

Health Equity Audit

Improving Access to Psychological Therapies

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EXECUTIVE SUMMARY

Health equity audits identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas, and the priority action to provide services relative to need. The overall aim is not to distribute resources equally but, rather, relative to health need. This process assists the planning and decision-making processes of organisations. It determines whether healthy inequalities exist and identifies areas where remedy and/or monitoring are required.

Improving Access to Psychological Therapies (IAPT) services provide evidence based treatments for people with common mental health disorders such as anxiety and depression. Nottingham City CCG delivers IAPT services under an Any Qualified Provider model. In 2015/16, data was available for the then three operational providers (Let's Talk Wellbeing; Insight Healthcare; and Trent PTS). Towards the end of 2016 a fourth provider (Turning Point) also commenced service delivery. All providers operate a stepped care model; a stepped-care model allows service-users and therapists to choose the most effective intervention to meet their need.

Despite a well-established service that works with a range of communities to help them achieve recovery, there remains a constant requirement to improve and adapt to the needs of the Nottingham City population. Furthermore, the Five Year Forward View for Mental Health identifies the need for continued growth in IAPT access rates.

Aim: To review access to IAPT services in Nottingham City and explore whether provision and access are appropriate for the areas/populations of need.

Methods: A mixed model approach using quantitative data from the minimum data set for all individuals accessing IAPT services and qualitative data from semi-structured interviews with provider representatives.

Key findings

Equity of access:

- It is estimated that 53,143 individuals aged 16-74 years of age have at least one Common Mental Health Disorder. In Nottingham City, in 2015/16, the data shows IAPT services engaged 12.7% of those with CMD.
- IAPT services are meeting estimated need to a similar degree for women (12.6 %) and men (12.8%).

- As expected, the proportion of need met by IAPT services decreases with age. The proportion of need met by IAPT services peaks at 20-24 years in men and 30-34 years in women.
- It is positive to note that IAPT services in Nottingham City receive the largest proportion of their referrals from the most deprived areas and this is in proportion to estimated need. Despite this, there remains variation in the level of need met by GP practices.
- Inequalities between ethnic groups also exists with a greater focus needed on meeting the estimated CMD need within Mixed/multiple ethnic groups and Asian/Asian British groups
- Those with impaired vision are under-represented in relation to the estimated number of individuals living with impaired vision in Nottingham City. Other disabilities are represented to a similar proportion in IAPT data as they are seen in the general population; however, as the burden of mental health illness in these populations is unknown, it remains unclear if IAPT access in these groups is adequate.
- Referral sources vary by provider and it was beyond the scope of this work to understand why. As a result, the choice of IAPT providers available to the public may differ depending on where and under what circumstances they present.
- Time to treatment differs by gender, ethnicity and for those with a learning disability. While small, it is important to understand the differences observed and work to improve equity.

Equity of outcomes

- Across Nottingham City CCG, reliable improvement, recovery, and reliable recovery rates are above national averages (UK average: 62.2%, 46.3%, 44% respectively).
- There are differences between providers with some outcome measures. This is most evident for 'Recovery' and 'Reliable recovery'. This remains unexplained.
- Despite a greater number of referrals in the most deprived areas of the City, outcomes in these areas are also worse. An understanding of what drives this inequality in outcome is needed.
- Overall white ethnic group have significantly better rates of reliable recovery than Mixed, Asian or Other ethnic groups.

- Service users who are Bisexual appear to have a lower reliable recovery rate than heterosexual service users.
- While differences exist, it is not possible to adjust for the impact of severity of mental health illness or other confounding factors on this data which may explain the differences seen.

Providers' views

Providers have a good awareness of key equity issues including both the barriers experienced by certain populations and some of the methods in which these barriers can be overcome. However, there remains inconsistency in eligibility criteria for peri-natal mental health and substance misuse. Similarly, there appear missed opportunities in using the skills and knowledge of the workforce to increase awareness of equity issues.

Each provider works in relative isolation to provide its own IAPT offering as guided by the commissioner; however, there are opportunities for shared learning and co-operative working to ensure that the IAPT service across the city as a whole is greater than just the sum of its parts.

Recommendations

- It is recommended that commissioners and providers come together to discuss the inequities highlighted within this report and create a joint plan to address inequalities.
- It is recommended that Nottingham City CCG view equity across the combined output of IAPT providers but work with individual providers to ensure any decisions they make to focus workload on specific sub-populations contributes appropriately to a city-wide goal for equitable IAPT coverage.
- GP practices, particularly those in deprived areas with low-referral rates, should be supported by commissioners and providers to increase referrals. This may include the need for improved case-finding or adapting referral processes in some GP practices. As variation between GP surgeries exists, sharing of good practice should be encouraged.

- Stakeholders should consider ways to improve data quality and identify areas, including substance misuse, where collecting new data would facilitate future learning around equity and patient pathways.
- Efforts should be made to promote the visibility of IAPT services amongst communities that currently have inequitable rates of access and to address barriers such as stigma.
- Undertake qualitative research to better understand why there are low referral rates to IAPT services amongst certain population groups.
- Undertake mixed methods (Quantitative and qualitative) research to explain and explore differences in treatment outcomes between populations.
- IAPT services should explore the reason individuals in some groups have lower recovery rates and identify changes to treatment (incl. the need for additional support) that may be needed.
- Stakeholders should work towards the consistent translation of the service specification into eligibility criteria for pregnant women and substance misuse.
- Providers should explore the possibility of better co-ordinating staff training, promotional activity and sharing best-practice as a way of maximising resource use.
- The commissioner should work with partners to ensure pregnant women with a history of mental health issues are given appropriate preventative support that, at present, is not provided by IAPT services.
- Commissioners and providers should continue their work together to ensure IAPT remains a sustainable and key component of the mental health pathway in Nottingham City.

1. Introduction

The Improving Access to Psychological Therapies (IAPT) programme began in 2008 in England and provides evidence-based interventions for people with a range of common mental health problems such as anxiety and depression.

The aim of this Health Equity Audit (HEA) is to determine the equity of access to, and outcome from, the IAPT services in Nottingham City. In this context, equity concerns the principle that the population should have access to a service based on need rather than demand. The results of the HEA will be shared with the commissioner of IAPT services in Nottingham City (Nottingham City CCG) and should inform future evaluation, design and procurement decisions and service evaluation.

1.1. Scope of the audit

Information on all individuals who are residents in Nottingham City and referred to any of the IAPT service providers commissioned by Nottingham City CCG, between 1 April 2015 and 31 March 2016 were included within the analysis.

The data is limited to adults only, and therefore this report does not consider equity amongst young people. The analysis concentrates on an analysis of equity, and does not review performance against national key performance indicators. It considers equity both between individual providers and as a whole across Nottingham City.

1.2. Background

Mental health problems are common, disabling and costly. There are many factors that influence mental health and wellbeing including personal relationships, childhood experience, employment, housing, safety, built and natural environment and experience of discrimination.

Mental health problems range from severe mental illness, such as schizophrenia to common mental health problems such as anxiety and depression. All these conditions can be highly disabling and affect family, working and social life.

Common mental disorders (CMD) comprise a range of conditions that often co-exist, including:

- Depressive episodes;
- Generalised anxiety disorders;

- Panic disorders;
- Phobias; and
- Obsessive compulsive disorders.

At any one time, it is estimated that 1 in 6 (15.7%) of the adult population in England will be experiencing symptoms suggestive of common mental health problems (McManus et al. 2016) with up to one in two adults experiencing problems at some point in their lives (Kessler 2007).

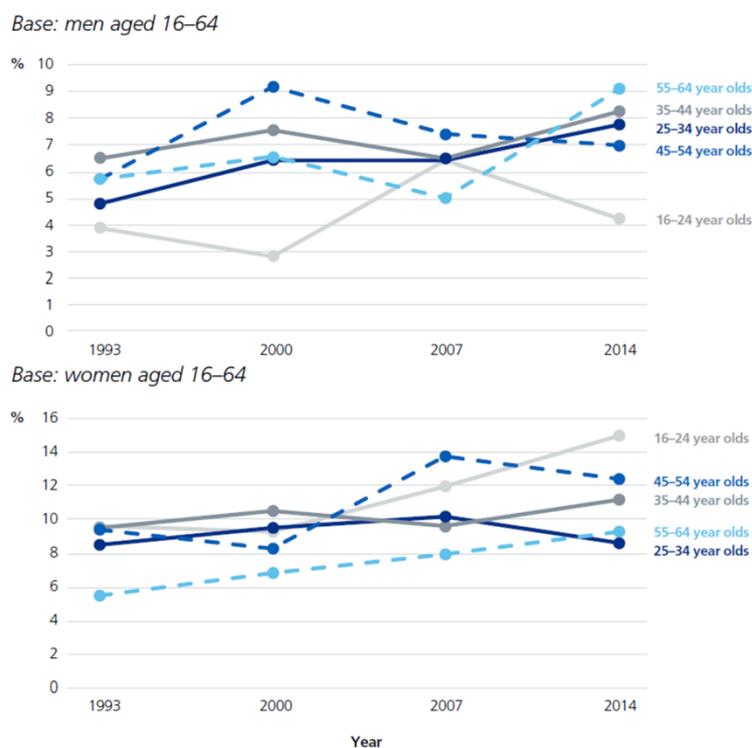
A proportion of individuals who experience CMD will achieve resolution without requiring treatment. For individuals with short-term duration (less than 6 months), it is estimated that 50-70% of individuals will recover within a few months, without the need for psychological therapy, but for individuals with longer-term duration of illness, the average self-recovery rate is considerably lower at between 5 and 20% (Clark et al. 2009).

The results of the Adult Psychiatric Morbidity Survey 2014 show that CMDs remain more prevalent in certain groups of the UK population (McManus et al. 2016):

Age and Sex - Between 2000 and 2014 there has been a small increase in the proportion of Women with CMD symptoms whereas the proportion of Men has remained stable. In 2014, Women were more likely than men to be affected with one in five (19.1%) women having CMD symptoms, compared with one in eight men (12.2%).

CMD is also associated with age. The pattern of association between age and CMD symptoms was different for men and women. In women CMD symptoms are most prevalent amongst the youngest group (16-24 year olds) with a second peak in midlife (45-54 year olds). In Men the rate of CMD symptoms remained stable up to 64 years old. However, since 2007 there has been an increase in CMD symptoms amongst late midlife men and women (55-64 years) since 2007 (McManus et al. 2016).

Figure 1: Prevalence of CMD symptoms (severe) by age and gender, 1993 to 2014 (McManus et al. 2016).



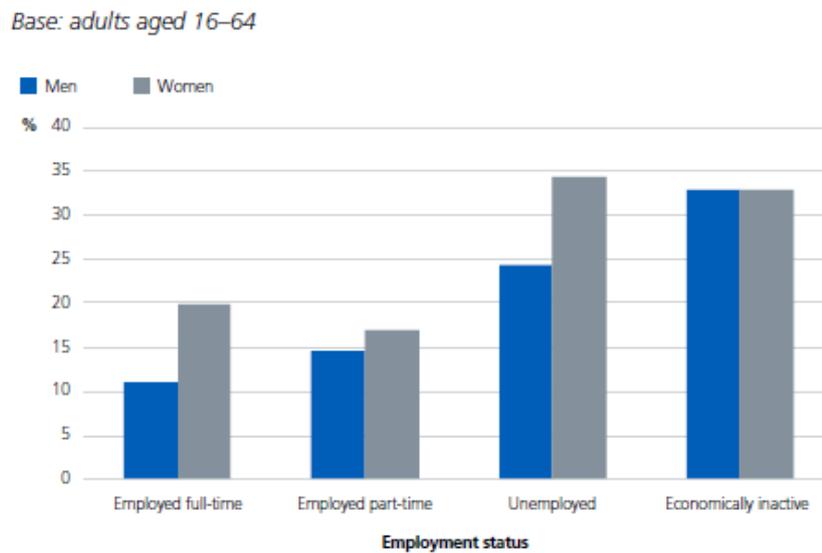
Ethnic group – While no significant variation was observed amongst men, non-British White women were less likely than White British women to have a CMD (15.6% v 20.9% respectively), while CMDs were more common in Black and Black British women (29.3%).

Household – Men and Women living alone were more likely to have CMD than people who lived with others. Compared to men in large households¹, a higher prevalence of CMD was observed in women in large households (13.7% v 26.4% respectively).

Employment – The rate of CMD in employed people was half that of adults not in employment (14.1% in full time employment v 28.8% in unemployed). Large differences in prevalence of CMD were also observed between those in receipt of particular benefits compared to those who were not.

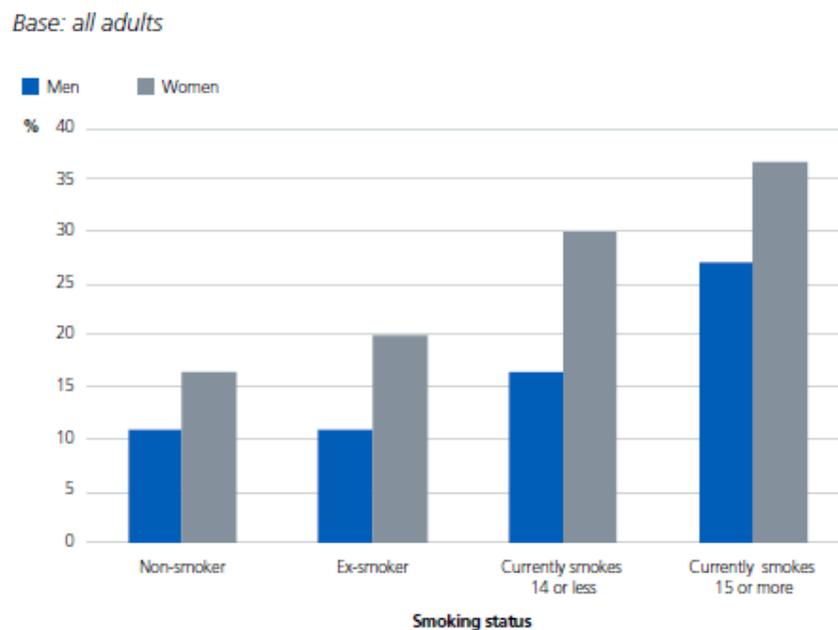
¹ at least one adult living with three or more children

Figure 2: CMD prevalence by employment status 2014 (McManus et al. 2016).



Smoking - Smokers were significantly more likely than non-smokers to have a CMD with prevalence highest amongst those smoking 15 or more cigarettes a day.

Figure 3: Prevalence of CMD by smoking status (age-standardised), 2014 (McManus et al. 2016)



Adults with enduring mental health problems can be one of the most socially excluded groups in society, experiencing stigma and wide ranging social disadvantage as well as poor physical health outcomes. Mental health and physical health are intrinsically linked. People with mental health problems experience higher rates of physical illness and a lower life expectancy (Hert 2011), and those with chronic or long term physical health problems are more likely to experience mental health problems (Naylor 2012).

Mental health problems impact on individuals, families, communities, and society as a whole, with immense social and financial costs. Mental illness is an important cause of social inequality as well as a consequence. Mental health problems contribute a higher percentage of total 'disability adjusted life years' in the UK than any other long term illness (14%, or 23% with drug and alcohol abuse included, compared to cardiovascular disease 12%, cancer 13% and respiratory illnesses 8%) (WHO 2009). Estimates put the full cost of mental health problems in England at £105.2 billion (Centre for Mental Health 2010), and mental illness accounts for about 13% of total NHS spend (Parsonage et al 2012).

Given this, reducing the prevalence of these conditions is a major public health challenge.

1.2.1. Psychological therapies

Improving Access to Psychological Therapies (IAPT) services, also commonly referred to as talking therapies or primary care psychological therapies, provide evidence based treatments for people with anxiety and depression. These encompass a wide range of interventions that follow different theoretical models and different forms of treatment, examples include cognitive behavioural therapy (CBT), interpersonal therapy (IPT) counselling and guided self-help in line with the principles advocated by NICE for a stepped-care approach to the treatment of common mental health problems, depending on the condition and severity of illness.

IAPT services were established in England in 2006, with subsequent roll-out across the whole country. The vision for the IAPT programme is

“to raise the standards of the recognition of, and treatment for, the mass of people who suffer from depression and anxiety.....to give greater access to, and choice of, talking therapies to those who would benefit from them”

The IAPT programme began in 2008 and, in England, over 900,000 people now access IAPT services each year. One in three people with CMD reported using mental health treatment in 2014; an increase on the 1 in 4 reported in 2000 and 2007 (McManus et al 2014).

1.2.2. IAPT services in Nottingham

Nottingham City CCG delivers IAPT services under an Any Qualified Provider model. In 2015/16, data was available for the then three operational providers (Let's Talk Wellbeing; Insight Healthcare; and Trent PTS). Towards the end of 2016 a fourth provider (Turning Point) was also commenced service delivery. All providers operate a stepped care model; a stepped-care model allows service-users and therapists to choose the most effective intervention to meet their need.

Despite a well-established service that works with a range of communities to help them achieve recovery, there remains a constant requirement to improve and adapt to the needs of the Nottingham City population. Furthermore, the Five Year Forward View for Mental Health identifies the need for continued growth in IAPT access rates.

1.2.3. Equity of provision of IAPT services

In 2010, a review of the first-wave of IAPT sites (32 services and 79,310 individuals) highlighted the majority of service users were of working age with older people being under-represented. The greater need of women was reflected in access to the service but white British individuals were over-represented and there was poor reporting of some protected characteristics (Glover et al, 2010).

Similar findings have also come from other analysis of IAPT services with older adults often under-represented but also being less likely to drop out and having higher recovery rates than working age adults (Prina et al. 2014; Brown et al, 2014). However, other studies have suggested that clinical factors (e.g. suicidal thoughts, severity of condition and illness duration) are more predictive of IAPT non-attendance than socio-demographic characteristics such as age, gender and ethnicity (Di Bona et al, 2014).

The Adult Psychiatric Morbidity Survey 2014 identified demographic inequalities in who received treatment for CMD across the UK. After considering levels of need, individuals who were white British, female or in mid-life (especially 35-54 years) were more likely to receive treatment (McManus et al, 2014). Further, Autism was the only condition where people with the condition

were no more likely to use treatment than the rest of the population; suggesting provision below their need.

1.2.3.1. Local equity analysis

There has been a previous equity analysis of the Nottingham City IAPT services conducted on 2013/14 data. This study was funded by Nottingham City CCG and conducted by researchers at The University of Nottingham. The report used quantitative data from the minimum dataset to consider whether the proportions of people accessing IAPT services locally were representative of those groups of people in the wider population. Qualitative data from semi-structured interviews with a range of service staff, patients and clinicians was also collected.

This study found that compared to the census population, women, working age adults and white British population were overrepresented amongst IAPT service users. The qualitative work provided several themes including patient identifying with IAPT as a service that may support them; patients' difficulties in conceptualising their issues as an illness; and service issues relating to referral options, assessments and the choice of therapist.

The report made a number of recommendations. These were:

- I. Consider use of social marketing campaigns aimed at target groups – workplace based messaging perhaps with softer ambient media approaches, to educate the public about IAPT and its benefits, how to access, who can access, etc.
- II. Work with large local business, HR and health and wellbeing departments. This could involve further research to fully understand key locations and innovations in method of delivery.
- III. Consider commissioning and designing training packages for public-facing public sector staff to engage on the subject of common mental health disorders
- IV. Consider therapists based in locations to reach those not in employment but do not link the therapy with a specified intended goal of returning to work. Therapy is for better wellbeing which may or may not lead to returning to work.
- V. Consider re-integrating 3rd sector organisations in commissioning strategies and as 'pathway sign-posters' – 3rd sector organisation staff interviewed were highly motivated and have close links with specific low access to IAPT populations. Working with 3rd Sector organisations would allow the development of a better understanding of needs of different groups and the embedding in 3rd Sector (e.g. having NHS therapists in places such as Bac-In).

- VI. Consider up-skilling of 3rd Sector counselling provision (e.g. could up-skill 10-15 3rd sector counsellors by providing CfD training for £30,000 which would be less than the cost of one counsellor in NHS – and qualifies these counsellors to be providing a NICE approved therapy. This also makes those counsellors more employable in NHS in future if needed.
- VII. Consider working with religious leaders in ethnic areas as the gateway to harder-to-reach groups
- VIII. Consider awareness raising and training of key NHS staff in religious sensitivities as part of therapist/PWP/IAPT training
- IX. Target the recruitment of counsellors that are multilingual and/or more representative of diverse groups looking to access services
- X. Consider knowledge transfer between CCG, GPs and service
- XI. Consider research examining the impact of communications between GPs, CAS, service providers and patients and the impacts this has on treatment take up, decision-making and therapy choice.
- XII. Re-consider the use of telephone assessment as a standard approach. Or if this is not financially viable then all prospective service users must receive a full and standardised pack informing them of the process, what to expect and copies of the questionnaires and measures prior to the telephone assessment call.
- XIII. PWP staff, if delivering initial assessments, must be helped to be more empathetic.
- XIV. Payment by Results (PbR) is an area that needs greater levels of research on the impacts on services providers and, therefore, service users.

This equity audit will not look to replicate any previous work and it is not felt that sufficient time will have passed to see the impact of any actions to implement recommendations.

2. Aim and Objectives

Aim: To review access to IAPT services in Nottingham City and explore whether provision and access are appropriate for the areas/populations of need.

Key objectives

The objectives of the HEA are to:

- Review equity of access to IAPT and equity of outcomes by service provider.
- Where possible consider substance misuse, in addition to the nine protected groups, as a characteristic for the equity of service provision.
- Gain an insight into the adaptations and processes in place by commissioned providers to ensure equity of access and outcomes.
- Undertake a literature review to identify effective interventions that increase access to or outcomes from talking therapies.

3. Methodology

3.1. Health Equity Audit

Health equity audits identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas, and the priority action to provide services relative to need. The overall aim is not to distribute resources equally but, rather, relative to health need. This process assists the planning and decision-making processes of organisations. It determines whether healthy inequalities exist and identifies areas where remedy and/or monitoring are required.

The Equality Act 2010 (HM Gov, 2010), informed by consultation with stakeholders from all sectors of the community and a major review of evidence on inequality, replaced the three existing public sector equality duties – pertaining to disability, race and gender – with a new Equality Duty. It covers nine protected characteristics, and there is a public sector duty to advance equality and reduce inequality for people with these protected characteristics, which are *age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation*.

The health equity process (Figure 4) includes 6 stages as outlined below. This report focuses on providing an equity profile (Highlighted in yellow) but will make recommendations on suggested local actions (Step 3).

Figure 4: Health equity cycle



3.2. Data collection

3.2.1. Quantitative

IAPT service providers are required to collect a minimum data set for all individuals that access the service. This dataset includes demographic, referral, appointment, treatment and outcome variables. Data from providers is collated by Nottingham City CCG.

Data was extracted by Nottingham City CCG for all individuals who had been in contact with one of the three IAPT service providers operational between 1 April 2015 and 31 March 2016 (Trent PTS; Insight; Let's Talk Wellbeing). A pseudonymised dataset was shared with Public Health at Nottingham City Council. Data for analysis was subsequently restricted to those being referred to IAPT services between the dates identified.

3.2.2. Qualitative

Qualitative research is the "Development of concepts which help us to understand social phenomena in natural (rather than experimental) settings, giving due emphasis to the meanings, experiences and views of the participants" (Pope & Mays, 1995). As previous qualitative work had focused on service users, this HEA focused on providers themselves and how they adapt services to different audiences.

Semi-structured interviews were conducted with representatives of each of the four providers commissioned to deliver IAPT services during 2016/17. This included the three providers on which quantitative analysis had been conducted as well as one additional provider, Turning Point. Interviews were conducted by one member of the public health team and prior to the results of quantitative analysis were known.

The semi-structured interviews focused on a number of case studies and lasted for around one hour each. Case studies were chosen based on the identified scope and priorities of the CCG. Thus, in addition to traditional equity categories such as ethnicity/culture and disability (Hearing), case studies centred around pregnancy and substance misuse (alcohol or drugs) were included. The case studies and prompt questions used can be found in *Appendix A*.

Interviews were recorded and key points and themes extracted from recordings of the interview. Provider responses have been kept anonymous or, where identifiable information is included, permission was sought before making the report public.

3.3. Measures of equity

Data from Public Health England, NHS England, Benefit claims, and the Adult Psychiatric Morbidity Survey will be triangulated to provide a picture of mental health need across Nottingham City CCG. However, as Common Mental Health Disorders may be transient in nature and may not require treatment, it is challenging to accurately depict need for services.

In addition, equity of outcome shall be considered by comparing the reliable recovery rates of different demographic sub-populations. Equity of provision and outcomes shall be considered as a whole and through comparison of the individual providers to identify examples of good practice and areas for improvement.

3.4. Definition of recovery

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. 'Caseness' is defined as having a score of 8 or more on the GAD7² scale, or 10 or more on the PHQ9³ scale. Thus recovery is defined as the movement of service users by their last appointment to a score of 7 or less on the GAD7 scale AND 9 or less on the PHQ9 scale.

i.e. Recovery rates are:

$$\frac{\text{Number of referrals that moved to recovery}}{\left(\begin{array}{l} \text{Number of referrals that} \\ \text{finished a course} \\ \text{of treatment} \end{array} - \begin{array}{l} \text{Number of referrals that} \\ \text{finished a course of} \\ \text{treatment and started} \\ \text{treatment not at caseness} \end{array} \right)} \times 100$$

However, this metric, despite being adopted by all IAPT providers and commissioners in England, also includes those who only just meet the criteria for caseness and show a small improvement in score and excludes those who see large improvements but do not cross the clinical threshold of

² The Generalised Anxiety Disorder Assessment (GAD7) is a self-reported questionnaire used for the screening for, and measurement of severity of, generalised anxiety disorder.

³ The Patient Health Questionnaire (PHQ9) is a self-reported questionnaire that is used to assess the severity of depression

'caseness'. Two complimentary measures have been developed to provide a better understanding of the benefit the service can provide:

- *Reliable improvement*: individuals whose improvement in scores exceeds the measurement errors of the questionnaires (an improvement of 6 or more on PHQ9 questionnaire and an improvement of 4 or more on GAD7 questionnaire).
- *Reliable recovery*: individuals whose improvement in scores exceeds the measurement errors of the questionnaires as above, and where the post-treatment score is below the clinical cut-off for the PHQ9 and GAD7 questionnaires.

As recovery is confounded by measurement error and may not reflect true improvement in all those categories as recovered, reliable recovery is considered as the primary outcome.

4. Results

4.1. Prevalence of common mental health

4.1.1. Public Health England - Mental Health key indicators

Public Health England (PHE) estimate that the prevalence of common mental health disorders in the 16 to 74 year old population of Nottingham City is 17.2% (PHE 2017). This is the highest prevalence in the North Midlands NHS region and is above the England average (15.6%). The prevalence of Common Mental Health Disorders in Nottingham City is below the average of its ten most similar (demographically) CCGs⁴ (*Figure 5 and Figure 6*).

The prevalence presented above by PHE is based on rates produced by the North East Public Health Observatory (NEPHO) in 2010. The model adjusted for differing needs between areas by adjusting for factors that are known to be key in determining the prevalence of common mental health problems. The data based on this and presented in the PHE Fingertips tool is for 16-74 years of age but does not consider age-related rates or the latest data on population age structure.

Using the Nottingham City PCT rates of Common Mental Health Disorders by age and sex from NEPHO for 16-74 year olds and the number of GP registrations as of October 2015, estimated CMD need has been calculated for Nottingham City (*Table 1*) by age and gender. As locally adjusted CMD rates for those aged 74 years and above is not available, UK average rates taken from the 2014 Adult Psychiatric Morbidity Survey were used. Estimates at a GP practice level have also been made but should be used with caution. GP level estimates are based on CCG rates and so only account for differences in population structure by age and sex and do not consider socio-economic or ethnic differences between practices (*Appendix B*).

⁴ Leeds West; Southampton; South Manchester; Central Manchester; South Reading; Portsmouth; Liverpool; Bristol; Sheffield; Coventry.

Table 1: Estimated prevalence of Common Mental Health Disorders in Nottingham City by age and gender

Age (Years)	Men			Women			TOTAL	
	Rate of CMD (per 1000)	CCG registered population	Estimated Need (actual numbers)	Rate of CMD (per 1000)	CCG registered population	Estimated Need (actual numbers)	CCG registered population	Estimated Need (actual numbers)
16-19	86.5	10740	929	240.5	11,202	2,694	23,911	3,972
20-24	98.6	24,539	2,419	255.2	25,061	6,395	49,600	8,813
25-29	150.9	20,111	3,034	266.2	15,168	4,038	35,279	7,071
30-34	130.7	16,203	2,117	256.7	13,243	3,399	29,446	5,517
35-39	156.2	13,494	2,108	241.6	10,577	2,555	24,071	4,663
40-44	164.4	11,809	1,941	289.9	9,932	2,879	21,741	4,820
45-49	206.6	11,301	2,334	237.5	9,990	2,373	21,291	4,707
50-54	151.9	10,447	1,587	311.9	9,666	3,014	20,113	4,601
55-59	136.3	8,462	1,153	225.3	8,020	1,807	16,482	2,960
60-64	148.2	6,855	1,016	188.9	6,624	1,251	13,479	2,267
65-69	51.1	6,242	319	185.9	6,048	1,124	12,290	1,443
70-74	66.8	4,266	285	148.6	4,695	698	8,961	983
75-79	56.0*	3,360	188	110.0*	4,132	455	7,492	643
80-84	56.0*	2,487	139	110.0*	3,390	373	5,877	512
85+	56.0*	1,925	108	110.0*	3,740	411	5,665	519
TOTAL	-	152,241	19,678	-	141,488	33,465	293,729	53,143

*No local estimated rates available therefore UK rates for these age-groups are based on APMS data

Figure 5: Mental Health Conditions and performance of IAPT services in Nottingham City CCG versus its 10 most similar CCGs.

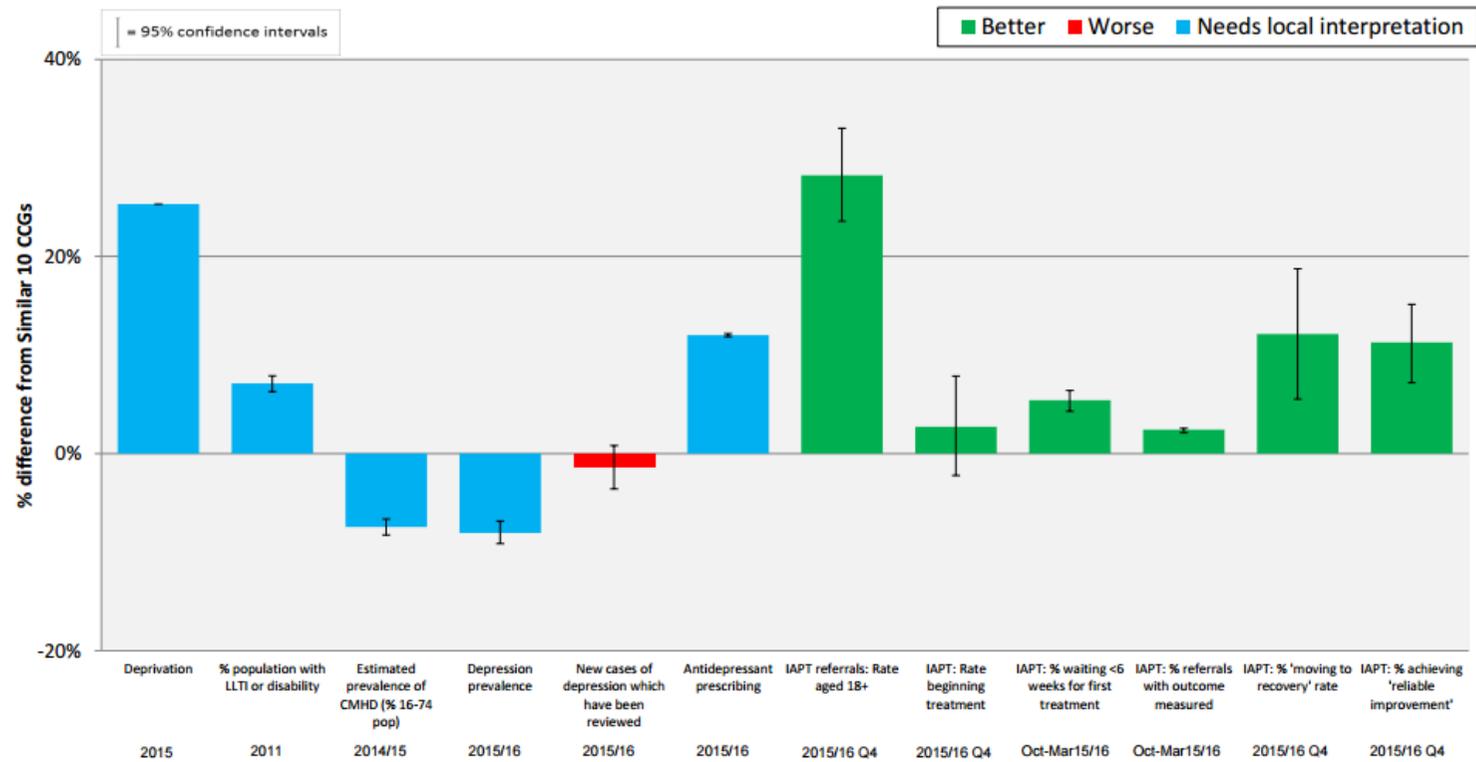
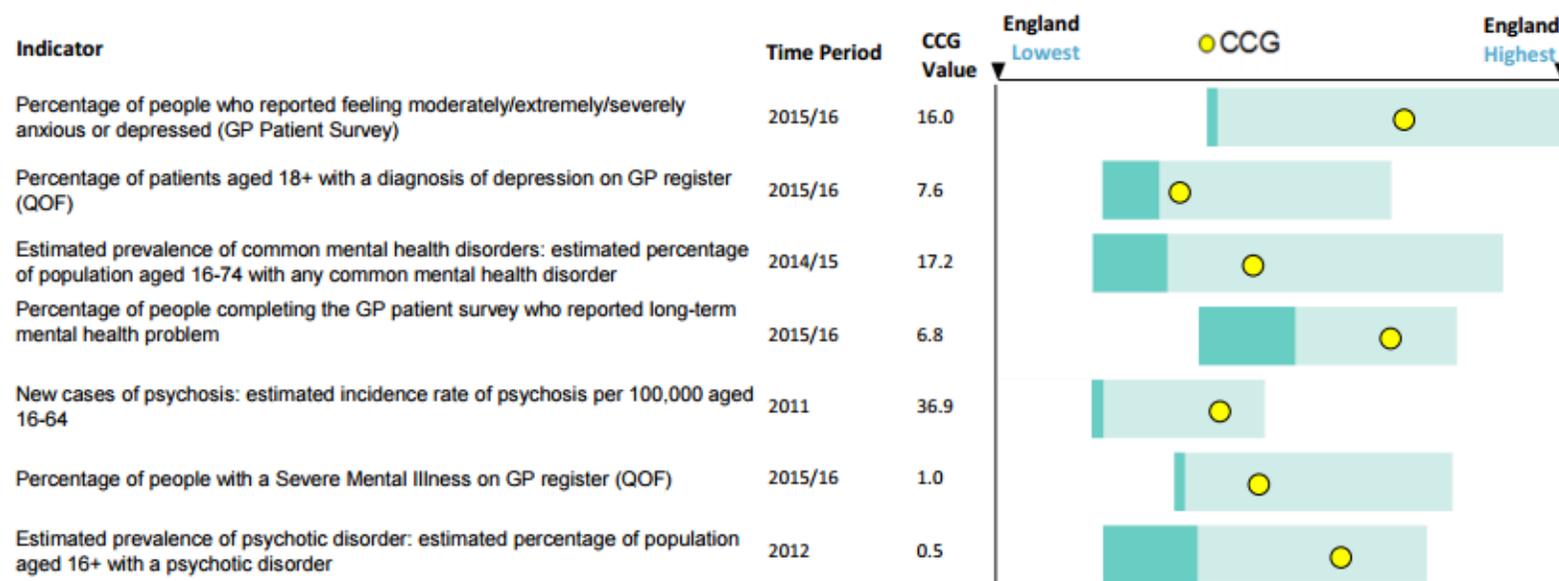


Figure 6: Key indicators for the estimated and reported prevalence of mental health disorders and severe mental illness in Nottingham City CCG in comparison to 10 similar CCGs (Blue range)



These indicators show the estimated and reported prevalence of common mental health disorders and severe mental illness in the CCG population. Low reported prevalence in primary care (through QOF) may reflect true prevalence rates, or it may indicate that some cases in the population are not being picked up. Prevalence rates should therefore be considered alongside estimates for those in the community who may be at risk, or prone to developing mental ill health

4.1.2. NHS England data

Recent analysis by NHS England on resource allocation for mental health aims to quantify the relative service need for each patient with a mental health illness. This weighting highlights the fact that two areas with a similar number of people with mental health illness can have very different needs in terms of services and the intensity of support required. It includes serious mental illness alongside common mental health disorders but is useful in showing that prevalence figures remain only part of the picture when considering need.

Across Nottingham, those with mental health illness are believed to require 24% more service (cost) than across the UK as a whole. However, this varies across the City. While in some areas the need of individuals with mental health issues is four times that of the UK average, in others (e.g. Cripps Health Care) it is 70% lower than the average. This suggests that while there may be need, it may be less 'severe' and require less service input (Table 2).

Table 2: Five highest and lowest GP surgeries of relative resource per individual with mental health illness.

	GP surgery	Need index^a
Highest 5 GP surgeries	St. Luke'S Surgery	3.71
	The Wellspring Surgery	3.04
	The Windmill Practice	2.41
	Family Medical Centre (Sood)	2.19
	Victoria And Mapperley Practice	2.11
Lowest 5 GP surgeries	Deer Park Family Medical Practice	0.78
	Radford Medical Practice (Kaur)	0.71
	Bilborough Medical Centre	0.67
	Wollaton Vale Hc (Ghaharian)	0.66
	Cripps Health Centre	0.32

^a Need index: Ratio of the MH service need per person with MH illness in the population versus average MH service need per person with MH illness in the UK.

4.1.3. Employment Support Allowance

In Nottingham City, the number of people claiming Employment and Support Allowance (ESA) for mental health problems can be broken down by age and gender (Table 3). This shows a greater number of men than women claiming financial support as a result of mental health problems. As expected, those in the 25 to 44 age range are greatest in number.

Table 3: Number of people in Nottingham City claiming ESA due to mental health in 2016 by age and gender.

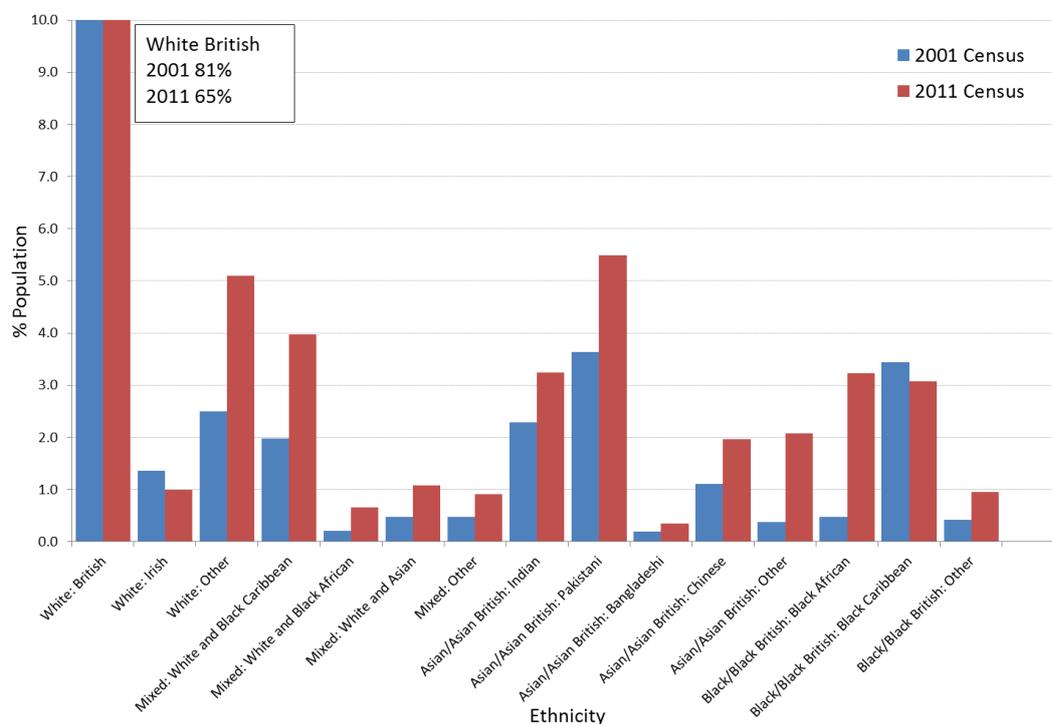
AGE	MALE	FEMALE	TOTAL
Under 18 years	10	*	10
18-24 years	480	340	820
25-34 years	1110	790	1900
35-44 years	1240	830	2070
45-49 years	700	560	1260
50-54 years	680	590	1270
55-59 years	530	490	1020
60 years and over	360	290	650
TOTAL	5090	3900	9000

4.1.4. Ethnicity

The large majority of Nottingham City Citizens are White British. In some of the outer estates, in 2011, 80% or more of the population were White British; in Clifton South the figure was 89%. The 2011 Census reported that 34.6% of the City's population are from Black and Minority Ethnic (BME) groups, which are defined as everyone who is not White British. This is an increase from 19.0% in 2001.

Between 2001 and 2011, the biggest changes in the ethnic 'make-up' of the city included an increase in the 'Other White' (2.5% to 5.1%), Mixed - White and Black Caribbean (2% to 4%), Black African (0.5% to 3.2%), and Pakistani (3.6% to 5.5%) populations. The largest groups other than White British are now Pakistani (5.5%) and Other White (5.1%) – which will include large numbers of people from Poland.

Figure 7: Change in proportion of the population from different ethnic groups between 2001 and 2011.



Mental wellbeing in adults is measured in Nottingham in the annual citizens' survey using the WEMWBS. It is not known how well it reflects the mental wellbeing of citizens who do not take part in the survey, but the measure itself is a good indicator for those who take part.

There are variations at local level echoing those at national level which would suggest inequalities in wellbeing amongst certain groups such as unemployed people, those with a disability or long term condition, people living in social rented housing who all tend to have lower mental wellbeing scores.

People who identify themselves as belonging to an ethnic minority group report less, poor mental health than those from mixed/multiple ethnic groups or white background which contradicts national ONS (2013) findings to suggest that people from black and minority ethnic (BME) backgrounds had lower levels of wellbeing than their non-BME counterparts (Table 4).

Despite the use of a validated questionnaire, this data may be influenced by cultural attitudes towards mental health. It is possible the 'hidden burden' for mental health is proportionally greater for ethnic minority groups than those who are White British.

National data also supports the finding that African-Caribbean people living in the UK have lower rates of common mental disorders than other ethnic groups. The statistics on the numbers of Asian people in the United Kingdom with mental health problems are inconsistent, although it has been suggested that mental health problems are often unrecognised or not diagnosed in this ethnic group.

In a 2013 survey of BME individuals who had been diagnosed with Mental Health Issues found major differences across ethnic groups with, for example, rates of depression were higher amongst Indians (61%) followed by Pakistanis/Bangladeshis (55%) than Caribbeans (44%) and Africans (43%) with similar patterns for anxiety⁵.

Table 4: Percentage of people with poor mental health as assessed by WEMWS in the pooled 2011 - 2015 Citizens' Survey by ethnicity.

Row Labels	Poor Mental Health (%)
White	13.9
Mixed / Multiple ethnic groups	17.4
Asian / Asian British	9.2
Black / African / Caribbean / Black British	7.8
Other ethnic group	8.5
Unknown	13.6
All	12.9

Data from the Adult Psychiatric Morbidity Survey 2014 shows that, among people with low mental wellbeing (lowest 15% in the population distribution as recorded by WEMWS) more than one in two met the criteria for at least one CMD (57.3%), compared with one in a hundred (1.1%) among people in the highest 15% of the wellbeing distribution. The proportion of people with poor mental health (lowest 12% of Nottingham City population) may therefore represent a useful proxy for the need for IAPT services.

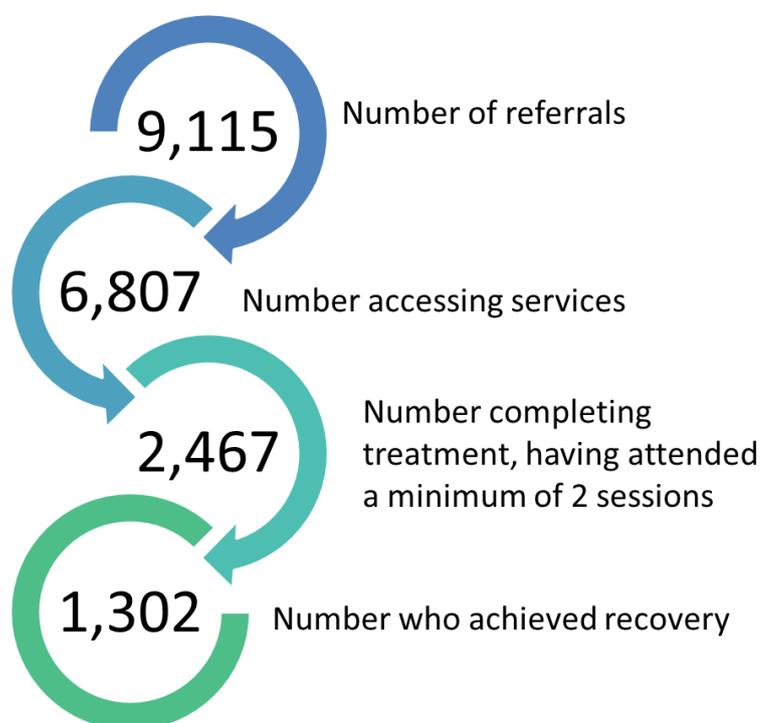
4.2. IAPT service users

During the period of April 1st 2015 and March 31st 2016, 9,115 individuals registered with a GP practice in Nottingham City were referred to IAPT services. Figure 8 shows the flow of individuals through the service.

⁵ http://www.time-to-change.org.uk/sites/default/files/TTC_Final%20Report_ETHNOS_summary_0.pdf

At each stage in the pathway, a proportion of service users drop out. There were 2308 individuals referred to IAPT services who did not receive a formal assessment (25%) and, of those that did, 4340 did not complete treatment (64% of those receiving an initial assessment). The criteria for recovery was not met by 1165 of those who completed treatment (47%) and the reliable recovery definition was achieved by 1,260 of those recovering (97%). Reasons for non-attendance or non-completion have not been received as part of this HEA.

Figure 8: Patient flow through IAPT services in Nottingham City CCG



4.3. Equity of access

In total, 9,115 referrals were received meeting 17.1% of the estimated CMD need. The minimum dataset included data on 6,791 individuals who were referred to and assessed by IAPT services in 2015/16 in comparison to an estimated need within the city of 53,143 adults (12.8%).

Of the IAPT providers, Lets Talk Wellbeing received the greatest proportion of all referrals (55.9%). Referrals to all providers declined in the opening months of 2016 having peaked in October 2015 (Figure 9).

In Nottingham City, 23.7% of females are estimated to have CMD compared to 12.9% of males. Gender was recorded for 99.9% of IAPT service users (n = 6782). More women than men access IAPT services in Nottingham; however, IAPT services reach 12.8% of the estimated need in men and 12.6% of the estimated need in women (Figure 10). There is no significant variation in access between the commissioned providers.

Figure 9: IAPT referrals by month of year 2015/16 for each commissioned provider

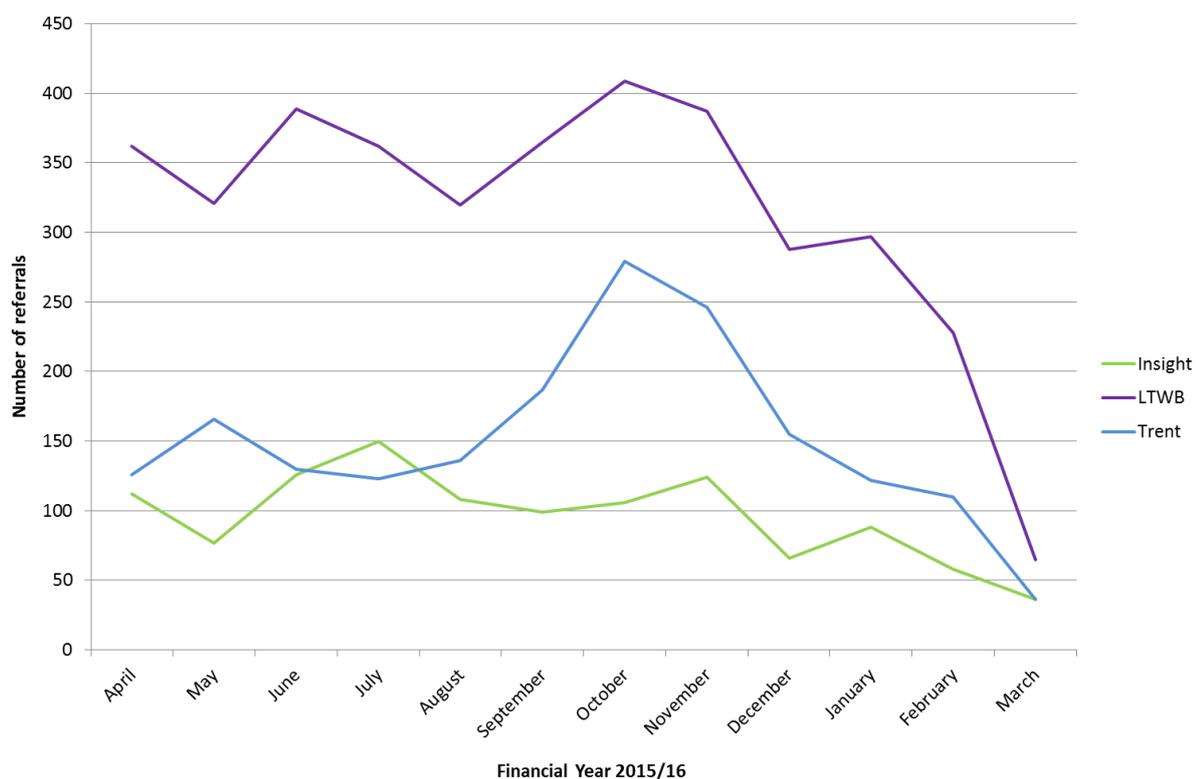
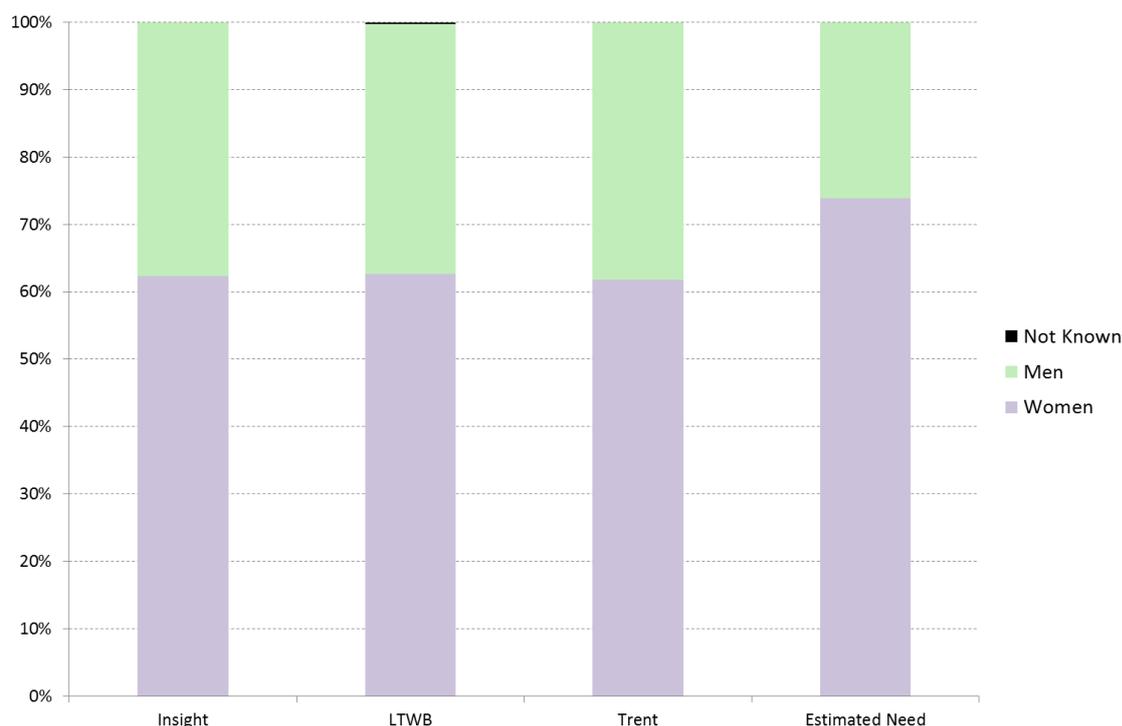


Figure 10: Access to IAPT services by gender for commissioned services and estimated need.



The prevalence of common mental health disorders by age differs for males and females. In men, rates of CMD are greatest between the ages of 25 to 54 years whilst in women rates remain high between 16 and 54 years of age.

Age was recorded for all IAPT service users. The majority of women being referred to the service were aged between 16-34 years of age. For men the majority were aged between 16 and 39 years of age (*Table 5*). There are no significant differences in the age distribution of service users between providers.

IAPT referrals account for between 2.8% (Men 80+ years) and 19% (Men 20-24 years) of the estimated need. For both men and women the proportion of need met by IAPT services declines with age (*Figure 11*).

4.3.2. Deprivation

All providers receive the largest proportion of their referrals from the most deprived areas. However, in comparison to the two other providers, LTWB receive a greater proportion of referrals for people in the two most deprived deciles (*Figure 12*). The distribution of IAPT locations is shown

alongside referral rate (*Map 1A*) and Deprivation (*Map 1B*). While these locations are specified, it will be discussed later how additional flexibility exists in the interaction between client and provider.

Table 5: Number and proportion of women and men referred to IAPT services in Nottingham City by age bands.

	Women								Men							
	Insight		LTWB		Trent		Est. Need		Insight		LTWB		Trent		Est. Need	
	n	%	n	%	N	%	n	%	n	%	n	%	n	%	n	%
16-19	69	9.6	158	6.6	99	8.8	2,694	8.1	27	6.2	77	5.5	32	4.6	929	4.7
20-24	167	23.3	477	20.1	290	25.9	6,395	19.1	75	17.3	244	17.4	141	20.3	2,419	12.3
24-29	96	13.4	365	15.3	167	14.9	4,038	12.1	62	14.3	202	14.4	130	18.7	3,034	15.4
30-34	90	12.6	340	14.3	111	9.9	3,399	10.2	57	13.2	185	13.2	72	10.4	2,117	10.8
35-39	72	10.0	211	8.9	75	6.7	2,555	7.6	53	12.2	158	11.2	64	9.2	2,108	10.7
40-44	62	8.6	191	8.0	89	7.9	2,879	8.6	47	10.9	153	10.9	69	9.9	1,941	9.9
45-49	56	7.8	202	8.5	104	9.3	2,373	7.1	34	7.9	130	9.2	64	9.2	2,334	11.9
50-54	41	5.7	151	6.3	77	6.9	3,014	9.0	29	6.7	103	7.3	56	8.1	1,587	8.1
55-59	27	3.8	120	5.0	51	4.5	1,807	5.4	19	4.4	77	5.5	31	4.5	1,153	5.9
60-64	14	2.0	71	3.0	24	2.1	1,251	3.7	16	3.7	39	2.8	20	2.9	1,016	5.2
65-69	8	1.1	32	1.3	22	2.0	1,124	3.4	4	0.9	20	1.4	3	0.4	319	1.6
70-74	9	1.3	21	0.9	4	0.4	698	2.1	6	1.4	8	0.6	8	1.2	285	1.4
75-79	1	0.1	21	0.9	4	0.4	455	1.4	3	0.7	7	0.5	2	0.3	188	1.0
80-84	4	0.6	13	0.5	4	0.4	373	1.1	1	0.2	3	0.2	3	0.4	139	0.7
85+	1	0.1	5	0.2	0	0	411	1.2	0	0	0	0	0	0	108	0.5
TOTAL	717	100	2378	100	1121	100	33,466	100	433	100	1406	100	695	100	19677	100

Figure 11: Proportion of estimated need met by IAPT services for age bands in men and women

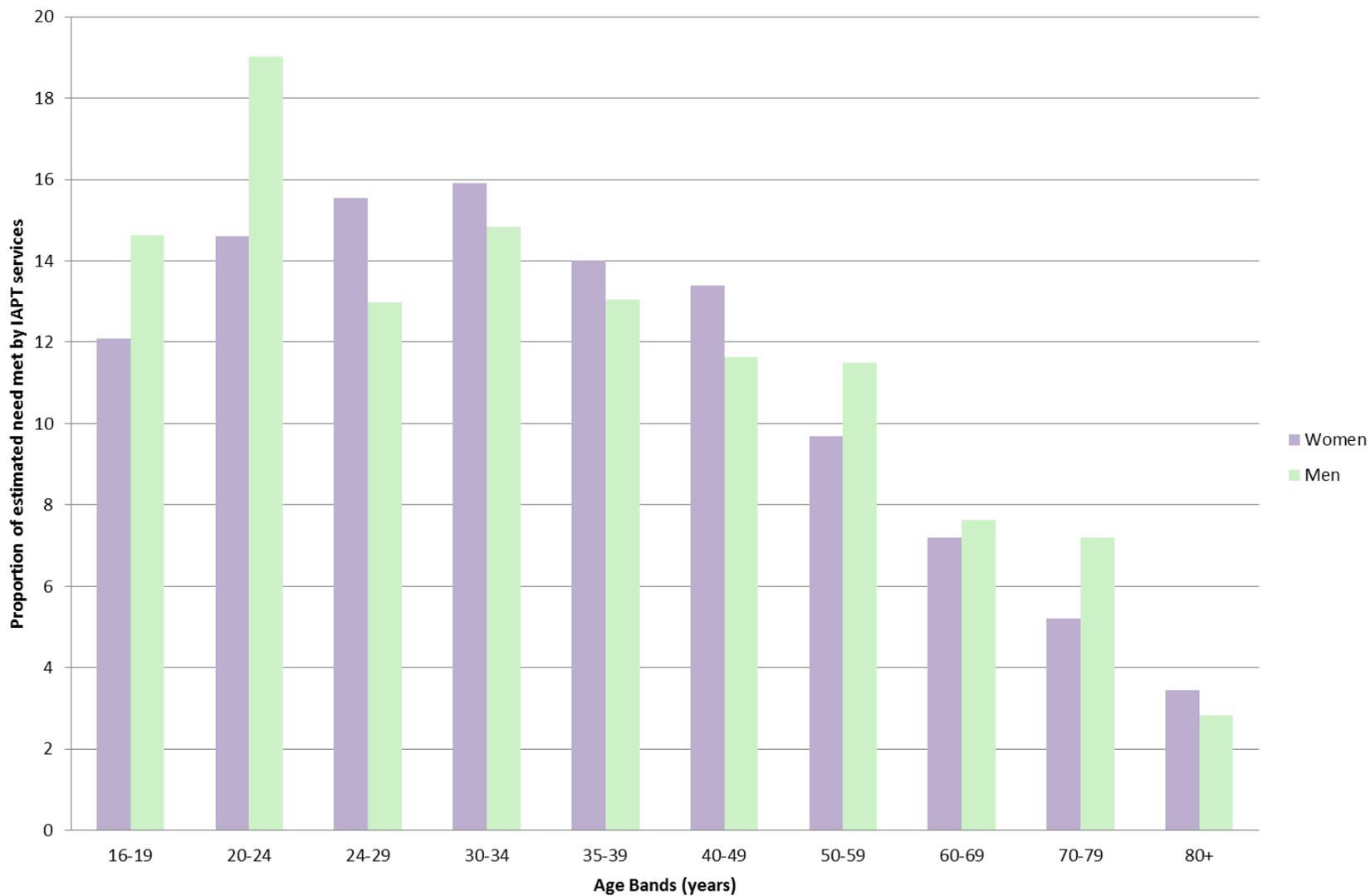
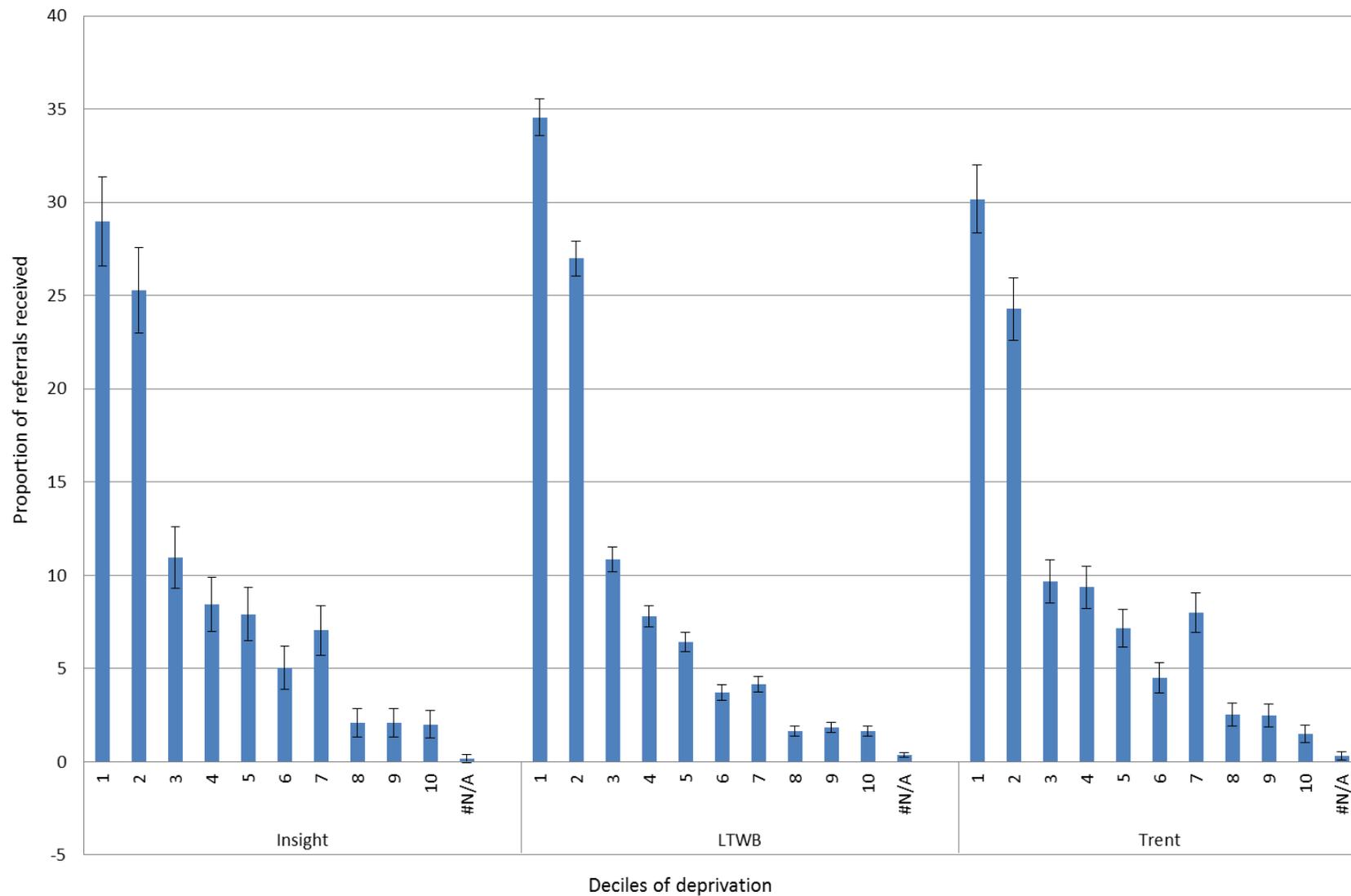
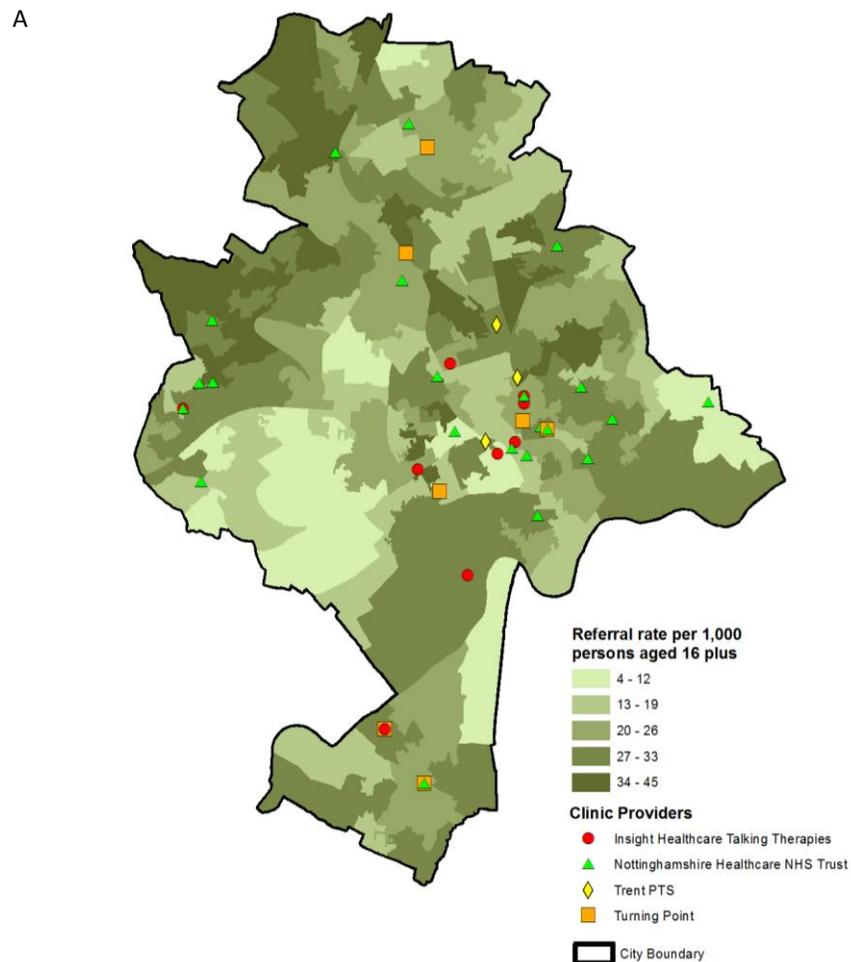


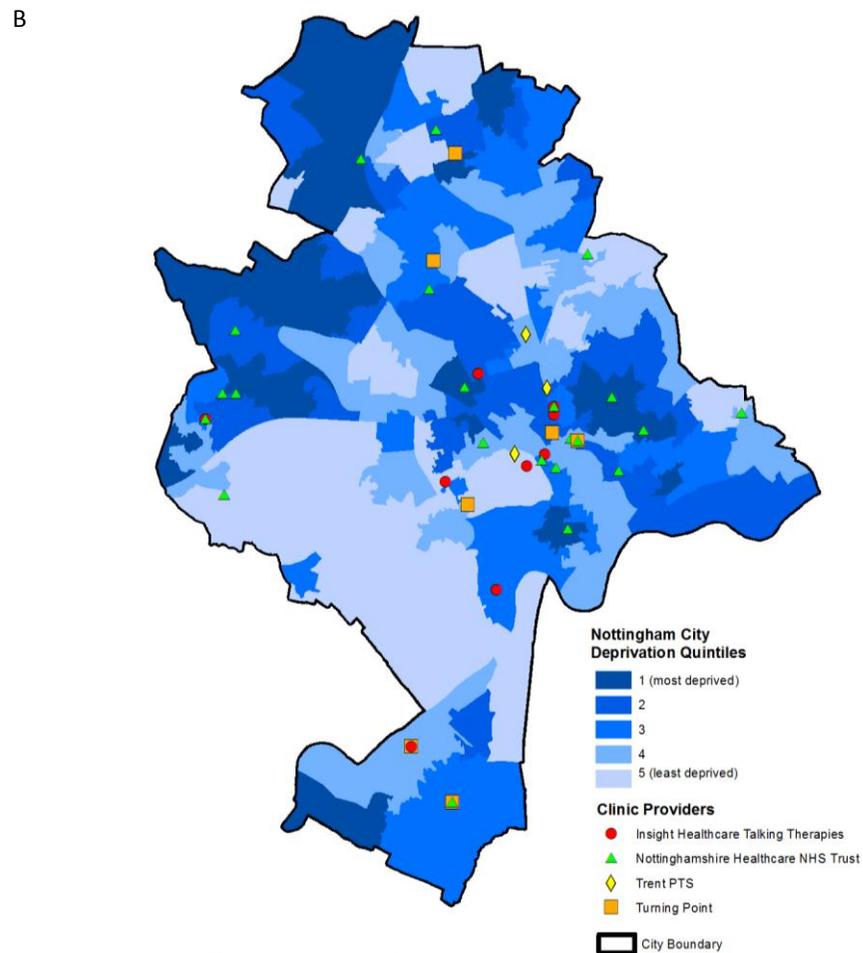
Figure 12: Proportion of referrals by national deciles of deprivation (1 = Most deprived)



Map: Location of IAPT centres in Nottingham City mapped alongside referral rate (A) and deprivation (B)



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4.3.3. GP Practices

A percentage of IAPT coverage by GP practice was calculated using the number of referrals made by GP practices and estimated CMD prevalence based on age and sex distribution. There is considerable variation in the equity of access scores between GP practices across Nottingham City ranging from 6.3% at Bakersfield Medical Practice to 28% in RHR Medical Centre (Table 6).

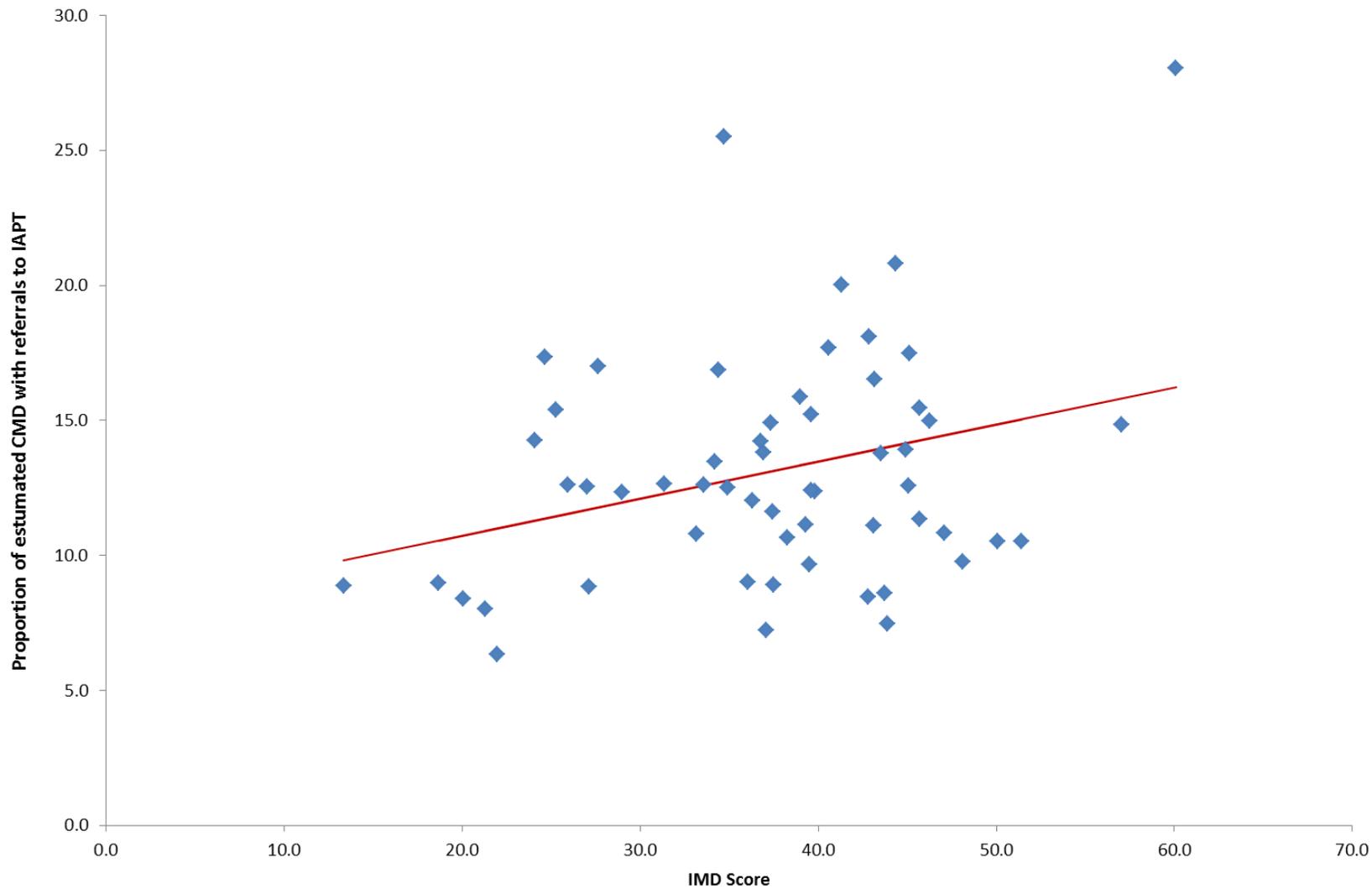
There is a statistically significant association between the percentage coverage of referrals and Index of Multiple Deprivation Score, by GP surgery exists in the data collected ($p < 0.05$). However, this relationship is not strong with only a 0.13% increase in coverage for every IMD unit increase in deprivation (Figure 13). However, despite deprivation being a key factor in determining need it is not possible to adjust for it in our estimates. Therefore, need may be underestimated in the most deprived areas and over-estimated in the least deprived areas. It is important to take this into consideration when interpreting the relationship observed.

Table 6: Top 10 and bottom 10 GP surgeries by the proportion of estimated need met by referrals

	Referrals	Est CMD cases ¹	Proportion of need met (%)
TOP 10			
RHR Medical Centre	110	392	28.05
Radford Health Centre (N Phillips)	131	514	25.51
Greenfields Medical Centre (Sharma Op)	66	317	20.82
Beechdale Surgery	110	549	20.02
Grange Farm Medical Centre	79	437	18.09
The Windmill Practice	207	1171	17.68
Parkside Medical Centre	170	972	17.49
Elmswood Surgery	238	1372	17.35
Victoria And Mapperley Practice	208	1224	16.99
Nems Platform One Practice	263	1559	16.86
BOTTOM 10			
Bakersfield Medical Centre	46	726	6.34
Queens Bower Surgery	48	664	7.23
Highgreen Practice (Khan)	106	1422	7.45
Wollaton Vale Hc (Ghaharian)	31	386	8.03
Cripps Health Centre	487	5801	8.39
St.Marys Medical Centre	14	166	8.44
Greenfields Medical Centre (Yvs Rao)	32	373	8.58
Lenton Medical Centre	30	339	8.84
Deer Park Family Medical Practice	104	1170	8.89
Radford Medical Practice (Kaur)	233	2620	8.89

¹ Estimated need based on age and sex. This may under-estimate need in the most deprived areas.

Figure 13: Proportion of coverage and deprivations scores by GP surgery (the red line is a visual representation of the association between the two variables i.e. the linear regression line)



4.3.4. Ethnicity

Ethnicity is recorded for 6220 referrals (92.0%). The majority of referrals to each provider are for people of White (British) ethnicity followed by those in Asian/Asian British and Black/African/Caribbean/Black British ethnic groups. There are few differences between providers; however, Insight appear to receive fewer referrals from the White (Other) group than other providers and have a significantly greater proportion of missing/not reported ethnicity data (*Figure 14*).

In comparison to the proportion of ethnic groups seen in the 2011 Census data, only Asian/Asian British are significantly under-represented in the IAPT referral data. However, when considering where need for services lies within the population, data suggests that, the proportion of need met is lowest in Mixed/Multiple ethnic groups and Asian/Asian British groups with the highest proportion of need being met in the Other ethnicity and Black/African/Caribbean/Black British groups.

The estimated values for the level of need have been created using the results of the Citizen's survey and Warwick-Edinburgh Mental Well-being Scale (WEMWBS). In addition, the 2011 census figures for the proportion of the population from different ethnic groups have been applied to the 2015 mid-year population estimate to estimate population size. These two factors mean that the estimate of need provided is likely of low quality and may be an underestimate of the need in some populations. This is reinforced by the overall proportion of need being met (16%) which is higher than that seen using more robust estimates of need earlier in this report (12%).

Figure 14: Proportion of referrals to Nottingham City CCG IAPT providers by ethnicity

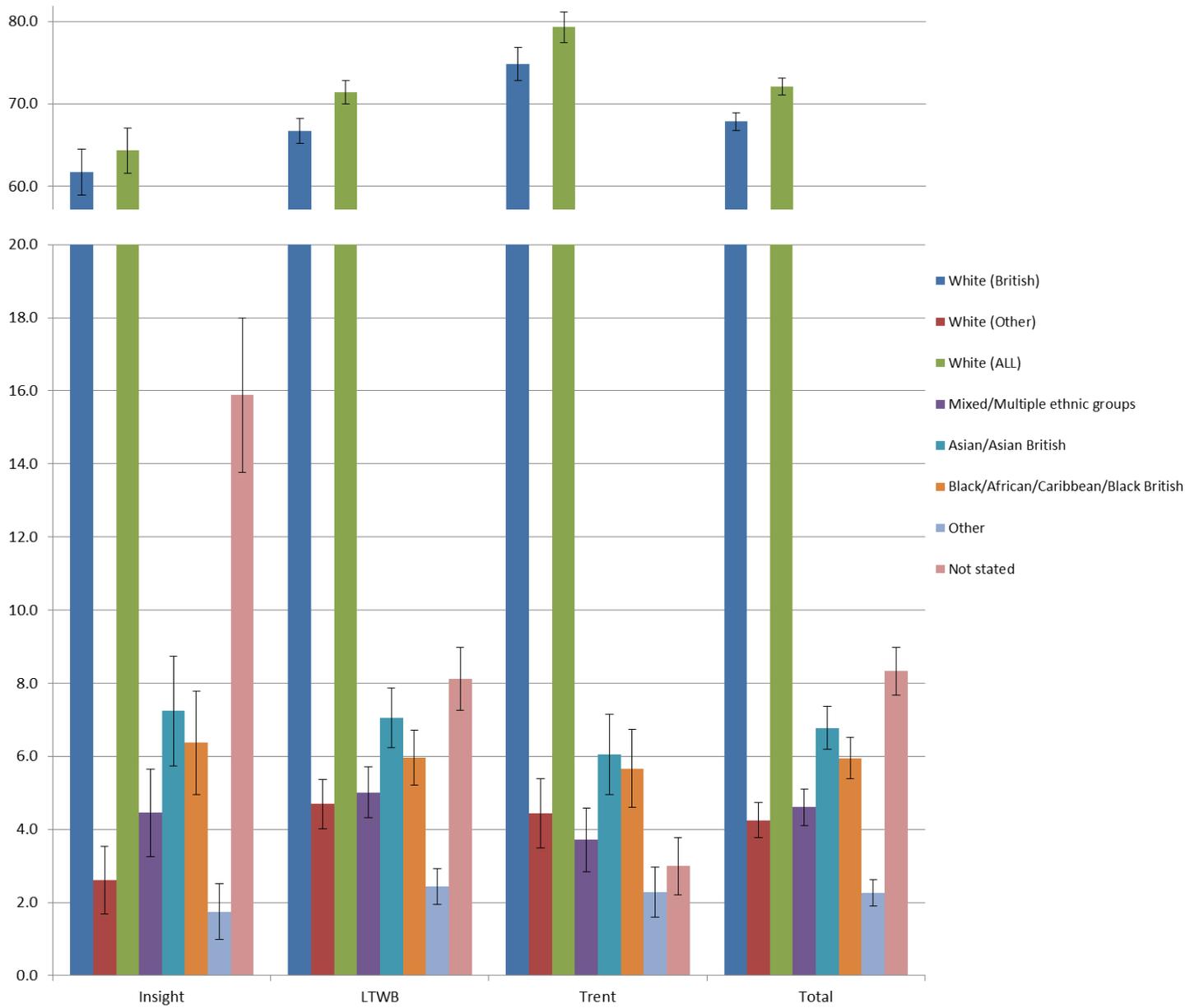


Table 7: Referrals to IAPT Nottingham City CCG providers by Ethnicity

Ethnicity	Insight	LTWB	Trent	Grand Total	Est. 2015 (based on 2011 census)	Est. Need	% of need met
White (British)	707	2,513	1,345	4,565	208,242	N/A	N/A
White (Other)	30	177	80	287	19,453	N/A	N/A
White (all)	737	2,690	1,425	4,852	227,695	31,650	15
Mixed/Multiple ethnic groups	58	214	85	357	21,366	3,718	10
Asian/Asian British	83	266	109	458	41,776	3,843	12
Black/African/Caribbean/Black British	73	225	102	400	23,280	1,816	22
Other	20	92	41	153	4,784	407	38
Not stated	179	306	54	539	N/A	N/A	N/A
Total	1,150	3793	1816	6,759	318,901	41,433	16

*As need is based on a) Wellbeing scores and b) 2011 Census data it may overestimate the level of need being met.

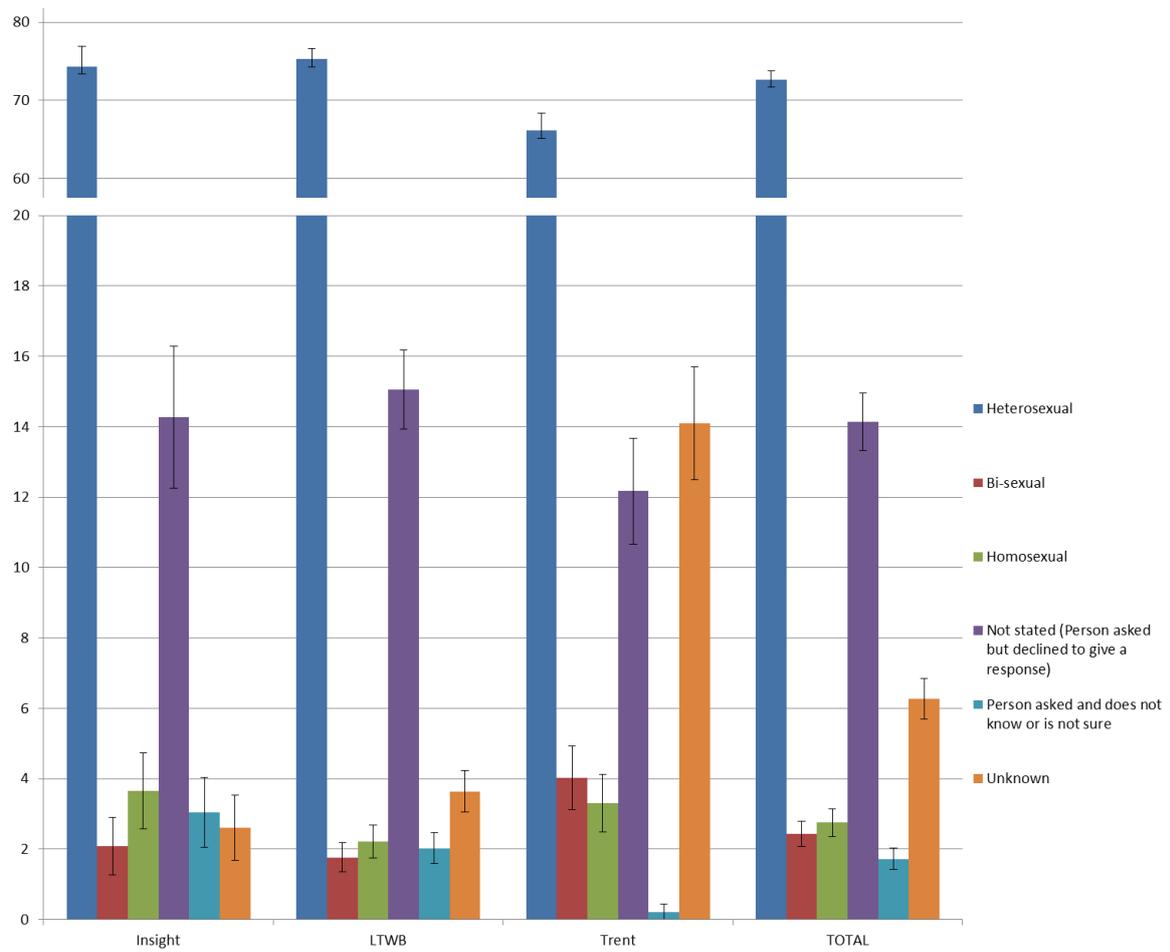
4.3.5. Sexual Orientation

Data on sexual orientation was not well collected by all providers. Overall, sexual orientation was available for 6335 individuals (93.7%). However, one provider reported 14.1% unknown data.

A number of recent epidemiological surveys have reported on mental health in relation to sexual orientation. Studies of mental disorders in relation to sexual orientation mainly show a higher prevalence of anxiety, mood disorders and substance use disorders in homosexual and bisexual people (Fergusson et al, 1999; Cochran et al., 2000; Cochran et al. 2003; Sandfort et al, 2001). However, estimating the level of need within the population is challenging as it is not part of the Adult Psychiatric Morbidity Survey in England and Wales.

The majority of service users were heterosexual (72.7%). A significant number of service users were asked but declined to give a response (14.1%). Few differences were observed between providers but in addition to significantly greater missing data, Trent PTS had a significantly lower proportion of service users who were asked about their sexual orientation but were unsure (Trent PTS 0.22% v 1.72% Overall) (*Figure 15*).

Figure 15: Proportion of referrals to IAPT services in Nottingham City by Sexual Orientation



4.3.6. Disability

The 2011 census found that in Nottingham City, 9.1% of the population reported that their day-to-day activities were limited a lot and a further 9.1% limited a little. This suggests there are a substantial proportion of individuals with long-term illness or disability that impacts their day-to-day lives. It is predicted that 7,788 people in Nottingham City aged 18-64 have a moderate or serious personal care disability. This is based on estimates from the Health survey for England 2001 applied to more up to date population data, and refers to people with some difficulty performing or who require help getting in and out of bed, dressing, washing, feeding, and using of the toilet.

There are an estimated 7,170 (2.2%) people living with some degree of sight loss in Nottingham in 2015. Of this total 4,650 are living with mild sight loss, 1,600 are living with moderate sight loss and 920 are living with severe sight loss. As of 2013/14, there were 1,470 people in Nottingham that were registered as blind or partially sighted (473 per 100,000 people); 44% are registered as blind and 56% as partially sighted. This accounts for less than 0.5% of the population. In 2014/15 a further 88 Certificates of Vision Impairment were issued in Nottingham (28 CVIs per 100,000 people).

As of 31/03/2010 there were 1285 people aged 18+ registered with the local authority as deaf (Source: HM Gov 2010b, now discontinued). These figures do not reflect the likely true total as registration is purely voluntary with no immediate benefit to the individual. In Nottingham, in 2014, according to Pansi (Institute of Public Care, 2015) there were an estimated 5,954 (1.86%) with moderate or severe hearing loss, and 49 with profound hearing loss. Most recently, annual GP Patient survey was completed by 5,633 Nottingham City CCG residents in 2016. Of these, 1% were found to be deaf and using sign language. This sample of individuals may not be representative of the general population within Nottingham City as the sample represents only 31% of those contacted.

GPs are asked annually how many of the adults on their practice list have a learning disability. These numbers are reported for a range of health service areas including Clinical Commissioning Groups. In Nottingham City CCG, 0.49% of people (all ages) were known by GPs to have a learning disability

Despite estimates of population size, it is very difficult to estimate the level and frequency of mental health problems specifically within the deaf/visually impaired/disabled community. However, the data provides an insight into access of mental health services by the disabled population in Nottingham City.

In 2016, 532 (7.87%) of the 6759 referrals were for people with one or more disabilities. In total, 44 (0.7%) were for those with impaired hearing; 11 (0.1%) had impaired vision; and 52 (0.8%) had a

learning disability (including memory or ability to concentrate) (Table 8). This suggests that it is likely that those with impaired vision are under-represented amongst those referred for IAPT services. Only one significant difference between providers was observed with Trent PTS having a significantly greater proportion of its referrals for individuals with Mobility and Gross Motor than Insight or LTWB.

Table 8: Proportion of referrals with disabilities by IAPT provider in Nottingham City CCG

Disability	% of referrals			
	Insight	LTWB	Trent	All
Behaviour and Emotional	0.3	1.8	1.2	1.4
Hearing	0.3	0.7	0.8	0.7
Manual Dexterity	0.2	0.2	0.3	0.2
Memory or ability to concentrate, learn or understand (Learning Disability)	0.5	0.7	1.0	0.8
Mobility and Gross Motor	1.5	1.6	4.0	2.2
Other	2.7	1.7	1.5	1.8
Personal, Self Care and Continence	0.0	0.0	0.1	0.0
Progressive Conditions and Physical Health (eg HIV, Cancer, Multiple Sclerosis, Fits etc)	0.3	0.5	0.8	0.5
Sight	0.0	0.1	0.3	0.2
Speech	0.2	0.0	0.1	0.1
None	94.1	92.6	90.0	92.1
Total	100	100	100	100

4.3.7. Referral source

The majority of referrals in 2015/16 came from self-referral (84.8%); second most frequent was General Medical Practitioners (9.4%) (Table 9). Some differences between providers were observed. LTWB receives a slightly greater proportion of its referrals from General Medical Practitioners and is the only provider to receive referrals from other secondary care specialists. Trent PTS received referrals from a greater number of different types of referrer; unlike the other providers it received referrals from the Education service, Probation service, School nurse and Jobcentre. In addition they received a greater number of referrals from other services/agencies which are un-specified in the minimum dataset.

Table 9: Proportion of referrals by referral source amongst providers of IAPT in Nottingham City CCG

Referral Source	% of referrals			Grand Total
	Insight	LTWB	Trent	
General Medical Practitioner	6.6	11.9	6.1	9.4
Health Visitor	0.0	0.0	0.2	0.0
Other Primary Health Care	0.6	0.0	0.2	0.2
Self	88.3	83.4	85.6	84.8
Carer	0.3	0.1	0.1	0.1
Education Service	0.0	0.0	0.1	0.0
Probation Service	0.0	0.0	0.2	0.1
School Nurse	0.0	0.0	0.2	0.0
Other Independent Sector Mental Health Services	0.0	0.0	1.0	0.3
Other secondary care specialty	0.0	4.5	0.0	2.5
Jobcentre plus**	0.0	0.0	0.9	0.2
Other service or agency	0.3	0.1	5.5	1.5
Not recorded	3.9	0.1	0.0	0.7
TOTAL	1150	3793	1816	6759

4.3.8. Time to treatment

The average days between referral and treatment was 15.1 days (Std 16.2); however, there remains a significant amount of variation between providers (Anova test; $p < 0.001$). The time between referral and treatment is longer for those referred to Trent PTS (23.3±16.6 days) than Insight (11.9±14.3 days) or LTWB (12.3±14.9 days).

On average men are seen 1.1 days sooner than women ($p < 0.01$; 95% CI: 0.30 to 1.89 days sooner). While variation occurs between ethnic groups these differences were not significantly different when compared to White (British) with the exception of those whose ethnicity was not reported who were seen on average 3.4 days later than those of White(British) ethnicity (95% CI: 1.22 to 5.7 days longer). Compared to those without a disability, those with Learning Disability or Mobility and Gross Motor disability had to wait, on average, 8.8 ($p < 0.01$; 95% CI: 1.76 to 15.81) days and 5.87 ($p < 0.001$; 1.71 to 10.02) days longer, respectively. No significant differences in time to treatment were observed by sexual orientation.

4.4. Equity of outcome

To consider equity of outcome, we have selected all those individuals who ‘completed’ treatment i.e. they received 2 or more sessions. In Nottingham CCG in 2015/16, 2467 individuals started and completed treatment (Table 10). Of these 71 had two completed treatment episodes and one, 3 completed treatment episodes.

Overall, 75.1% of those who completed treatment saw reliable improvements in their pre to post measurement scores; this did not differ significantly by provider. Recovery rates in those classified as ‘caseness’ in their assessment were 55.4% overall; however, LTWB had lower rates than that seen across all providers (49.6%). Finally, the proportion of those classified as ‘caseness’ in their assessment who saw both reliable improvement and crossed the caseness threshold was 53.6% across all providers with Trent PTS performing significantly better (59.9%) and LTWB significantly worse (48.3%) than combined rates for all providers.

Table 10: Completed treatment episodes and rates of improvement and recovery across IAPT services in Nottingham City CCG

Provider	Referrals, n	Caseness, n (%)	Reliable improvement, % of referrals (95%CI)	Recovery, % of caseness (95% CI)	Reliable Recovery, % of caseness (95% CI)
Insight	452	433 (96%)	78.3 (74.3-81.9)	54.7 (50.0-59.4)	53.8 (49.1-58.5)
LTWB	1118	1051 (94%)	71.8 (69.1-74.4)	49.6 (46.6-52.6)*	48.3 (45.3-51.4)*
Trent	897	867 (97%)	77.6 (74.7-80.2)	62.7 (59.5-65.9)*	59.9 (56.6-63.1)*
Overall	2467	2351 (95%)	75.1 (73.4-76.8)	55.4 (53.4-57.4)	53.6 (51.6-55.6)

*Significantly different to the overall rate observed across all providers

4.4.1. Gender

Across the Nottingham City CCG IAPT service, there is no significant difference between the reliable improvement (*Figure 16*) or reliable recovery rates (*Figure 17*) of women and men. Trent PTS had a greater recovery rate in men than seen when aggregating data from all providers.

Figure 16: Reliable Improvement rates for men and women attending Nottingham City CCG IAPT services

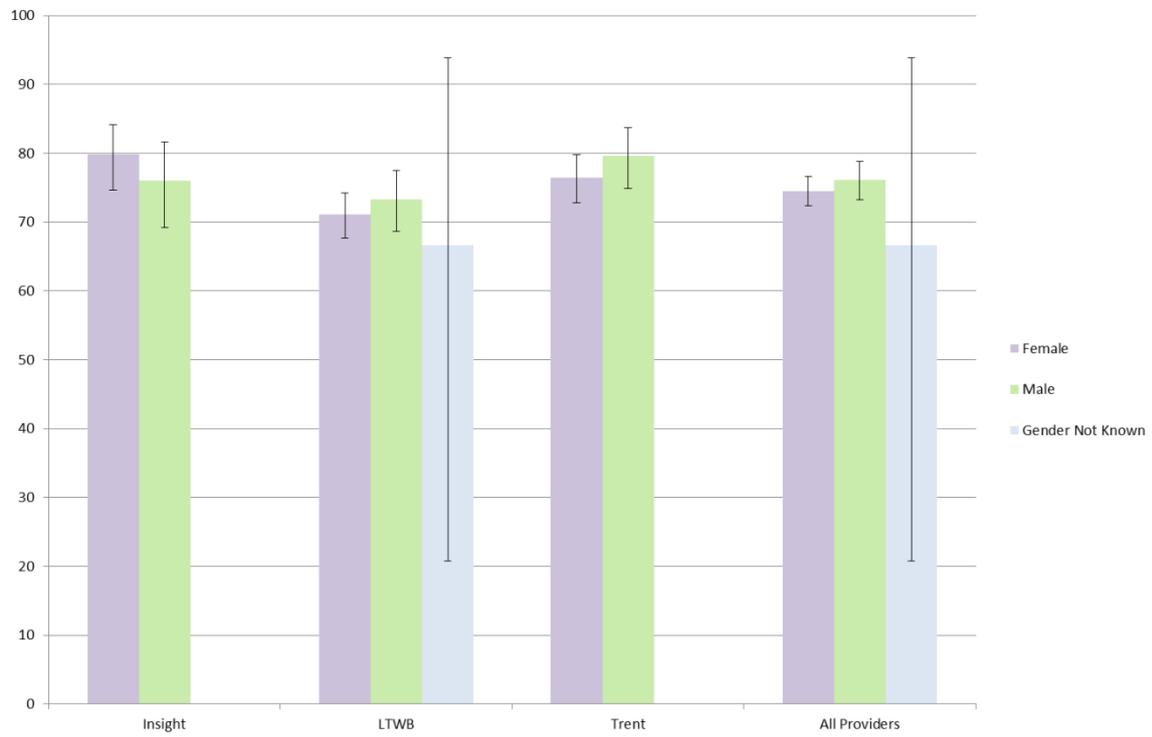
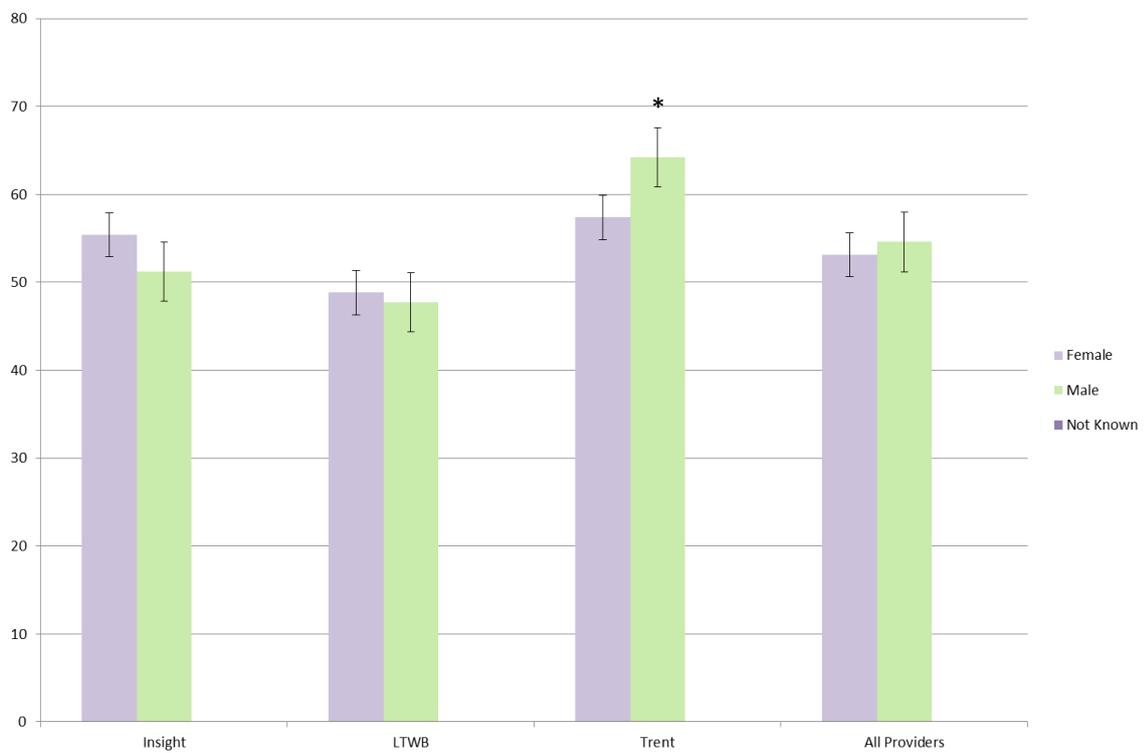


Figure 17: Reliable recovery rates for men and women attending Nottingham City CCG IAPT services



*differs significantly to 'All Providers'

4.4.2. Deprivation

A weak but statistically significant, negative association exists between GP practice reliable improvement rates and GP practice IMD scores (*Figure 18*: $R^2 = 0.12$; $p < 0.01$). There is a moderate and statistically significant, negative association between practices' reliable recovery rates and practices' IMD scores (*Figure 19*: $R^2 = 0.22$; $p < 0.001$); i.e. as deprivation levels increase, reliable recovery rates decrease. However, these associations have not been adjusted for practice size or other demographic variables. There is no significant difference between the rates of reliable improvement or recovery for deprivation deciles by individual providers in comparison to the rates observed when combining the data from all providers..

Figure 18: Reliable improvement rates and deprivation scores by GP surgery (the red line is a visual representation of the association between the two variables i.e. the linear regression line)

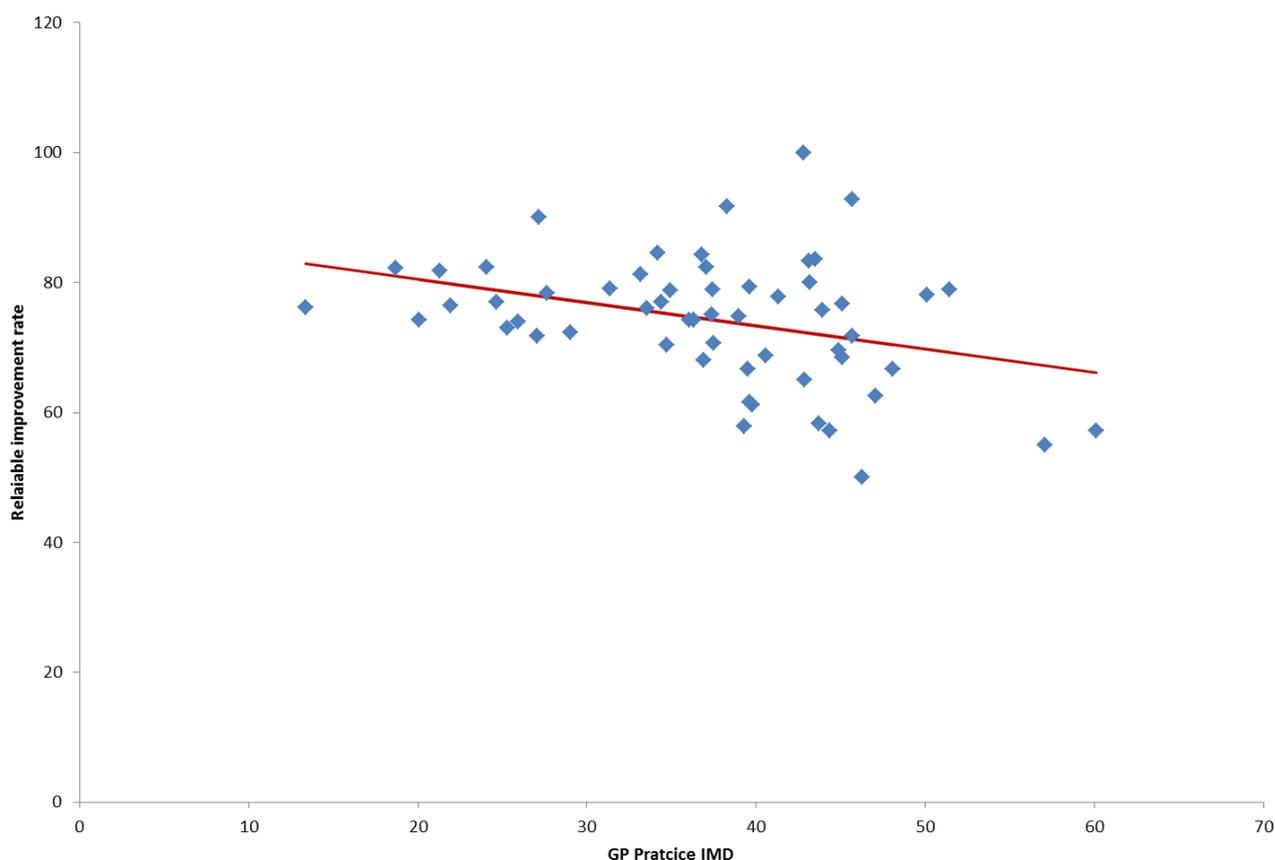
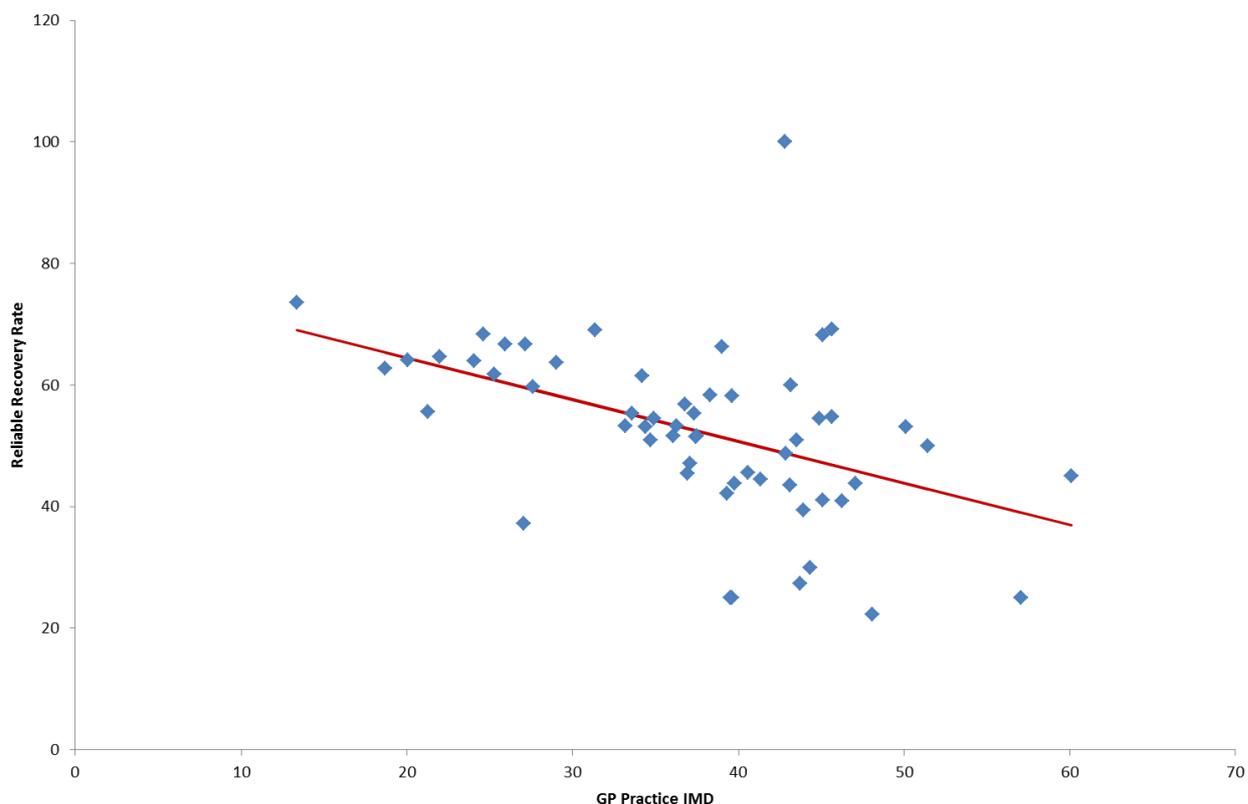


Figure 19: Reliable recovery rates and deprivation scores by GP surgery (the red line is a visual representation of the association between the two variables i.e. the linear regression line)



4.4.3. Ethnicity

No significant differences are observed between the reliable improvement rates for individual providers and the overall, combined rates. Similarly, no significant differences between ethnic groups were seen for the rate of achieving reliable improvement (*Figure 20*).

Overall white ethnic group have significantly better rates of reliable recovery than Mixed, Asian or Other ethnic groups. There is some variation in reliable recovery rates by ethnic groups within each provider; however, it is not possible to say if these are significant. However, this variation is similar to and thus contributes to the pattern seen across the whole of Nottingham City's IAPT services. This is particularly relevant for Trent PTS where there is a significantly higher rate of reliable recovery in the white ethnic group than seen across Nottingham as a whole (*Figure 21*).

Figure 20: Reliable improvement rate by ethnic group; combined data from all providers.

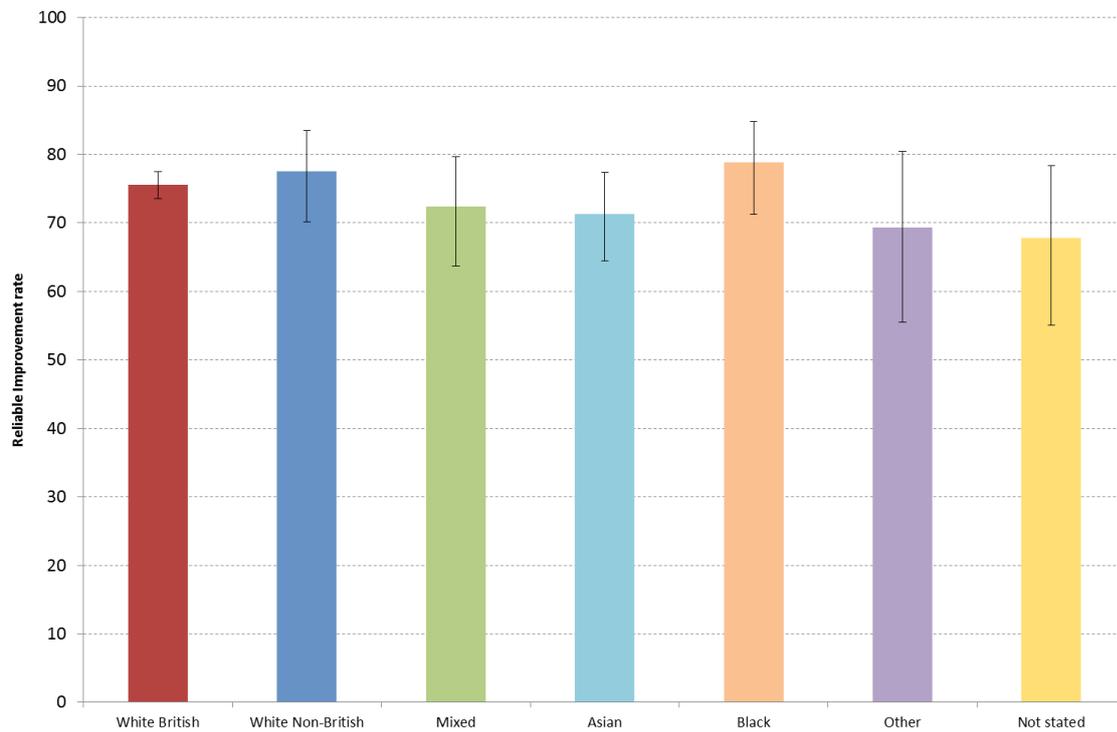
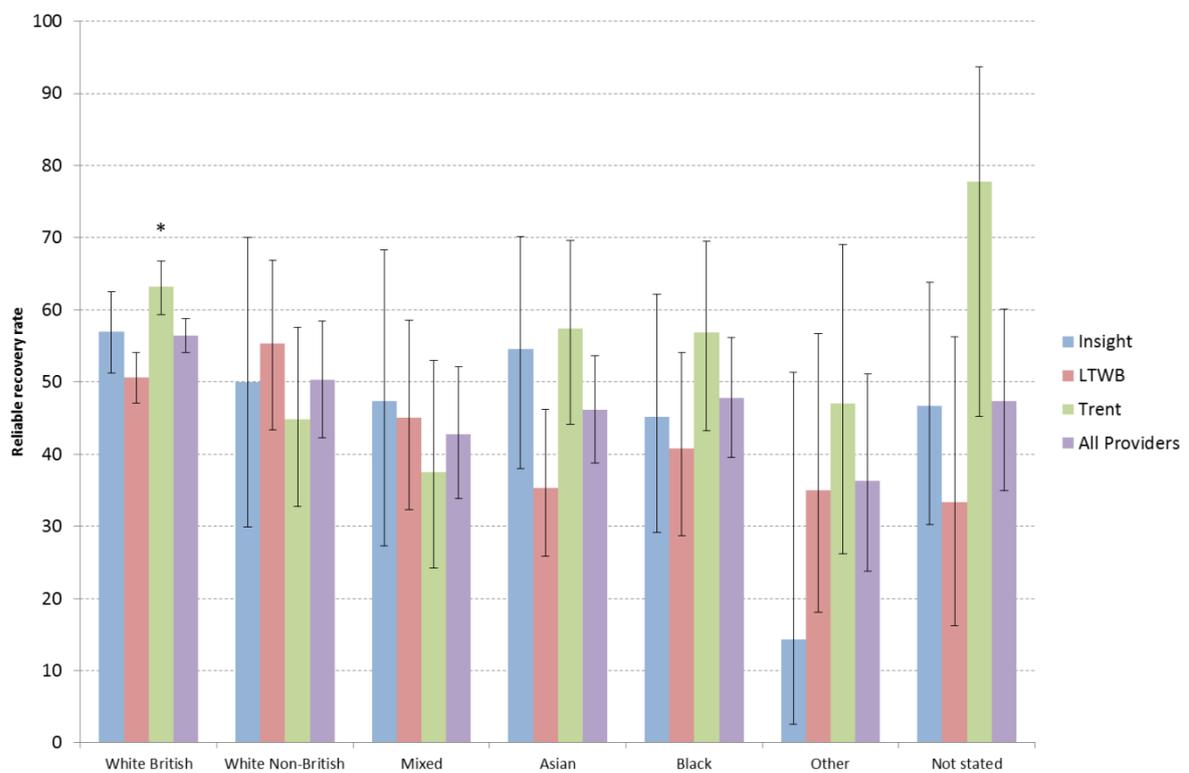


Figure 21: Reliable recovery rate by ethnic group and Nottingham City CCG IAPT provider



*differs significantly to 'All Providers'

4.4.4. Sexual orientation

There are no significant differences between the reliable improvement rates for sexuality and no differences between the combined rates and those of individual providers (*Figure 22*). Service users who are Bisexual appear to have a lower reliable recovery rate than heterosexual service users. While some significant differences are observed (*Figure 23*) between the rate of reliable recovery in individual providers in the largest group (Heterosexual), these are likely part of a bigger picture that contributes to the differences mentioned when considering data from all providers.

Figure 22: Rate of reliable improvement across all IAPT providers by sexual orientation

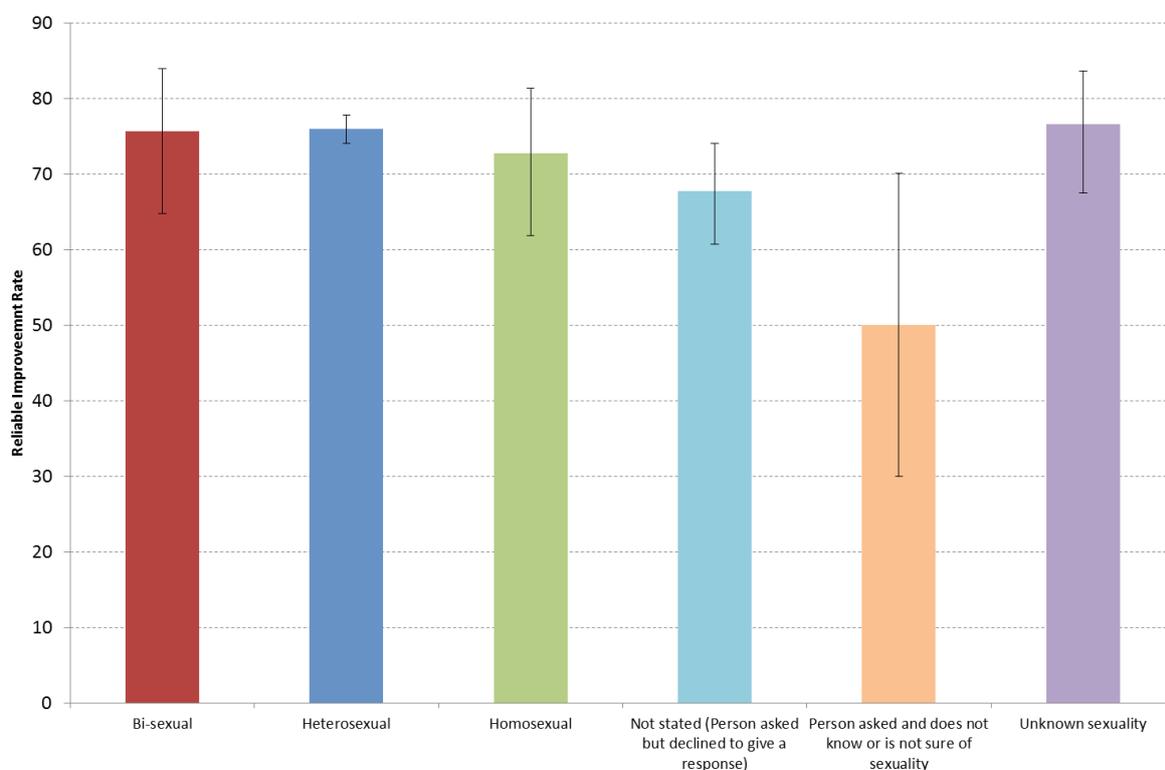
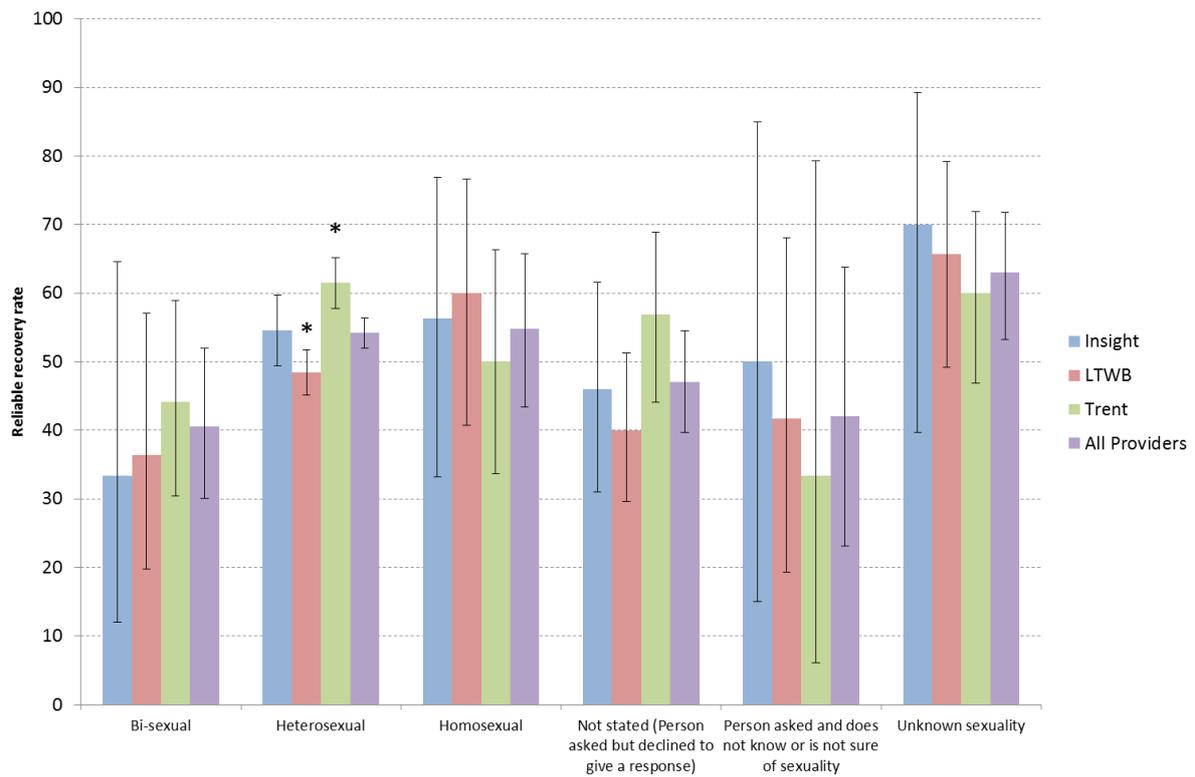


Figure 23: Rates of reliable recovery by sexual orientation and IAPT provider.



*significantly different to 'All providers'

4.4.5. Disability

There are no significant differences between providers and combine reliable improvement or recovery rates. Similarly, there are no significant differences between disability categories and the rate of reliable improvement or recovery (Figure 24 and 25 respectively) and as such the variation observed may be random and due to the small numbers of individuals seen in each group.

Figure 24: Reliable improvement and disability across all providers of Nottingham City CCG IAPT services.

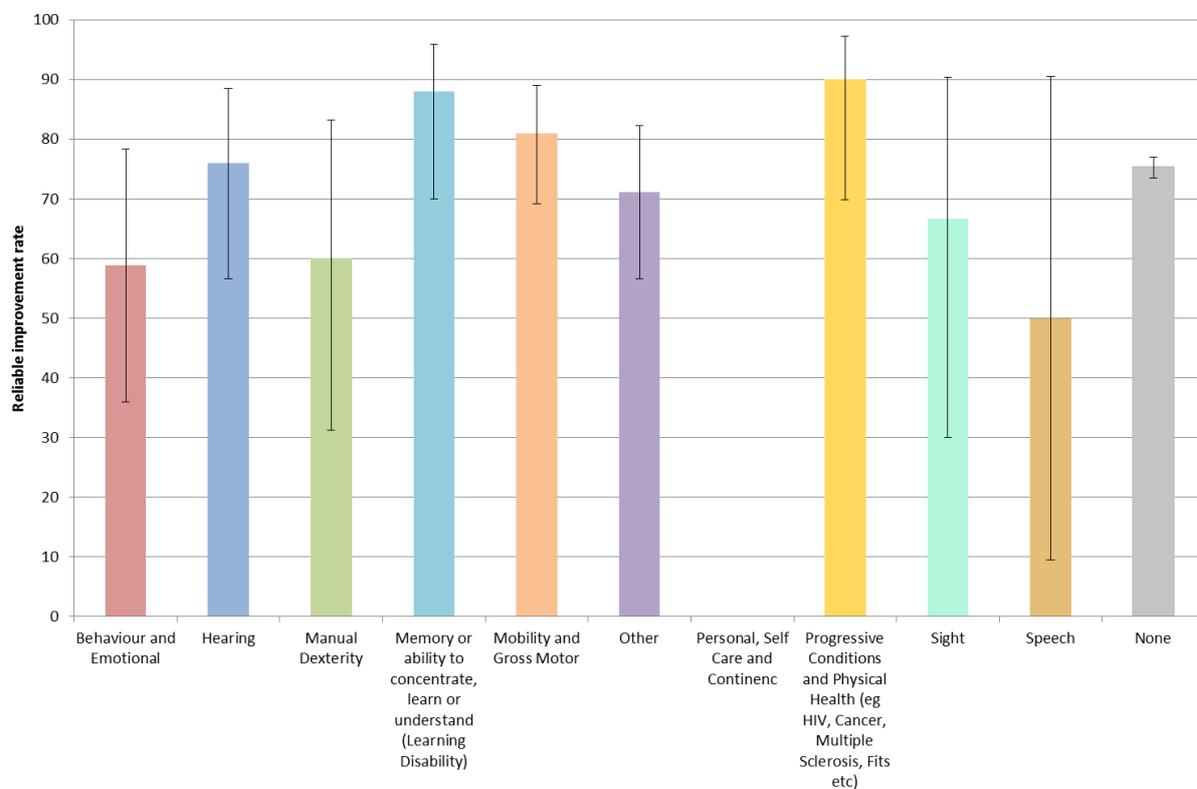
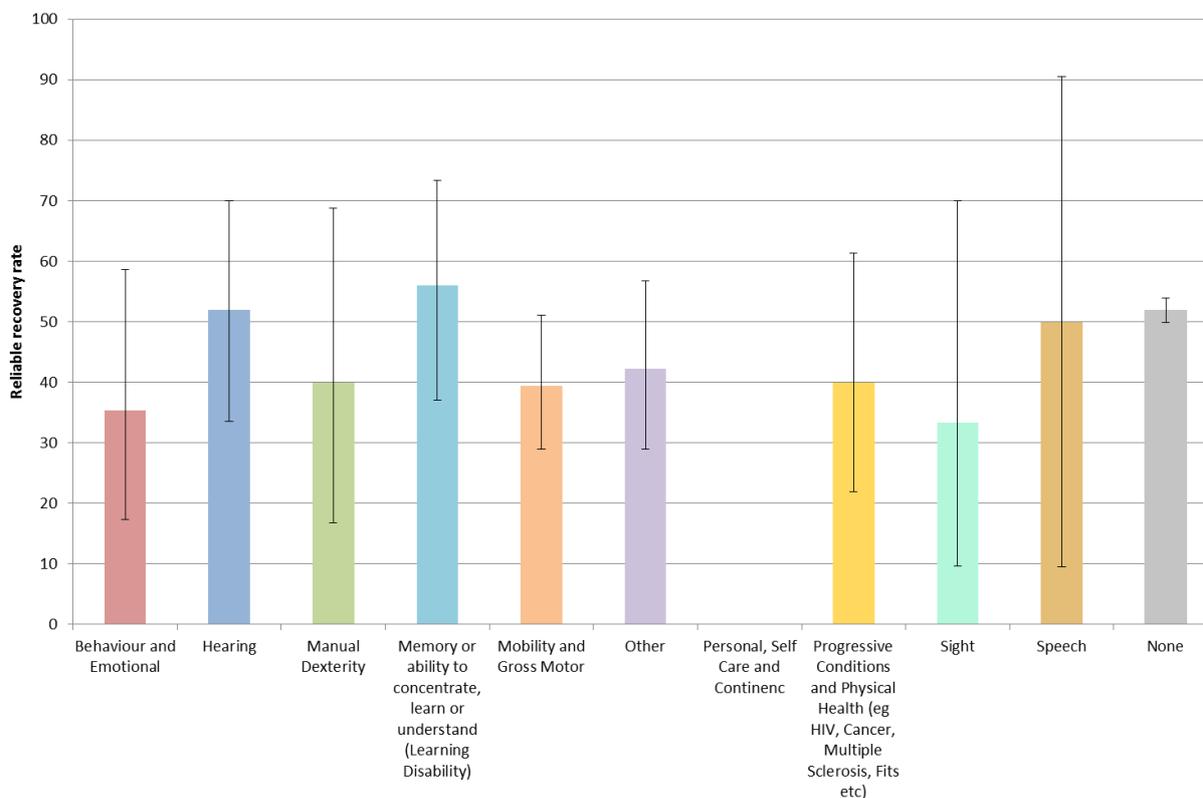


Figure 25: Reliable recovery and disability across all providers of Nottingham City CCG IAPT services.



4.5. Qualitative data

All four providers took part in semi-structured interviews. After the first interview, it was decided participants would be provided case studies (without prompts) prior to the interview to save time and allow the participants to talk to colleagues about any uncertainties they had prior to discussion. The participant from the first interview was then provided the opportunity to submit additional comments (based on the prompt questions used) in writing. All participants were invited to send any additional information they thought relevant and two providers emailed electronic copies of relevant policies after the interview. The results are summarised by population group discussed and themes identified within each area.

4.5.1. Awareness/visibility of the service

Providers discussed the importance of engagement activity predominantly in the context of BAME communities. One provider discussed having very few individuals from BAME communities reporting having seen leaflets etc but instead coming after GP prompting. At the same time, providers discussed the need to break down stigma when running promotional events and making services more visible with diversity in the images on pamphlets and connecting with communities. Providers each talked about their individual efforts to speak to local organisations to help them understand the IAPT offer and pathways into the service as well as attending various events throughout the city to engage the public. One provider highlighted that while they were all out there individually, they hoped all providers were marketing IAPT services in general; however, no co-ordinated approach to doing this was discussed.

4.5.2. Referral and Assessment

At several points during discussion several of the providers highlighted the ability to self-refer online; something offered by all providers. While assessment is usually conducted via telephone, many acknowledged that this could be done face-to-face; this was brought up specifically in relation to case studies for those with hearing impairment.

While all providers acknowledged the need to reassure the Young African-Caribbean male who was afraid of being detained (Theme 2, Case study 1), one provider highlighted that, during a telephone referral or assessment, if a patient becomes distressed during an assessment they would be passed directly to the practitioner on duty at the time.

No providers highlighted any concerns regards referral pathways for pregnant women with one highlighting that referrals can come from any health professional.

Providers were asked their views on the current referral system which is dominated by self-referral and by individuals prompted by their GPs. All providers seemed positive about this model and that actually their self-referral packs meant they received more information this way. However, providers did mention some challenges with self-referral including inappropriate self-referrals due to unrealistic expectations or misinformation on the purpose of IAPT services, and difficulties when patients have complex issues that they have not been informed about that either place the patient and/or therapist at risk.

4.5.3. Eligibility

This theme was discussed in relation to peri-natal mental health and substance misuse; however, several providers acknowledged that, if they were struggling to meet the needs of an individual patient they may be referred to a more tailored voluntary/focused mental health services.

All of the providers reported that unless pregnant women have an active mental health disorder they would not be eligible as they would not meet the 'caseness' criteria for IAPT support. Several providers acknowledged that development of mental health problems can occur rapidly in this population and suggested they would make the patient aware they could come back if they developed any issues. One provider said they 'may' offer some self-help materials by post/email and links to interactive, online self-help material. Another provider explained that their understanding was that health visitors get involved at an earlier stage if women have past mental health issues and all providers suggested that pregnancy was a priority referral with expedited referral pathways.

Only one provider suggested there were restrictions on when pregnant women could engage with their IAPT service. This provider limits IAPT referrals for pregnant women to the second trimester only. No other providers mentioned restrictions other than in women who are within a week of or past their due date.

In comparison, eligibility criteria for substance misuse appear more complex and variable. Three of the four providers stated no specific restrictions on methadone use or alcohol use but described the need for 'stability'. Discussion around how stability is defined included:

- Can show motivation to reduce use, can engage in tasks set and agree to abstinence in the time frame around treatment
- Engaged with drugs and alcohol services, already made improvements and understands what it means take part in treatment.
- On withdrawal programme and seeing someone regularly.

These discussions centred around not having specific doses/thresholds for engagement, assessing on a case-by-case basis and continuing to monitor attendance and the ability to engage. One provider provided details of their own policy that provides examples of issues that are likely to impact on an individual's ability to engage e.g. chaotic life but also provides ideal thresholds for alcohol (not drinking daily and not at a level that exceeds 50 units per week for males and 35 units per week for females) and illicit drugs (prescribed less than 15mg buprenorphine or less than 55ml methadone and less than 6mg benzodiazepine). Despite these ideal thresholds, the policy suggests consideration on a case-by-case basis which was reinforced in the interview where it was suggested issues such as body size need to also be considered.

One provider expressed their disappointment that there is not an agreed approach within this population and that different criteria make it difficult for patients to know at what stages of their recovery they can get help and who will offer them that help.

4.5.4. Treatment

All providers described adaptations they may make based on the case studies presented.

All organisations had written materials in a variety of languages and interpreters they could call upon including for British Sign Language. All providers described a flexibility that enabled translators to be changed if the patient knew them and/or preferred someone else. One provider said the discussion had sparked a need to look into how service users can flag up concerns outside of the consultation space; other providers did not mention how this process occurred in their organisation.

Two providers indicated that service users who were 'scared' to engage the service could conduct their treatment solely online. One provider highlighted their use of SilverCloud; a piece of software that allows therapists to interact and feedback to service users on their online progress. One provider said they could arrange for consultations to occur at a client's home and, along with another provider, within services such as drugs and alcohol. The other two providers commented

that consultations usually take place in their own buildings although some work in GP surgeries and other venues is occasionally conducted.

4.5.5. Safeguarding

All providers picked up on the safeguarding issues in Case Study 1. Discussions often focused on the importance of open dialogue with clients and how the service would link with social services and other organisations. All respondents highlighted internal processes where case management discussions and/or a method of flagging cases for review by clinical leads take place.

In addition, all providers showed a willingness to take a more holistic approach discussing that for some cases links with other services e.g. employment and/or legal issues, would be beneficial.

4.5.6. Workforce

One provider reported having Champion roles with protected time that are, in the most part, aligned with CCG priorities. One provider reported having Champions but for treatment modalities rather than population groups and another reported historically having champions. One provider reported that due to its small size, having champions was a challenge.

As a result of the above circumstances, no providers reported having a deaf aware practitioner but two providers reported having material available from a Long Term Conditions Champion or a historical post.

All but one provider mentioned specific equity and diversity training. All of the providers highlighted other elements of training relevant to some of the case studies. For instance, one provider invited substance misuse services in to provide training to staff and some providers mentioned specific training sessions on hearing impairment and peer-led learning in various areas.

4.5.7. Miscellaneous

Providers were offered the opportunity to shout about the successes in their organisation with regards equality and/or flag up any challenges and support they feel is needed.

One respondent indicated they felt there was no specific help that was required in achieving equitable service and there were no issues they were aware of. Other respondents' highlighted specific challenges such as being responsive to the changing landscape e.g. with BME lived experiences and beliefs about mental health; accessing local data to target and market to different communities; and 'getting the right staff'.

Work that providers flagged as being important were:

- Placement of staff within drug and alcohol services in order to break the stigma and make people aware that 'blanket bans' are no longer in place and they can access services.
- Several providers championed their on-line offering including the increased flexibility the SilverCloud service provides including the ability to access treatment at any time and in any place while still getting to interact with a therapist.
- Breakfast Meetings where support agencies/charities are invited in one morning to talk about what they do.
- Champion roles were described by one provider as 'not new' but that they were now at a level that offered the champion protected time and the ability to impact on referral pathways and create links to other agencies.

5. Summary and recommendations

Health equity audits identify how fairly services or other resources are distributed given the relative need within different populations. This HEA has helped identify population groups within Nottingham City who have a greater need for IAPT services as well as those that experience inequality in access and outcomes from IAPT services in Nottingham City.

In comparison to other areas (Alabady et al. 2014; Little et al, 2015), data completeness is greater. However, there remain areas where great improvements can be made by individual providers and with respect certain characteristics.

Attrition remains an issue for IAPT services across the UK. In Nottingham, 25% of those referred did not receive a formal assessment and of those that did, 64% did not complete treatment. This is similar to the attrition rates reported by other IAPT services (Little et al 2015; HSIC 2015). It was beyond the scope of this work to understand why individuals were not accessing services or completing treatment. However, as this attrition both at referral and during treatment impact on both commissioners and providers it is in the common interest to identify the reasons behind attrition in order to inform service design.

Inequalities in access

It is estimated that 53,492 individuals ages 15-74 years of age have at least one Common Mental Health Disorder. In Nottingham City, in 2015/16, the data provided suggests the number of referrals received equates to 17.1% of the estimated CMD need. However, based on the number of individuals with which IAPT engaged, only 12.7% of the estimated CMD need was met.

IAPT services appear to have taken positive steps to meet the additional need expected in the most deprived areas of the city; however, geographic variation still exists and there remains the potential of a hidden mental health burden in deprived areas that cannot be accounted for in the methods used to estimate need. As such IAPT services are encouraged to continue targeted promotion of services in communities where current access rates are low and/or where need is expected to be high.

There are a number of population groups that currently experience lower rates of access including women, older adults, Asian and Mixed ethnic groups and individuals with a disability. It is important to understand the barriers to access experienced by these groups and take steps to remove them.

This may range from tackling stigma and the attitudes around mental illness within the groups to engaging with communities to improve the visibility and availability of services.

Inequalities in outcomes

The IAPT service in Nottingham City CCG has reliable improvement (75.1%), recovery (55.4%), and reliable recovery (53.6%) rates above those observed nationally (UK average: 62.2%, 46.3%, 44% respectively). However, variation between providers exists. It is not possible to explain this variation as there are few differences between providers as to the populations accessing services. In addition there appears little difference in the PHQ9 (Insight: 15.95 [5.6]; LTWB 15.6 [5.7]; Trent PTS 15.8[5.7]) and GAD scores (Insight 13.7[4.8]; LTWB 13.9[4.6]; Trent PTS 14.0[4.6]) measured at baseline.

A number of population groups who experience lower reliable recovery rates have been identified including the 'Mixed', 'Asian' or 'Other' ethnic groups and those who are Bisexual. This could in part be explained if these individuals experience more severe mental illness but it is not possible to make conclusions on this due to small numbers and so the results presented should be considered by therapists when determining the needs of an individual.

Providers' views

Providers have a good awareness of key equity issues including both the barriers experienced by certain populations and some of the methods in which these barriers can be overcome. However, there remains inconsistency in eligibility criteria for peri-natal mental health and substance misuse. Similarly, there appear missed opportunities in using the skills of the workforce to impact on equity issues e.g. Champions. There are a number of areas of work that providers are rightly proud to be doing and recognition of the importance of equity.

Each provider works in relative isolation to provide its own IAPT offering as guided by the commissioner; however, there are opportunities for shared learning and co-operative working that may be being missed that would ensure that the IAPT service across the city as a whole is greater than just the sum of its parts.

6. Recommendations

- It is recommended that commissioners and providers come together to discuss the inequities highlighted within this report and create a joint plan to address inequalities.
- It is recommended that Nottingham City CCG view equity across the combined output of IAPT providers but work with individual providers to ensure any decisions they make to focus workload on specific sub-populations contributes appropriately to a city-wide goal for equitable IAPT coverage.
- GP practices, particularly those in deprived areas with low-referral rates, should be supported by commissioners and providers to increase referrals. This may include the need for improved case-finding or adapting referral processes in some GP practices. As variation between GP surgeries exists, sharing of good practice should be encouraged.
- Stakeholders should consider ways to improve data quality and identify areas, including substance misuse, where collecting new data would facilitate future learning around equity and patient pathways.
- Efforts should be made to promote the visibility of IAPT services amongst communities that currently have inequitable rates of access and to address barriers such as stigma.
- Undertake qualitative research to better understand why there are low referral rates to IAPT services amongst certain population groups.
- Undertake mixed methods (Quantitative and qualitative) research to explain and explore differences in treatment outcomes between populations.
- IAPT services should explore the reason individuals in some groups have lower recovery rates and identify changes to treatment (incl. the need for additional support) that may be needed.
- Stakeholders should work towards the consistent translation of the service specification into eligibility criteria for pregnant women and substance misuse.

- Providers should explore the possibility of better co-ordinating staff training, promotional activity and sharing best-practice as a way of maximising resource use.
- The commissioner should work with partners to ensure pregnant women with a history of mental health issues are given appropriate preventative support that, at present, is not provided by IAPT services.
- Commissioners and providers should continue their work together to ensure IAPT remains a sustainable and key component of the mental health pathway in Nottingham City.

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Appendix A – IAPT Interview Script

Semi-structured interview: IAPT providers

REMINDER: Let the interviewee tell you the patient journey and use the questions below as probes/reminders

Consent: Responses will be kept until a final report has been signed off by the CCG and published at which point they shall be deleted along with any audio recordings. Quotes may be used in the report but will not be attributable to individuals or providers. Where the information included may identify the provider or individual, any quote will be checked with the provider/individual before inclusion. Verbal consent shall be sought for the above. Any responses received in writing to the below are assumed to imply consent to use the data as outlined above.

INTRODUCTION

- **Health Equity Audit (HEA)**- Health equity audits identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas. It determines whether health inequalities exist and identifies areas where remedy and/or monitoring are required.
- There are 9 protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation). In addition to these, substance misuse shall be included where possible in the HEA. However, this interview will not cover all of these.
- Previous work has been done with GP's and patient groups but no work has been done to identify the adaptations providers make to treatment pathways to account for the needs of individuals/groups.

METHOD

Please consider the Case Studies below. The interview will allow the opportunity to discuss each case study freely. The interviewer may use prompts to guide discussion if further information is required. Written feedback may also be provided after the interview to fill in any details that could not be recalled at the time of discussion; these responses will be reported alongside and not separately to any verbal responses.

THEME 1: Deaf community**Case Study 1:**

Jessica is profoundly deaf and uses BSL as her first language. She is 48, and has just divorced from her hearing husband (an interpreter) after having an affair with a deaf man with whom she is now living. Her ex-husband is threatening to keep their 4 children (two are deaf) and not to allow her to see them. She is depressed and highly anxious about her children not being looked after properly. She described her ex-husband as being controlling and hiding things from her. There are suspicions that he was violent towards her and may be a risk to the children. She is highly suspicious of hearing people and could be described as paranoid. Jessica's current partner, the deaf man has been arrested for being physically aggressive towards the ex-husband.

Could you talk through the journey Jessica would have through your service?

PROMPTS:

In your opinion, what are the main problems you foresee for Jessica?

What sort of support might Jessica get?

Are you aware of other services that may benefit Jessica?

Do you have any views on the paranoia described by Jessica? Is this unusual or common?

Case Study 2:

Brian is a deaf man who has lost his job at the age of 32. He used to work in a bread factory as a shift leader. The company was reorganised and he says he was forced out of his job because he was deaf. He doesn't know much about it because when he went to the meetings with the managers and there was no interpreter there. Brian can speak fairly well, although not clearly and his English is not fully fluent. He has a cochlear implant in his right ear and a digital hearing aid in his left ear. He can also communicate fairly well in British Sign Language (and in meetings he says that he understands more in BSL than when he tries to lip-read) but he prefers speaking. He says that he does not like the local Deaf club because there is a lot of bullying and gossip - he prefers not to get involved with other deaf people and he says that they are not as clever as he is. Brian is frustrated and angry about how he has been treated at work. He has been arrested for being drunk and sending texts to his ex-boss, warned about 'stalking his ex-boss, and also for hitting a police officer when he was arrested.

Could you talk through the journey Brian would have through your service?

PROMPTS:

In your opinion, what are the main problems you foresee for Brian?

What sort of support would Brian get?

Are you aware of other services that may benefit Brian?

Would you ensure Brian was happy with the choice of BSL interpreter?

GENERAL:

Does deaf mental health differ from hearing mental health?

What materials would you consider using to support the treatment of Brian and/or Jessica?

Does the service have champions/deaf-aware practitioners available?

THEME 2: BME Communities**Background:**

The latest BME Health Needs Assessment highlights important barriers for BME communities in accessing mental health services including statements such as:

‘...low aspirations and unemployment lead to crime, you turn to drugs and alcohol to cope and to fit in with your peers, this leads to poor mental health and before you know it your sectioned or in jail or something’

Case Study 1:

Young African-Caribbean male who experiences mental health problems has never accessed talking therapies previously or approached his GP about mental health. He is concerned about accessing services as he knows of many people within his community who have been detained and is unsure if the staff will get what he is going through and has to deal with on a day-to-day basis.

Could you talk through this case study with relation to the service you provide?

PROMPTS:

Do you see this viewpoint amongst the BME communities you engage?

What are the key challenges with regards mental health in the BME communities?

What cultural/religious awareness training is provided for staff?

Do you ‘match’ IAPT staff and service users based on cultural backgrounds?

Case study 2:

Anahita is a resident, born in Western Asia but who has been living in the UK for a number of years. She is a relatively confident English speaker. She is in an arranged marriage and is suffering a mental health issue due to major cultural and dynamic issues within the family. In addition, she feels that black magic has been done to her and her children by her in-laws and is constantly distressed, can't sleep, eat or focus on anything.

Could you talk through the journey Anahita would have through your service?

PROMPTS:

How might Anahita come in contact with your service?

Are there services other than yours that may help Anahita?

GENERAL:

Many BME service users may find CBT difficult, in part due to literacy, what adaptations or alternatives are available to address this issue?

THEME 3: Substance misuse

Case Study 1:

Michael is a 32 year old man who was until recently living with his girlfriend until their relationship broke down. This was, in part a result of an addition to Heroin and growing social anxiety and depression. He also has diabetes, which was not under control, has HIV and Hepatitis B.

Michael is too vulnerable to sustain tenancy on his own. A referral to Nottingham Community Housing Association housing has led to accommodation at Forest Road Framework centre.

Michael initially struggled to engage with the support he was receiving. However, he continues to receive withdrawal support for his substance misuse including methadone and his physical health has shown signs of improvement.

Could you talk through the journey Michael would have through your service?

PROMPTS:

Can you describe if/how you work with organisations such as Nottingham Community Housing Association, Framework and/or substance misuse services?

Case study 2:

Catherine is 27 years old. As a child she was physically abused by a relative. Previously, she lived at home with her mother until she spent time in hospital for alcohol withdrawal. While in hospital she was considered at risk of suicide and so was discharged to an accommodation based service. Two years ago she received support to live independently and has been doing so ever since.

Recently, Catherine has become known to the police for a series of assaults, mostly attacks on her mother but some involving members of the public. These offences were considered to be a result of her mental health issues.

Catherine attends an assessment session. She arrives late sweating and shaking; she explains she has been in a rush to get to the appointment. Catherine reports difficulty sleeping and shows the signs and symptoms of depression and anxiety. She reports not having had alcohol and has no noticeable alcohol odour. Catherine fails to attend her next session and attempts to contact her are unsuccessful.

Could you talk through the journey Catherine would have through your service?**PROMPTS:**

What training do staff receive on identifying substance misuse issues?

How do you work with other organisations regards known service users who may have started re-using or users not known to them who appear to be misusing drugs/alcohol?

GENREAL:

What are the greatest challenges for your service with regards referrals in individuals currently receiving substance misuse support?

How does the service identify when mental health support is appropriate?

- Is this a subjective judgement or one based on a validated screening tool?

Theme 4: Perinatal mental health**Case study 1:**

Jen is a 35-year-old woman who has previously suffered from anxiety and depression. She and her partner, Pete, are due to have their first baby after 5 years trying to conceive. The couple achieved this pregnancy following several attempts using Assisted Reproductive Technology (ART).

Could you talk through your services role in Jen's pregnancy?

Additional information if required:

Jen has attended all antenatal care appointments to date and no mental health concerns have been raised. Pete has contacted the midwife during the middle of Jen's 32nd week saying he is concerned about Jen, she seems to be crying all the time for no reason and has become very picky with the food she eats and obsessive with cleaning the house, her hands etc.

Would this additional information change the involvement/approach of your service in Jen's care?

PROMPTS:

What would you expect to be Jen's pathway into your service?

Are adjustments to the service pathway made for pregnant women?

Case Study 2 (if time or appropriate as may come up in response to the above):

Same as Case study 1 but symptoms such as loss of appetite, tearful, withdrawn present at 2 weeks postpartum in discussion with health visitor.

Could you talk through Jen's journey within your service?

PROMPTS:

How are decisions made over if it is appropriate to begin treatment before or after pregnancy?

Theme 5: General

Do you feel access to your service is equitable?

Which innovations to promote equity of access and outcome are you most proud of in your service?

How do you ensure the type of treatment offered to those in risk groups e.g. learning difficulties, substance misuse, is appropriate and/or in-line with the latest research?

What challenges do you see to making service access and outcomes more equitable?

It is suggested GP's do not refer individuals directly into IAPT services and instead prompt patients to self-refer; is this an approach you feel works well? Is this the same for all mental health presentations?⁶

Thank you for your time!

Appendix B – GP Practice referrals and CMD need met

	CODE	IMD	REFERRALS	EST CMD Cases	% COVERAGE	RANK
St Albans Medical Centre	C84004	45.1	137	1091	12.56	28
Elmswood Surgery	C84011	24.6	238	1372	17.35	8
Family Medical Centre (Sood)	C84018	39.6	198	1301	15.22	15
Cripps Health Centre	C84023	20.1	487	5801	8.39	53
Churchfields Medical Practice	C84034	37.4	175	1505	11.63	35
Derby Road Health Centre	C84039	24.1	214	1502	14.24	19
Leen View Surgery	C84043	45.7	188	1216	15.46	13
Deer Park Family Medical Practice	C84044	13.4	104	1170	8.89	49
Clifton Medical Practice	C84046	36.8	168	1181	14.23	20
Rivergreen Medical Centre	C84060	34.9	158	1263	12.51	30
Greenwood & Sneinton Fmc.	C84063	36.1	87	965	9.02	46
Parkside Medical Centre	C84064	45.1	170	972	17.49	7
The Wellspring Surgery	C84072	51.4	147	1398	10.52	43
Hucknall Road Medical Centre	C84078	33.6	237	1879	12.61	26
John Ryle Medical Practice	C84081	36.3	108	899	12.02	34
Victoria And Mapperley Practice	C84085	27.6	208	1224	16.99	9
Aspley Medical Centre	C84091	50.1	108	1026	10.53	42
Bridgeway Practice	C84092	36.9	88	637	13.81	22
Radford Health Centre (N Phillips)	C84096	34.7	131	514	25.51	2
The Forest Practice	C84103	44.9	105	755	13.92	21
Greenfields Medical Centre (Sharma Op)	C84104	44.3	66	317	20.82	3
Fairfields Practice	C84105	43.5	138	1001	13.78	23
Melbourne Park Medical Centre	C84116	43.1	124	1118	11.09	38
Radford Medical Practice (Kaur)	C84117	37.5	233	2620	8.89	48
Wollaton Park Medical Centre	C84122	18.7	93	1038	8.96	47
Dr Mc Jones & Partners	C84129	25.9	125	993	12.59	27
Queens Bower Surgery	C84135	37.1	48	664	7.23	56
St. Luke'S Surgery	C84136	39.8	69	557	12.39	32
Springfield Medical Centre	C84138	47.1	43	397	10.83	39
Meadows Health Centre (Larner)	C84144	38.3	54	506	10.67	41
St.Marys Medical Centre	C84145	42.8	14	166	8.44	52
The Medical Centre (Irfan)	C84151	39.6	39	314	12.41	31
Mapperley Park Medical Centre	C84602	33.2	38	353	10.78	40
Tudor House Medical Practice	C84619	31.3	113	893	12.66	25
Sherwood Rise Medical	C84628	37.4	118	792	14.90	17

Centre						
Lenton Medical Centre	C84633	27.1	30	339	8.84	50
Wollaton Vale Hc (Ghaharian)	C84635	21.3	31	386	8.03	54
Bilborough Surgery	C84647	48.1	20	205	9.76	44
Boulevard Medical Centre	C84650	34.2	34	253	13.46	24
Welbeck Surgery	C84664	25.3	88	571	15.40	14
The Dale Surgery	C84672	39.3	64	575	11.12	37
Greenfields Medical Centre (Yvs Rao)	C84676	43.7	32	373	8.58	51
Rhr Medical Centre	C84680	60.1	110	392	28.05	1
Sherrington Park Medical Practice	C84682	27.0	81	645	12.55	29
The Windmill Practice	C84683	40.6	207	1171	17.68	6
Bilborough Medical Centre	C84688	39.0	216	1361	15.87	12
Highgreen Practice (Khan)	C84691	43.9	106	1422	7.45	55
Bakersfield Medical Centre	C84693	22.0	46	726	6.34	57
Lime Tree Surgery	C84694	46.3	71	474	14.96	16
The Alice Medical Centre	C84695	39.5	44	455	9.66	45
Strelley Health Centre (Cockrill)	C84698	57.1	86	580	14.82	18
Beechdale Surgery	C84704	41.3	110	549	20.02	4
Sunrise Medical Practice (Ghattaora)	C84714	29.0	116	941	12.32	33
Riverlyn Medical Centre	C84717	45.7	48	423	11.35	36
Nems Platform One Practice	Y02847	34.4	263	1559	16.86	10
Grange Farm Medical Centre	Y03124	42.9	79	437	18.09	5
Southglade Health Centre	Y03363	43.2	42	254	16.51	11