensuring that infants receive the best start in life; intersectionality (meaning here the way in which who you are, where you live and how you are treated impacts upon your wellbeing); and the potentially cumulative effects of discrimination, poverty and exclusion. This is translated into policy framework that takes a proportionate universal approach to promoting wellbeing and preventing poor mental health.

1.6 Local Drivers

Work undertaken in Leeds in recent years has highlighted that a complex and diverse configuration of primary and secondary community based mental health services has developed over time in response to need and commissioning priorities; however it has lost coherence as whole system. Much of what is delivered is high quality, responsive and valued by those service users who gain access. However, it is fragmented and difficult for both the public and professionals to navigate, service outcomes and eligibility are not clear, it is long overdue for review as a "whole system".

Service users, commissioners and providers highlighted key problem areas:

- Difficulty of accessing information
- Mental health system is not easy to understand to anyone outside of it
- Services are not consistently "outcome" focused
- The wait for talking therapies is too long
- There is inconsistency of care packages
- There is a 'gap' between service provided by IAPT and those provided by CMHTs

Our five outcomes

1. Focus on Keeping People Well – to build resilience and self-management
2. Mental Health and Physical Health services will be better integrated
3. Mental Health services will be transformed to be recovery and outcome focused
4. We will ensure access to high quality services informed by need
5. We will challenge stigma and discrimination

The Leeds Mental Health Framework 2014 -17 is a statement of intent organised around 5 Outcomes with an implementation programme which focusses on 4 key priorities forming part of the overall

Our Four Priorities

1. Information
2. Crisis and Urgent Care
3. Community Based Mental Health Services
4. Children & Families

Transformation Portfolio for the Leeds Health & Social Care economy. This new model development has been completed in partnership between health and social care commissioners, providers and service users. As the task of delivering care is becoming greater and more complex with the scale and scope of change increasing, it requires us to make a shift to an outcomes based approach to create a common purpose and guide all of us in the redesign mental health services with a focus on recovery, resilience and self-reliance.

The development of the Leeds Mental Health Framework has involved significant consultation and analysis of service data. As such it forms an integral part of this needs assessment.

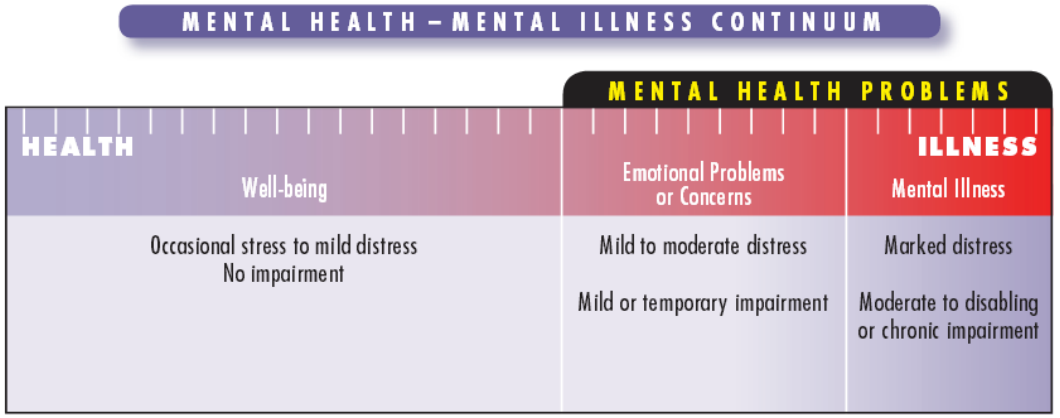
2. Understanding Mental Health: Risk and Protective Factors

2.1 Conceptual Frameworks

Understanding mental health and illness is complex. People's mental health is affected by many factors and may change from day to day. Figure 2 suggests one way in which it can be understood.

Common mental health disorders are on a continuum. People may move up and down this continuum dependent upon current life experiences and individual risk/protective factors. Some people may find it easy to recover from bouts of ill mental health due to increased resilience (explored below). For people with serious mental illness, there may be less movement across the whole spectrum, although significant periods of remission and recovery. ***Crucially, a sense of emotional health and wellbeing is found across the whole spectrum of mental health along with physical health.***

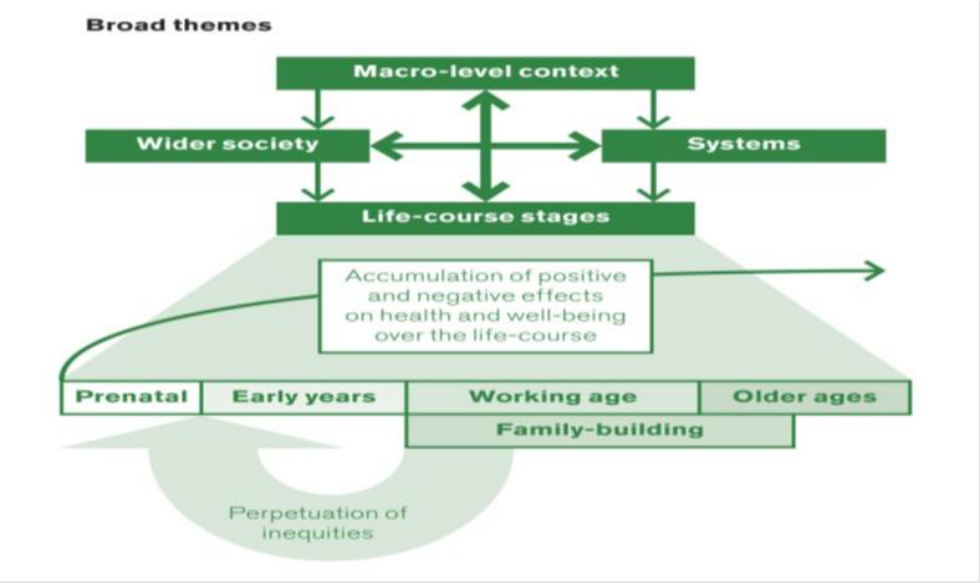
Figure 2 A conceptual model for mental health



Source: MHealthy – University of Michigan Health & Well-Being Services, "Understanding U: Managing the Ups and Downs of Life – What Is Mental Health?", 2012. http://hr.umich.edu/mhealthy/programs/mental_emotional/understandingu/learn/mental_health.html.

It is useful to think about the possible causes of mental ill health in terms of risk, protective and mediating factors. There are many possible relationships (both indirect and direct) between context, individuals and communities. Figure 3 shows one way in which to understand the role of these different factors across a whole population.

Figure 3 Factors that affect mental health across the lifecourse

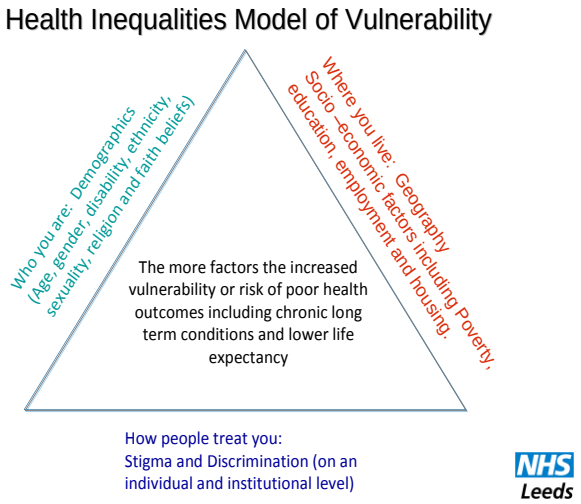


Source: CMO Report (2013)

The way that these factors affect an individual's mental health will vary. However, there are some groups that may experience many factors at the same time – which may mean that they are more vulnerable to developing mental health problems.

One way in which to conceptualise 'vulnerability' is shown in Figure 4. This illuminates the role that intersectionality plays eg, between place and people and the mediating role that mental health stigma or discrimination has on people's lives.

Figure 4



2.2 Evidence Summary

The evidence base regarding the development of mental ill health makes distinction between relationships between factors and mental ill health that suggest *causation* and those that simply show an *associatio*n. The recent Adult Psychiatric Morbidity Survey (2014) is a cross sectional study (albeit as part of group of studies, one that can review trends over time). This means that while the report indicates that the following groups had higher rates of poor mental health, the authors do not draw firm conclusions about why this may be the case.

Figure 5 Summary of APMS 2016: Groups with higher identified rates of mental health problems

Groups	**Associations**
Adults aged 16 – 24 years	Higher rates of positive screens for bipolar disorder than older age groups
Young women 16 – 24 years	High rates of CMHD and self-harm High rates of positive screens for PTSD and bipolar disorder compared to other groups.
Adults aged 55 – 64 years	Increasing rate of CMHD overall and high risk of suicide for men in this group.
Women	Increased rates of CMHD (since 2000)
Black/Black British women	CMHD: Higher rates than White women
Black/Black British men	Psychosis (x3 higher than White men)
Black/Black British ethnic group	Low treatment rates/access to services: across all MH disorders Highest rates of drug dependency of all ethnic groups Higher rates of PTSD when compared to other ethnicities
Adults under the age of 60 who lived alone	All MH disorders that were reviewed – high rates compared to other types of households
Adults not in employment (economically inactive or unemployed)	All MH disorders that were reviewed – high rates compared to being employed
People in receipt of benefits (particularly ESA)	All MH disorders that were reviewed – high rates compared to not being in receipt of benefits
Chronic, physical health conditions	Higher rates of severe CMHD and poorer emotional wellbeing.
Heavy Drinkers and Drug users	Associated with increased risk of CMHD and some other psychiatric conditions
Low IQ scores	Higher rates of severe CMHD, probable psychotic disorder and poorer emotional wellbeing

The Chief Medical Officer (2013) also identified: the following groups of people as being at risk of developing mental illness

- Homeless people
- Adults with a history of violence/abuse
- Travellers, asylum seekers and refugees
- Isolated older people
- People in care or who are in care leavers

*Definition of Black includes: Ethnic groups are based on those used in the latest Census and are drawn from the ONS harmonised ethnic group questions for use on national surveys. The groups were subsumed under four headings: White; Black/Black British; Asian/Asian British; and those who reported their ethnic group as mixed, multiple or other. It should be noted that these small groups are highly heterogeneous, for example the 'Black' group could include both recent migrants from Somalia and Black people born in Britain to British parents. The results of analysis by ethnic group should therefore be treated with caution. (Source: APMS, 2016)

2.3 Risk and Protective Factors

This evidence summary is divided into risks/protective factors under the headings of People and Place and only includes studies which are suggestive of causation (rather than association) - between a factor and the development of poor mental health.

Figure 6 Risk and Protective Factors for mental health problems

People	***Childhood determinants are very important – family environment moulds infant's brain and determines vulnerability throughout life. Later in life, risk and protective factors are important as they influence rates of recovery, remission and relapse***.
Childhood	**Adverse childhood experiences**, individually and collectively, are predictors of adult health (mental and physical). These include: Abusive or neglectful parenting/Drug and alcohol misuse/Parental mental illness/ Divorce or bereavement
	Poor attachment relationships predict poor mental health
	Protective Factors: Responsive parenting, healthy attachment relationships
Adolescence 16 - 24	**Quality of parent child relationship** is still crucial. Poor mental health at this point is associated with negative social outcomes and heightened risk of developing an eating disorder and self-harm
	Particularly at risk are **Vulnerable and looked after children** - high risk of poor mental health:
	For women aged 16 – 24 years: Early evidence suggests links between mental illness and Social Media exposure /Excessive use of computers and mobile phones possibly mediated by sleep loss
	Protective factors: Developing resilience in this group
Adults 16 - 64	Adverse life events (eg serious illness/job loss/violence and trauma) are associated with mental illness Adults have impact on and responsibility for other people
	Unhappy relationships are predictive of mental health problems
	Caring responsibilities can have a negative impact upon mental wellbeing
	LGBT populations are at an increased risk of poor mental health
	People who are **unemployed** are more likely to develop anxiety and depression.
	Debt and financial strain are associated with depression and anxiety. Evidence is suggestive of a causal association
	Protective Factors: Access to community resources or social capital has an impact on mental health/Social networks
Later life 65+	The needs of older people may not be identified/ met. This age can be the point at which cumulative impacts of poor mental health/adversity are most strongly felt. Retirement can be positive but can also be a time associated with loneliness.
	Many older people are **carers**
	Loneliness - higher risk of experiencing depression
	Protective Factors: Social networks

Place	***Communities and neighbourhoods have an important role in supporting physical and mental health.*** ***Prevalence of mental illness maps closely with deprivation due to 'drift' of people with mental health problems and the way in which separate risk factors for mental illness coalesce in certain areas***
	Quality of Housing and Homelessness – significant association with MH problems
	Living in densely built areas has an influence on the risk of developing schizophrenia
	Protective Factors: **Workplace provides an important opportunity for people to build resilience develop social networks and develop their own social capital** **Social inclusion and social networks and 'escape facilities in communities' (such as cafes and community centres) improve mental wellbeing** **Living in an area with green spaces has a lasting positive effect on wellbeing for all ages and socio-economic groups**

(Taken from: Faculty of Mental Health/mental Health Foundation, Better Mental Health for All 2016)

2.4 Poverty and Mental Health

- Poverty refers to a lack of money/material possessions but also to being in a state of having insufficient means (including social and material possessions).
- There is strong evidence that inequality or the experience of having less than others has a direct impact upon mental health and that more equal societies experience better mental wellbeing (Wilkinson and Pickett, 2009)
- People living in poverty have higher prevalence of mental health problems - due to there being a direct association between aspects of poverty such as mental illness and 'drift' of those with mental health problems into poverty.
- The Marmot review of Health inequalities and the Sustainable Development Commission have both shown how people with mental health problems experience area inequalities. The populations of deprived areas are characterised by concentrations of disabled people, including those with mental health problems.
- There is a social gradient to poverty and mental health. Across the UK, people in the poorest fifth of the population are twice as likely to be at risk of developing mental health problems as those on average incomes. This is related to the way in which individual risk factors for mental illness coalesce in poor areas, and the effects of intergenerational disadvantage, complex trauma, stigma and inequity in terms of access to and provision of services that meet the needs of this group.
- Mental illness can also be seen as a mediating factor in itself – in a complex relationship with physical illness and deprivation

2.5 Complex Needs and Trauma

Whilst trauma and/or abuse are independent risk factors for mental illness (see above) people who experience several, complex and interrelated issues are often at higher risk of mental health problems. Often these needs can originate in traumatising events from early in life and can be exacerbated by more current issues such as ability to maintain relationships, poverty, housing and substance misuse.

There is clear evidence that having experienced trauma and abuse is implicated in the development of mental illness across the spectrum – from anxiety and depression to increased risk of psychosis (Lancet Public Health 2017: http: dx.doi.org/10.1016/s2468 – 266 (17) 30104 – 4)

2.6 Key Groups

Particular groups of people have been shown to be at increased risk of mental ill health (Figure 5). It is likely that these groups experience greater levels of risks, or combinations of risks that increase their vulnerability to developing mental health problems. **The way in which the mental health needs of these people are being met will be explored in this report or where more in depth work is needed, through further pieces of work during 2017/18.**

Identified groups include:

- **BME groups – particularly Black/Black British women**
- **Women – particularly young women.**
- **People with Learning Disabilities and comorbid mental ill health**
- **People with dual diagnoses – mental health and substance abuse**
- **Homeless people**
- **Asylum Seekers and Refugees**
- **Gypsy, Roma and Traveller Groups**
- **Carers**
- **Care Leavers**

2.7 Mental Health Stigma

Mental health stigma is a significant barrier to people developing an understanding of mental health and illness and to accessing treatment. In underpins all aspects of mental health – from emotional wellbeing to serious mental illness and may be experienced differently by different population groups or communities. In the UK reducing stigma and discrimination relating to mental health is a key priority and is championed nationally by The Time To Change Campaign. National surveys show the overall attitude trend between 2008 and 2016 was positive with a 9.6% change (4.1m people) with improved attitudes towards mental illness.

3. Demographic Summary

This chapter uses available demographic data to firstly, provide a demographic overview of the population of Leeds. It then combines the evidence about risk factors for poor mental health (covered in Chapter 2) with data about the Leeds population - in order to quantify, where possible, levels of potential mental health need in the city.

The Leeds Joint Strategic Needs Assessment (2015) describes Leeds as a growing city, where many people have benefited from the success of the city's economy over the last two decades, both within the city, and beyond in neighbouring localities. In the last decade the BME population in the city has increased from 11% to 19%, and the number of residents born outside of the UK has almost doubled to over 86,000 people. Leeds also has one of the highest student populations in the UK with over 60,000 students attending the city's three universities, with the student population heavily concentrated in the city centre and Inner West areas

3.1 Population Size

Until 2011, the ONS mid-year estimates for Leeds population tallied closely with GP registration populations. Following the 2011 Census, ONS revised their figures downwards.

The latest GP registration data (January 2016) puts the population of Leeds at 823,632 (this is based on those who are registered with a Leeds GP living inside Leeds, using MSOA boundaries as the filter) - higher than the most recent ONS mid-year projection of 774,100 (ONS, 2015)

The potential time-lag between GP registrations and de-registrations may be one explanation for the variation, although the possibility of the mid-term projections underestimating the population could also be a contributing factor. In terms of trends in GP registrations, recent years have seen a steady increase in total Leeds resident registrations from 771,800 in 2006, to 823,632 in 2016.

Figure 7 ONS Population Estimates

Total population (2015)

	Leeds (numbers)	Yorkshire and The Humber (numbers)	Great Britain (numbers)
All people	774,100	5,390,600	63,258,400
Males	379,800	2,658,400	31,165,300
Females	394,300	2,732,200	32,093,100

(Source: ONS Population estimates - local authority based by five year age band)

3.2 Deprivation

The Index of Multiple Deprivation is used to assess relative, multiple deprivation at the small area level (LSOAs and MSOAs are used in this report), based on the idea of distinct dimensions of deprivation which can be recognised and measured separately. These are experienced by individuals living in an area.

The overall IMD is conceptualised as a weighted area level aggregation of these specific dimensions of deprivation (i.e. the individual indices of deprivation are combined to produce one overall percentage of deprivation in an area which allows comparison with other areas in terms of deprivation).

The Department for Communities and Local Government (DCLG) published The English Indices of Deprivation 2015 in September 2015:

- Leeds is 31 out of 326 when ranking on proportion of neighbourhoods (LSOAs) in most deprived 10% nationally. (IMD 2015)
- Leeds has 105 neighbourhoods (LSOAs) in the most deprived 10% nationally. This is 22% of all Leeds LSOAs (2015).

Detailed and interactive analysis using the IMD can be found on the Leeds Observatory http://observatory.leeds.gov.uk/Leeds_Deprivation/

Super Output Areas (SOAs) are a useful geography for the collection and publication of small area statistics, such as the IMD). SOAs avoid the problems caused by the inconsistent and unstable electoral ward geography. They are better for statistical comparison as they are of much more consistent size and each layer has a specified minimum population to avoid the risk of data disclosure (releasing data that could be traced to individuals). SOAs will not be subject to frequent boundary change, so are more suitable for comparison over time.

There are currently two levels of SOA in use in England and therefore in Leeds. These are Lower Layer Super Output Areas (LSOA) and Medium Layer Super Output areas (MSOA). There are 476 LSOAs within Leeds which are grouped together to form 107 MSOAs. When formed in 2004, LSOAs had a minimum size of 1,000 residents and 400 households, and an average population size of 1,500. MSOAs had a minimum size of 5,000 residents and 2,000 households, and an average population size of 7,200.

Deprived Leeds is used to designate the area of the city within the 10% most deprived LSOAs in England, according to the Index of Multiple Deprivation 2015. Nearly 200,000 people in Leeds live in neighbourhoods that are ranked in these areas; this represents over 20% of the city's population. At CCG level, NHS Leeds South and East CCG have the highest proportion of its population living in Deprived Leeds.

The most deprived communities are in the Inner East and Inner South areas of the city, with a further hotspot in Hawksworth in Inner West. Of note are Gipton and Harehills, Burmantofts and Richmond Hill, and Middleton Park – all wards that face significant challenges.

Deprivation Deciles are based on the IMD scores of the LSOAs/MSOAs. They are calculated by listing all of the SOAs in order of their IMD score and dividing the list into 10 equally sized groups (in terms of the number of SOAs each group contains). If Leeds were to exactly match the profile of the country as a whole there would be 10% of its LSOAs in each of the IMD deciles.

Figure 8 shows that the most deprived deciles in Leeds (shown in dark blue) are concentrated in the inner part of the city. Figure 9 shows that there are 100 LSOAs in Leeds (20%) which are in the most deprived 10% of deciles (when deprivation is ranked nationally). Chapter 2 explored how risks for poor mental health often cluster in such deprived areas and noted the link between poverty and mental ill health. The *pattern* of deprivation in Figure 8 and the *level* of deprivation in the city shown in Figure 9 are likely to have consequences on mental health need and ultimately on both service design and delivery

Figure 8 Leeds by Deprivation Deciles

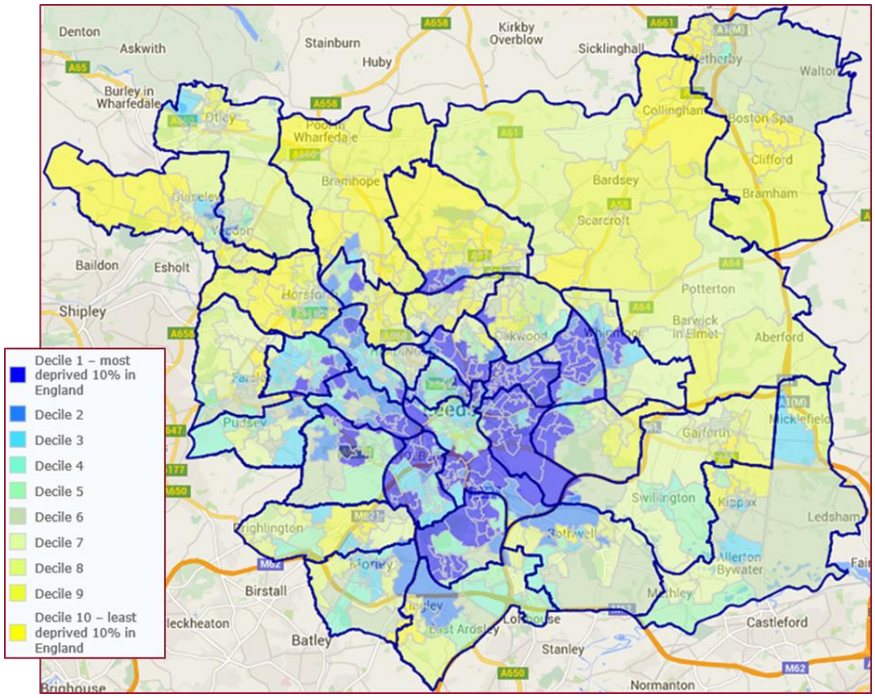
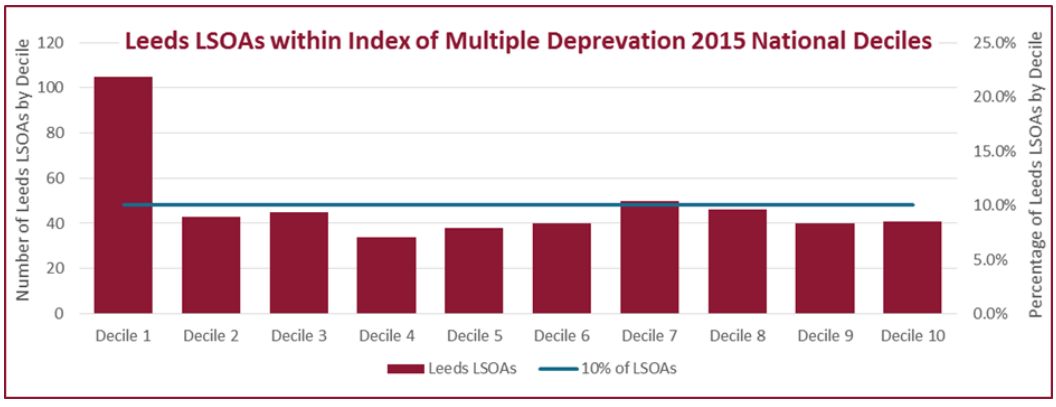


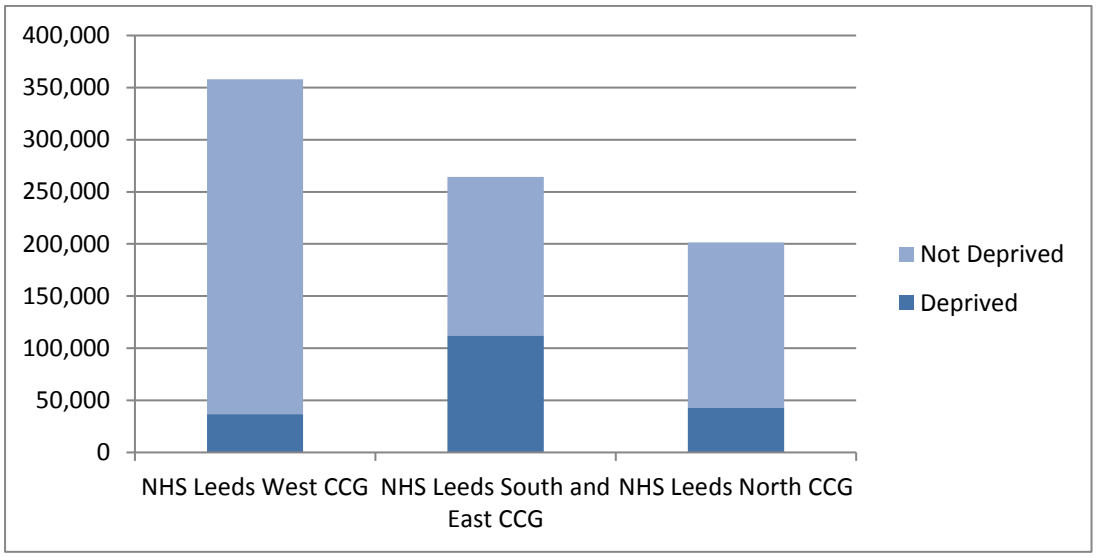
Figure 9 Leeds LSOAs by national Deprivation Deciles



(Source: http://observatory.leeds.gov.uk/Leeds_Deprivation/)

Figure 10 shows how deprivation is patterned across the 3 Leeds CCGs. It clearly shows that a higher proportion of the GP resident population living in LSE CCG live in 'Deprived Leeds'

Figure 10 Deprived Leeds/Non Deprived Leeds by CCGs 2016

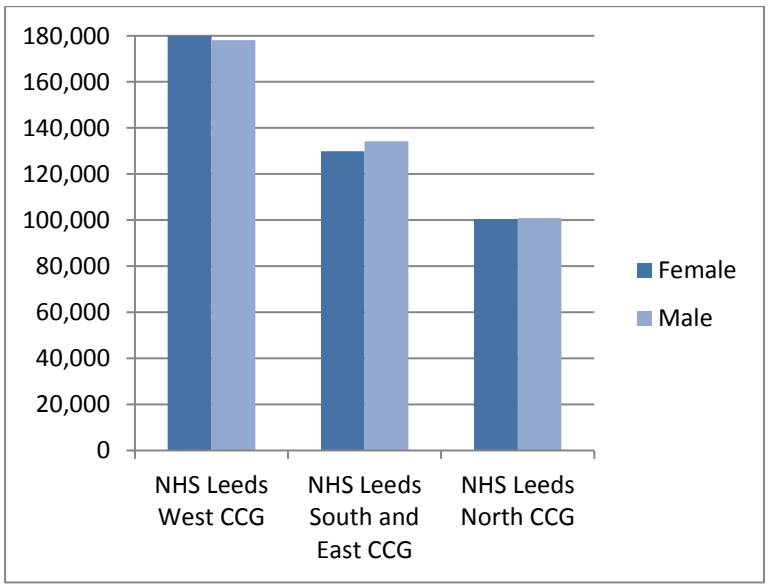


(Source: GP Registered Population/Resident in Leeds Jan 2016. PH Audit)

3.3 Gender

In general, men and women experience different risk factors for mental illness. Figure 11 shows broadly similar proportions of the sexes across the three Leeds CCGs

Figure 11 Male/Female populations by CCG

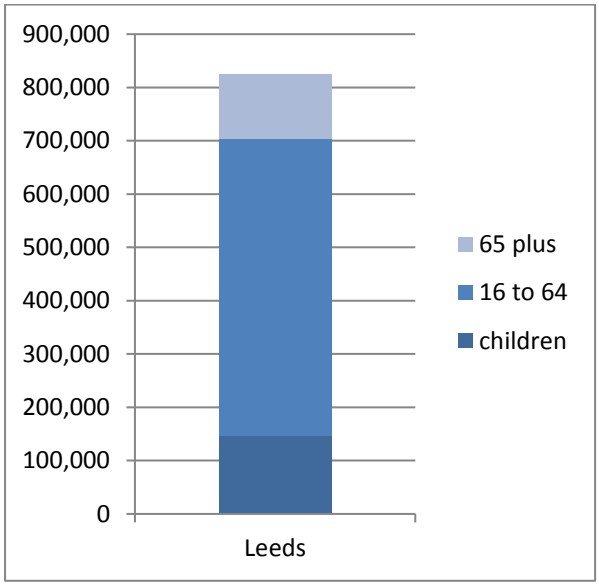


(Source: GP Registered Population/Resident in Leeds Jan 2016. PH Audit)

3.4 Age

Different factors can affect people's mental health across the lifecourse; an awareness of the age profile of the city therefore informs not only an understanding of risk factors but likely ways in which mental health can be improved. Whilst Figure 12 shows that the 'working age population' (16 – 64 years) is the single largest group, Leeds has an ageing population. The 60-74 age group is projected to grow by over 8,000 (+8%) and the 75+ group by almost 6,000 (+10%) between 2015 and 2021. The city also has a higher proportion of 20 to 24 year olds due to large its student population which is situated primarily in Leeds West CCG.

Figure 12 Age proportions of the Leeds population



(Source: GP Registered Population/Resident in Leeds Jan 2016. PH Audit)

3.5 Ethnicity

Approximately 70% of the Leeds resident population that is registered with a GP is from a White background with the remaining largest single groups being people from an Asian background (7%) and a Black background (4%) – as shown Figure 13. However, these proportions vary significantly across CCGs, neighbourhood areas, and between GP practices**.**

ONS estimates suggest that the White population accounts for 80% of the population in Leeds – this discrepancy may be caused by missing ethnicity codes in Primary care records and different population definitions. Around 15% GP registered patients do not have an ethnicity code. People from Black and Minority Ethnic population and young men are least likely to have a code recorded

Figure 13 Number and Percentage Broad Ethnic category

	Number	%
White Background	572,910	70
(blank)	97,532	12
Asian Background	59,517	7
Black Background	31,358	4
Ethnicity Not Known	23,121	3
Chinese & Other Background	20,440	2
Mixed Background	16,925	2
Unknown	1,592	0.2
Not Stated	237	0.03

(Source: GP Registered Population/Resident in Leeds Jan 2016. PH Audit)

3.6 Immigration

The Leeds Joint Strategic Needs Assessment (JSNA) notes the 'rapid demographic changes, particularly in some of Leeds most deprived communities, driven by a complex combination of immigration and the local housing tenure (http://observatory.leeds.gov.uk/leeds_jsna/. Broad population estimates cannot capture these types of small scale and rapid changes. They are likely to have resonance for understanding the mental health of the population. However, immigration is complex and the mental health need of some groups will not be as great as others.

Economic Migration The largest group of people coming to live in Leeds are Polish, and are predominantly economic migrants who come to Leeds to work in the city, followed by people from Romania, Spain and India.

Asylum Seekers

- In Leeds in 2016, the top countries of origin of Asylum seekers were Sudan, Eritrea, Iran, Pakistan, Syria, Afghanistan and Iraq
- 82% of all new cases in 2015 are singles- mostly men
- The majority of single asylum seekers from countries like Sudan, Eritrea and Syria are granted positive decisions

(Source: Migration Yorkshire Leeds Local Migration Profile July 2015)

Further in depth analysis regarding migration trends is available from:
www.migrationyorkshire.org.uk

Students

There were 7700 ***international students*** registered at a Higher Education institution in Leeds in the 2013-2014 academic year (an increase of nearly 350 students on the previous year. Over three quarters came from outside the EU.

3.7 Economic Activity/Benefits

Being in work is a protective factor for good mental health. Overall, Leeds has a higher proportion of its total population who are aged 16 – 64 years (working age) than both Yorkshire and Humber and Great Britain (Figure 14). It has higher overall unemployment than the regional and UK average but has broadly comparable rates of benefits claimants (Figure 14)

Figure 14 Employment and unemployment (Apr 2015-Mar 2016)

	Leeds (numbers)	Leeds (%)	Yorkshire and The Humber (%)	Great Britain (%)
		All people		
Economically active†	411,200	78.9	77.0	77.8
In employment†	387,100	74.2	72.2	73.7
Employees†	340,200	65.7	62.5	63.2
Self employed†	42,300	7.7	9.1	10.2
Unemployed (model-based)§	25,900	6.3	6.1	5.1

Figure 15 Working-age client group - main benefit claimants (February 2016)

	Leeds (numbers)	Leeds (%)	Yorkshire and The Humber (%)	Great Britain (%)
Total claimants	63,970	12.7	13.4	11.8
By statistical group				
Job seekers	11,230	2.2	2.0	1.5
ESA and incapacity benefits	32,480	6.4	6.8	6.2
Lone parents	6,510	1.3	1.2	1.1
Carers	7,120	1.4	1.9	1.6
Others on income related benefits	1,370	0.3	0.3	0.2
Disabled	4,460	0.9	1.0	1.0
Bereaved	800	0.2	0.2	0.2
Main out-of-work benefits†	51,590	10.2	10.3	9.0

Source: DWP benefit claimants - working age client group
*† Main out-of-work benefits includes the groups: job seekers, ESA and incapacity benefits, lone parents and others on income related benefits. See the **Definitions and Explanations** below for details Figures in this table do not*

3.8 Carers

Finally, Leeds has a significant number of people who provide care – often to family members. Carers are at increased risk of poor mental health themselves

Figure 16 Provision of unpaid Care: Leeds Carers

DC3301EW - Provision of unpaid care by general health by sex by age						
ONS Crown Copyright Reserved [from Nomis on 08 September 2015]						
geography	Leeds					
sex	All persons					
general health	All categories: General health					
time	2011					
Age	**All categories: Provision of unpaid care**	**Provides no unpaid care**	**Provides unpaid care: Total**	**Provides 1 to 19 hours unpaid care a week**	**Provides 20 to 49 hours unpaid care a week**	**Provides 50 or more hours unpaid care a week**
All categories: Age	731,373	660,143	71,230	45,385	9,434	16,411
Age 0 to 24	238,948	233,249	5,699	4,272	828	599
Age 25 to 49	263,908	238,034	25,874	16,941	3,666	5,267
Age 50 to 64	122,100	97,036	25,064	17,250	3,165	4,649
Age 65 and over	106,417	91,824	14,593	6,922	1,775	5,896
					18,868	32,822

(Source: www.ons.gov.uk)

Figure 17 uses the evidence about risk factors and available data about the population in Leeds to estimate the numbers of people in the city at increased risk of poor mental health. This is not an exact science - as 'mental ill health' here covers mild/moderate conditions and other potentially more serious disorders like personality disorder and psychosis. People also very often experience more than one 'risk'. However, it provides some indication regarding the potential sizes of the populations under consideration in this needs assessment and in further ongoing reports/analysis.

Figure 17 Top level Summary of key risk factors for mental ill health Leeds

Risk Factors	**Number of people**
Debt and financial strain	100,000
Unemployment	40,000
Adverse experiences such as trauma and abuse	45,000
Caring responsibilities	70,000
Long term health conditions	200,000
Social Isolation	40,000

Figure 18 uses the evidence about protective factors to summarise circumstances, resources and programmes in Leeds that afford protection against mental ill health.

Figure 18 Top level Summary of key protective factors of good mental health in Leeds

Protective Factor
Support to develop healthy relationships (Leeds Best Start Programme)
Celebration of positive role models (Gay Pride, Leeds West Indian Carnival, Leeds Triathlon)
Resilience work for young people (MindMate)
Community resources, social capital and social networks (Leeds' strong and vibrant Third Sector and faith, community groups)
Access to green spaces across the city (Middleton Park, Temple Newsam etc)
Employment support and anti-poverty programmes

Health Needs Assessment

The following chapters assess the mental health needs of the Leeds population. They include estimates of mental health prevalence/incidence, analysis of service users and feedback from service use and professionals.

A note on estimating mental health prevalence/incidence: The latest population survey of mental health need in England - The Adult Psychiatric Morbidity Survey (APMS) has been used to estimate levels and types of mental health need in Leeds. Each individual screening tool used in this survey has its own interpretation of clinical disorders and specific caveats. Where there are significant reasons for caution to be exercised around estimates, these are noted. However, the APMS adopts a scientific and robust approach to the epidemiology of mental health and provides an excellent platform for local analysis. More detail about the APMS can be found here: http://content.digital.nhs.uk/catalogue/PUB21748

Populations: APMS rates are applied to local Leeds populations sometimes at different geographies Different denominators are used which each have their limitations. ONS mid-year estimates are sometimes used to provide an overview. However, these figures have limitations in terms of being able to predict small and rapid changes in populations. For more detailed analysis, GP registers are used (which can then be presented at the level of CCGs). GP registers have more readily available data about ethnicity and populations defined by geography and physical/mental health condition. However, around 13% of GP registers have no ethnicity recorded and some people in Leeds (most likely to be people with greatest needs or 'hard to reach' groups) are not registered with a GP.

Definitions:

Directly standardised rates: These show the expected number of events/cases that would occur in a standard population, if the population had the same age-specific rates as the local area. The standard population that is most commonly used is the European Standard population which is a hypothetical population of 2 million people, split by 5 year age bands. The rates are usually calculated per 100,000 and, because rates are applied to the same population, rates across areas can be compared.

Confidence Intervals: In this report 95% confidence intervals are quoted. These indicate that if a similar sampling method was used to select a different sample from the total (Leeds) population. 95% of people/cases would fall within the range quoted. They are only used when the group of people being considered is large enough to warrant their inclusion.

Stakeholder Views: Gathering the perspectives of clinicians, practitioners, service users and providers is central to triangulating an understanding of mental health needs and being able to 'sense check' the findings suggested by the quantitative data. Stakeholder perspectives have been gathered by collating existing qualitative research; through 1:1 discussions with key stakeholders, and by regular presentation of the needs assessment as it has progressed. The MHNA in draft format has also been distributed at regular intervals for comment.

4 Common Mental Health Disorders

4.1 Background

Common mental health disorders (CMHDs) comprise different types of depression and anxiety. They cause marked emotional distress and interfere with daily function. They include: generalised anxiety disorder (GAD), panic disorder, phobias, and obsessive compulsive disorder (OCD). Symptoms of depression and anxiety frequently co-exist, with the result that many people meet criteria for more than one CMHD. If left untreated, CMHDs can lead to long term physical, social and occupational disability and premature mortality.

4.2 Policy Overview

The primary delivery framework for NICE-recommended psychological treatments for CMHD is the Improving Access to Psychological Therapies (IAPT) programme. This brings together evidence-based treatments informed by clinical guidelines with the delivery of interventions, in a stepped-care model. Validated patient-reported outcome measures (including GAD7 and PHQ9) are used to assess, monitor and evaluate treatment

The Five Year Forward View for Mental Health (2016) includes an aspiration that, nationally, at least 19% of people with anxiety and depression will access treatment by 2018/19 and 25% by 2020/21. Target groups for this expansion include those people with comorbid physical and mental problems, people out of work and those with psychosis, bipolar disorder and personality disorder. In addition, the expansion aims to reduce variation in access to services for different population groups – including people from black and minority ethnic groups, people with a learning disability, older people, and women in the perinatal period (Five Year Forward View, 2016)

4.3 Epidemiology

Figure 19 APMS Estimates CMHD applied to GP registered population.

	APMS Estimated rates of CMHD (16+)	GP Reg Figs Jan 2016	Leeds Prevalence (95% Confidence Intervals)
All (12 or more CIS – R)	15.7%	677,501	106,368 (105,690 – 107, 045)
Women	19.1%	339,199	64,787
Men:	12.2%	338,302	41,273
Severe (18 or more CIS - R)	8.1%	677,501	54,878 (54,200 – 55,555)
Women	9.8%	339,199	33,242
Men	6.4%	338,302	21,651

(Source: APMS 2014/PH Audit GP Registered Populations)

Figure 19 takes the rates of CMHD that were reported in the APMS study and uses these to model prevalence in Leeds. It suggests that there are 106,368 people in Leeds within a year (using GP patient figures from January 2016) with a CMHD - as measured by the CIS – R tool ([1]). Whilst local service providers use different diagnostic criteria the APMS findings are interesting as they suggest that around half of CMHD can be classed as severe.

Being out of work is a risk factor for poor mental health. Modelled estimates, for numbers of people in Leeds who have a CMHD, by employment and benefit status, are shown in Figure 20 and 21.

Figure 20 APMS estimated rates of CMHD by Employment status (Applied to Leeds figs)

All 16 – 64 years	**APMS (%)**	**Denominator** (Jun 15 – June 16) NOMIS	**Leeds Prevalence**
Full time employment (16 – 64)	14.1	305,000	**43,005** (42,700 – 43,310)
Part time employment	16.3	125,000	**20,000** (19,750 – 20,250)
Unemployed looking for work	28.8	25,900	**7,252** (7,123 – 7,407)
	33.1%	**114,500**	**37,900** **(37,556 – 38,243)**

(Source: APMS 2014/PH Audit GP Registered Populations)

Figure 21 APMS estimated rates of CMHD by Benefits Claimants (Applied to Leeds figs)

ESA/Incapacity	**APMs %**	**Denominator** (NOMIS Feb 2016)	**Leeds Prevalence**
	66%	32,480	**21,437** (21,274 – 21, 599)

(Source: APMS 2014/www.nomisweb.co.uk)

CIS – R: The revised Clinical Interview Schedule (CIS-R) has been used in every wave of APMS to measure CMD symptoms and to identify people meeting CMD diagnostic criteria. This chapter focuses on differences in treatment rate by CMD. Treatment and service use among people with other types of mental disorder is addressed in the disorder-specific chapters. *CMD symptoms*The CIS-R score provides an indication of overall non-psychotic symptom severity, and is used in the analyses in this chapter to indicate level of mental health service required. **CIS-R score of 12 or more:** is used to indicate the presence of clinically significant symptoms of CMD, and identifies people with 'symptoms of CMD' sufficient to warrant recognition.**CIS-R score of 18 or more:** is also a threshold applied in this chapter anis used to indicate the presence of 'severe symptoms of CMD', sufficient to
warrant intervention

Figure 22 takes reported rates from the APMS and applies to the Leeds population across all diagnostic criteria for CMHD (ie. Including OCD and Panic Disorder) by gender, age and ethnic group. This provides some indication regarding the pattern of CMHDs in the population across different conditions.

Figure 22 APMS estimated rates applied to age groups n Leeds GP registered and resident population (January 2016)

	White British	White Other	Black/ Black British	Asian/ Asian British	Mixed, multiple and other
Men					
GAD	*10342.5*	*805.0*	*677.9*	*1397.2*	*255.8*
Depressive Episode	*5966.8*	*547.4*	*221.9*	*832.9*	*337.7*
Phobia	*3182.3*	*257.6*	*431.4*	*725.5*	*450.2*
OCD	*1591.2*	*966.0*	*480.7*	*483.6*	
Panic Disorder	*795.6*				
CMD NOS	*11337.0*	*2382.8*	*887.5*	*1639.0*	*634.4*
	26254.0	*4379.2*	*1688.7*	*3304.9*	*1422.2*
Women					
GAD	*15239.4*	*1636.2*	*796.6*	*1664.4*	*363.8*
Depressive Episode	*8055.1*	*944.0*	*829.8*	*676.2*	*181.9*
Phobia	*6748.9*	*377.6*	*431.5*	*1014.2*	*201.1*
OCD	*3265.6*	*503.4*	*166.0*	*312.1*	*143.6*
Panic Disorder	*1306.2*	*62.9*	*298.7*	*624.1*	*220.2*
CMD NOS	*20464.3*	*2202.6*	*1969.4*	*2158.5*	*1570.1*
	44411.8	*4751.2*	*3529.4*	*5539.3*	*2489.2*
All adults					
GAD	*25412.5*	*2546.6*	*1520.4*	*3066.8*	*614.0*
Depressive Episode	*14164.4*	*1528.0*	*1169.5*	*1533.4*	*515.0*
Phobia	*9998.4*	*636.7*	*865.4*	*1744.9*	*633.8*
OCD	*4999.2*	*1464.3*	*584.8*	*793.1*	*158.4*
Panic Disorder	*2083.0*	*63.7*	*350.9*	*581.6*	*217.9*
CMD NOS	*31661.5*	*4583.9*	*3087.5*	*3754.1*	*2218.3*
	70405.2	*9167.8*	*5613.6*	*8724.4*	*3921.6*
Bases					
Men	**198894**	**32200**	**12326**	**26869**	**10232**
Women	**217705**	**31465**	**11064**	**26006**	**9574**
All	**416599**	**63665**	**23390**	**52875**	**19806**

(Source: APMS 2014/PH Audit GP Registered Populations)

4.4 Evidence Review

Although evidence exists for the effective treatment of depression and anxiety, prevalence of CMHD have remained relatively static over recent years (APMS, 2014) .This may be because CMHDs are relapsing conditions that can recur many years after an earlier episode, because the stressors that cause them can endure for a long time, or because people with CMH D do not always adhere to or seek treatment (APMS, 2014). Interventions do exist however with a convincing evidence base. For

example, Cognitive Behavioural Therapies (CBT) have been found to be effective across a range of mental health disorders

There is evidence that the IAPT programme, as a key service delivering CBT (amongst other therapies) is not as effective for people living in deprived areas as it is for more affluent communities. Delgadillo et al (2011) showed that poorer areas have higher referral rates to IAPT, but lower numbers entering and finishing treatment and lower average recovery rates overall. Delgadillo et al also found that disability, some long term conditions, unemployment, and younger age (<20), functional impairment, baseline depression and whether someone thought the intervention was likely to work, predicted post-treatment improvement scores (Delgadilo, 2011 & 2016)

There is an emerging evidence base in prevention of CMHD and multifactorial risk algorithms for predicting major depression and anxiety disorders have been shown to be effective. Such tools could provide one way in which to develop population level interventions to reduce morbidity of this type (King et al, 2011 a&b)

4.5 Service Use Data

This section sets out a range of service use data which, in comparison with preceding prevalence estimates helps to highlight the volume of mental health need which is met by services. Importantly, it also indicates where there is variation or inequality in access and outcomes

People with CMHD may receive support from a number of services – often at the same time. These include, projects that aim to reduce social isolation (such as social prescribing or a range of third sector services), from their GP, and via the IAPT service (which itself provides a range of interventions).

Overview CMHD Clustering

The commissioning of mental health services is based upon clusters – people's functional needs are assessed by mental health practitioners and they are then assigned to a cluster and the most appropriate treatment. Figure 23 shows the results of a snapshot/audit of the number people assigned to clusters across Third Sector commissioned mental health services. Clusters 1 – 4 are classed as CMHD – although, in practice, Cluster 4 often incudes people with stable depressive bi-polar symptoms. More detail taken from this audit is included in Appendix 1.

Figure 23 Third Sector Cluster Audit

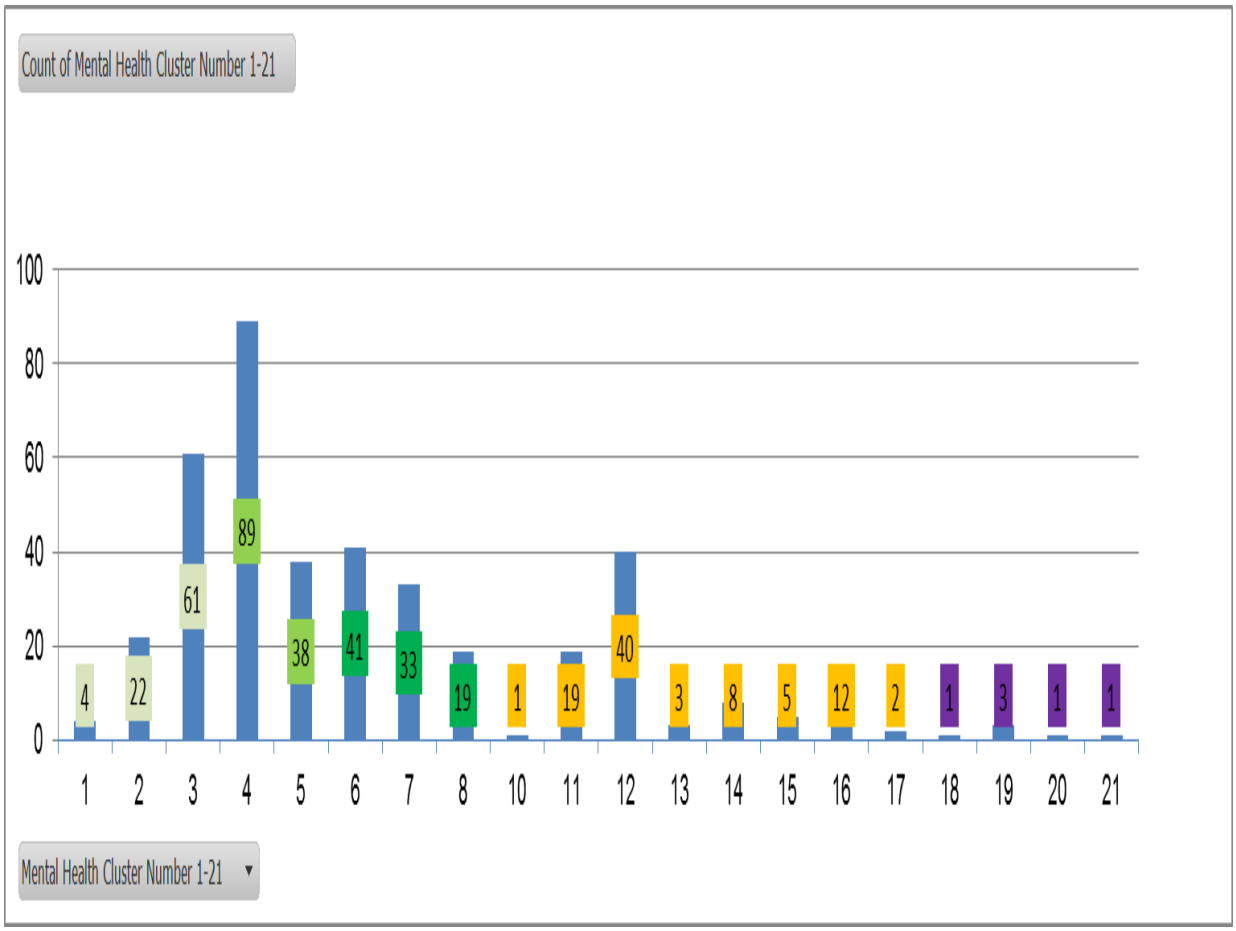
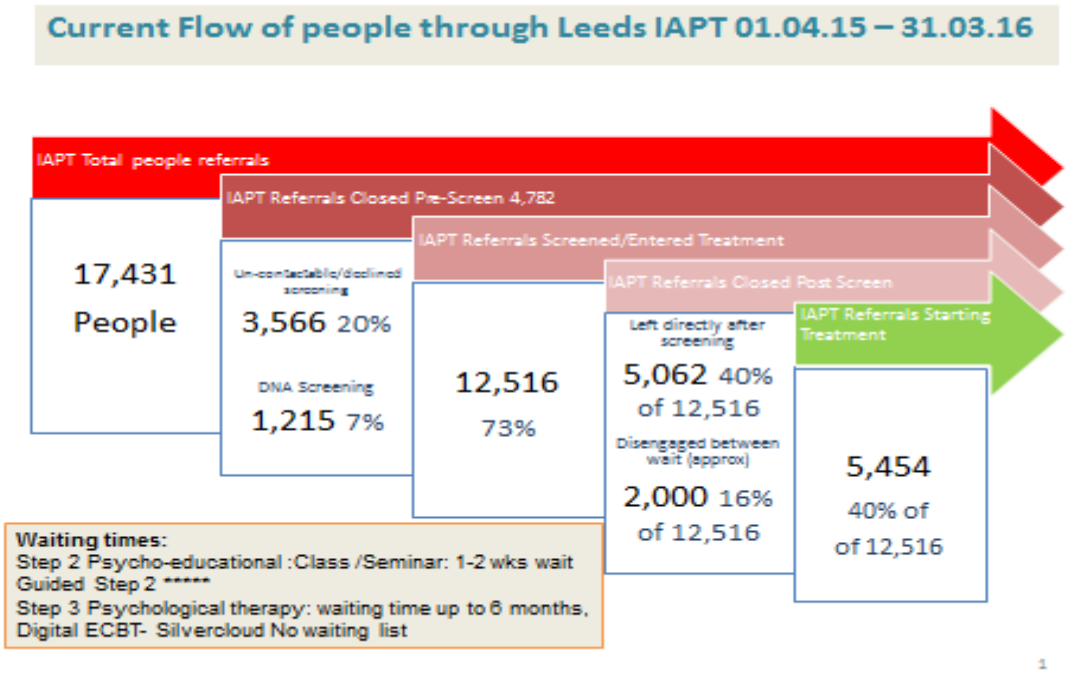


Figure 24 Current Flow of people through Leeds IAPT April 2015 - March 2016



The flow of people through the IAPT service (above) provides one way in which to assess unmet need. Nearly 12,000 people from referral to entering treatment are 'lost' from the process – either because of the level or type of need is not appropriate or due to the individual's ability to engage with the programme.

Rightcare

The Rightcare mental health focus pack presents analysis of a wide range of indicators focussing on: Spend Activity, Quality and Outcomes. CCGs are compared to the 10 most demographically similar CCGs. This is used to identify realistic opportunities to improve health and healthcare for local populations. The Similar 10 Explorer Tool is available on the NHS England website:https://www.learnenv.england.nhs.uk/similar#search_results, and sets out in more detail the methodology behind the comparisons.

Common opportunities for improvement, identified by Rightcare across the city, are service related:

- IAPT activity and outcomes
- Bio-psycho social assessment for adults with new cases of depression

Social Prescribing Data

There are three social prescribing projects commissioned by the Leeds CCGs. Each has a slightly different focus and operational approach. However, all projects report that a significant proportion of their referrals/service users have mental health problems, or that they are experiencing social/economic circumstances that are likely to put them 'at risk 'of poor mental wellbeing

Social Prescribing in Leeds is meeting significant mental health need. This is measured differently across the projects. However, as a conservative estimate, the projects are meeting the mental health needs of at least 2,000 people per year. It is likely however that much mental health need is not recorded, or is recorded as a proxy measure – eg 'worried about housing'. Through monitoring local people's needs the projects are also highlighting gaps in the wider mental health and social care system. Consultation with the social prescribing projects undertaken whilst compiling this report, along with analysis of monitoring data and evaluations, shows that social prescribing project are meeting the following needs or have highlighted the following issues:

- Long waiting lists for 1:1 support through IAPT
- An apparent increasing number of people 'off work' with mental and physical health problems
- Limited access to anger management support in the city
- Gaps in provision of befriending support.

Primary Care

CMHD are recorded in Primary care on the QoF payment system. They include: Depression, Anxiety, OCD, Panic, Phobia, PTSD, and Postnatal Depression. The Public Health Intelligence Team audit GP registers on a quarterly basis. Once someone has been recorded on a register it is likely that they will remain on that register – even if, for example, their depressive spell has ended. This data therefore represents 'lifetime primary care prevalence' and not the number of people in a given year that might be experiencing CMHD. Anecdotally, there is wide variation in the recording/coding practices of GPs. Mental illness may in itself also not be recorded at all, so the data presented must be treated with caution.

Figure 25 a) Number of people on Primary Care CMHD QoF Register (by Age)

All Age	Number of People	Percentage	Dsr/100,000
LNCCG	30483	14.4	15,022
LSECCG	41564	15.2	16,061
LWCCG	57563	15.5	16,780
Total	**129,610**		
16 – 24	10,701	8.7	
60+	35,789	21.6	

(Source: Public Health GP Audit October 2016)

Figure 25 a) shows that there are around 130,000 people registered as having a CMHD in Primary Care. It shows that, by CCG, these accounts for approximately 16% of the GP registered population. Directly standardised rates are included here which remove the effect of variation in the relative proportions of different age groups in CCG populations

Figure 25 b) CMHD Register by age for Anxiety, Depression and Anxiety& Depression

Anxiety							
	18 - 24	**%**	**25 to 65**	**%**	**66 plus**	**%**	**Grand Total**
Numbers and % of people on anxiety register	4609	6	54367	72	14,067	19	**75,019**
GP registered pop 18+ and %	105773	15	467996	68	119,548	17	693,317
% of GP registered pop on anxiety register		4		12		12	11

Depression							
	18 to 24	**%**	**25 to 65**	**%**	**66 plus**	**%**	**Grand Total**
Numbers and % of people on depression register	2098	4.6	35840	79	7573	17	**45,623**
GP Registered pop	105773	15	467996	68	119548	17	693,317
% of GP registered pop on dep register		2		8		6	7

Anxiety and Depression							
	18 to 24	**%**	**25 to 65**	**%**	**66 plus**	**%**	**Grand Total**
Numbers and % of people on depression register	914	3.3	21287	79	4706	17	**26,907**
GP Registered pop	105773	15	467,996	68	119,548	17	693,317
% of GP registered pop on anx/dep register		1		5		4	4

Source: GP Audit Data 2016

Figure 25 b) shows that of the 3 primary CMHD diagnoses, Anxiety is the largest single group, followed by Depression and then Anxiety & Depression.

Figure 26 Prescribing: 12 months data April 15 – April 16 All age: Antidepressants and Anxiolytics

CCG	**Number of individual prescriptions**
Leeds North CCG	17,332
Leeds South and East CCG	32,954
Leeds West CCG	24,891
TOTAL	**75,177**
Including EMIS practices (estimated)	**93.971**

(Source: Systm1)

Figure 26 shows the number of people who received at least one prescription for an antidepressant or anxiolytics during a 12 month period. People on the SMI register have been removed from this analysis. The data may however, include people with bipolar disorder, and occasionally these drugs are used for other purposes than mental ill health.

Deprivation and CMHD in Primary Care

Figure 27 and 28 compare Deprivation Quintiles with recorded CMHD in primary care (age standardised rates per 100,000 of the population). Figure 27 shows a familiar pattern. The inner parts of the city are characterised by high levels of deprivation (shown in Red and Orange). As detailed earlier, individual risk factors for CMHD (eg. poor housing, higher rates of crime, debts and trauma) cluster and coalesce in deprived communities; because of this it is estimated that low income neighbourhoods have more than twice the risk of CMHD than neighbourhoods of average incomes (CMO, 2013). Figure 28 however, shows recording of CMHD in Primary Care. It suggests that there may be under reporting/recording of CMHD in the Inner North and Inner West parts of the city

Figure 27 Leeds Deprivation Quintiles 2015

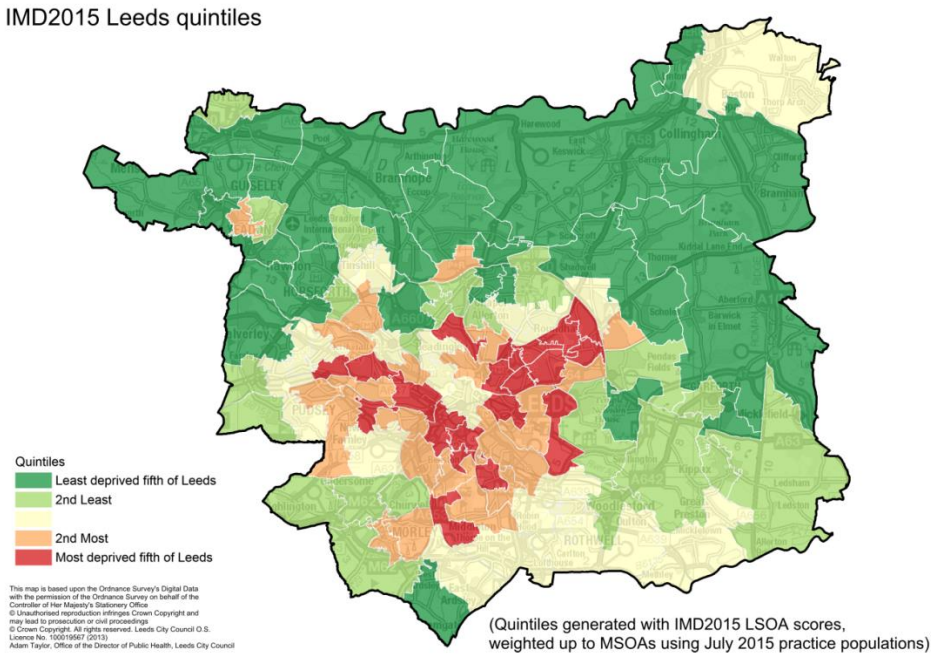
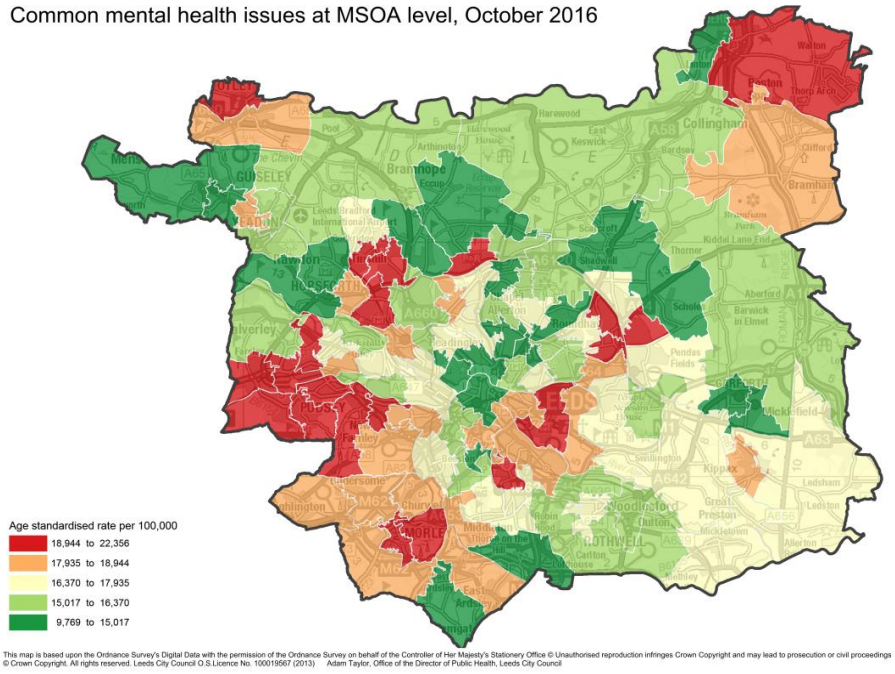


Figure 28 Recorded CMHD by quintile

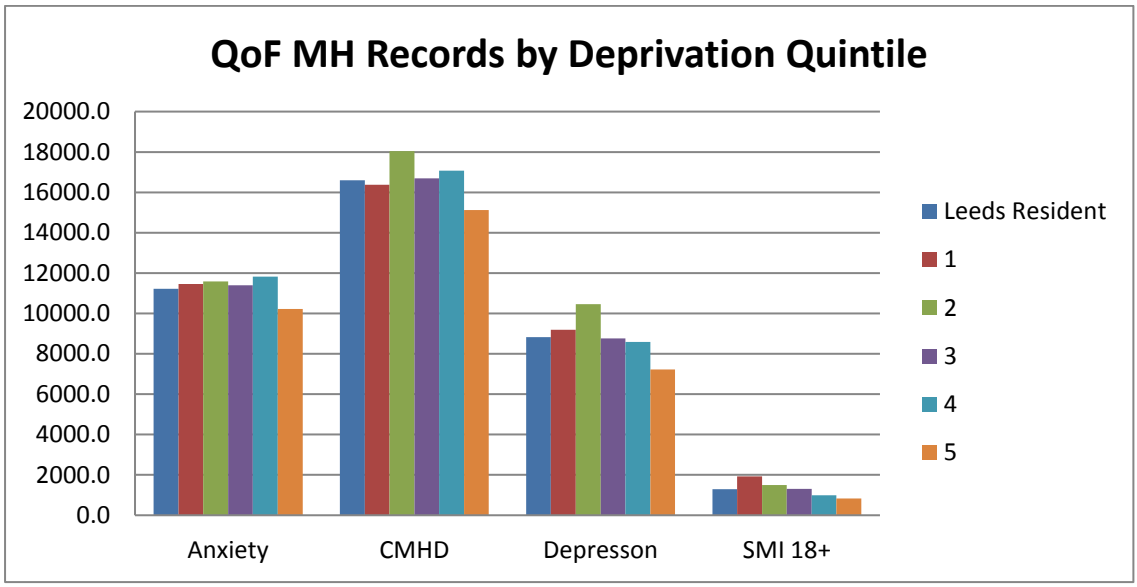


(Source: Public Health GP Audit October 2016)

Figure 29 reviews recording of CMHD in Primary Care by deprivation quintile and mental health condition. Serious Mental Illness shows an expected association with deprivation - with highest rates (per 100,000 of the population) in the most deprived quintiles – decreasing to the least deprived.

For depression, recorded rates appear highest not in the most deprived quintile as might be expected, but in the second least deprived. This pattern is also apparent in the CMHD register overall (of which anxiety and depression are a subset). National data notes a close association between deprivation and depression (Delgadillo, 2016). This data therefore suggests that there is under-recording or under-detection of depression in the most deprived parts of the city.

Figure 29 QOF Mental Health Records by Deprivation Quintile



(Source: Public Health GP Audit June 2015 snapshot)

Deprivation quintiles: 1 (most deprived) to 5 (least deprived)

Gender and CMHD in Primary Care

Figure 30 reviews the CMHD register by gender. It shows that there are nearly twice as many women as men recorded as having a CMHD in Primary Care

Figure 30 People on the CMHD in primary care, by gender.

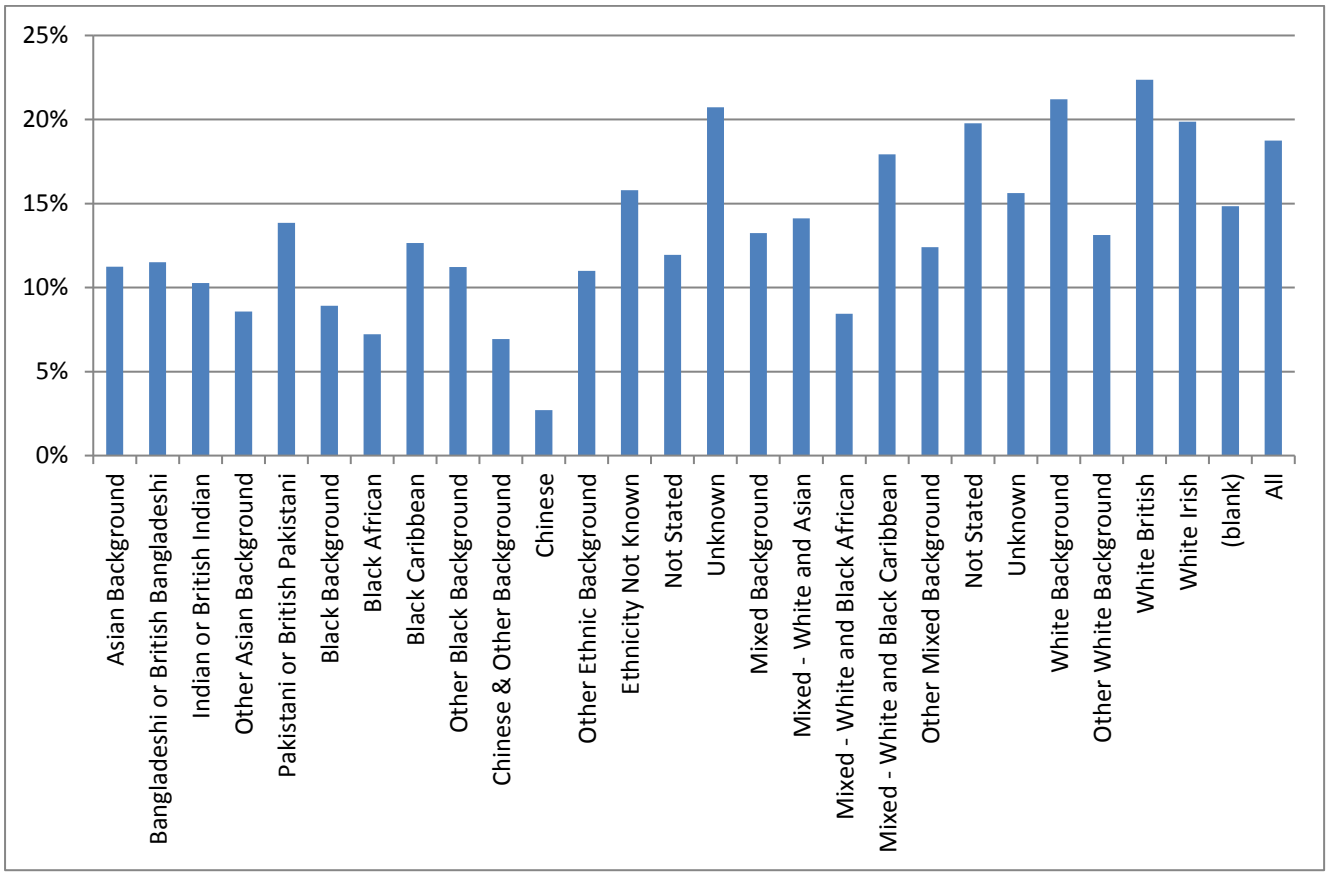
	Number	% of GP registered population
Females	81,622	19%
Males	47,987	11%

(Source Public Health GP Audit Jan 2016)

Ethnicity and CMHD in Primary Care

Figure 31 shows that, of the GP registered population in Leeds who are White British more than 20% are recorded on the CMHD register. This compares with people from a Black background (9%) and people from Bangladeshi/British Bangladeshi groups (12%). This variation may be due to a number of factors - stigma may prevent disclosure of mental illness and/or mental distress may be expressed differently in different communities. It may also be indicative of some communities experiencing barriers to accessing care.

Figure 31 Percentage of the GP registered population (16+) recorded on the QoF CMHD register (by ethnciity)



(Source: Public Health GP Audit January 2016)

Longterm Conditions and CMHD in Primary Care

There is significant co-morbidity between CMHD and long term conditions. Within Primary Care in Leeds nearly 37 % of people on the CMHD register have at least 1 co-morbid long term condition

Figure 32 Rates (16+) of people on the CMHD register who have at least 1 LTC

Leeds	NCCG	SECCG	WCCG
36.6%	*37.1%*	*38.6%*	*34.9%*

(Source: PH audit October, 2016)

(Longterm conditions included here are: Asthma/COPD/CHD/Hypertension/Diabetes)

Improving Access to Psychological Therapies (IAPT)

IAPT is commissioned to meet the needs of 15% of the 'prevalent 'population. This is determined by NHS England to be 105,000 people in Leeds. 15% of the prevalent population equates to 15,750 people in the city. This is divided across the CCGs. Targets are split on a CCG % 'fair share' basis, (which is determined by population size for the CCG). Overall, Leeds is considered to have higher levels of 'acuity' – more people with greater levels of mental health need, than other cities. This is reported to have a number of effects including:

- Lower access to Step 3 interventions across the city, than elsewhere as people need support at this level for a longer time period – thus reducing available capacity
- Lower recovery rates than the national average

Data about IAPT is collected rigorously and reported via a national database system. Headlines are presented here. Much available data is for the time period 2015/16 and therefore may not reflect current service activity, however broad trends in access and outcomes can be observed.

Figure 33 shows number of people being referred to IAPT, those entering treatment and those who finish a course of treatment. It is expected that around one third of people will 'drop out' at each stage, so the picture presented here is comparable with other services nationally. All 3 CCGs have broadly comparable 'drop off' rates between those receiving treatment, entering and finishing a course of treatment.

Figure 33 Referrals, entering treatment and finishing treatment by CCG 2015/16

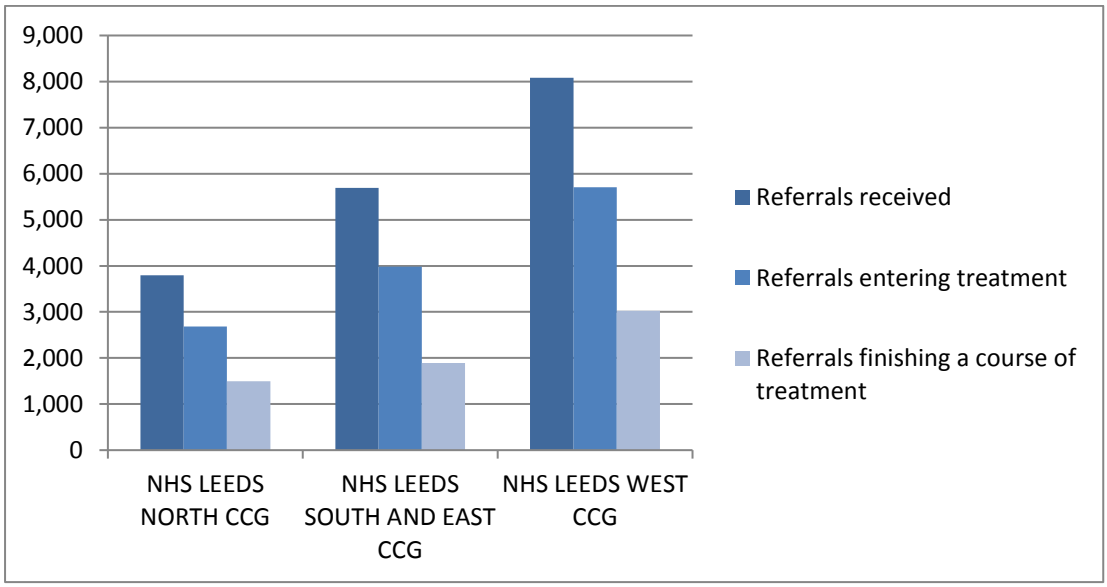
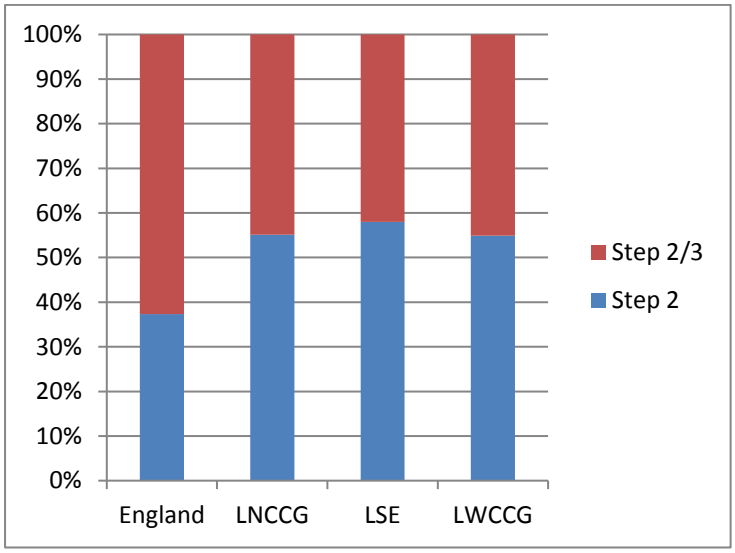


Figure 34 shows the relative proportions of people accessing Step2 and Step 3 compared to the whole of England. It shows that in Leeds across all three CCG areas a higher proportion of people are accessing interventions at a more intensive level (Step 3) than the England average.

Figure 34 Percentage of people accessing Step 2 or Step 2 and/or Step 3



(Source: Leeds Community Healthcare IAPT Report 2015/16)

Leeds has a higher percentage of people taken onto caseload who access Step 2 (group work) rather than Step 3 - individual counselling and support.

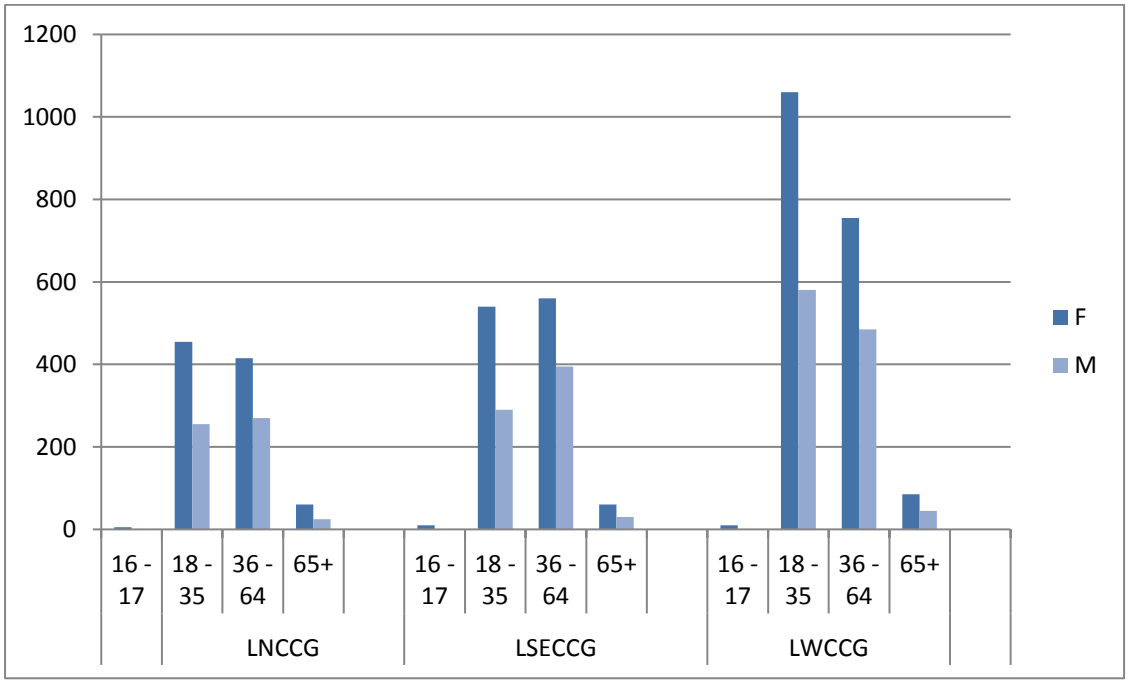
There are three main measures used within IAPT which provide detail about the service. These are referrals, recovery and reliable improvement. Referral and recovery rates by CCG are presented in Figure 35. It suggests a broadly comparable picture across the city, although Leeds South & East CCG has lower recovery rates.

Figure 35 Numbers of referrals, referral rate, treatment and recovery by CCG 2015/16

CCG (of GP)	N	SE	W	None	Grand Total
Referrals	3803	5168	7570	79	16,620
Referral rate/100,000	**2,280**	**2,409**	**2,440**		**2,403**
Entered	2,716	3,611	5,344	38	11709
% of referrals who entered treatment	71%	70%	71%		
% who entered treatment who recovered	**42.6**	**38.2**	**42.9**	**25.0**	**41.5**

(Source: Leeds Community Healthcare IAPT Report 2015/16)

Figure 36 IAPT: Number of people finishing a course of treatment 2015/16 by age and gender



(Source: https://www.gov.uk/government/statistics/psychological-therapies-annual-report-on-the-use-of-iapt-services-2015-to-2016)

Figure 36 shows that men are less likely to finish a course of treatment than women – although Figure 42 which looks at recovery - shows that rates of recovery are similar across the genders. It

also shows that older people across all CCG areas are the group with the lowest number of people finishing a course of treatment.

Figure 37 is taken from the IAPT service quarterly returns. It indicates that a very small proportion of older people (>65 years) access the service, despite there being good evidence that older people experience rates of anxiety and depression to the same rate, if not higher, than the general population. The specific mental health needs of older people are covered in a separate piece of work.

Figure 37 Referrals by age, ethnicity and long term condition

	Q1	Q2	Q3	Q4		% of referrals
WHOLE CONSORTIUM	**Referrals in quarter**	**Referrals in quarter**	**Referrals in quarter**	**Referrals in quarter**		**Total Referrals 17,373**
BME (all groups other than A-White, Not known and Not stated)	652	663	673	699	2,100	12%
Young People	492	459	647	739	1,894	11%
Older People (over 60)	343	350	315	332	1,340	18%
Older People (over 65)	217	235	170	198	820	5%
Long Term Conditions	1037	1096	1144	1222	4,499	26%

(Source: Leeds Community Healthcare IAPT Report 2015/16)

Figure 38 shows the 'level of need' that people for referrals to IAPT present. 'No score recorded' includes those clients who for whom a score was not collected or who did not engaged with the service. It indicates that 44% of people referred to the service have severe anxiety and 37% have moderate/severe or severe depression

Figure 38 IAPT Acuity: 2015-16 Referrals

GAD - 7	%
Score below 5	3.2%
Mild anxiety (scores of 5-9)	8.5%
Moderate anxiety (scores of 10-14)	15.7%
Severe anxiety (scores of 15 and over)	44.0%
No score recorded	28.7%
Grand Total	**100.0%**

PHQ - 9	%
Score below 5	3.5%
Mild depression (scores 5-9)	10.5%
Moderate depression (scores 10-14)	20.6%
Moderate/severe depression (scores 15 – 19)	27.0%
Severe depression (scores 20-27)	9.7%
No score recorded	28.7%
Grand Total	**100.0%**

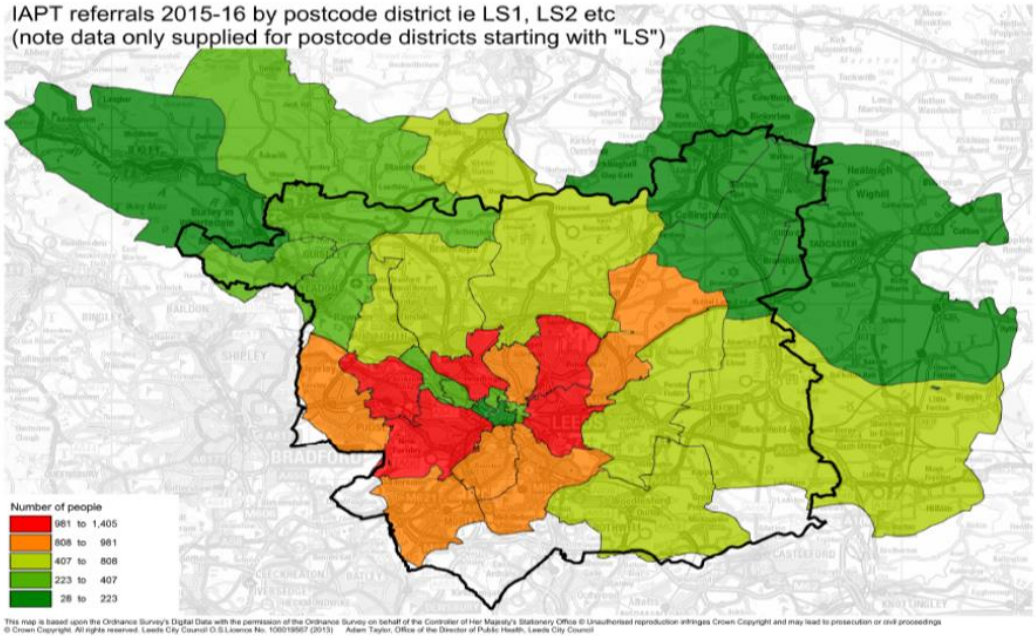
Referral rates

(Source: Leeds Community Healthcare IAPT Report 2015/16)

IAPT and Deprivation

Figure 39 shows that a greater *number* of referrals come from more deprived parts of the city.

Figure 39 IAPT: Number of referrals by top level postcode



(Source: Leeds Community Healthcare IAPT Report 2015/16)

IAPT Recovery Rates

Moving to Recovery in IAPT is measured in terms of 'caseness' – a term which means a referral has severe enough symptoms of anxiety or depression to be regarded as a clinical case. A person has moved to recovery if they were a clinical case at the start of their treatment ('at caseness') and not a clinical case at the end of their treatment, measured by scores from questionnaires tailored to their specific conditions. The Government target is that 50% of eligible referrals (those people taken onto treatment) to IAPT services should move to recovery.

Recovery rates are measured by assessing whether somebody moves from being a 'clinical case' (scoring highly on measures for anxiety/depression, to scoring below a certain level). If someone has high levels of need then they may not recover as measured by IAPT. Amongst other factors, such as age, unemployment and the presence of some long term conditions (Delgadillo 2016) recovery rates are therefore affected by levels of acuity and ability to engage with the service. Higher relative levels of deprivation in Leeds may account for lower recovery rates.

Figure 40 shows recovery rate by CCG – for depression and anxiety. It shows broadly comparable recovery rates for both anxiety and depression, across all CCGs. However, LSE CCG recovery rates are lower than the other two CCGs - this is marked for depression.

Figure 40 Recovery rate by problem descriptor, 2015-16, counts and percentages, Clinical Commissioning Groups (CCGs)

Recovery rate by problem descriptor, 2015-16, counts and percentages, Clinical Commissioning Groups (CCGs)								
	CCG Name	**Referrals finishing a course of treatment in the year[5]**	**Referrals finishing a course of treatment in the year who were initially at caseness[6]**	**Referrals finishing a course of treatment in the year who were initially not at caseness[6]**	**Moved to recovery by problem descriptor**			
					Depression		**Anxiety and stress-related disorders (total)**	
					Number	**%**	**Number**	**%**
	England total	537,131	487,523	46,736	53,015	46.7	110,257	48.8
	NHS LEEDS NORTH CCG	1,495	1,380	115	120	43.4	300	41.4
	NHS LEEDS SOUTH AND EAST CCG	1,890	1,795	95	125	34.9	380	40.6
	NHS LEEDS WEST CCG	3,025	2,835	190	245	43.2	635	43.8

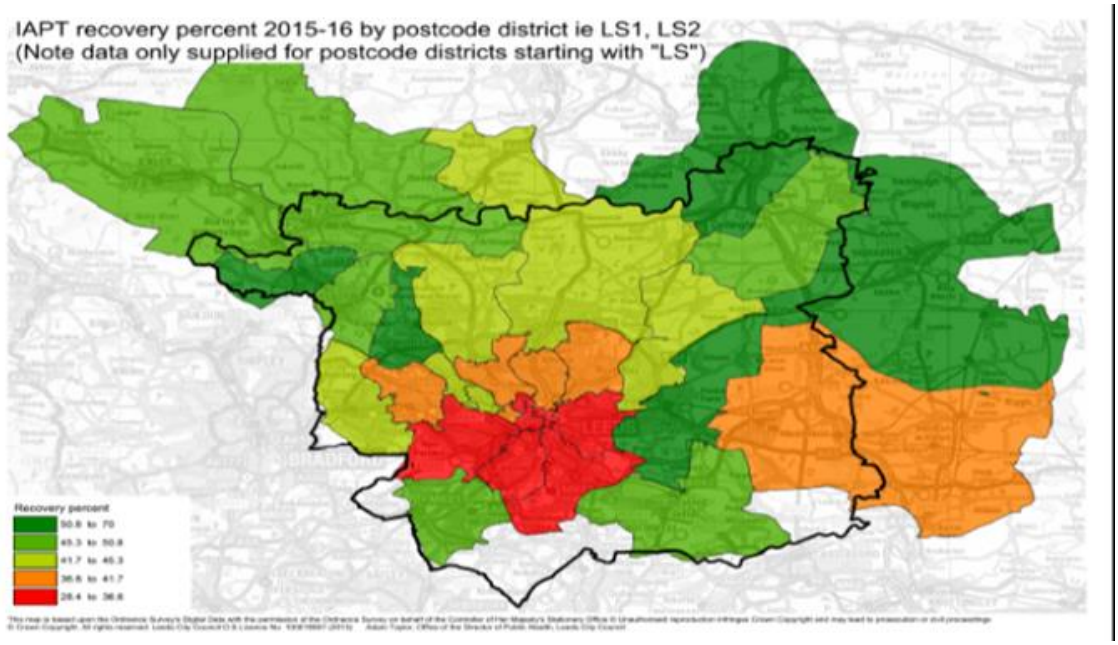
(https://www.gov.uk/government/statistics/psychological-therapies-annual-report-on-the-use-of-iapt-services-2015-to-2016)

IAPT Recovery Rates and Deprivation

Figure 41 shows the percentage of people who recovered after a course of IAPT treatment, by 'top level' postcode ie. LS8, LS9.

It is not possible to directly compare this map with Figure 61, which shows *number* of people referred. This is because rates of recovery are measured by assessing the percentage of people who recovered who had been taken onto caseload and who were at 'caseness'. Rates of recovery may also appear artificially 'better' in the outer parts of the city where crude numbers of people referred are low. However, with those caveats, it remains possible to suggest that IAPT recovery rates are lowest in the most deprived parts of Leeds.

Figure 41 IAPT: Recovery (%) 2015-16 by top level postcode

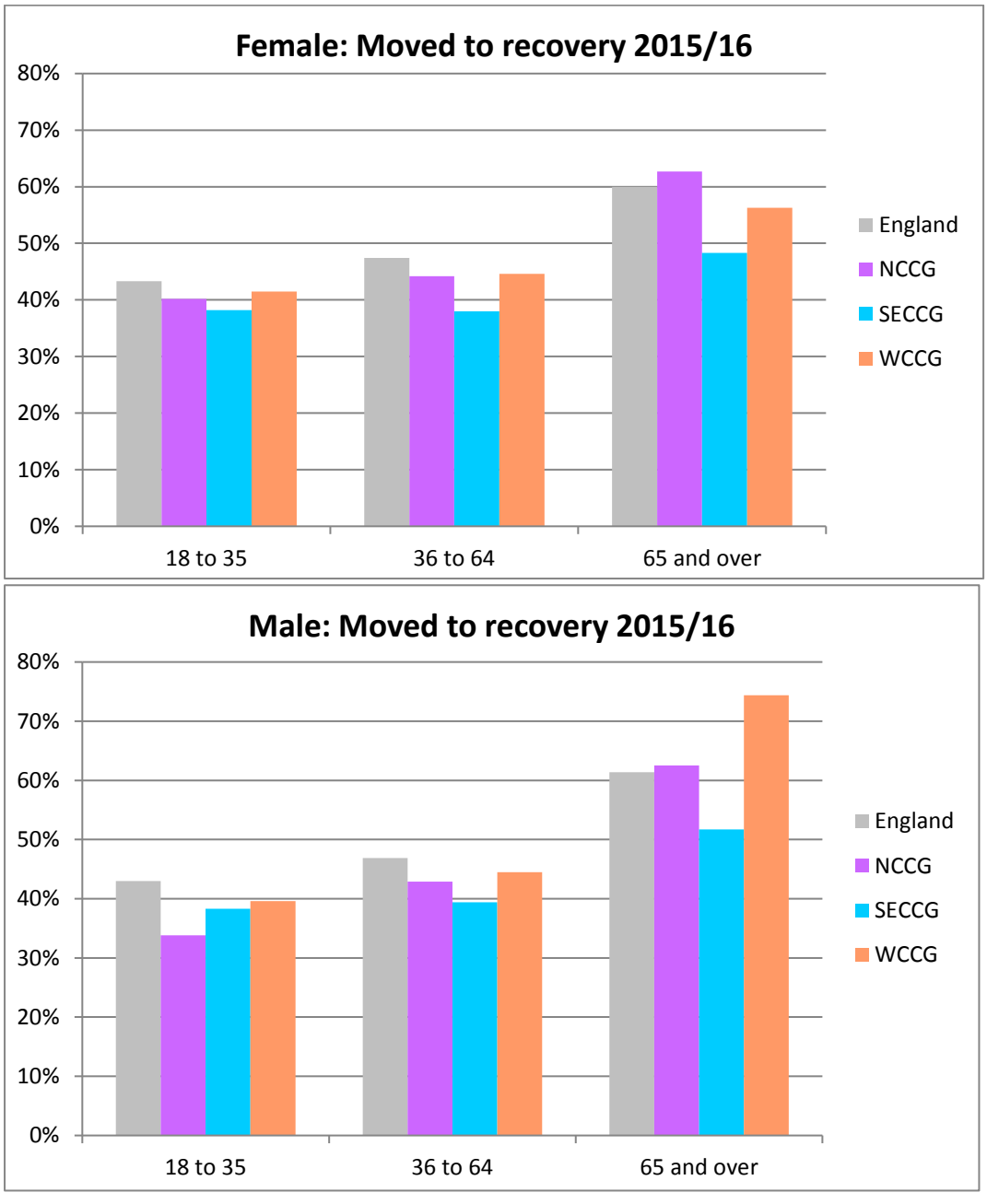


(Source: Leeds Community Healthcare IAPT Report 2015/16)

IAPT Age and Gender

Figure 42 shows the percentage of people who recovered after a course of IAPT treatment by both age and gender. It shows that during 2015/16 there was very little difference in recovery rates between genders. It does show that increasing age is associated with increased recovery rates.

Figure 42 IAPT recovery rates by age and gender (2015/16) by age and gender



Source: https://www.gov.uk/government/statistics/psychological-therapies-annual-report-on-the-use-of-iapt-services-2015-to-2016

IAPT Reliable Improvement

Reliable Improvement is a supplementary measure to recovery. This assesses progress where individuals may not 'recover' as measured nationally but whose symptoms may lessen. Figure 43 shows the percentage of people who entered treatment who reliably improved. Reliable improvement rates in Leeds are comparable with the national rates.

Figure 43 Percentage of people who reliably improved 2015/16

	%
England	62.2
Leeds West CCG	63.6
Leeds North CCG	62.6
LSE CCG	60.5

(Source: https://www.gov.uk/government/statistics/psychological-therapies-annual-report-on-the-use-of-iapt-services-2015-to-2016)

Figure 44 IAPT Access and treatment by broad ethnic group 2015/16

Table 9a: Number of referrals received[1], entering treatment[2] and finishing a course of treatment[3] in the year by ethnic group and gender, 2015-16, counts, Clinical Commissioning Groups (CCGs)[4]

			All[5]										
CCG Code	CCG Name	Ethnic group	Referrals received	Referrals entering treatment	Referrals finishing a course of treatment	GP Registered popln Oct 2016	Referrals received per 100,000 popln	Referrals entering treatment per 100,000 popln	Referrals finishing a course of treatment per 100,000 popln	2011 Census population, aged 17+	Referrals received per 100,000 popln	Referrals entering treatment per 100,000 popln	Referrals finishing a course of treatment per 100,000 popln
	NHS Leeds total	Asian or Asian British	717	562	254	47,123	1,522	1,193	539	36,840	1,946	1,526	689
		Black or Black British	445	325	140	24,549	1,813	1,324	570	18,747	2,374	1,734	747
		Mixed	555	420	182	12,094	4,589	3,473	1,505	10,912	5,086	3,849	1,668
		Other Ethnic Groups - incl Chinese	365	237	99	18,524	1,970	1,279	534	11,258	3,242	2,105	879
		White - British	12175	9675	4990	428,006	2,845	2,260	1,166	502,043	2,425	1,927	994
		White - Any Other White Background	560	465	270	65,839	851	706	410	25,604	2,187	1,816	1,055

(Source: https://www.gov.uk/government/statistics/psychological-therapies-annual-report-on-the-use-of-iapt-services-2015-to-2016)

Figure 44 uses nationally available IAPT data on number of 'referrals', 'entering treatment' and 'finishing a course of treatment', recorded by ethnic group. Crude numbers have been turned into rates – using both GP records and 2011 census data as denominators. There are limitations in both datasets related to the accuracy of recorded ethnicity.

However, across both datasets, the rate of White British Groups referring to IAPT, per 100,000 of the population is around 2,500/100,000. All other ethnic groups are lower than this – with the exception of the Mixed Ethnic Group which is higher.

The conversion of referrals to entering treatment is similar across all categories. However, the rate of: 'finishing a course of treatment' for the White British Group is around 1,000/100,000. All other BME groups have lower rates (with the exception of the mixed ethnic group). This suggests that, across ethnic groups, there is some evidence of inequality of access to the IAPT service and inequality of outcome.

Mental Health Assessment Worker: Touchstone IAPT: Support for Asylum Seekers and Refugees

A Mental Health Assessment Worker is commissioned by the 3 Leeds CCGs to assess and support the mental health needs of Asylum Seekers and Refugees. The post is employed by Touchstone but based at PAFRAS. The MHAW not only assesses need and informs people about mental services but importantly, supports people to access services.

Q4 data (Jan - March 2017) indicates:

- 50 new clients were referred and 61 regular clients had contact with the service.
- Service users from Iraq, Iran. Pakistan and Afghanistan are significant users of the service
- Depression, anxiety and stress are key issues– particularly related to immigration status and the unpredictability of the process of seeking asylum seeking
- People accessing the service often have experience torture and have high levels of trauma. Women often present with some domestic violence/abuse or history of trafficking.

4.6 Stakeholder Views (Practitioners and Service Users)

- There is broad consensus in the city that the IAPT service is a useful and, for many people, an effective way in which to address common mental health disorders but that it is not able to meet the needs of all people who are referred.
- Some people need support to become 'IAPT ready' – this may include help with external issues such as housing or debt and/or support with emotional stability.
- There is in addition a group of people who are referred to IAPT who may have higher levels of need than can be accommodated within the IAPT service. They may have complex lives/high levels of risk, a personality disorder or they may have experienced significant trauma. These people may have concurrent anxiety/depression but will not meet criteria for IAPT treatment. In many cases the needs of these people are also not suitable for referral to Community Mental Health Teams

- There is significant pressure in Primary Care with GPs reporting that they are supporting a large number of people with all levels of mental health needs - anecdotally, mental health is associated with 40 % of all consultations
- Waiting lists for IAPT, particularly Step 3 1:1 support are perceived to be too long which deters referrals
- The IAPT service report that reasons for waiting times at Step 3 include: Increased acuity/increased demand for Step 3. This is compounded by a reduction in non-recurrent resource that CCGs provided for Step 3 therapists which has had reduced Step 3 capacity.
- Recent steps taken locally such as have improved recovery rates further – these include not discharging people when they drop out of Step 2 treatment and offering top up treatment or step up to Step 3.
- The Third Sector – both specific mental health organisations and services which provide wider social support are reported to be supporting many people with CMHD.
- Social Prescribing report that a significant proportion of service users have mental health problems and there are gaps in accessing timely 1:1 mental health support.
- There may be a higher 'tolerance' for depression in some areas of the city – such that mental health problems may be overlooked due to the need to address social problems, or indeed physical health needs. There may also be disincentives in the recording of depression in some cases.
- People with LTC and CMHD are a key group that need support but at a session held to discuss physical health and mental health in March 2016, stakeholders noted that co-ordination across the city is fractured. Mental and physical healthcare and priorities/incentives cut cross organisational boundaries. This makes joined up provision difficult from a service perspective and risks gaps or duplication of holistic approaches.

There has been a range of insight work carried out in recent years to explore the mental health needs of black and minority ethnic groups. Whilst this has not always specifically defined Common Mental Health Disorders there are key themes which are of central importance here:

Workshop with Touchstone with Community Development Workers (July 2016)

This workshop identified a number of mental health and well-being issues affecting Black and Minority Ethnic communities and a number of service issues. These were grouped under the headings below:

Mental health issues / Wellbeing issues: Many issues for Black and Minority Ethnic populations are the same as for the population overall, but some are 'hidden' for example, Eating Disorders or Depression in South Asian women.

Address wider causes / determinants of mental health problems: Mental health prevention work is important – this needs to be culturally sensitive; view faith/religion as a source of capital and address issues of stigma. It is important to understand intersectionality within/connected to issues of race. Domestic violence, homelessness and poverty are also significant problems.

Improve services / new services: There is a need for**:** culturally appropriate mental health crisis services and alternatives to IAPT that are effective for refugees and asylum seekers and other BME

communities, greater use of behavioural activation and more BME community mental health workers

A report that analysed **Refugee and Asylum Seekers access to mental health services** (2016, Touchstone), noted gaps around advocacy and support for Refugees and Asylum Seekers to access mental health services and the need for improved training on mental health and Refugees and Asylum Seekers for GPs and Mental health workers

Finally, two reports were compiled in 2016 that explored the needs of Black women born outside of the UK (Woodward et al 2106) and Roma men (Robinson et al 2016)

Black women born outside of the UK reported that:

1. Mental health problems are often associated with extreme, negative behaviour but there are signs this perception is starting to change.

2. Risk factors for mental health problems include a lack of language skills and cultural differences.

"They feel unhappy, because, as I said, the main thing is the language barrier if you come to a new country that you can't speak the language that's a big challenge, that's big mental health, because you aren't able to communicate, even if you want something, how could you explain and try to analyse so they can understand, so that's big impact."

3. Refugees and asylum seekers experience great fear and uncertainty, which negatively affects their mental health. Issues include; traumatic past experiences, fear for (or of) their family and the asylum process creating fear of being deported or detained, uncertainty, disorientation and not feeling valued.

4. Barriers to accessing services include denial, a lack of language skills, fear of authority or that a diagnosis will impact on other areas of their life and perceptions that GPs don't have the time or understanding to help.

5. Voluntary and community organisations (VCOs) provide critical support

Work with Roma men concluded that:

1. Roma communities face serious challenges in their daily lives – including being safe from discrimination and abuse, finding shelter, security to stay in one place and country, food needs, social inclusion and interaction, schooling, and income – which present great risks for stress and mental health. Barriers of stigma, language, and expectations and practices concerning primary health care also prevent Roma mental health concerns being recognised and treated.

2. It is important to strengthen voluntary-statutory partnerships: to listen to unheard voices; to develop organisational roles for Roma; to build Roma led organisations; and develop safe cultural spaces for Roma to meet. Mental health education and support can be included in this way.

Lesbian Gay Bisexual and Trans (LGBT+) Mental Health

A recent survey undertaken as part of the production of a report: **Leeds LGBTQ+ Mapping Project (2017)** gathered responses from 126 people who identified as LGBTQ+. Mental health was the top health and wellbeing priority for the people completing this survey. Key findings include:

- 30% of respondents said they had a ‘mental health condition such as depression, schizophrenia or anxiety disorder’
- 90% reported having a mental health experiences(s) that impacted severely in their day to day functioning in the last five years
- 65% of these people did not have a formal mental health diagnosis and over half did not seek support for their difficulties

Reasons for poor mental health within this group are reported as being associated with discrimination, violence, bullying and alienation, along with:

‘limited access to culturally appropriate mental health services and support for LGBT+ people, and a lack of trust in mental health practitioners’

Recommendations include:

- Development of LGBT+ led mental health services
- Improved training for mental health staff about LGBT+ communities - particularly the experience of trans and non-binary people.

(Stewart, 2017)

Key Findings

- There are an estimated 106,000 people who, every year in Leeds experience a Common Mental Health Disorder (CMHD) such as anxiety and depression. This estimate is not adjusted for socio-economic status and it may be that the 'true' number is much higher.
- It is estimated that around half of all CMHD are 'severe'. This equates to over 50,000 people in the city. The needs of people with CMHD are met across a range of services including Improving Access to Psychological Therapies (IAPT), Primary Care and by Third Sector services.
- There is good evidence that CMHDs have a social gradient and that they are strongly linked to risk factors associated with having limited resources - such as an adequate income and stable housing. With this in mind, there appears to be under recording of CMHD in Primary Care in the most deprived parts of the city. This is particularly noticeable in the case of depression.
- Primary Care data shows that were 130,000 people recorded as having a CMHD in 2016 (this includes all new cases in a year and past cases, so is greater than estimated annual rates). Anxiety was the largest single mental health condition recorded (n= 75,000), followed by Depression (n = 46,000).
- The primary mental health service designed to support people with CMHD is IAPT. However, IAPT is commissioned to meet only 15% of 'need' - around 15,000 people in Leeds. 6,000 people finished a course of treatment in 2015/16.
- Setting estimated rates of CMHD against IAPT service use suggests that much CMHD in the city goes untreated by psychological/talking therapies.
- There were nearly 94,000 single prescriptions for anti-depressants and anxiolytics in 2015/16 which suggests that a significant proportion of estimated CMHD need is being addressed in Primary Care.
- IAPT is effective for those people who finish a course of treatment. Recovery is measured very crudely, but even so, nearly 50% of people in the city do recover and around 60% of people 'reliably improve'. This means that their mental health needs may have been quite severe when they started treatment; and whilst they may not leave the service symptom-free, their mental health will be significantly better.
- The benefits of IAPT have not been realised equally across the city. 'Recovery' rates are lowest in the South of the city (where deprivation is greatest), older people do not access the service to the same rates as the working age population and rates of 'finishing a course of treatment' are low for some ethnic groups (compared to White British Groups). This suggests that IAPT has not historically been able to meet the needs of the whole Leeds population and, despite significant efforts from the service; there is inequality of both access and outcomes
- However, recent steps taken by the service offer some promise. These include not discharging people when they drop out of Step 2 treatment and offering top up treatment or step up to Step 3. This approach has implications for Step 3 waiting time but the service report it is improving recovery rates.
- Nationally, the mental health of young women is of increasing concern. Locally, whilst there are twice as many women as men in Leeds who are recorded has having a CMHD, only 9% of

young women are recorded as having a CMHD in primary care, compared to 20% of women overall.

- Men are under-represented in both Primary Care data and IAPT referrals. This may reflect women's poor mental health but also may signal the fact that men may not seek support for this type of mental distress. It is notable however, that when men do access IAPT, recovery rates are similar to those of women.
- Qualitative surveys recently undertaken in Leeds suggest that certain communities experience a range of factors that put them at increased risk of CMHD. These include people from some BME communities (including refugees and asylum seekers) and LGBT+ populations.
- Finally, there are groups whose needs have not been assessed here. These include people with Learning Disabilities, Autism, ADHD and/or physical disabilities - including the deaf community. More work is needed to explore the particular mental health needs of these groups.

5 Serious Mental Illnesses

This chapter reviews Serious Mental Illness. These are defined as Psychotic Disorders (including schizophrenia, schizoaffective disorder, and affective psychosis) and Bipolar Disorder.

5.1 Background

Psychotic disorders produce disturbances in thinking and perception severe enough to distort understanding of reality.. People with a psychotic illness can make a full recovery, although some will have repeated psychotic episodes over their lifetime or some degree of persistent disability. There is significant comorbidity between these types of mental health problems and physical health conditions.

Bipolar disorder, previously known as manic depression, is a common, lifelong, mental health condition. It is characterised by recurring episodes of *depression* (feelings of low mood and lethargy) and of *mania* (feelings of elation and overactivity). Bipolar disorder is often comorbid with a number of other disorders such as substance misuse, anxiety disorders, personality disorders and attention-deficit/ hyperactivity disorder. Furthermore, the risk of suicide among those with bipolar disorder is greater than that in the general population. It has a peak age of onset between 15–19 years, though it is recognised that there is often considerable delay between onset and treatment, (NICE 2015).

5.2 Policy Overview

Improving the care and outcomes for people with SMI is a central tenet of the Five Year Forward View for Mental Health (2016). Key commitments include:

- Improved access to high quality 24/7 crisis care (including a national Crisis Care concordat) for people in mental health crisis
- Early delivery of intervention services to people experiencing their first psychotic episode
- Reduced out of area placements
- Good liaison mental healthcare in acute hospitals [1]
- Improved step down care – such as residential rehab or forensic /assertive outreach[2]
- Supporting people with serious mental illness to find or stay in work through the Individual Placement and Support (IPS) scheme
- IAPT/Psychological support for people with SMI.

1. Liaison mental health services meet the psychological needs of people who are being treated primarily for physical health problems or symptoms. They are usually provided to people attending general or acute hospitals

2. Assertive outreach services are mental health services which are provided for people with complex and enduring mental illnesses.

5.3 Epidemiology

Psychotic disorders

First Episode Psychosis

First episode psychosis (FEP) is defined as the first time someone experiences disturbances in thinking which may include delusions or distort reality. Early intervention in psychosis is a key service/intervention which can reduce the early negative impacts of FEP and improve longer term outcomes.

National incidence modelling of FEP via www.psymaptic.org underestimates local service need consistently in the North of England – for reasons that are not entirely clear. NHS England therefore has advised local areas to review service use and pathways and use a specific formula to inform decisions about likely future incidence. **Mental Health Service providers, NHS Leeds Commissioners and Public Health have worked together to agree an incidence in Leeds of 32/100,000. This compares to 24/100,000 estimated by www.psymaptic.org.uk.**

Methodology for estimating psychosis incidence

Nationally, FEP services have historically focussed upon meeting the needs of young people (<25). However, recent guidance from NHSE has been to expand the age range. NHSE Yorkshire and Humber recommend using actual caseloads to devise incidence, in the absence of accurate modelling, and to increase the 14 – 35 year caseload by 25% to estimate total need. This is shown in Figure 45 below.

Figure 45 Estimated Psychosis Incidence

	Caseload	'Incidence' (ONS, 2014 mid-year population estimates 14 – 64 yrs)
Current referrals to 14 – 35 service (Aspire 15/16)):	133 (actual)	51/100,000
25% for 35 – 64	33 (predicted)	13/100,000
Total	**166 (predicted)**	**32/100,000**

(Source: APMS 2014/PH Audit GP Registered Populations)

However, recent analysis of service use to date (2017/18) suggests that this modelling is likely to be an under estimate – with numbers exceeding estimated figures (above) in the first nine months of 2017/18. Nationally, it is estimated that for every person experiencing a First Episode of Psychosis, there will be another person in the community who are at an 'At Risk Mental State' (ARMS)

Figure 46 indicates, in line with national modelling, that the highest service use of EIP services in Leeds is the 18 – 24 year old age group. **Notable is the high proportion of people using the service from a BME background. Approximately, 30% of service users are from a BME background – this compares to around 20% of the Leeds population**.

Figure 46 Early Interventions in Psychosis Service Use (Age and Ethnicity) 2015/16

Age Groups	Number	% service use
Under 18	12	3.7
18- 24	141	43
25-29	83	25
30-34	66	20
35-39	25	7.6
	327	

Broad Ethnic Group	Number	% service use
Asian	46	14
Chinese	1	0.3
Black	36	11
Mixed	26	8
White	180	55
Client declined to answer	2	0.6
Not known/to obtain	27	8.3
Other	7	2.1

Psychotic Disorder

APMS estimates modelled to Leeds population:

The disorders discussed here are based on the WHO International Classification of Diseases chapter on Mental and Behavioural Disorders Diagnostic Criteria for Research (ICD-10) (WHO 1992). They consist of two main types: schizophrenia and affective psychosis. The reference period for psychotic disorder was the year prior to interview (APMS, 2014). The methodology used by the APMS means these figures may be an underestimate [1]

Figure 47 applies the rate from the APMS to the Leeds population. It is estimated that during 2015/16 in Leeds, there were 3,388 people who experienced a psychotic disorder.

Figure 47 Estimated Psychotic Disorder Prevalence (last 12 months): Adult General Population

	APMS Estimate	Leeds Pop 16+ GP reg figs 2016	**Leeds Prevalence**
General Population	0.5%	677,501	**3,388**

(Source: APMS 2014/PH Audit GP Registered Populations)

There are 3,212 people recorded as having psychotic disorders or schizophrenia in Primary care (Q3 Snapshot 2015/16: PH audit), so estimates are broadly comparable. Figure 47 applies APMS rates to figures from the ONS Annual Population Survey (www.nomisweb.co.uk). It estimates the number or people in Leeds who might be expected to have a psychotic disorder, by employment status. It suggests **that there are nearly 3,000 people in Leeds who are unemployed/economically inactive and who have may a psychotic disorder. This represents a significant proportion of the estimated total number of people with a psychotic disorder.**

Figure 48 Rates of Psychotic Disorder (prevalence) by Employment status

All 16 – 64 years	**APMS (%)**	**Leeds Figs** (Jun 15 – June 16)NOMIS	**Leeds Prevalence** **(95% Confidence Interval)**
Full time employment (16 – 64)	0.1%	305,000	**305**
Part time employment	0.1%	125,000	**125**
Unemployed looking for work	0.6%	25,900	**155** (130 – 181)
Economically inactive	2.3%	114,500	**2,633** (2,519 – 2,748)

(Source: APMS 2014/www.nomisweb.co.uk)

1.The APMS is a household survey so does include offenders and people living in institutions – where rates of psychosis may be higher. People who are stable on treatment or in remission are probably not included in this figure. Prevalence could also be underestimated since studies which have access to case notes as well as interview data, have been shown to ascertain more cases of psychotic disorder than studies using interview information alone (Kirkbride et al. 2012) The figures for 2007 and 2014 are very similar and are consistent with rates being stable, but they also do not rule out there having been an increase in the proportion of the population affected.

Gender and Ethnicity

Ethnicity is a key factor in psychosis diagnoses. The APMS (2014) found that rates in Black men were three times greater than the population overall, which mirrors findings elsewhere (UCL, 2016). Figure 49 applies the estimated rates from the APMS (2014) to the Leeds population by Gender and Ethnicity. The APMS did not report variation in rates of psychotic disorder across other ethnicities or between the sexes that met statistical significance – this does not mean that these differences might exist, but rather that the sample size was too small to be able to detect them. Accordingly the general population rate (0.5%) has been applied in Figure 48 across all female ethnic groups and to all male ethnic groups (with the exception of Black men – where the difference was significant)

Figure 49: Estimated Psychotic Disorder by Gender and Ethnicity

	White	**Black**	**Asian**	**Mixed/Other**
Men	1,155	394	134	51
Women	1,246	55	130	48
Men	231,094	12,326	26,869	10,232
Women	249,170	11,064	26,006	9,574

(Source: APMS 2014/Public Health GP Audit)

*(Mixed/other group is combined total of "Mixed / Multiple ethnic groups" and "Other ethnic background"). Estimated rates are rounded up to nearest unit/person

Bipolar Disorder

Bipolar disorder was assessed in the APMS 2014 self-completion questionnaire using the Mood Disorder Questionnaire (MDQ), a self-report 15-item scale based on DSM-IV criteria (the diagnostic classification system current at the time the survey was in development). It was designed to screen for bipolar spectrum disorders, i.e. bipolar I, bipolar II, cyclothymia and bipolar not otherwise specified.

Figure 50 applies the rate from the APMS (2014) to the Leeds population. It is estimated there are around 13,550 people with Bipolar Disorder in the city.

Figure 50 APMS Estimated Bipolar Disorder (last 12months) Adult General Population

Bipolar Disorder	APMS Estimate	Leeds Population GP figs	**Leeds Population**
General Population (16+)	2.0%	667,501	13,550

(Source: APMS 2014/Public Health GP Audit)

Figure 51 uses rates from the APMS (2014) and applies these to figures from the ONS Annual Population Survey (www.nomisweb.co.uk). It estimates the number or people in Leeds who might be expected to have a bipolar spectrum disorder by employment status. It suggests that there are nearly 6,000 people in Leeds who are unemployed/economically inactive and who may have experience this type of disorder in 2015/16

Figure 51 Estimated rates of Bi Polar Disorder (prevalence) by Employment status

All 16 – 64 years	**APMS (%)**	**Leeds Figs** (Jun 15 – June 16)NOMIS	**Leeds Population**
Full time employment (16 – 64)	1.9	305,000	5,795
Part time employment	1.9	125,000	2,375
Unemployed looking for work	3.9	25,900 (958 – 1062)	1,010
Economically inactive	4.3	114,500 (4,809 – 5038)	4,924

(Source: APMS 2014/www.nomisweb.co.uk)

The 15-item Mood Disorder Questionnaire was added to the 2014 survey.
A positive screen required endorsement of at least 7 lifetime manic/hypomanic symptoms, as well as several co-occurring symptoms, together with moderate or serious functional impairment. A positive screen indicated the likely presence of bipolar disorder and that fuller assessment would be warranted

The APMS (2014) found that rates of Bipolar disorder were broadly comparable across ethnic groups. Where the survey did discover variation was across age – with younger people more likely to screen positive for '7+ symptoms that have caused significant problems' (likely Bipolar disorder). APMS rates are used in Figure 52 to model numbers of people in Leeds who might similarly score highly if screened for bipolar disorder. It indicates potentially 8, 500 people under age 34 with likely Borderline personality disorder.

Figure 52 Estimated numbers of people in Leeds with Bipolar Disorder by age category.

	APMS %	**GP pop Oct 2016**	**Leeds Population**
16 - 24	3.4	120,352	4,092
25 – 34	3.1	142,050	4,404
35 - 44	2.4	115,844	2,780
45 - 54	1.6	108,006	1,728
55 - 64	1.5	82,491	1,237
65 - 74	0.4	66,626	267

(Source: APMS 2014/Public Health GP Audit)

5.4 Evidence Review

First Episode Psychosis There is clear evidence that treating FEP leads to improved long term outcomes and that delay is costly. Having an extended 'Duration of Untreated Psychosis' means that people are more likely to drop out of education or employment and their physical health will suffer. A range of research reviewed as part of the Centre for Mental Health report (2016) found that, by utilising FEP services, total health service costs are reduced by 20 – 50% compared with standard care for up to five years. **The estimated cost of EIP services (national averages) are: £2,560 per patient or £7,680 over three years. Savings to the NHS alone are estimated as being: £8,510 per patient in the first year and £24,727 over 3 years**

Evidence Based Supported Employment Services There is extensive evidence that employment is beneficial (Centre for Mental Health, 2016) but that people with SMI face significant barriers in finding and maintaining work - despite many people wanting to do so. In particular, Individual Placement and Support is highly effective across a range of employment outcomes - as high as 82% employment rates compared to 42% for a control service in a review of employment support for people with SMI aged Under 30 (Bond et al 2014 in Centre for Mental Health 2016). Reductions in health service costs have been reported. In a six site European study only 20% of IPS participants were hospitalised at any one time compared with 30% o. **The Centre for Mental Health estimate saving of £5,125 per service user gained from IPS.**

Community Based alternatives to acute inpatient care (Crisis) A Cochrane Review (Murphy et al 2012) found that at 3 month follow up people in the UK supported by crisis teams had a better mental states than those who had received standard care.

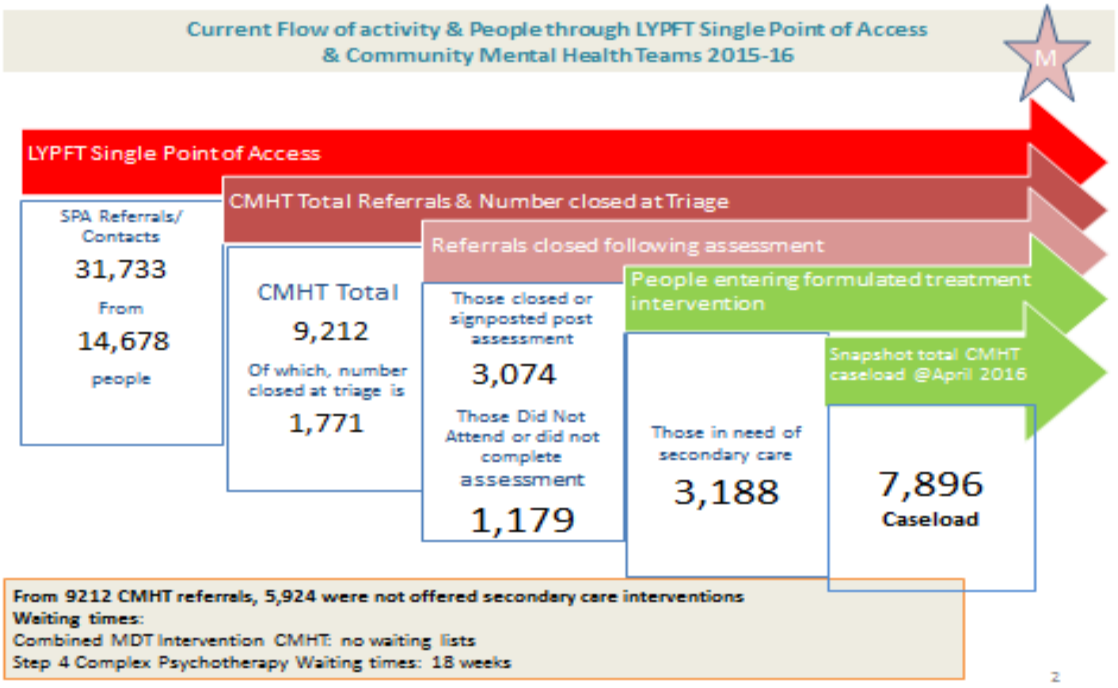
There is emerging evidence regarding models and approaches to improving the physical health of people with serious mental illness – these are covered in Section 6

5.5 Service Use Data

Service use data included here is taken from across the whole metal healthcare system and incorporates detail from both Primary care and LYPFT. In many cases psychotic disorders and bipolar disorders are not separated out and 'SMIs' may also include, in some cases, counts of severe, enduring depression.

Figure 53 shows that during 2015/16 there were 31,733 contacts or referrals to acute mental health services from nearly 15,000 people. A snapshot caseload taken in April 2016 shows 7,896 people were on the caseload.

Figure 53



Serious Mental Illness in Primary Care

Figure 54 shows that Leeds North CCG and Leeds LSE CCG have a significantly higher proportion (than the England average) of the GP practice population who are recorded on the QOF Severe Mental Illness register

Figure 54 Recorded number (% of GP registered population) of people with Severe Mental Illness (on QoF SMI register) 2014/15 All age

Area Name	% of GP registered population	Lower CI	Upper CI	Count	
England	.88	.88	.88	500451	
NHS Leeds North CCG	1.08	1.04	1.13	2188	significantly higher
NHS Leeds South And East CCG	0.94	0.91	0.98	2533	significantly higher
NHS Leeds West CCG	0.85	0.82	0.88	3133	no significant difference

(Source: Quality and Outcomes Framework (QoF): http://www.hscic.gov.uk/qof)

Figure 55 uses data taken from an audit of GP practice data January 2016 (only including people who are registered with a Leeds GP and are resident in Leeds). It shows that there are almost 8,000 people in the city recorded in Primary Care as having an SMI

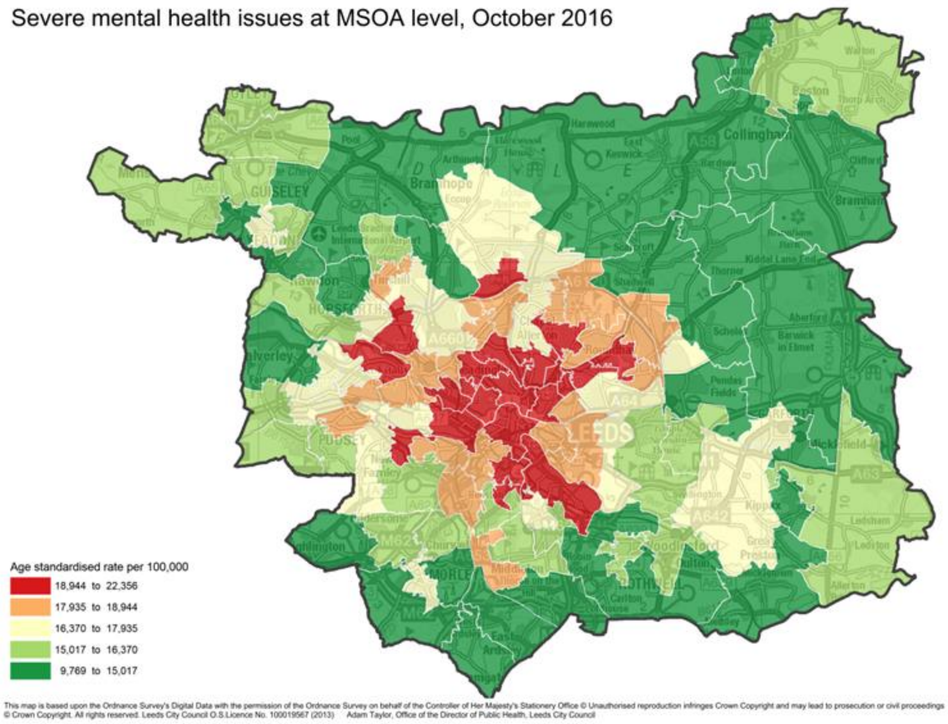
Figure 55 Registers in Primary Care Q3 2015/16 (% of total GP registered population)

	Prev Count	Pop count	Prev (%)	Dsr
LN CCG	2,175	211,774	1.09	1,095.221
LSE CCG	2,609	273,330	0.95	1,033.44
L W CCG	3,114	371,940	0.84	961,64
Leeds	7,999	857,044	0.92	1,017.45

(Source: Public Health GP Audit October 2016)

As noted in Section 2 living in a deprived area may increase someone's risk of developing a serious mental illness. In addition, people with SMI may 'end up' living in deprived inner city areas where housing – particularly if they are unable to maintain employment and/or training. Figure 56 shows this close association between deprivation and severe mental illness.

Figure 56



Mental Health Services Dataset

The mental health minimum datsaset records activity data for secondary mental health services. This is then reported via the Health and Social Care Information Centre/NHS Digital). Local commissioners have experienced significant challenges in being able to access the MHMDS due to the shifting governance arrangements alongside numerous version releases. However, Public Health England published an overview of data from MHMDS during 2016 that summarises activity and some outcomes related to psychosis. Headlines are presented below.

Figure 57 shows that per 100,000 of the population, LSE CCG has the highest rate of people recorded as having psychosis. However, overall the data does not match local experience - given the higher than average levels of FEP in Leeds is it is likely that the rate of people with psychosis in the city is actually higher than elsewhere in England. The data below may therefore, not reflect local need, and instead, may be symptomatic of issues with the clustering process.

Figure 57 Recorded number of people with psychosis (people assigned to psychosis supra cluster) Nov 2015 (16 and over).

Area Name	Value (rate/100,000)	Lower CI	Upper CI	Count	Denominator	Comparison with England
England	400.89	399.03	402.77	176446	44013062	
NHS LEEDS NORTH CCG	318.23	291.33	346.94	515	161834	significantly lower
NHS LEEDS SOUTH AND EAST CCG	376.40	349.59	404.73	730	193942	no significant difference
NHS LEEDS WEST CCG	335.18	313.57	357.87	895	267024	significantly lower

(Source: NHS Digital) Definition: The number of people in scope for Mental Health currencies at the end of November 2015 assigned to the psychosis supra cluster expressed as a rate per 100 000 resident populationSource: Mental Health and Learning Disabilities Statistics reports November 2015: http://www.hscic.gov.uk/mhldsreports

1. Clusters describe a group of people with similar characteristics as identified from a holistic assessment and rated using the Mental Health Clustering Tool (MHCT). Clusters are the way in which mental health payment by results (PbR) are structure

Figure 58 shows that, for someone living in LSE CCG who has a diagnosis of psychosis (and has been assigned to a psychosis cluster), there is a higher rate of admission to A&E than for people with similar mental illness in both other parts of the city and in England

Figure 58 Emergency hospital admissions: psychosis: indirectly age standardised rate per 100 000 resident population, age 15 – 74 years

Area Name	Value	Lower CI	Upper CI	Count	Comparison with England
England	35.83	35.24	36.41	14479	
NHS Leeds North CCG	44.16	33.43	54.90	65	no significant difference
NHS Leeds South and East CCG	57.81	47.00	68.61	110	significantly higher
NHS Leeds West CCG	33.57	26.39	40.75	84	no significant difference

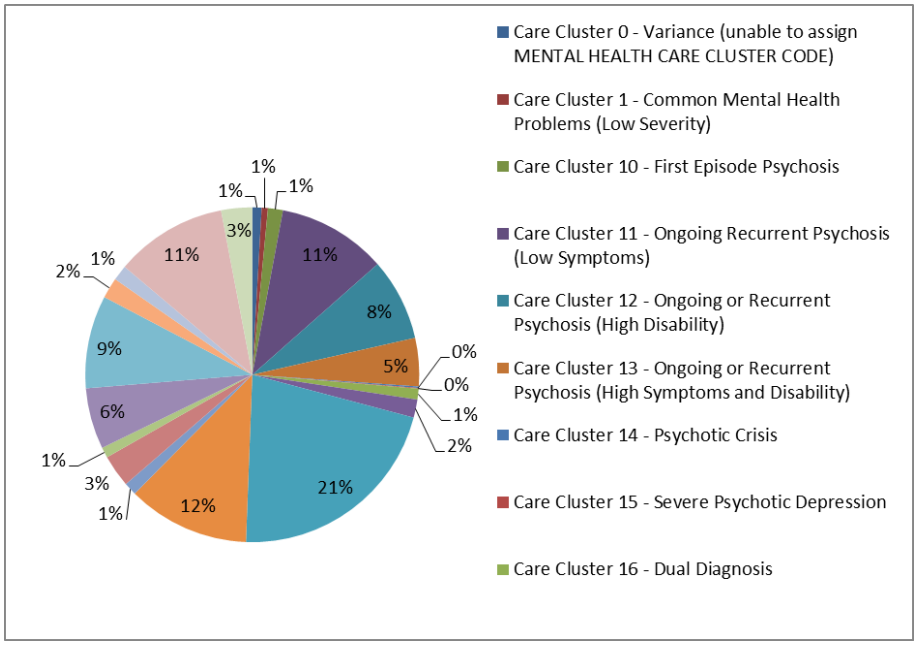
(Source: NHS Digital) Definition: Emergency hospital admissions: psychosis: indirectly age standardised rate per 100 000 resident population, 15 – 74 years Sources Hospital Episode Statistics

Such a difference in rates for LSE CCG may be as a result of barriers to accessing appropriate healthcare before problems become more serious.

LYPFT Service Use Data

Acute mental health service users are assigned to a cluster as part of the 'Payment by Results' system. LYPFT supports people with a range of mental health problems such as dementia and occasionally, people with Common Mental Health Problems. In February 2016, there were 5,662 active service users who had been assigned to a cluster. Including those whose cluster has expired gives a total of 7,145. Active service users who had been assigned a cluster associated with mental illness (not dementia) are shown in Figure 59

Figure 59 LYPFT Cluster Data (Snapshot: February 2016)



(Source: LYPFT report/PARIS system)

Figure 60 LYPFT Total Number of Care Events 2016/17 by cluster

SMI

MHCL_NATIONAL_CODE	MHCL_DESCRIPTION	Count (ID)
0	Care Cluster 0 - Variance (unable to assign MENTAL HEALTH CARE CLUSTER CODE)	155
1	Care Cluster 1 - Common Mental Health Problems (Low Severity)	98
2	Care Cluster 2 - Common Mental Health Problems (Low Severity with Greater Need)	166
3	Care Cluster 3 - Non-Psychotic (Moderate Severity)	606
4	Care Cluster 4 - Non-Psychotic (Severe)	840
5	Care Cluster 5 - Non-Psychotic Disorders (Very Severe)	202
6	Care Cluster 6 - Non-Psychotic Disorder of Over-Valued Ideas	114
7	Care Cluster 7 - Enduring Non-Psychotic Disorders (High Disability)	176
8	Care Cluster 8 - Non-Psychotic Chaotic and Challenging Disorders	109
10	Care Cluster 10 - First Episode Psychosis	222
11	Care Cluster 11 - Ongoing Recurrent Psychosis (Low Symptoms)	189
12	Care Cluster 12 - Ongoing or Recurrent Psychosis (High Disability)	136
13	Care Cluster 13 - Ongoing or Recurrent Psychosis (High Symptoms and Disability)	92
14	Care Cluster 14 - Psychotic Crisis	85
15	Care Cluster 15 - Severe Psychotic Depression	34
16	Care Cluster 16 - Dual Diagnosis	35
17	Care Cluster 17 - Psychosis and Affective Disorder (Difficult to Engage)	24
18	Care Cluster 18 - Cognitive Impairment (Low Need)	1117
19	Care Cluster 19 - Cognitive Impairment or Dementia Complicated (Moderate Need)	728
20	Care Cluster 20 - Cognitive Impairment or Dementia Complicated (High Need)	267
21	Care Cluster 21 - Cognitive Impairment or Dementia Complicated (High Physical or Engagement)	70
(blank)	(blank)	
Grand Total		**5,465**

Rightcare

The Rightcare mental health focus pack presents analysis of a wide range of indicators focussing on: Spend Activity, Quality and Outcomes (www.rightcare.nhs.uk). Across all three CCGs, NHS Rightcare indicates that improvement is needed to address the high rates of 'People subject to the mental health act' in Leeds. These rates are shown in Figure 61. This shows that all the Leeds CCGs have higher rates of people subject to the mental health act than the England average, and that Leeds South and East CCG has rates that are almost double the national average.

Figure 61 People Subject to the Mental Health Act. Rate per 100,000 population aged 18+ (end of quarter snapshot 2015/16 Q2)

	Per 100,000
England	37.9
Yorkshire and Humber	44.3
Leeds North CCG	50.9
Leeds South and East CCG	74.3
Leeds West CCG	42.2

(Source: https://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/data#page/0/gid/1938132719/pat/6/par/E12000003/ati/19/are/E38000001)

LYPFT: Local Data Mental Health Act

The below tables show the number of new detentions per month. Each use of the Mental Health Act 1983 is counted as an occurrence, e.g. if a patient was detained on section 5(2), which was then converted to a Section 2, this is counted as two occurrences.

Figure 62 Mental Health Act Leeds 2015 - Sept 2016

Section	Oct 2015 – Sept 2016
2	522
3	449
4	0
5(2)	166
5(4)	18
TOTAL	1,155

(Source: LYPFT: Mental Health Legislation Report Quarter 2, 1 July – 30 September 2016)

LYPFT: ALPS (Acute Liaison Psychiatry Service)

The ALPS service is the Acute Liaison Psychiatry service, based within Accident and Emergency. It provides specialist psychiatric support for patients seen in emergency care. 42% of people accessing this service attend again within the same month.

Figure 63 Total number of people assessed and numbers re-attending within the same month (April 2015 – March 2016)

Number of people assessed	2,296
Number of people who re attended within the same month	954

(Source: PARIS and Symphony operating systems. Recorded as part of KPI target, these are cumulative figures taken over 12 months)

LYPFT: Liaison Psychiatry In-Reach Service

Liaison Psychiatry provides psychiatric care to patients using acute physical health services - people may have long term conditions, cancer or disabilities. The service provides support at the 'interface' of physical and mental health needs. A brief service audit was undertaken of the Leeds Liaison Psychiatric in-reach team. Referrals are accepted by this team from all the wards at St James hospital except the accident and emergency department (A&E). The audit assessed electronic psychiatric case notes of patients who were referred to the ward-based liaison psychiatry service (18 – 65 years) over a 3 month period between 1st January 2016 and 31st March 2016. The audit concludes:

'It is interesting to note that a significant proportion of those who were seen during the audit period were single, unemployed, living alone in rented property, had a history of depression and they had no young or school going children. We don't know why this is the case, however it is possible that those referred have multiple adversity' (Mziz and Henderson, 2016)

Crisis Services

Crisis services are an important part of acute mental health provision. Within Leeds, crisis services are provided by LYPFT and in the community by the Third Sector (including Dial House and The Well-Bean Café provided by Touchstone/Leeds Survivor Led Crisis). People may also attend A&E in mental health crisis or with a psychological/psychiatric condition. It is likely that people attending crisis services may have a psychotic disorder of some type – however, a proportion of service users may also have other less clearly defined needs – possibly associated with enduring depression or complex/risky social circumstances. Accordingly, data included here regarding crisis services may cover a wider range of mental health needs than just psychosis or bipolar disorder

There is evidence to suggest that people from certain ethnic groups are more likely to use mental health service when in crisis (APMS, 2014). LYPFT service data (crisis admissions) has therefore been used in Figure 64 to assess likelihood of admission by broad ethnic group – for 12 months data only. **It suggests that within Leeds people from Black or Mixed (Black/White British or Asian/White British) groups are twice as likely to be admitted to crisis services as White British groups. This correlates with services reporting that young black men, in particular are over-represented**.

Figure 64 Rates per 100,000: Admission to crisis mental health services by broad ethnic group.

	2015/16 service figs/ GP registered pop 16 – 74 years 2015	Rate per 1,000 (95% CI)	Risk ratio (Cf White Groups)
Asian	52/42,520	1.22/1,000 (0.9 – 1.6)	1.4
Black	40/21,817	1.83/1,000 (1.3 – 2.5)	2.1
Mixed	23/10,313	2.23/1,000 (1.4 – 3.3)	2.6
White British	317/369,454	0.86/1,000 (0.8 – 1.0)	1

(Source: LYPFT Service data/Public Health Audit 2015)

The Well-bean Café: This service, provided by Touchstone and Leeds Survivor Led Service is a new provision designed to meet a range of crisis/mental health needs in a community setting. A snapshot of data from Q3 shows that 10 individuals used the service. These people made 49 visits. All people using the service in this time period were of a White British ethnicity. The needs being met by the service include:

- Coping with multiple complexities, including physical ill health.
- Intense suicidal thoughts
- Loneliness/depression

Dial House (Connect Helpline) receives around 2000 calls a quarter (3 month period)

Dial house @Touchstone (Touchstone/Leeds Survivor Led Crisis): Dial House is a mental health crisis service based in East Leeds. It provides one hour of 1:1 support from crisis support workers and an environment in which people in crisis can relax. It targets people from Black and Minority Ethnic population groups, and as service data shows it is successful in meeting that need. Q1 – 3 service data shows the service is accessed relatively equally by men and women (162 visits were by men/152 visits were by women) and out of 327 visits, 25 of this were made by people defined themselves as Lesbian/Gay women The ethnicity of service users is very diverse and notably, includes a large number of Irish people (possibly due to the location of the service), and people from Caribbean ethnic backgrounds

Figure 65 Dial House at Touchstone: Ethnicity Q1 – 3 (number of visits) 2015/16

White British	7
Irish	55
Any other white	46
African	9
Caribbean	39
Bangladeshi	3
Indian	8
Kashmiri	9
Pakistani	59
Any other Asian Background	12
Mixed Ethnicity	31
Other Ethnic Groups	41

(Source: Quarterly Monitoring Returns)

Dial House

Q1-3 data for Dial House which is a 'generic 'crisis service (although offering the same type and level of support) shows:

Across Q1 – 3:

- 1,363 visits (73%) were by women/506 (27%) visits were by men. Over twice as many visits were made by women compared to men.
- The age group to make the most visits was aged 25 – 34 years (n= 716). In the time period reviewed, nearly three times as many visits were made by this group compare to age brackets.
- 32% of visits were made by people who identified as LGBT.

Figure 66 Dial House Ethnicity Data Q1 – 3 (Number of Visits)

White British	1,444
Irish	38
Any other white group	41
African	1
Black Caribbean	7
Any other Black group	2
Chinese	2
Indian	2
Kashmiri	4
Pakistani	
White and Asian	9
White and Black	3
Any other mixed group	3
Any other group	142
Prefer not to say	510

(Source: Quarterly Monitoring Returns)

Accident and Emergency

The following data explores A&E activity where a coded entry of Psychological Condition is present. Care must be taken with interpretation, as the activity reflects the nature of the attendance and not the patient. Self-harm has a different code, so it is unlikely that 'psychological condition' here includes self-harm.

Mental Health in A&E – Leeds April 15 to April 16

Figure 67 Psychological condition attendances (number) by gender

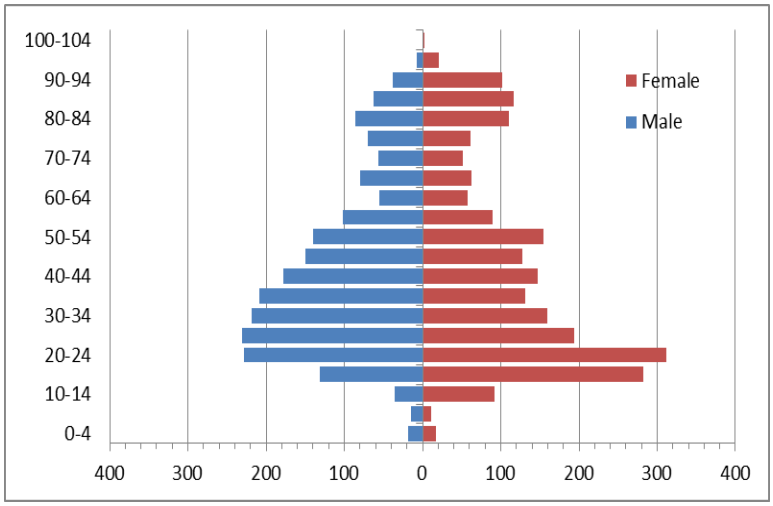
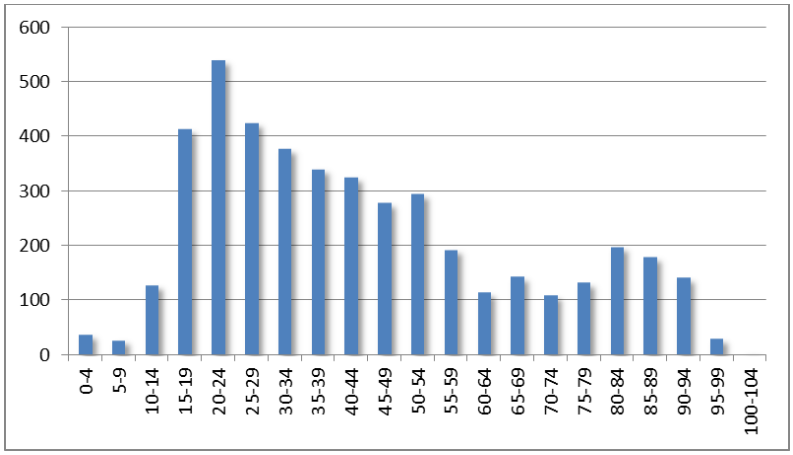


Figure 68 Psychological condition attendances (number) by age band



(Source: LTHT A&E SUS (Secondary Uses Service) Dataset)

Figure 67 and 68 indicate that young people aged 20 – 24 years are the single largest group who in this time period accessed A&E services for psychological reason. Young women appear disproportionately in this dataset. It is likely the large numbers of young people are in part attributed to the student population in the city.

LYPFT and Touchstone Assertive Outreach Teams

Assertive outreach teams (AOTs) are specialist mental health services that provide support for people with serious mental illnesses but whose needs are very complex. In Leeds the AOT resource is split between an LYPFT AOT (one of their CMHTs) and Touchstone third sector service (called the Community Support Team):

- **LYPFT AOT** (snapshot June 2017: 165 people on caseload,
- **Touchstone Community Support Team Current Caseload**: They are commissioned to work with 130-135 service users. Usually **90-100 service users are on caseload at any one time**. They work a flexible 7 day a week service.

These services work with people who have:

- been in hospital many times and have often used crisis services,
- problems working with mental health services, or
- complex needs such as:
    - violent behaviour,
    - serious self harming,
    - not responding to treatment,
    - drug or alcohol use and mental illness. This is known as dual diagnosis, or
    - unstable accommodation or are homeless.

The team aim to support the service user to get help from other services. This support can help them to manage their condition better and reduce the chances of going back to hospital.

The support from an AOT might be the following:

- Help with daily living such as shopping, budgeting, cooking and cleaning.
- Help with medication.
- Talking therapies.
- Help with drug or alcohol use.
- Support to be involved in community for isolated service users.
- Help to improve physical health.
- Support to find suitable education, employment and training.
- Support to find and keep accommodation.
- Make a plan to help service users manage their condition and prevent relapse by identifying triggers. Regularly review plan with service users.
- Crisis planning.

AOTs try to have most of their appointments in the community or the home. Service users usually will agree with AOT on a place they feel comfortable.

Employment Support Workplace Leeds

As noted earlier, employment is a key protective factor for good mental health. Being in stable employment can also support people who have experienced mental health problems with their recovery and 'keeping well'.

As noted above, the Centre for Mental Health estimates that for every person who is in receipt of evidence-based employment support services (average cost £2,700 per person) £3,000 is saved in mental healthcare costs whilst wider savings (across the whole health & social care economy) could equate to £5,000 per person

Across 12 months, local analysis suggest that this local Leeds service (140 new referrals per quarter) may potentially be reducing costs across the health and social care system in Leeds by nearly £1 million pounds.

5.5 Stakeholder Views (Practitioners and Service Users)

- Services and commissioners note that CMHTs have significant caseloads and that some of the need that is being met is 'inappropriate' – some people may benefit from being discharged to primary care if they have a stable mental illness, and/or some people have ongoing psychological needs which are not able to be met. Psychology capacity is not sufficient in the city.
- Commissioners note the high numbers of people identified with first episode psychosis and that it will be important to ensure that services are commissioned to meet this need adequately to enable NICE concordant care.
- LYPFT note the over representation of Black men, in particular in crisis services.
- There is broad recognition that there is a need, across the system to address the physical health needs of this population group

Together We Can

Together we can is a network of around 150 people with lived experience of seeking mental health support in Leeds. The network is supported by Leeds Involving People and has been closely involved in developing the Leeds Mental Health Framework. In Autumn 2015, Together We Can developed a range of 'I Statements' which focus on what individual's mental health needs are, and how services can best meet these needs. The 'I statements' were developed through consultation with 235 members through focus groups, exiting networks and face to face discussions. Networks included members from a range of third sector groups. People's stories were collated and analysed thematically. These themes informed the development of the statements below

There are six 'I statements' in total:

1. I am more than a mental health diagnosis. Treat me like an individual human being.
2. I may rely on family and friends to stay well. Give them support, information and respect.
3. I want to be heard and included, regardless of my identity. Offer me accessible and culturally competent support.
4. I may be facing more than just a mental health challenge (eg substance s including alcohol or a physical health condition). Respond to these creatively and without judgement.
5. I will know the name of the person responsible for my support. Show me that you are a human being too.
6. I have story to tell. Share information effectively with my permission, so I don't have to repeat myself

(Source: Mental Health 'I statements': I statements developed by users of mental health services in Leeds August 2016)

The Refugees and Asylum Seekers (RAS) Mental Health Network has identified a number of key areas that result in, or are suggestive of, mental health inequalities experienced by this population. These include:

- The crisis pathway is the only method of access to mental health services for some Refugee and Asylum Seeker clients – in particular destitute asylum seekers
- Existing barriers to primary care results in late referrals or rapid escalation towards crisis services. This can be the result of barriers to registering with a GP or barriers to accessing/finishing treatment for CMHD.
- Inconsistencies in the ability to access interpreters speaking appropriate language/dialects.

A number of organisations in the city work to support people in acute distress/with serious mental health problems, who do not access statutory provision.

Leeds Asylum Seekers Support Network report that they are regularly approached by staff from the Becklin Centre or Adult Social Care seeking a place to discharge/accommodate people with serious mental health problems who also do not have recourse to public funds. Sometimes these people are asylum seekers. Sometimes they are EU nationals who are not exercising their treaty rights.

There is a need for there to be a clear understanding of the accommodation needs of asylum seekers and migrants without recourse to public funds, and the impact that having no money and no accommodation has on mental health and their ability to engage with mental health services

5.6 **Key Findings**

- Many people with Serious Mental Illnesses such as psychosis and bipolar disorder maintain employment and relationships, and have fulfilling lives. For other people, these conditions bring with them significant disability and may also be complicated by poor physical health and significant socio-economic disadvantage.
- There are nearly 8,000 people recorded as having a SMI in Primary Care registers in Leeds. These registers show a significant association with deprivation - with rates highest in the inner part of the city.
- Leeds has higher rates of people experiencing First Episode Psychosis than the England average, and locally modelled estimates that use adapted methodologies. More work is needed to explore the impact of this high level of need on FEP services along with the needs of people who experience 'At Risk Mental States' (which may precede a first psychotic episode).
- There is a significant gap between locally modelled estimates of prevalence rates for psychotic disorder and bipolar disorder and LYPFT cluster data. This may be due to the fact that some services provided by LYPFT do not cluster and/or indicate unmet mental health need in the population.
- There is a relationship between having a SMI and being out of work. Workplace Leeds is a key source of employment support for people with mental illnesses in the city. Using national economic modelling and applying these to Leeds suggests that the service may be saving the city in excess of £1 million a year.
- There is robust national evidence to suggest that young men are at greater risk of developing psychosis and that Black men in particular are three more likely to be diagnosed with psychosis. This is reflected locally - with LYPFT noting an over representation of Black men in crisis services.
- At a population level, people from Black or Mixed ethnic groups are twice as likely to be admitted to a crisis service as people from White ethnic groups. This may represent higher levels of need in some population groups (associated with worse mental health) and/or failure across the mental health and social care pathways to meet the needs of these groups before crisis occurs.
- Crisis services in the community offer a well evidenced alternative to inpatient stays. Services provided in Leeds are meeting significant mental health needs of a wide and diverse groups– including people from LGBT communities and from a range of minority ethnic groups.
- People with a diagnosis of psychosis who live in LSECCG are more likely to be admitted to hospital in an emergency (through A&E).
- Leeds has higher rates of people subject to the mental health act when compared to the England average – rates are particularly high in the South and East of the city. It is not clear whether this is due to higher need in Leeds or if it reflects that there limitations on community services to be able to support people before crisis occurs.

6. Mental Health and Physical Health

'The relationship between mental and physical ill health is intimately connected with social deprivation…..and represents an important mechanism through which inequalities are perpetuated'

(The King's Fund, 2016)

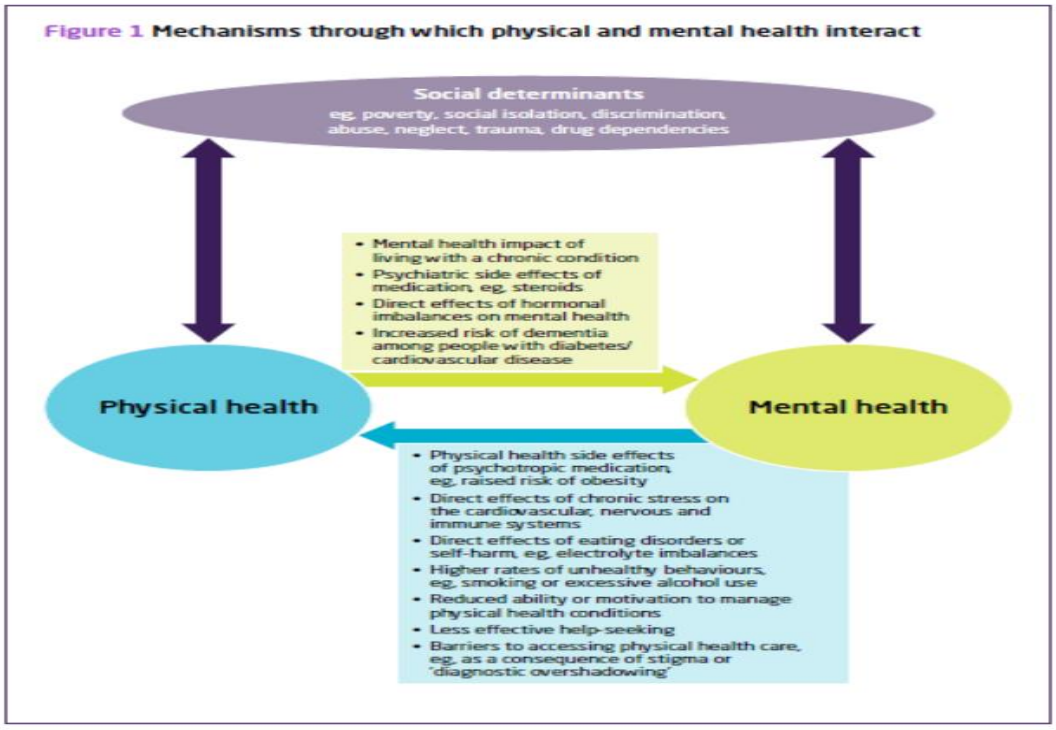
6.1 Background

Physical and mental health is interdependent– a factor not always recognised by health service design. However, the case for seeking to support physical and mental health in a more integrated way is compelling. The Kings Fund has set out four related challenges. These are:

- high rates of mental health conditions among people with long-term conditions
- poor management of 'medically unexplained symptoms'
- reduced life expectancy among people with serious mental illness, largely related to poor physical health
- limited support for the wider psychological aspects of physical health and illness.

(The Kings Fund, 2016)

Figure 69 suggests ways in which these challenges may interact.



In order to address these interconnected challenges, Alderwick et al (2015), suggest that building closer connections between integrated care and public health is crucial - in order to move from an emphasis on the *care of patients* to the *health of populations*. Such a shift may be achieved by multi-specialty community provider and local development of accountable care organisational models.

6.2 Epidemiology

Barnett et al (2012) undertook a cross sectional study using a large sample drawn from Primary Care systems in Scotland. The study assessed ***multi-morbidity*** (defined as two or more long term disorders– including mental health) and **co-morbidity** (both physical and mental health conditions).

The study reported a number of findings which are of significance locally:

- Most people with a long term disorder had more than one condition.
- The rate of multi-morbidity increases with age and is greatest in people over 65 years. However, the *actual number* of people with multiple disorders was largest in the Under 65s.
- There were higher rates of multi morbidity in young and middle aged adults in the most deprived areas.
- Socio-economic deprivation was particularly associated with multi - morbidity that included mental health and physical health.
- In keeping with other studies, women had higher rates of multi morbidity and higher rates of mental health disorders than men.

6.3 Service Improvement across the health system

The Kings Fund (2016) consulted with service users to identify a number of elements that could be used to underpin effective, integrated care. These were used to inform ten suggested priority areas for improvement across the health system (Figure 70)

Figure 70 Priority areas for improving health across the health system (Kings Fund)

Incorporating mental health into public health programmes
Health promotion and prevention among people with severe mental illnesses
Improving management of 'medically unexplained symptoms' in primary care
Strengthening primary care for the physical health needs of people with severe mental illnesses
Supporting the mental health of people with long-term conditions
Supporting the mental health and wellbeing of carers
Mental health in acute general hospitals
Physical health in mental health inpatient facilities
Integrated support for perinatal mental health
Supporting the mental health needs of people in residential homes

(King's Fund 2016)

These themes and recommendations are reviewed in more depth in the rest of this chapter.

6.4 Common Mental Health Disorders and Long Term Conditions

6.4.1 Background

Whilst important in their own right, co-morbidity of physical and mental illness has been shown to lead to poorer clinical outcomes, poorer quality of life for patients and increased care costs. (Kings Fund, 2012) These issues are becoming even more critical due to a) the ageing population – leading to greater numbers of people with long term conditions and b) the economic situation – meaning there is increased need to manage people more effectively in the community

This section reviews CMHD in the population who have one of more LTCs in Leeds. The physical health needs of people with serious mental illness are considered later in this chapter.

6.4.2. Policy Overview

The Five Year Forward View for Mental Health provides targets around increasing IAPT provision so that by 2018/19, up to 25 % of the prevalent population are able to access the service. This includes a target for **600,000 more adults with anxiety and depression to access care (and 350,000 complete treatment) each year by 2020/21.**

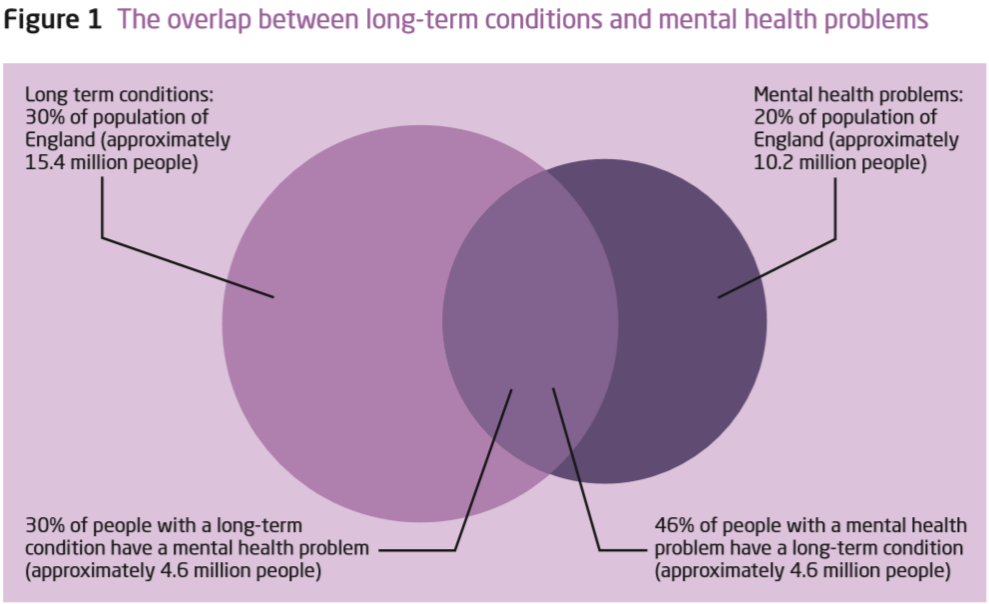
A growing evidence base indicates that more holistic, person centred care that 'joins-up' (or integrates) the physical and mental aspects of healthcare holds the potential to improve quality of life and physical health outcomes for patients.

This mirrors drives in the wider health and social care economy around 'population based health systems' and new models of integrated care such as Multispecialty Community Providers and vertical Primary and Acute Care Systems as outlined in the Five Year Forward View (2014).

6.4.3 Epidemiology

Fifteen million people in England (30% of the population) are reported to have a long term condition and of these, it is estimated that 30% experience a mental health disorder (Kings Fund 2012). The way in which longterm conditions and mental health problems overlap is shown in Figure 71

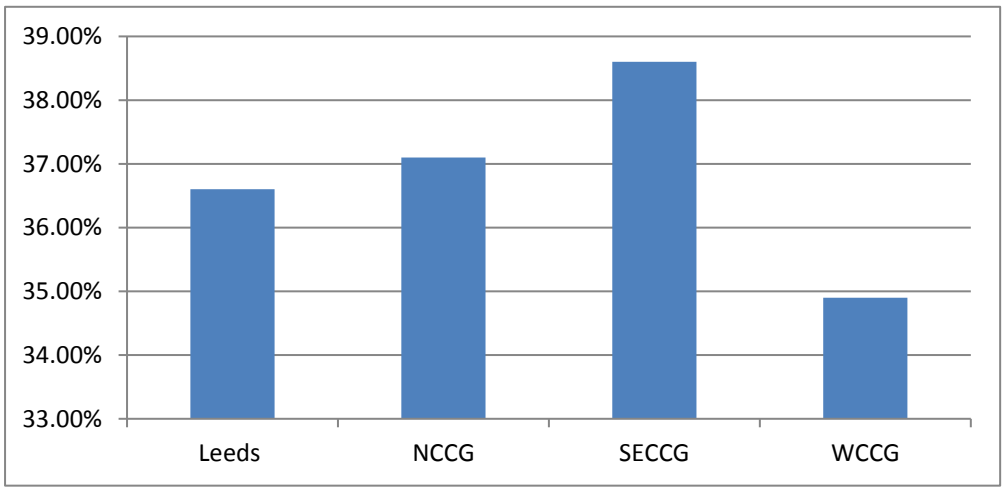
Figure 71



Co-Morbidity in Leeds

Figure 72 shows the percentage of people on CMHD registers in Primary Care in Leeds who have at least 1 Long term Condition (Included here are: Asthma, COPD, CHD, Hypertension, Diabetes, Heart Failure). It shows that in Leeds, 36.6% of people on CMHD register have at least 1 LTC. The rate is highest in Leeds South and East CCG where 38.6% of people on the CMHD registers have at least 1 LTC

Figure 72 Percentage pf people on the CMHD register in Primary care with at least 1 LTC



(Source: Public Health GP Audit October 2016)

6.4.5 Evidence Review

The association between physical and mental co-morbidity is not clearly understood and there are a number of possible explanations. However, understanding potential mechanisms or relationships provides a useful framework for developing both preventative measures and treatment pathways. The factors below consider a hypothesis whereby a long term physical condition leads to a mental health problem; however it is recognised that many factors will occur in both directions and the picture may be multifactorial for each individual, consistent with a biopsychosocial model of mental illness

Possible pathways to explain association between long term conditions and mental health

- Genetic predisposition
- Inflammatory pathways
- Neuroendocrine eg serotonin, hyperglycaemia
- Ischaemic brain disease (eg following stroke)
- Neurological disease impacting mood regulation
- Behavioural
- Psychosocial eg psychological impact of disease and reduced functional ability
- Medication side effects

From a review of the evidence, The Centre for Mental Health (2016) notes the potentially significant benefits of adopting a 'whole person approach' or collaborative care model. It is suggested that for at least some conditions this can lead to savings that cover the cost of interventions.

Key target groups include:

Patients with clusters of co-existing physical illnesses, that have compatible management guidelines – eg, diabetes and coronary heart disease and patients whose psychiatric condition is at a diagnostic threshold above the management of GP – as an estimate around 10% of all those with LTC

Based on a review of the evidence it also recommends

- Improved training for physical healthcare staff about mental health
- Increased detection of comorbid mental health problems – linked to care pathways for LTC
- Closer working between GPs and IAPT services - with IAPT taking the lead in providing talking therapies for patients with LTC.

6.4.6 Service Use

Mental health support for people with LTC and co morbid CMHD is similar to that offered to those people without LTC (with the exception of some embedded mental health services in acute physical health pathways – for example diabetes and COPD).

Figure 73 sets numbers of people with co morbid LTC/CMHD in Primary Care against numbers of people referred to IAPT with those conditions. IAPT is commissioned to meet 15% of need/prevalence. The final column shows how many people would be referred to IAPT if this target was being met. There are limitations with this analysis – see below.

Figure 73 Long Term Conditions and IAPT referrals 2015/16

	1.Number of people on Primary Care LTC register (Jan 16)	**2.% of people also on the CMHD register**	**3.Number with LTC and CMHD (Prevalent Population)**	**4.Numbers of people referred to IAPT (15/16)**	**5.IAPT Target: 15% of prevalent pop'n (3)**
Asthma	89,552	*25*	22,388	1,194	3,358
COPD	16,874	*32*	5,400	140	810
Hypertension	104,389	*24*	25,053	305	3,758
Diabetes	41,516	*24*	9,964	355	1,495
Heart Failure	6020	*24*	1,445	47	217

(Source: GP data and IAPT 2015/16 referrals LTC)

Limitations with this analysis:

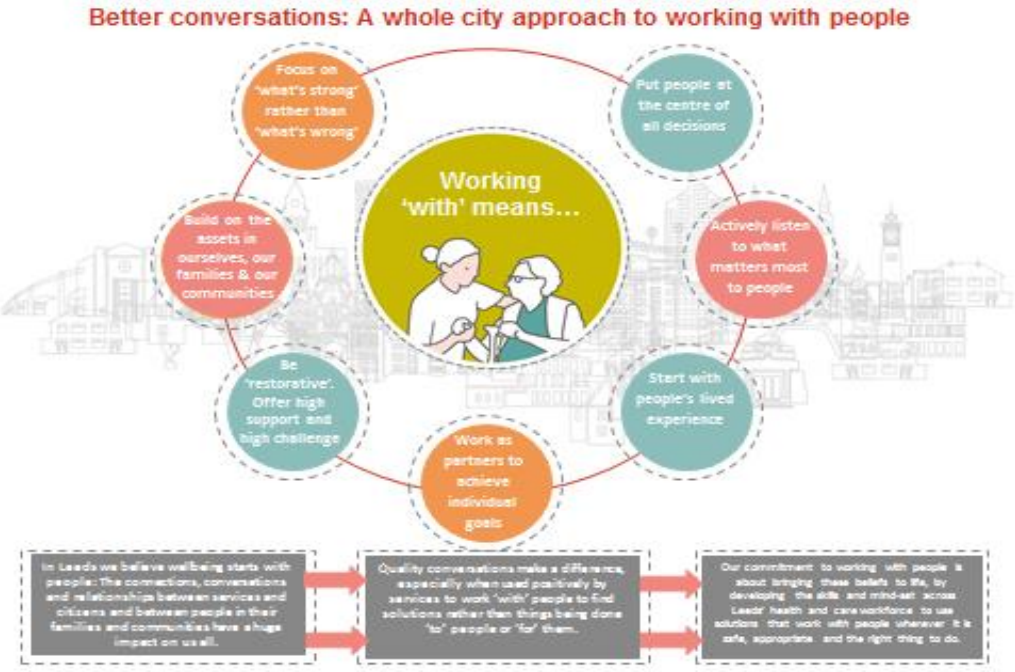
- *Some people from the prevalent population may have accessed IAPT previously – there is currently no way of removing these people from the total figure*
- *On being referred to IAPT, people may not disclose that they have a long term condition*
- *Some people's mental health needs may be supported by embedded pathways in physical health services (eg. COPD) or in Primary Care, which is why they may not appear in IAPT data.*

With these caveats it is still possible to suggest that numbers of people with LTC appear under-represented in the IAPT service data.

Health Coaching

The city is developing health coaching approaches to working with people to address their physical and/or mental health needs.

Figure 74



Liaison Psychiatry

Liaison Psychiatry is commissioned to provide a number of services. Information about in-reach liaison psychiatry (to LTHT wards) and Acute Liaison Psychiatry (via A&E) is included elsewhere in this needs assessment.

The outpatient team has particular expertise in addressing problems that have arisen at the interface between mental and physical health. The service offers assessment and treatment to people who have a mixture of psychological and physical difficulties. As such, service users may have the full range of mental health disorders/illnesses from anxiety and depression to serious mental illnesses like psychosis. Service data from 2015/16 showed 1,400 referrals and 1,145 individual service users

Figure 75: Liaison Psychiatry (Outpatients): Service Use 2015/16

Referral To Team Name	Count of Referrals	Count of Service Users
LP -LIAISON PSYCHIATRY OUT PAT	1400	1145

(Source: LYPFT Report/PARIS 2016)

6.4.8 Stakeholder View (Practitioners and Service Users)

Two meetings were convened by mental health commissioners during 2016 and 2017 to review physical health and mental health priorities. Key messages form these sessions included:

- A key priority should be to improve access to psychological therapy early (soon after diagnosis) in order to improve physical health conditions.
- There are basic skills about medical (physical health) conditions that staff working in mental health could benefit from, along with basic skills concerning mental health that staff working in physical health services need.
- There is a significant role for health coaching, behaviour activation and structured education to play in improving outcomes across physical and mental health

Leeds Involving People

In 2015, Leeds Involving People were commissioned to undertake a piece of work (on behalf of Public Health in Leeds City Council and Leeds South and East CCG) to gather insight from those with long term conditions. Part of this work inquired about mental health. The work took place in two phases; phase one, which engaged with 110 people with either respiratory disease (28), cardiovascular disease (29), diabetes (27) or dementia (11). Participants in the research were recruited from community/ social groups, fitness groups, structured education groups or other groups specific to long term conditions. Carers of those with dementia were also interviewed.

Demographic information was available for 90/110. Of these 90 participants, 70% were aged over 60 years, and 78% were of White British ethnicity.

Phase 2 specifically recruited people from harder to reach groups and engaged with 59 people with either respiratory disease, cardiovascular disease or diabetes.

In each phase, participants were asked '*would you say that your condition has impacted on your mental health?*'

The summarised results are presented below in Figure 76

Figure 76 Findings from Local Insight into mental health and long term conditions

Long term condition	Answered 'yes' or 'at times' to 'condition has impacted on their mental health' (%)	
	Phase 1	Phase 2
Respiratory disease	56%	30%
Cardiovascular disease	35%	30%
Diabetes	19%	18.5%
Dementia	27%	-

6.4.9 Key Findings

1. More than 1 in 3 people on the CMHD primary care register in Leeds have at least 1 LTC – approximately 48,000 people.
2. 25% of people with six individual long term conditions reviewed here (as recorded in Primary Care) are also recorded as having a CMHD (compared to 20% of the general population). This increases to 32% of people with COPD. However, it is likely that much mental ill health goes un–reported so it may be that this figure is much higher.
3. Referrals to IAPT for people with LTC do not appear to reflect local estimated prevalence and it is not clear how new national drives for IAPT provision to target people with LTC will be developed locally
4. Despite efforts being made to improve the holistic care provided in both mental health and physical healthcare services, stakeholders report that there are challenges associated with communication across provider organisations and development of appropriate skills.
5. The physical and mental health needs of people with LTC are met across both primary care and acute settings which increases complexity for service users.
6. New models of care provide a significant opportunity to support people's physical and mental health needs. However, there is separation between mental health New Models of Care driven by mental health commissioners and citywide approaches driven by a focus upon long term conditions.
7. Health coaching approaches provide a significant opportunity to meet the needs of the population with both LTC and CMHD

6.5 Medically Unexplained Symptoms

6.5.1 Background

A large number of people experience physical symptoms for which no clear biological cause can be identified. These symptoms are often chronic in nature (for example, persistent pain, tiredness or gastric symptoms); they can cause people significant distress, and they often have an important psychological component (APMS, 2014). 'Medically unexplained symptoms' is an umbrella term to cover all physical symptoms that do not have an obvious cause/diagnosis. Somatoform disorder, in contrast relates to a specific type of mental health problem with a clear diagnostic criteria.

It is estimated that MUS cost the NHS £3.25 billion a year. People with MUS also often have co-morbid mental health problems such as anxiety and depression. Evidence regarding the effectiveness of interventions to address MUS is limited. However, CBT appears promising and The Centre for Mental Health economic analysis suggest that a combination of CBT and self- help may be a useful starting point for people with mild/moderate symptoms (2016)

6.5.2 Policy Overview

The NHS Five Year Forward View details how the expansion of Improving Access to Psychological Therapies (IAPT) services will focus on people with long term conditions or medically unexplained symptoms. National pilots are underway to assess the efficacy of IAPT for these groups,.

6.5.3 Epidemiology

A recent systematic review (Haller et al, 2015) found that the prevalence of somatoform disorders and medically unexplained symptoms in primary care populations was variable. Between 26.2–34.8% of patients under the care of general practitioners reported at least one somatoform disorder and 40.2–49% at least one medically unexplained symptom. Risk factors include being female, anxiety disorders and low educational attainment. There is also a complex relationship between MUS, social isolation and poverty (Barksy, 2014; Lieb 2002)

6.5.4 Service Use

Leeds Liaison Psychiatry has a speciality multi-disciplinary team that supports people with medically unexplained symptoms. The service supports people with very complex presentations – a high proportion of referrals come from GPs and from physical health specialities in the acute trust. The service is referenced in the 'Joint Commissioning Panel for Mental Health: services for people with medically unexplained symptoms, as an example of good practice.

6.5.6 Stakeholder Views

- Anecdotally, patients with medically unexplained symptoms/somatic health seeking behaviour are reported to constitute a high proportion of service use in Primary Care.
- Supporting these patients is a key priority locally and has informed the development of the Mental Health Framework - people with regular use of primary care service for unexplained reasons may benefit from psychologically informed interventions that can provide more in depth support and develop greater understanding of unmet needs.

6.5.7 Key Findings

- It is estimated that up to 40% of all consultation in Primary care may be attributed to MUS with around 20% linked specifically to somatoform disorders.
- It is challenging to assess levels of mental health need associated with medically unexplained symptoms and somatic behaviours - as by their very nature, these conditions are very complex.
- Within Leeds, a Liaison Psychiatry service supports people who have very complex medically unexplained symptoms within a bio-psycho-social model.
- It is not currently clear whether the planned national expansion of IAPT to support people with MUS will be successful nationally and no plans are in place locally to address the needs of this group through the existing IAPT service; current existing provision remains with the specialist MUS service delivered via Liaison Psychiatry.

6.6 Serious Mental Health and Physical Health

6.6.1 Background

Evidence shows that people with Serious Mental Illness (SMI) die, on average 15 – 20 years younger than the general population (CMO Report, Mental Health 2013).

There is a strong inter-relationship between physical and mental health. Mechanisms for this comorbidity are complex, although are broadly related to: lifestyle factors, medication side effects and barriers to healthcare. Antipsychotic medication can have a harmful effect on physical health; mental illness is associated with social isolation, stigma and deprivation and there is increasing evidence that inequity in health provision and access contributes significantly to the inequality experienced by people with SMIs

5 years survival rates have been shown to be lower for patients with mental health problems for a number of key conditions including stroke, diabetes and respiratory disease (Disability Rights Commission, 2005) and people with mental illness use more emergency hospital care than people without mental ill health (Dorning, Davies and Blunt, 2015)

6.6.2 Policy Overview

The Five Year Forward View for Mental Health includes a recommendation that by 2020/21, at least 280,000 people living with severe mental health problems should have their physical health needs met - via screening and secondary prevention. In addition, current incentive schemes for GPs to encourage monitoring of physical health should continue and extra efforts should be made to reduce smoking - one of the most significant causes of poorer physical health for this group.

There are two National NHS CQUINs in place for acute mental health providers, designed to incentivise improved physical health care of people with SMI.

CQUIN 3 Improving physical healthcare to reduce premature mortality in people with SMI:

3a	Cardio metabolic assessment and treatment for patients with psychoses: To demonstrate cardio metabolic assessment and treatment for patients with psychoses in the following areas: a) Inpatient wards. b) All community based mental health services for people with mental illness (patients on CPA), excluding EIP services. c) Early intervention in psychosis (EIP) services. (2017/18)
3b	Collaborating with primary care clinicians: 90% of patients to have an up to date CPA (care programme approach), care plan or a comprehensive discharge summary shared with their GP. A local audit of communications should be completed.

CQUIN 9 Preventing ill heath by risky behaviours – alcohol and tobacco

9a	Tobacco screening
9b	Tobacco brief advice
9c	Tobacco - referral and medication offer
9d	Alcohol screening
9e	Alcohol brief advice and referral

The Lester Tool: The Lester tool is physical health monitoring guidance for people experiencing psychosis and schizophrenia. It is recommended in NICE guidance. http://www.rcpsych.ac.uk/pdf/RCP_11049_Positive%20Cardiometabolic%20Health%20chart-%20website.pdf) and for use to achieve CQUIN 3 (above).The tool has been adapted for use by Bradford Care Trust and the Health Science Network in the North of England is supporting roll out of the tool and are adapting it for use on PARIS. Leeds is a pilot site. The tool is also available for use by Primary Care (on Systm1)

Figure 77 is extracted from performance monitoring provided by LYPFT community teams against the CQUINs. It indicates that to date (2017), over half of community caseloads have had appropriate information collected regarding alcohol, smoking and nutrition and have had cardio metabolic screening – in line with CQUIN targets (above).

Figure 77 Summary LYPFT Community caseload physical health CQUIN. (2017)

Referral Team Name	% Alcohol, Smoking, Nutrition and Substance Use Information Collected	% Blood Glucose, Blood Pressure and Cholesterol Information Collected
AS - ASSERTIVE OUTREACH LEEDS	81.0%	83.9%
CLOZAPINE ENE	82.5%	57.5%
CLOZAPINE SSE	57.7%	46.2%
CLOZAPINE WNW	88.4%	79.1%
CMHT LEEDS ENE LOCALITY	65.1%	69.9%
EX - ASPIRE	70.6%	64.0%
CMHT LEEDS SSE LOCALITY	58.9%	58.9%
CMHT WNW - MILLFIELD	51.7%	30.8%
CMHT WNW - CENTRAL	41.0%	29.9%
CMHT WNW - WEST	44.7%	30.4%
	63.0%	**57.6%**

6.6.3 Epidemiology

The rate of excess deaths for people with serious mental illness in Leeds is 414.9% (four times greater than the general population).The rate of premature mortality (<75s) is 1,405/100,000 (2012/13) (fingertips.phe.org.uk)

Figure 78 compares the percentage of the GP registered population with six different long term conditions and the percentage of the population with an SMI (as recorded in Primary Care) who have a LTC. **It shows that across all 3 CCGs in Leeds the rate of LTCS within the population who are on the SMI register is greater than in the general population. This is striking for COPD, Diabetes (where rates are more than double) and Hypertension.**

Figure 78 Comparison of GP registered population with a LTC (%) and SMI register with a LTC (%)

(Source: Public Health GP Audit October 2016)

6.6.3 Evidence Review

Smoking cessation: There is clear evidence to show that people with mental illnesses smoke more than the general population and that prevalence varies across mental disorders (Adult Psychiatric Morbidity Survey, 2007). New evidence suggests that many people with serious mental illness do want to stop smoking and, if offered evidence based support they are able to quit (Happell et al 2012; Banham and Gilbody 2010.), with limited effects upon mental wellbeing (Nady et al 2002).

Going smoke free mental health inpatient settings has positive effects in terms of health outcomes, and increases in time spent on therapeutic activities (Public Health England, Smoking Cessation in Secure Mental Health Settings 2015). The Centre for Mental Health proposes that the most effective intervention of smoking cessation (as evaluated by NICE) is a multi-component intervention. This would nationally, save £100.8 million and would increase life expectancy among this group by 7 years.

Ethnicity: Evidence regarding the efficacy of interventions to improve the physical health of patients with SMI, who are from BME groups, is limited. This is a significant gap given the higher prevalence of conditions such as diabetes in some ethnic groups.

Workforce: Of note is a training package for practice nurses setting up nurse led physical health clinics. This has been developed by Northampton University and Rethink mental Illness. The training has been shown to be effective in increasing the proportion of patients on SMI registers who received comprehensive physical health check (Hardy, Hinks and Gray, 2014).

6.6.4 Service Use Data

Emergency Hospital Admission

People with serious mental illness often use emergency health services to a greater extent than the general population.

Figure 79 shows the rate of emergency hospital admission for people who have been assigned to a mental health psychosis cluster in Leeds. **It compares rates for the three Leeds CCGs with the overall rate for England and suggests that LSECCG has a significantly higher rate of admission than both the other two Leeds CCGs and the England average.**

Figure 79 Emergency hospital admissions (A&E): psychosis: indirectly age standardised rate per 100, 000 resident populations, age 15 – 74 years (2015/16)

Area Name	Value	Comparison with England
England	35.83	
NHS Leeds North CCG	44.16	no significant difference
NHS Leeds South and East CCG	57.81	significantly higher
NHS Leeds West CCG	33.57	no significant difference

(Source: NHS Digital)

Physical Health Checks in Primary Care

NICE guidance recommends that people on the serious mental illness register receive six physical health checks. These were included in QoF until 2014, but are now no longer associated with payment. The health check indicators were:

The percentage of patients with schizophrenia, bipolar disorder and other psychoses who have a:

1) record of alcohol consumption in the preceding 15 months
2) record of BMI in the preceding 15 months
3) record of blood pressure in the preceding 15 months
4) The percentage of women aged from 25 to 64 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years
5) The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol: hdl ratio in the preceding 15 months
6) The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 15 months

Figure 80 shows the percentage of the GP registered population in Leeds who received the full list of physical health checks in Primary Care (2015/16). Whilst variance form the England average is not significant, it shows that only around a third of people with SMI have received their checks.

Figure 80 People with severe mental illness who have received the complete list of primary care physical health checks

Area Name	Value %	
England	34.8	
NHS Leeds North CCG	35.6	no significant difference
NHS Leeds South and East CCG	34.8	no significant difference
NHS Leeds West CCG	35.6	no significant difference

Smoke Free and smoking cessation within acute settings (LYPFT)

As noted above, smoking rates within the population of people with SMI are higher than the general population and the evidence base for smoking cessation with this group is robust. LYPFT took the step of taking acute settings 'smokefree' in 2016. However, the smoke free policy has proved difficult to implement - with service users have continuing to smoke in the hospital grounds.

The acute mental health 'heathy living service' reports greater success however providing Nicotine Replacement Therapy and brief advice/interventions to both staff and patients.

(Source: NHS Digital)

Definition: The percentage of people with SMI who have received complete list of physical checks. Only referring to primary care. If patients with SMI are in long term, institutional care and are not on a GP list, they are not included. Standard Quality and Outcomes Framework (QOF) definitions are used:(a) patients in remission from SMI are excluded (b) smoking status uses the QOF definition (c) the cholesterol:hdl ratio is only required for patients aged 40 and above who do not have established cardiovascular disease (CVD)(d) blood glucose or HbA1c tests should only be performed for people aged over 40. Source: A data period of 12 months is used to produce an annual output; the data is provided by GPES on a pre-determined extraction date following the end of the financial year."

6.6.5 Stakeholder (Practitioner/Service Users)

Stakeholder s report that:

- There is a shared care protocol in place, however, it is not effective and communication between acute services and general practice is a barrier to improving care. This is frustrating for both mental health service providers and general practice
- Suggested solutions include: Leeds Care Record being able to 'include' LYPFT, and LYPFT being able to access the main bloods server. This would mean that GPs could review bloods taken and download them into SystmOne/EMIS.
- People with SMI may face barriers to attending primary care screening appointments.
- There is not a standardised template in place in Primary Care to assess the physical health needs of people with SMI, and incentives via QoF payments have been removed
- Referrals between acute mental health services and community dietetics are not always effective
- There is further need to address the needs of people with SMI in Public Health interventions.
- Early Findings from the 'Pharmacy Project' in Leeds North CCG shows the benefit of providing specialist mental health expertise for SMI patients in Primary Care – in terms of improving better medicines management and being able to identify when physical health checks need following up.

6.6.6 Key Findings

1. The rate of premature mortality in people who have a serious mental illness in Leeds (<75s) is 1,405/100,000 (2012/13). The rate of excess deaths is 414.9% (four times greater than the general population). This is symptomatic of significant health inequalities –associated with deprivation, poor physical health (due to anti-psychotic medications and health behaviour) and barriers to health promotion messages and healthcare services.
2. There is a relationship between serious mental illness and long term conditions. This is notable, in the case of diabetes, COPD and hypertension.
3. There is good evidence that smoking cessation is effective with this population group, and that people with SMI have the same desire to stop smoking as the rest of the population.
4. Incentives in the QOF system to complete the 'six NICE recommended checks' in primary care for people with SMI has been removed. Whilst rates in Leeds are comparable with the rest of the country - these are low across the whole of England.
5. There are systemic barriers to screening and improving the health of this population group:

    - There is a shared care protocol in place but communication between acute services, and general practice is a barrier to effective care.
    - There are opportunities to use standardised templates (eg. The Lester Tool) in Primary Care to support assessment of the physical health needs of people with SMI

6. People with SMI may face barriers to attending primary care screening appointments and healthy living messages/services.
7. People who have a SMI and who live in the South of the city are more likely than elsewhere to be admitted to hospital in an emergency.

7 Complex Mental Health Problems

7.1 Introduction

This chapter reviews the needs of people with a range of mental health problems, defined by stakeholders as people (***singly or in combination***):

- For whom no current appropriate service exists; they may have **moderate** '**psychological needs'** that are not defined as either a CMHD or a serious mental illness
- Who exhibit **high levels of risk** than cannot be supported through IAPT services, but who do not meet criteria for Community Mental Health Teams
- Who have **substance use problems or personality disorders** which complicate engagement with existing services
- Who may have **eating disorders** with symptoms that do not meet the threshold for treatment by specialist services.

Stakeholders note that these needs may be associated with historic and ongoing trauma/abuse intergenerational disadvantage and poverty. People with this range of complex problems may also be more at risk of suicidal thoughts/attempts and self-harm.

'Complexity' is sometimes used to define the needs of groups of people with the needs identified above. However, it is worth noting that this may be service centric term – whilst some people's needs may indeed be complex, the term may also be used as a 'catch all' to cover situations and diagnoses where services do not currently exist.

The wide range of presentations makes detailed understanding of this group, and levels of need difficult to obtain However, Fig 24 in this report (IAPT service flow 2015/16) shows that from 17,000 referrals, around 10,000 were closed either pre-screen or directly after screening. Figure 53 (Activity through LYPFT SPA 2015/16) shows that from 14,678 referrals, 1,771 were closed at triage and 3,074 were closed post assessment.

This equates to nearly 15,000 referrals over a 12 month period, which were not translated onto an initial caseload.

This chapter provides a brief overview (epidemiology and service use) regarding the needs of people with complex mental health problems, or with mental health problems that may not be well met by current service configuration.

New Models of Care/Mental Health Pilots have been designed to explicitly address this gap in provision and meet this range of needs. Early Findings are therefore also included in this chapter.

7.2 Personality Disorder

Personality disorders interfere with the ability to make and sustain relationships. Along with substantial social difficulties, individuals with personality disorder also often experience poor general health and reduced life expectancy. There is considerable debate about personality disorder (alternative perspectives to diagnosis, suggest that what is being described are clusters of symptoms often the result of trauma). The Adult Psychiatric Morbidity Survey (2014) summaries the possible definitions (and limitations with these) below:

- **Anti-social personality disorder**: Characterised by disregard for and violation of the rights of others. People with ASPD have a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence

- **Borderline personality disorder**: Characterised by high levels of personal and emotional instability associated with significant impairment. Self-harm and suicidal behaviour is common. A considerable proportion of people with BPD are known to have experienced some form of physical, emotional or sexual abuse or neglect in childhood.
- **Unitary**: Population-based studies have failed to demonstrate a bimodal distribution of abnormal personality traits that support the above definitions. Furthermore, the diagnostic criteria for individual personality disorder subtypes considerably overlap. Given these limitations, it has been proposed that personality disorder should be classified as a unitary disorder, characterised by core interpersonal dysfunction

7.2.1 Epidemiology

The APMS (2014) screened for personality disorders based only on 'phase one self-report data', at a single point in time. A positive screen for personality disorder only indicates that someone may have sufficient traits to warrant further and fuller investigation. Such types of screening tend to result in higher than actual rates of disorder. With these caveats, estimates have been applied to the Leeds population:

Anti-Social Personality Disorder and Borderline Personality Disorder

The self-completion Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II) was used among 16–64 year old participants in the first phase interview to screen for antisocial personality disorder (ASPD) and borderline personality disorder (BPD).

Figure 80 APMS estimated rates of Personality Disorder applied to GP registered population

	16 – 64 yr olds	Leeds (16 – 64) Oct 16	Leeds Est
ASPD	3.3%	568,743	18,769

	16 – 64 yr olds	Leeds (16 – 64)	Leeds Est
BPD	2.4% 95%	568,743	13,650

(Source: APMS, 2014/Public Health GP Audit October 2016)

Personality Disorder as Unitary:

A general personality disorder screen (the SAPAS) was added to APMS 2014 to screen adults of all ages for 'any personality disorder' (PD). This found that: 13.7% of people aged 16 and over screened positive for any PD, with similar rates in men and women.

Any PD (16+)	Leeds (16+)	Leeds Est
13.7%	677,501	92,818

(Source: APMS, 2014/Public Health GP Audit October 2016)

7.2.3 Personality Disorder Service

The Leeds Personality Disorder (PD) Service supports people with relationship difficulties, emotional problems and issues with identity, plus high levels of complexity and risk.

The PD services take a socio-psychological and occupational approach to working with people across the health and social care system. Interventions and services include:

- Primary Care: 3 x groups of the Journey programme per year.
- Support delivered via CMHT.
- Approximately 40 people are supported via care co-ordination at any one time for up to 2 years.

- Practitioners report the increasing number of young people accessing the service – the average age is 26 years
- 70% of service users are women and 90% are White British.

Whilst the Leeds personality disorder service only supports people with high levels of complexity and risk, the modelled estimates (above) suggest that there may be a significant number of people in the city who experience challenges around developing and maintaining healthy relationships and by implication engaging with services. In addition, waiting lists for the Journey programme suggest unmet need in the wider population.

7.3 Dual Diagnosis

Dual diagnosis refers to someone having a mental health diagnosis and co-morbid substance misuse problems. Drug and alcohol use are risk factors for poor mental health.

Figure 82 shows estimated rates of 'probable dependence' on alcohol/drugs and mental health treatment using the estimated rates from the APMS and applying this to the Leeds population.

Figure 82 APMS estimated rates of Dual Diagnosis applied to Leeds population

	16 – 74 year olds	**Leeds Est**
Alcohol/Mental Health	0.3%	1,865
Drugs/Mental Health	0.4%	2,487

(Source: APMS (2014) applied to GP reg figures Oct 2016)

Figure 83 Dual Diagnosis: Leeds, Regional and National service use 2015/16

Compared with benchmark: Lower | Similar | Higher | Not compared

Indicator	Period	England	Yorkshire and the Humber region	Barnsley	Bradford	Calderdale	Doncaster	East Riding of Yorkshire	Kingston upon Hull	Kirklees	Leeds	North East Lincolnshire	North Lincolnshire	North Yorkshire	Rotherham	Sheffield	Wakefield	York
Number in treatment at specialist drug misuse services	2015/16	203808	25092	1284	3248	902	1583	689	2105	1817	3655	991	861	1401	1239	2608	1894	815
Number in treatment at specialist alcohol misuse services	2015/16	85035	10129	509	1291	375	421	464	520	737	1927	234	281	1026	490	825	558	471
Numbers in stop smoking services	2014/15	450582	36277	2728	-	2042	2131	1946	3040	2358	3165	1199	1253	2319	2221	3148	3385	739
Concurrent contact with mental health services and substance misuse services for drug misuse	2015/16	22.1	22.3	21.5	14.1	17.0	24.9	23.6	38.7	24.2	28.7	9.9	15.1	25.4	11.0	12.0	30.1	20.7
Concurrent contact with mental health services and substance misuse services for alcohol misuse	2015/16	20.8	22.9	29.9	10.6	11.8	32.1	29.2	35.8	15.3	33.4	3.0	13.7	34.6	9.2	15.4	27.9	21.1

Using service *contacts* – the Fingertips data in Figure 83 indicates that Leeds has a higher percentage pf people contacting drug/alcohol services who had a mental health diagnosis than regional and England average.

The data in Figure 83 is taken from Forward Leeds – the city's drug/alcohol service, It shows that overall, 22% of people accessing the service had a mental health diagnosis. This dataset shows that more men accessed the service than women. However, women were more likely to have a formal mental health diagnosis,

Figure 83 Forward Leeds Mental Health and Substance Use Data by Gender 2015/16

Gender	Mental Health Diagnosis	No Mental Health Diagnosis	Total
Female	471 (28%)	1235	1706
Male	771 (21%)	2985	3756
Total	1242 (22%)	4220	**5462**

7.4 Trauma and Sexual Abuse

Trauma and abuse are often implicated in complex mental health presentations; ***however, trauma itself is also an independent risk factor for mental illness in the absence of other complexities***.

A new module of questions included in the Crime Survey for England and Wales (CSEW) between 1 April 2015 and 31 March 2016 asked adult respondents aged 16 to 59 whether they had experienced a range of abuse while a child. The questions were restricted to abuse carried out by an adult and included psychological, physical, and sexual abuse and also having witnessed domestic violence or abuse in the home

- 9% of adults aged 16 to 59 had experienced psychological abuse,
- 7% physical abuse,
- 7% sexual assault and
- 8% witnessed domestic violence or abuse in the home.
- With the exception of physical abuse, women were significantly more likely to report that they had suffered any form of abuse asked about during childhood than men."

(www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/abuseduringchildhood/findingsfromtheyearendingmarch2016crimesurveyforenglandandwales)

Local Estimates: Applying a figure of 8% to the Leeds adult population suggests that there may be 45,000 people who have experienced some form of abuse whilst a child.

A summary of recent research about the link between trauma and mental ill health concludes that:

- Trauma is a common risk factor for a broad range of disorders – from personality, mood and substance misuse to psychosis
- It is associated with reduced responses to treatment in mood disorders
- Childhood adversity is associated with a 1.5 – 3 x increased likelihood of psychotic experience
- There is limited evidence to guide clinicians in treatment of trauma

(Lancet Public Health 2017: http: dx.doi.org/10.1016/s2468 – 266 (17) 30104 – 4)

Innovative Practice: Trauma Informed Services Clinical Link Pathway developed by Tees, Esk and Wear Valleys NHS foundation Trust. This aims to use standard trust processes to facilitate trauma informed services. The pathway and algorithm for treatment decisions can be 'clipped' to any mental health pathway

Local Action: The Visible Project

A new city-wide partnership, Visible, is now in place in the city to raise the profile of child sexual abuse and improve responses across the mental health system. The aims of this project include:

- Providing opportunities for Networking Leeds adult mental health services at strategic, organisational and frontline levels
- Designing, developing and piloting a Quality Mark by which organisations can improve their responses and support
- Designing, developing and piloting training for workforce development

7.5 Supported Housing

Supported housing services provide tailored support to people who may be homeless, vulnerably housed and/or need intensive support to manage a tenancy. Poor housing is a risk factor for poor mental health and people with moderate/severe mental health problems may struggle to maintain tenancies or need additional support. Detail from two services is included below:

Housing Related Support: Adults & Health Commissioning: Overview

- New Intensive & dispersed supported housing service: 234 units.
- Specialist supported accommodation: 68 units.
- Emergency accommodation: 32 units
- Young Person provision: 150 units
- Rough sleepers 13 units

Number of units/people able to receive housing related support at any one time: **Total: 497**

Housing support provision: Overview

- 1500 units of visiting housing related support through Engage Leeds..
- 255 visiting housing related support units.
- **Total: 810**

Services report that a 'Significant number' of people living in supported housing will experience some form of mental health problem.

7.6 Summary

Not all aspects that give rise to someone having a complex mental health presentation are covered above. This chapter only attempts to highlight some of the ways in which people may experience a number of (sometimes interrelated) issues that simultaneously put them at greater risk of mental illness and mean that accessing and engaging with treatment is challenging. It also goes someway to quantifying numbers of people in Leeds who may experience these multiple challenges

In addition, this overview highlights the fact that trauma is strongly associated with the development of a range of mental health problems (that may be part of a broader complex picture – or may be a key factor in a mental health diagnosis) and that there are a significant number of people in Leeds who are estimated to have experienced some form of trauma or abuse.

7.7 **New Models of Care**

The Kings Fund Report (2016): Mental Health and New Models of Care – sets out 4 key groups that benefit from integrated approaches to mental health.

- **People with multiple physical and mental health conditions** including older people with frailty as well as younger people with highly complex needs
- **People with long term physical health conditions** who would benefit from support for the psychological aspects of adjusting to and living with their condition
- **People with persistent physical symptoms such as chronic pain** that can be maintained and reinforce by psychological and biological processes acting in tandem
- **People with severe mental health problems who can often experience poor physical health** and less effective care and support for their physical health needs

A recent national survey from the Kings Fund notes however that the level of priority given to mental health in the development of new models of care has not been sufficiently high (Kings Fund 2017).

Locally, the review undertaken as part of the Leeds Mental Health Framework, identified that there are many people who do not receive the right mental health treatment, at the right time for them – and who may 'bounce' around the system. Some of these groups are the same people identified by the Kings Fund, though others have more specific needs related to mental health. Often with high levels of complexity/risk, this group includes people who, as noted earlier:

- Benefit from assistance with navigating mental health services,
- Require specialist psychological support that is neither IAPT nor CMHT (for issues such as personality disorder or unresolved abuse/trauma).
- Have complex social circumstances which mean they might benefit from support with wider issues such as housing/debt or a support to 'stabilise' emotionally so that they can engage with mental health services.
- May require brief psychologically informed interventions and bespoke support for a short time or appropriate referral onwards to specialist treatment (after in –depth assessment).

7.7.1 Local Service Response

Three different pilot models have been established in order to address these unmet mental health needs. They aim to remove barriers to appropriate treatment and to improve care. These Primary Care /Mental Health New Models of Care seeks to bring psychiatric expertise closer to primary care in order to improve decisions made at this level and reduce the burden on primary care due to repeat appointments.

The individual projects are:

- **Early Intervention and Liaison** (mental health staff supporting a number of identified practices in Leeds North CCG and LSECCG)
- **Pharmacy Support** to a group of GP practices in Leeds North CCG

- **360 project** - to support people who are stable back into acute primary care – so physical and mental health needs can be met holistically

Early Findings from the Early Intervention and Liaison Project are included below:

Early Intervention and Liaison:

Expected Outcomes:

- People are seen by the right person and the right place.
- Access to an assessment and brief intervention for patients with mental health needs in Primary Care.
- Patients with both Mental and Physical Health needs are treated holistically

Two areas have piloted these models:

Chapeltown Pilot: Community mental Health Liaison Practitioner:

- 462 Face to Face contacts (Quarter 3 2015/16)
- Referrals: 4 CMHT/23 IAPT/6 Social Prescribing/2 Forward Leeds/2 Social Services. Quarter 3
- Around 70% of people have a brief intervention (1 – 3 sessions) and 30% have longer contact
- There has been a 25% reduction in GP appointments from service users over the first quarter, though it is not clear if this attributable to the pilot programme.
- The pilot is being well received by GPs, who are finding the 'decision support' offered by mental health staff invaluable.

The needs being met include:

- 'Stabilisation' – assistance in reducing external stresses and 'chaos' so that people can engage more effectively with mental health services
- Signposting to services that can help reduce stress from wider determinants such as debt
- Signposting and ongoing support for issues related to unresolved trauma and/or abuse.

Leeds South and East: Community Mental Health Liaison Practitioner for the 12 month period from May 2016

The post is funded by the Leeds South and East Clinical Commissioning Group (CCG) as part of a 12 month pilot project to determine the effectiveness and need for the role. The pilot consists of a single Band 7 Community Mental Health Liaison Practitioner (RMN) employed and managed by Leeds and York Partnership Foundation Trust (LYPFT). The purpose of the role is to support primary care services with high level decision making in relation to the unmet mental health needs of their client group, and to facilitate the development of the workforce, to meet complex needs arising from mental health difficulties and co-morbidities;

Early Findings:

A wide range of mental health needs are being met. These include:

- Medication advice
- Referral for care co-ordination/consultant review
- Referral to Journey programme (Personality Disorder)
- Recommendation or referral to IAPT
- Mind Peer Support

- There appears to have been a reduction in inappropriate referrals to acute mental health services, and a reduction in people who are on the CMHT caseloads with Clusters 13 and stable psychosis (Cluster 11)

Demographics:

- The service is currently meeting the needs of a youthful population: 50% are aged less than 45 years old.
- Only 5% of people seen by the service were from a BME community

Key Findings

- Local stakeholders identify that there are a group of people whose needs are not well met by current service provision (structured around common mental health disorders or serious mental illness). This group is heterogeneous and includes people who may have psychological needs related to unresolved trauma, complex social problems or enduring depression.
- 'Complexity' is differently defined and experienced. Being able to meet this wide range of mental health needs suggests requires that responses should be culturally appropriate, evidence-based and adaptable to meet the need of the individual.
- More work is needed to understand the burden of illness that is attributable to 'complex needs' in the city; however numbers of people 'screened out' from IAPT and CMHTs provides an initial starting point.
- A new partnership, funded until 2019 is now in place in the city - the visible project aims to raise the profile of child sexual abuse and improve responses across the mental health system.
- Personality Disorder is a complex diagnosis often associated with previous trauma and abuse. Developing accurate estimates of numbers of people affected is challenging given the disagreement over terms and complexities of screening for these conditions. However, it is probable that there are a significant number of people in Leeds who struggle with forming healthy relationships and experience high levels of risk
- Leeds has a greater number of people accessing drug/alcohol services who have a comorbid mental health problem than modelled estimates predict. It also has higher rates of service use contacts (for alcohol/drug services) from people with mental health problems. This suggests high levels of need in the Leeds population.
- Drug and alcohol use is a significant predictor of mental ill health. Dual diagnosis services in the city are meeting needs that exceed modelled estimates. 22% of people accessing Forward Leeds in 2016/17 had a mental health diagnosis. More men accessed the service than women. However, women were more likely to have a formal mental health diagnosis (28% of women, compared to 21% of men).
- There is clear evidence that trauma is associated with a full range of mental illnesses. If rates from national surveys are applied to the Leeds population this suggests that around 45,000 people in the city may have experienced some kind of trauma and abuse.
- New pilot ways of working – bringing mental health services closer to primary care (mental health 'test beds') have to date, developed separately to emerging 'new models of care'
- Early findings suggest that the Primary Care /Mental Health test beds developed as part of the Leeds Mental Health Framework are meeting a range of mental health needs and the impact on primary care workload appears promising.
- The models show the potential of system change/integration. Early results suggest that bringing mental health staff 'closer' to Primary Care appears to improve the appropriateness of referral and a reduction in GP contact time for some people.
- It will be important, going forward to assess the 'net effect' of all three models on the wider health and social care economy - and in particular on their ability to respond flexibly to need.

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Appendices

Appendix 1

Snapshot Cluster Audit 2016

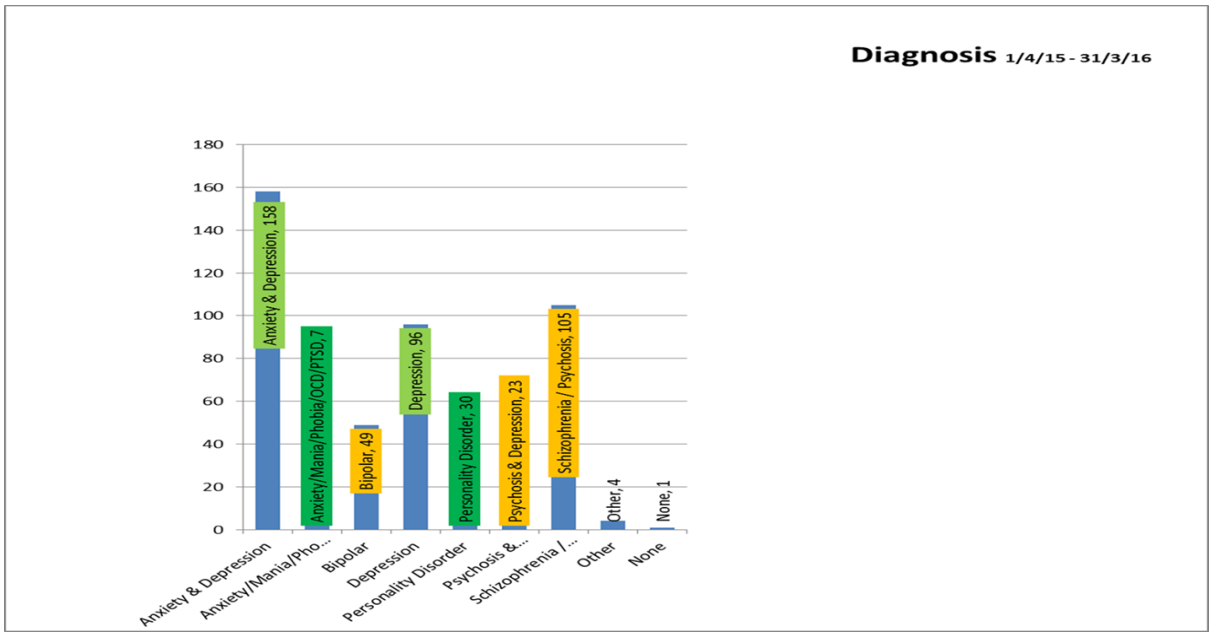
How mental health needs are met across the system:

= common mental health

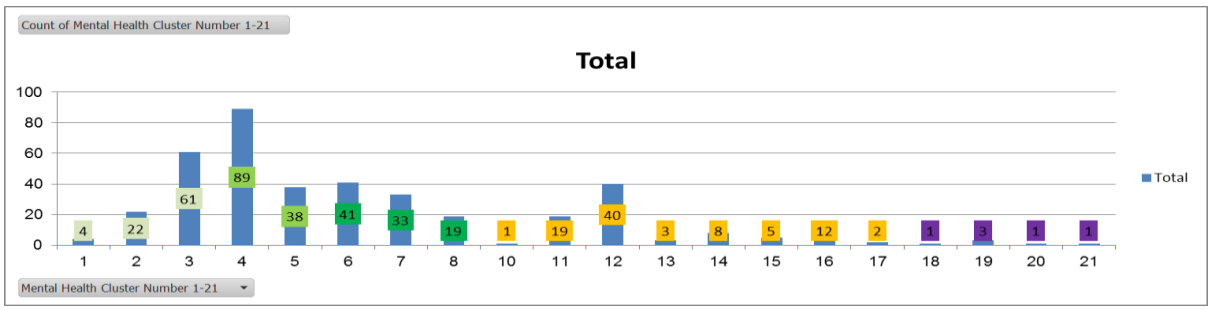
= complex common mental health

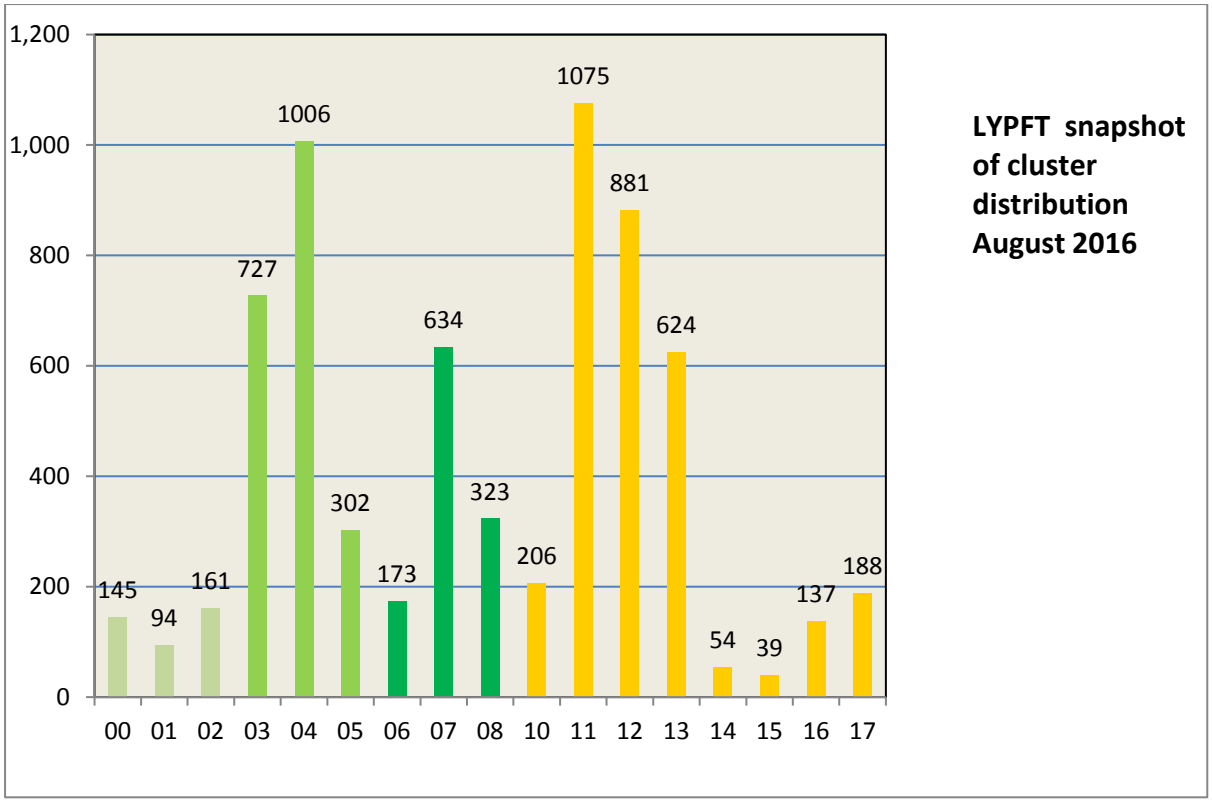
= psychosis

Social Care Cluster Audit:



Third Sector Cluster Audit Snapshot Q1, 2016





LYPFT snapshot of cluster distribution August 2016