Mental Health
Prevention
Health Needs
Assessment

Focusing on the prevention of mental health problems and the promotion of positive mental health and wellbeing in Northamptonshire

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Purpose of this document

Good mental health is vital to overall health. It is associated with better productivity, is a protective factor for some physical health conditions, and is a vital asset for dealing with life’s stresses. Good mental health is not just the absence of a mental health problem, but having the ability to think, feel and act in a way that allows us to enjoy life and deal with the challenges it presents (1)

The purpose of this document is to provide a clear understanding of the key risk and protective factors in relation to mental health affecting local communities in Northamptonshire, and to determine which specific interventions should be prioritised to meet local needs, to prevent mental health problems, and to promote mental wellbeing.

Scope

• To provide consideration of the wider determinants of mental health
• To identify risk factors for mental ill health in Northamptonshire
• To consider and describe protective factors for mental health
• To consider the evidence about what interventions have been shown to be effective
• To note local demographic characteristics
• To includes details of known health inequalities
• To note details of community assets
• To include data about children and adults

Note about mental ill health

Details about the prevalence of mental ill health, and of the usage of mental health services in Northamptonshire, will be captured in further work for the Joint Strategic Needs Assessment on mental Health, and so is not reproduced in this document.
Executive Summary

1. Key findings

In Northamptonshire as a whole, the main risk factors identified via Public Health England’s (PHE) Mental Health and Wellbeing Fingertips profile, and PHE’s fingertips profile of wider determinants of health include:

- Women smoking at time of delivery – high across the county, particularly in Corby
- Violent crime (including sexual violence). – significantly increasing trends
- Fuel poverty – Significantly increasing, particularly in Corby
- Housing affordability – high ratio indicates less affordable housing for residents, highlighted as more of a concern in Daventry, Northampton, South Northants and Wellingborough
- Excess weight in adults – High prevalence across the county, particularly in Corby, East Northants, Kettering and Northampton
- Smoking prevalence in adults – high health impact and particular concern in Northampton based on latest data.
- Alcohol admissions to hospital – high across the county and increasing, particularly in Northampton, Corby, Kettering and Wellingborough.
- Overall numbers of looked after children
- Children in need due to abuse, neglect or family dysfunction

In addition, data is provided about associated risk factors including deprivation, self harm, social isolation, substance misuse, and also the significance of adverse childhood experiences.

Protective factors such as educational achievement, employment, participation in physical activity, and quality of living environment are also noted.

2. Recommendations

These will be structured around the Faculty of Public Health recommendations in “Better Mental Health for All (2016)”(2), using their “Universal, selective or indicated” prevention model (shown on page 39). In addition to the summary provided on pages 39-43, further details are set out in a separate action plan.
1. Introduction

Terminology

The World Health Organization defines mental health as,

‘... a state of wellbeing in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community’ (3).

Mental health can be seen as a determinant and consequence of physical health, as well as a resource for living.

“Good mental health is very important to overall health. It is associated with better productivity, is a protective factor for some physical health conditions, and is a vital asset for dealing with life’s stresses. Good mental health is not just the absence of a mental health problem, but having the ability to think, feel and act in a way that allows us to enjoy life and deal with the challenges it presents” (4).

Research suggests that “over three quarters of all mental health problems have emerged by the age of twenty, making childhood determinants primary in future mental wellbeing. Of these determinants, family relationships are pre-eminent because they mould the infant social and emotional brain and thus determine vulnerability throughout life. Later in life, risk and protective factors are important because they influence rates of recovery, remission and relapse from physical health conditions as well as mental health problems” (5).

Structure of this Health Needs Assessment

This health needs assessment will consider the key determinants of mental health, including both risk factors and protective factors. These factors will be considered across the life course, and across the whole of the county, to help identify local variation and inequalities.

As noted by the Faculty of Public Health, most risk factors in mental health “are correlated with each other and many are associated in a cause and effect way. They may act as mediators or moderators rather than primary determinants” (5). Accordingly, this report will attempt to compare risk factors and build up local profiles where the available data allows.

The emerging evidence base of effective public mental health interventions will then be considered, in terms of best practice and anticipated “return on investment”, and some recommendations made to support the local ambition of developing a strategic approach to promoting mental health and reducing the incidence of mental ill-health in the county.

The determinants of mental health

There is now an extensive evidence base to suggest that mental health, and many common mental problems are shaped to a great extent by the social, economic, and physical environments in which people live (6).
There is good evidence, for example, that common mental disorders (depression and anxiety) are
distributed according to a gradient of economic disadvantage across society and that the poor and
disadvantaged suffer disproportionately from common mental disorders and their adverse
consequences (7), (8).

A systematic review of the epidemiological literature on common mental disorders and poverty in
low and middle-income countries found that of the 115 studies reviewed over 70% reported positive
associations between a variety of poverty measures and common mental disorders (9).

In addition, researchers have pointed to a “social gradient” in the distribution of good mental health
and mental health problems, i.e. social and economic differences in health status reflect, and are
caused by, social and economic inequalities in society, “with those in the most deprived
neighbourhoods experiencing the worst mental health and the most discrimination” (10).

Taking into account the social determinants of mental health noted above, the World Health
Organisation (WHO) have recommended taking a “Public Mental Health” approach which entails
action to improve the conditions of daily life from before birth, during early childhood, at school age,
during family building and working ages, and at older ages provides opportunities both to improve
population mental health and to reduce the risk of those mental disorders that are associated with
social inequalities.

While comprehensive action across the life course is needed, there is considerable scientific
consensus that giving every child the best possible start will generate the greatest societal and
mental health benefits (5).

In addition, the WHO recommends that action needs to be universal: across the whole of society,
and proportionate to need in order to level the social gradient in health outcomes (6).

**Risk Factors over the life course**

The life course approach provides a framework for understanding the development of mental health
across the population, both in terms of mental wellbeing and mental health problems. It offers a
framework for understanding the origins of the inequalities affecting mental health and identifying
pressure and transition points significant to mental health.

This approach recognises points in the life course, such as times of transition and change, when
there are both opportunities to promote mental wellbeing and opportunities to intervene in at risk
populations (5).

Research suggests that the majority of mental health problems emerge in childhood, with 75%
present by the age of twenty four. Therefore, the most modifiable and important risk factors for
mental health problems and the most important determinants of mental wellbeing lie in the family,
the environment, the community and the society into which a child is born and raised (5). To
enable taking a life course perspective on mental health, the WHO have developed a succinct way
of illustrating risk factors and the context in which they might arise (see graphic below) (11).
Figure 1: Schematic overview of risks to mental health over the life course


Risk groups identified in PHE guidance

The Public Health England guidance document, Prevention Concordat for Better Mental Health: PHE prevention planning resource for local areas (2017) (1), suggests that the following groups should be considered:

- People living with long term physical health problems
- Those experiencing social isolation or discrimination
- Black and minority ethnic communities
- People who misuse alcohol and/or drugs
- People in contact with the criminal justice systems
- People who are homeless or in insecure or unsafe living arrangements
- People who are unemployed or family conflict
- People living with problematic debt. (1)

In addition, and in support of the Armed Forces Covenant, it is important to note the potentially heightened risk factors experienced by serving and former Armed Forces personnel and their families. It is estimated that Northamptonshire has an armed forces community of 65,000 - this figure includes regular serving personnel, veterans, reservists and their dependant families (12).
Since the start of the UK military interventions in Iraq and Afghanistan there has been considerable public, political and media concerns about the treatment of serving and ex-serving members of the UK military who have served in either or both conflicts (13).

A parliamentary report in 2016, in summarising the available research, noted that the prevalence of common mental health problems in the military is higher than in the general population and that regulars who leave service early, and reservists, have a higher risk of developing mental health problems than their peers (14).

The parliamentary report cited a study in 2015 by Goodwin and colleagues that suggested Veterans aged 16 to 54 are more likely to experience common mental health problems, such as depression and anxiety, than comparable age groups in the general population and that veterans who have experienced combat are more likely to experience Post Traumatic Stress Disorder (PTSD). In addition, there is growing evidence that some cases of PTSD occur years after personnel have left the services (15).

The epidemiological evidence relating to prevalence rates of post-traumatic stress disorder (PTSD) within veterans suggests levels of approximately 4%, (with increased rates in reservists and those in combat roles, as noted above) (16).

**Protective factors – overview**

Individual characteristics such as control, self-efficacy and resilience, as well as the social characteristics described as ‘social capital’, such as social networks, can protect health from the effects of stressors in some circumstances, and thus positively influence health outcomes (17).

In childhood, the key factors that contribute to such protection are supportive parenting, a secure home life and a positive learning environment in schools (11).

Protective factors support or increase the development of individual level attributes such as coping abilities, self-efficacy and resilience, and the ability to learn and to develop social skills – all of which may encourage healthy behaviours and mental health and wellbeing. These attributes contribute to the ability to have control over one’s life. Research suggests that a sense of “control” is a key mediator in the relationship between social position and health (18), (19).

In addition to these attributes being supportive of good mental health, research suggests that mental wellbeing and resilience are themselves protective factors for physical health, as they reduce the prevalence of risky behaviours such as heavy drinking, illegal drug use, smoking and unhealthy food choices which are often used as coping and management mechanisms in the absence of other support (5).

An “at a glance” way of conceptualising protective factors has been mapped out by the World Health Organisation, who have mapped out the protective factors for mental wellbeing in relation to known risk factors (see below) (11).
Figure 2: Overview of vulnerabilities and risk factors

<table>
<thead>
<tr>
<th>Level</th>
<th>Adverse factors</th>
<th>Protective factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual attributes</td>
<td>Low self-esteem</td>
<td>Self-esteem, confidence</td>
</tr>
<tr>
<td></td>
<td>Cognitive/emotional immaturity</td>
<td>Ability to solve problems and manage stress or adversity</td>
</tr>
<tr>
<td></td>
<td>Difficulties in communicating</td>
<td>Communication skills</td>
</tr>
<tr>
<td></td>
<td>Medical illness, substance use</td>
<td>Physical health, fitness</td>
</tr>
<tr>
<td>Social circumstances</td>
<td>Loneliness, bereavement</td>
<td>Social support of family &amp; friends</td>
</tr>
<tr>
<td></td>
<td>Neglect, family conflict</td>
<td>Good parenting / family interaction</td>
</tr>
<tr>
<td></td>
<td>Exposure to violence/abuse</td>
<td>Physical security and safety</td>
</tr>
<tr>
<td></td>
<td>Low income and poverty</td>
<td>Economic security</td>
</tr>
<tr>
<td></td>
<td>Difficulties or failure at school</td>
<td>Scholastic achievement</td>
</tr>
<tr>
<td></td>
<td>Work stress, unemployment</td>
<td>Satisfaction and success at work</td>
</tr>
<tr>
<td>Environmental factors</td>
<td>Poor access to basic services</td>
<td>Equality of access to basic services</td>
</tr>
<tr>
<td></td>
<td>Injustice and discrimination</td>
<td>Social justice, tolerance, integration</td>
</tr>
<tr>
<td></td>
<td>Social and gender inequalities</td>
<td>Social and gender equality</td>
</tr>
<tr>
<td></td>
<td>Exposure to war or disaster</td>
<td>Physical security and safety</td>
</tr>
</tbody>
</table>

World Health Organisation (2012)

2. **Overview of effective interventions**

**General approach**

The principles underlying public mental health are not dissimilar from those underpinning any public health approach (20).

The Faculty of Public Health recommend six principles that are especially important when developing strategic intervention plans:

(1) Interventions which focus on the positive have added value over those which focus on finding or preventing the negative. Promoting mental wellbeing moves the focus away from illness and is central to an individual’s resilience, social purpose, autonomy and ability to make life choices.

(2) The social, economic, cultural and environmental determinants of mental health need to be considered and addressed. Different interventions can potentiate (increase power/effect) each other.

(3) A proportionate universalism approach which addresses whole population mental wellbeing promotion and provides additional support for high risk groups is the optimum approach.

(4) Engagement, both community and individual is central to public mental health. The former is concerned with building on assets and involving communities in framing the issues and the solutions, the latter with developing individual strengths and resilience.

(5) Since personal risk and protective factors are determined in early childhood, primarily in the context of family relationships, a life course approach is essential.

(6) A truly multidisciplinary and inter-sectoral approach must be adopted as no one discipline has all the knowledge or power to effect the required level of change.
What works to promote mental wellbeing

Children

Given that research shows the majority of mental health problems emerge in childhood, with 75% present by the age of twenty four, the most modifiable and important risk factors for mental health problems and the most important determinants of mental wellbeing lie in the family, the environment, the community and the society into which a child is born and raised (5).

There is an extensive evidence base supporting the provision of parenting programmes to improve mental health and emotional wellbeing with a focus on prevention and early intervention which also aligns with the most important protective factor of Adverse Childhood Experience, (e.g. being a child and young person having at least one trusted adult in their life). These programmes have a highly beneficial impact on a wide range of outcomes including conduct disorder (19) and parental mental health (20). The Faculty of Public Health note that there is a wide number of parenting programmes available, and to help local areas to determine the best one to adopt to fit their local circumstances a database of parenting programmes in the UK and the evidence to support them has been developed by the National Academy for Parenting (5).

The Faculty of Public Health note that “Universal” infant programmes, which include programmes offered in the context of antenatal care and programmes offered at birth to help all parents develop sensitivity to their infants, have been shown to be effective in improving parental mental health as well as that of the infant, thereby improving social and emotional attachment between a parent and child. These programmes show parents what infants are capable of, help them to identify temperamental differences, provide them with knowledge of child development, and help them manage infant behaviours like sleep and crying.

In addition, the Faculty of Public Health cite the approach of “Promotional interviewing”, an approach which focuses on the positive and aims to empower and support parents as well as to identify needs, (which was recommended in the English Child Health Promotion Programme 2008) as being useful to consider in relation to programmes to implement during pregnancy and the postnatal period (20).

Universal

The English Healthy Child Programme (2009) covers children from 0 to 19 year olds and sets out the recommended framework of universal and progressive services for children and young people in order to promote optimal health and wellbeing.

School based programmes to prevent bullying and initiatives to prevent depression in children and young people are highly recommended by Public Health England, in terms of cost effectiveness and efficacy (21).

NICE advices supporting schools to adopt a comprehensive ‘whole school’ approach to promoting the mental wellbeing of children and young people (read more on this in creating healthy places section below) (22).
Targeted
In terms of targeted interventions to support high risk groups, including those at risk of perinatal mental health problems, parents who abuse drugs and alcohol, and parents who experienced adverse childhood experiences such as abuse or being in care are also at higher risk, the Faculty of Public Health note that programmes to support these groups can only work if the parents engage with them. Usually, this group of parents have experienced childhoods which have made it difficult for them to trust others. Effectiveness is therefore dependent on highly skilled facilitation with practitioners who are able to engage with and develop trusting relationships with these parents (5).

It is important to ensure that children with risk factors such as living in care, having parents with mental health problems or using drugs or alcohol are identified for additional support. Vulnerable children are exposed to factors that place them at higher risk of developing a mental health problem. These factors include poverty, discrimination and long term health conditions. Some programmes are available which support children in the context of their families (see below).

The NICE quality standards for looked after children featured the central commendation that looked after children should have sufficient involvement in decisions to do with their care. It has also been emphasised in the Child Health Promotion Programme (Department of Health 2013) that these children should have access to nurturing relationships that foster attachment (22).

Research also supports the development of targeted wellness services towards clusters of children identified as being at high risk of multiple poor behaviours, rather than providing single issue services only (19).

The Faculty of Public Health guidance (5) notes that the Early Intervention in Psychosis (EIP) model, which was developed in Melbourne and has been adopted in England and Wales, is an effective intervention that should be implemented at a local area level (21).

It should also be noted that the Increasing Access to Psychological Therapies (IAPT) programme has recently been extended to children, including those aged five and under, and an IAPT programme aimed primarily at the practitioners who support parenting is also being planned.

Adults
In terms of intervention to promote the mental wellbeing of adults, the key “universal” approaches recommended by the Faculty of Public Health include:

- providing mental health literacy training to frontline housing and advice workers to help individuals and families to secure and sustain appropriate accommodation, manage debt and maximise their incomes

- the use of social media and other avenues to disseminate universal public mental health messages such as those promoted in the “5 Ways to Wellbeing” and “Action for Happiness”

- Mindfulness has a rapidly expanding evidence base and is increasingly popular in both people with mental health problems and risk factors, and in the general population (25).
Recent (small scale) research also notes the potential benefits of online mindfulness interventions (26).

- In addition to which the Faculty of Public Health note the potential benefits of promoting walking and exercise on prescription schemes, books on prescription schemes, social prescribing and wellbeing pledge programmes in primary care. They note that there is a small evidence base to support their effectiveness of exercise that “stills the mind” like Yoga and Tai Chi, which are increasingly popular and acceptable to the public.

- Research also promotes the use of volunteering, such as timebanks as a way of linking local people who share their time and skills, and enabling them to live well, improve their health and wellbeing, and link them to their community. Timebanking can help lower the number of GP visits by removing the kind of visits that do not require medical attention (27).

In addition to which, Public Health England have identified the following interventions as being cost effective (19):

Workplace programmes to promote mental health and initiatives to help adults at risk of stress, anxiety and depression. Detailed guidance on the development of these initiatives, and the importance of taking a comprehensive and holistic approach to promoting mental health in the workplace, has been produced by Public Health England and Business in the Community (2016) (28).

In addition, mental health support integrated into the pathways and interventions for people with long term physical health problems e.g. diabetes and heart disease, is highly recommended given research evidence about the heightened risk of depression and anxiety experienced by people with long-term physical health problems.

Public Health England also highlight research about the benefits of group based social activities, including volunteering, to address mental wellbeing risk factors in older, especially in relation to depression arising from social isolation.

There is also considerable research evidence about debt and poor health, including mental health (29), (30), (31), (32) (33). In developing recommendations about community level interventions, PHE highlight the potential benefits of having financial advice services for people with debt problems and have evidenced the financial returns based on a service located in primary care (21).

In terms of identifying key risk groups to focus interventions on, PHE notes the importance and very large potential benefits of initiatives to identify and support people who have self-harmed and are potentially suicidal. The detailed modelling work they present in their guidance focuses on increasing the use of psychosocial assessment when individuals present to hospital accident and emergency departments as a key action to complement population-wide approaches to suicide prevention (21).
Addressing inequalities

Recent research from the Institute of Health Equity suggests that psychosocial pathways are significant in mediating the effects of social determinants (social, environmental, economic, political and cultural factors) on health.

Researchers suggest that the accumulation of positive and negative effects of social, economic and environmental conditions on health and wellbeing throughout life is largely responsible for inequalities in health.

They note that stressors, from daily frustrations and difficulties at home or at work to major traumatic events, affect everyone to a greater or lesser extent. Their combined effect on population mental and physical health and wellbeing is substantial.

Given that stressors exert effects from early childhood, throughout life, they suggest that it is therefore vital to take a life course perspective in considering the health effects of stressors, and by implication in developing suitable interventions (17).

In addition to recommending a life course approach, researchers at the Institute of Health Equity suggest that interventions should take into account “psychosocial pathways”, as illustrated in the schematic diagram below (17).

Figure 3: Psychosocial pathways: linking social determinants with psychobiological processes, health behaviours and distribution of health outcomes

Public Health England and University College London Institute of Health Equity report (2017)
3. **Current situation in Northamptonshire**

**Overview of Risk Factors identified by Public Health England dataset**

The following indicators are taken from the Mental Health JSNA toolkit (details [here](#)), which collates public health data on the Fingertips website to provide a local summary.

The tables have been colour coded by combining information on comparisons to England and trend data where available so may differ to the colours used in the tool which look at both separately.

For the purposes of this analysis the following key should be used:

<table>
<thead>
<tr>
<th>Significance – Compared to England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="#" alt="Better" /></td>
</tr>
</tbody>
</table>

**Local RAG definitions**

- Better than or not significantly different to national benchmark and improving/not worsening
- Worse than national benchmark and improving/not worsening
- Worse than national benchmark and worsening

The information presented in the following tables has been taken from a dataset specifically designed by Public Health England for the purposes of getting a rounded understanding of risk factors relating to mental health. A green colour does not indicate low priority as many other factors need to be taken into account such as inequalities and health impact. The summary provides a snapshot of the data for further investigation.

**Table 1: Overview of mental health risk factors for Northamptonshire**

<table>
<thead>
<tr>
<th>Risk Factors Measure</th>
<th>Current</th>
<th>Trend</th>
<th>Local RAG</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking at time of delivery: % of mothers</td>
<td>14.4</td>
<td>↓</td>
<td><img src="#" alt="Yellow" /></td>
<td>2016/17</td>
</tr>
<tr>
<td>Low birth weight of term babies: % of all live births</td>
<td>2.4</td>
<td>↓</td>
<td><img src="#" alt="Green" /></td>
<td>2016</td>
</tr>
<tr>
<td>Child poverty: % of children in low income families (under 16s)</td>
<td>13.5</td>
<td>↓</td>
<td><img src="#" alt="Green" /></td>
<td>2015</td>
</tr>
<tr>
<td>Excess weight in Reception year : % of children aged 4-5</td>
<td>22.1</td>
<td>↓</td>
<td><img src="#" alt="Not compared" /></td>
<td>2016/17</td>
</tr>
<tr>
<td>Excess weight in year 6: % of children aged 10-11</td>
<td>34.2</td>
<td>↑</td>
<td><img src="#" alt="Not compared" /></td>
<td>2016/17</td>
</tr>
<tr>
<td>Children in care</td>
<td>61</td>
<td>↑</td>
<td><img src="#" alt="Yellow" /></td>
<td>2017</td>
</tr>
<tr>
<td>16-18 year olds not in education, employment or training: % of 16-18 year olds</td>
<td>6.7</td>
<td>↓</td>
<td><img src="#" alt="Red" /></td>
<td>2016</td>
</tr>
<tr>
<td>First time entrants to the youth justice system: rate per 100,000 population aged 10-17</td>
<td>219</td>
<td>↓</td>
<td><img src="#" alt="Green" /></td>
<td>2017</td>
</tr>
<tr>
<td>Statutory homelessness - households in temporary accommodation: rate per 1,000 households</td>
<td>1.7</td>
<td>↑</td>
<td><img src="#" alt="Green" /></td>
<td>2017/18</td>
</tr>
<tr>
<td>Statutory homelessness - eligible homeless people not in priority need: rate per 1,000 households</td>
<td>0.3</td>
<td>↓</td>
<td><img src="#" alt="Red" /></td>
<td>2017/18</td>
</tr>
<tr>
<td><strong>Estimated prevalence of opiate and/or crack cocaine use: rate per 1,000 population aged 15-64</strong></td>
<td>7.5</td>
<td>2014/15</td>
<td></td>
<td></td>
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<tr>
<td>---</td>
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<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Alcohol-related hospital admission (narrow): directly standardised rate per 100,000 population</strong></td>
<td>766</td>
<td>↑</td>
<td>2016/17</td>
<td></td>
</tr>
<tr>
<td><strong>Excess weight in adults: % of population aged 18+</strong></td>
<td>65.7</td>
<td>2016/17</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Smoking prevalence in adults - current smokers: % of population aged 18+</strong></td>
<td>15.9</td>
<td>↓</td>
<td>2017</td>
<td></td>
</tr>
<tr>
<td><strong>Long-standing health condition: %</strong></td>
<td>53.1</td>
<td>2016/17</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>First time offenders: rate per 100,000 population</strong></td>
<td>205.2</td>
<td>↓</td>
<td>2017</td>
<td></td>
</tr>
<tr>
<td><strong>Violent crime (including sexual violence) - violence offences : rate per 1,000 population</strong></td>
<td>22.2</td>
<td>↑</td>
<td>2017/18</td>
<td></td>
</tr>
<tr>
<td><strong>Domestic abuse related incidents and crimes recorded by the police - current method: rate per 1,000 population</strong></td>
<td>27.3</td>
<td>2016/17</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fuel poverty: % of households</strong></td>
<td>10.4</td>
<td>↑</td>
<td>2016</td>
<td></td>
</tr>
<tr>
<td><strong>Housing affordability ratio</strong></td>
<td>7.7</td>
<td>↑</td>
<td>2017</td>
<td></td>
</tr>
<tr>
<td><strong>Pupils with social, emotional and mental health needs: % of school pupils</strong></td>
<td>2</td>
<td>2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Living in 20% most deprived areas: % of population (IMD 2015)</strong></td>
<td>16.2</td>
<td>2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Long term unemployment: rate per 1,000 working age population</strong></td>
<td>2.9</td>
<td>↓</td>
<td>2017</td>
<td></td>
</tr>
<tr>
<td><strong>Long term health problem or disability: % of population</strong></td>
<td>16.2</td>
<td>2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Older people living in poverty: % of population aged 60+ (IDAOPKI)</strong></td>
<td>13.5</td>
<td>2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Older people living alone: % of households occupied by a single person aged 65 and over</strong></td>
<td>4.58</td>
<td>2011</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Black arrows show direction of trend but no significance and blank cells represent no data.
PHE Source - [https://fingertips.phe.org.uk/](https://fingertips.phe.org.uk/)

**Local variation of mental health risks factors across Northamptonshire**

To support understanding of the data, and to help with action planning, local analysis has been undertaken of key risk factors, and is set out in the table below in relation to districts and boroughs in the county, as at July 2018:
Table 2: Local variation of risk factors

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Corby</th>
<th>Daventry</th>
<th>East Northants</th>
<th>Kettering</th>
<th>Northampton</th>
<th>South Northants</th>
<th>Wellingborough</th>
<th>Northamptonshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking at time of delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Low birth weight of term babies</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Excess weight in Reception Year</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Excess weight in Year 6</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Excess weight in adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Smoking prevalence in adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td>Alcohol admissions</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Living in 20% most deprived areas</td>
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<td></td>
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<tr>
<td>Long term unemployment</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fuel poverty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing affordability</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory homelessness - eligible homeless people not in priority need</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*local RAG applied – all other represet comparison to national average
PHE Source - [https://fingertips.phe.org.uk/](https://fingertips.phe.org.uk/)

Risk factors in Northamptonshire

Headlines

In Northamptonshire as a whole, the main risk factors identified include:

- Women smoking at time of delivery – high across the county, particularly in Corby
- Violent crime (including sexual violence). – significantly increasing trends
- Fuel poverty – Significantly increasing, particularly in Corby
- Housing affordability – high ratio indicates less affordable housing for residents, highlighted as more of a concern in Daventry, Northampton, South Northants and Wellingborough
- Excess weight in adults – High prevalence across the county, particularly in Corby, East Northants, Kettering and Northampton
- Smoking prevalence in adults – high health impact and particular concern in Northampton based on latest data.
- Alcohol admissions – high across the county and increasing, particularly in Northampton, Corby, Kettering and Wellingborough.
- Overall numbers of looked after children
- Children in need due to abuse, neglect or family dysfunction
Detailed information about risk factors for Northamptonshire

Smoking in pregnancy
Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and the health of the mother. The babies of mothers who smoke in pregnancy have an increased risk of developing behavioural and emotional disorders and mental health conditions in later years, although it is not clear if this relationship is causal. In Northamptonshire, 14.4% of mothers were smoking at time of delivery in 2016/17, significantly higher than England (10.7%). Although the rate has shown a significant decrease since 2012/13 (15.7%).

The smoking JSNA here highlights a number of areas across the county with higher risk factors associated with smoking in pregnancy and these are concentrated in the more deprived areas in the county, Corby, Wellingborough and Northampton.


Violent crime
In Northamptonshire 20.6 violent offences per 1,000 population were recorded in 2016/17, significantly higher than the national average. The trend is also significantly increasing. The feature is most marked in urban centers including parts of Northampton, Kettering, Corby and Daventry, with further detail illustrated in the map below (published in the Northamptonshire County Council Director of Public Health report 2016-17).

![Violent Crime 2013-2016](image-url)

Violent Crime 2013-2016
Rate of ‘violence against the person’ per 1000 population for 4 complete years (2013-2016) is shown as both a quintile map and a significance map. The map shows the data at Middle Super Output Area (MSOA) level. In order to produce the quintile maps the rates for each MSOA were ranked and divided into five groups as evenly as possible. The areas with highest rates are shown in darker colours.
Fuel poverty
The risk factor of ‘fuel poverty’, where an individual because of their low income cannot afford to keep their home adequately warm, impacts adversely on both physical and mental health. Children living in cold homes are more than twice as likely to suffer from a range of respiratory problems compared to those living in warm homes (29). In addition to which, cold housing has been identified as having indirect, negative effects on children’s educational attainment, emotional wellbeing and resilience (30).

Material factors also act through the mind (the psychosocial pathway). In the example of cold housing, there is evidence that mental health is negatively affected by fuel poverty and cold homes for any age group, and that living in cold housing is associated with an increased risk of multiple mental health problems among adolescents (31) (32).

The map below shows large areas of Northamptonshire where people are thought to be living in conditions of fuel poverty (based on a “low income, high cost” methodology), higher rates in areas in East Northamptonshire, Kettering, Daventry and South Northamptonshire.

The percentage of households that experience fuel poverty based on the “Low income high cost” methodology. Midlle level Super Output Area – MSOA (Boundaries 2011).

Source: Dept for Business, Energy and Industrial strategy.
Obese adults – June 2018

From Local Health here accessed 21/06/2018.

The map above shows the estimated percentage of the population, aged 16 years and over, who are obese. Individuals are regarded as obese if they have a body mass index of over 30. Areas of East Northants, including in Raunds, Rushden, and wards in Wellingborough, Kettering, Corby and Daventry are highlighted. The pattern of distribution suggests that interventions might be fruitful in some rural areas which do not appear highlighted in other risk factors illustrated below.

There is evidence cited by Public Health England that obesity can spread via social networks, and that psychosocial influences can play a role in diet in at least three ways:

1. Social and cultural norms and family habits are a strong influence on taste preferences and dietary choices.

2. Food consumption is affected by emotional states: some people adopt patterns of ‘emotional eating’, also described as ‘comfort eating’, including over-consumption of energy-dense foods with low nutritional value. Others may lose their appetite and reduce their food consumption in response to stressful emotional states (31), (33).

3. In addition, a relatively new theory proposed by Mani and colleagues (2014), suggests that people living in poverty are less able to make decisions that favour long-term benefits: being poor imposes a mental load that crowds out reasoning ability (32). Research also suggest that people living in poverty already have difficult trade-offs to make about household expenditure, for example there is evidence that the poorest of older households are sometimes having to choose between eating and heating (33). Consequently, making healthy food choices is more difficult for those living in such circumstances, and so the action points and recommendations in this report will take into account these issues.
**Children in care**

Being in care when young is a predictor of poor mental health and wellbeing which, unless addressed, is a determinant of adult mental ill-health, and is associated with increased levels of antisocial behaviour, emotional instability and psychosis (2), (34), (35).

The rate of children in care in Northamptonshire (61 per 10,000 population under 18 years) is similar to the national average (i.e. 62) but is showing a significantly increasing trend.

The most recent (March 2018) local figures (66 per 10,000 population under 18 years) show the rate has continued to increase.

In addition, in terms of risk factors effecting children, in 2015 the proportion of children in Northamptonshire identified as ‘in need’ with abuse, neglect or family dysfunction (75.4%) identified as primary reason for assessment, was significantly higher than the national average (67.3%).

In 2017 Northamptonshire’s figure has decreased to 73.2% compared to a national increase to 68.3%.

**Adverse childhood experiences**

There is a strong relationship between the experience of adverse childhood events (ACEs) and subsequent ill health in adulthood (2). ACEs include being the victim of physical abuse, sexual abuse, domestic violence, parental separation, emotional neglect and emotional abuse, living with an alcoholic or drug abuser or having a parent in prison.

Research that was conducted in Northamptonshire and neighbouring counties suggested that the prevalence of low mental wellbeing was significantly associated with ACE counts, and that individuals who had experienced more ACEs before the age of 18 are more likely to have low mental wellbeing when they grow up (no ACEs, 8.3%; 4+ ACEs, 27.0%, \( \rho = 0.120, p<0.001 \)). (36)

After controlling for the effect of deprivation, the research suggested that ACE counts still had a significant association with the prevalence of low mental wellbeing. The odds of having low mental wellbeing were 3.54 times higher for those with 4+ ACEs compared to those with none (AOR=3.54, CI= 2.27, 5.52) (Figure 4).

**Figure 4: Low mental wellbeing: % and AOR by ACE count**

![Low mental wellbeing score: % and AOR by ACE count](image)

In Northamptonshire, an action plan has been drawn up in relation to the findings of the ACE’s research. The priorities for action in the Northamptonshire ACE plan are set out as:

Priorities:

- High risk, High need families (Police lead)
- Under 5s (Public Health/CCG lead)
- Training (All)
- Mental Health (Northamptonshire Healthcare Trust lead)
- Awareness raising campaign (Public Health lead)

Bullying and victimization in childhood
In terms of taking into account the issues of bullying and harassment, national research published by Young Minds (2016) notes the significant impact of childhood experiences of enduring discrimination, harassment, hate crime, isolation, and prejudice, especially resulting from homophobia, sexism, racism, or disablism, and suggests that Lesbian, Gay, or Bisexual children and young people are at higher risk than their heterosexual peers, of experiencing poor mental health and lower wellbeing, harming themselves and considering suicide as a consequence of the prejudice they face (37).

The risk is even higher for those who are both LGBT and from a Black or Minority Ethnic (BME) community and/or have a learning disability. Studies by the charities Stonewall (38) and Metro (39) both found that over half of LGBT youth reported deliberately harming themselves, and 44% had considered suicide. Trans young people are also at higher risk of depression, self harm, substance misuse, and suicide (40) (41).

Substance misuse
There is a strong link between substance misuse and mental health issues. People with mental health issues may turn to drugs and/or alcohol as a form of self-medication. Substance misuse itself may also exacerbate or cause mental health issues.

According to prevalence estimates modelled by the University of Sheffield, in 2014 there were 6,535 dependent drinkers in Northamptonshire. In addition, the Crime Survey for England and Wales 2016/17 found that 2% of adults aged 16-59 reported frequent drug use (which was classed as having using any drug more than once in the past year). This would be equivalent to 8,327 adults in Northamptonshire.

Data from local treatment services (Change, Grow, Live) show that in 2017/18, 863 people received structured treatment for alcohol use only, and 1,902 people received structured treatment for drug use (with or without concurrent alcohol use).

In 2016/17, Northamptonshire’s rate of admissions to hospital for mental and behavioural disorders caused by alcohol was significantly higher than the national average at 84.9 per 100,000 population compared to 72.3 per 100,000. This was a significant increase compared to 61.3 per 100,000 in 2015/16.
Corby had the highest rate in the county at 132.1 per 100,000. Daventry, East Northamptonshire and South Northamptonshire are the only districts with admission rates that were not significantly higher than the national average; Daventry and South Northamptonshire had rates significantly lower than England.

**Figure 5: Admission episodes for mental and behavioural disorders due to use of alcohol (Persons)**

In 2016/17, Northamptonshire’s rate of admissions to hospitals for drug related mental health and behavioural disorders was 101 per 100,000 population. This was lower than the England average of 149 per 100,000, but it is not possible to tell from the data whether this difference is statistically significant. Figures are not available at district level.

**Hospital admissions for alcohol attributable conditions, standardised admission ratio 2011/12 – 2015/16​ Middle Level Super Output Area – MSOA (Boundaries 2011).**

Source: Hospital Episode Statistics (2017)
4. Additional considerations and concerns to be addressed in the Mental Health Prevention action plan:

**Self harm:**
Self-harm is major public health challenge, not just due to the longer term psychological and physical impact of self-harm but also the association between self-harm and suicide. Although most self-harm is not fatal it highlights signs of emotional distress and prevalence peaks in adolescence. Adolescence is a life stage where change is possible, the fastest change after infancy and therefore an important life stage for intervention with huge potential for development of new skills and capabilities such as resilience. It is an important time to intervene to reduce the risk of suicide and to ensure early intervention is implemented following an episode of self-harm.

The child and maternal profile shows Northamptonshire has high rates of emergency admissions for self-harm in comparison to other areas in the East Midlands and the England average. Rates are significantly higher than the national rate for each age group (10-14, 15-19 and 20-24 years).

**Figure 6: Hospital admissions as a result of self harm**

An analysis of hospital admission data in relation to those who have self harmed, shows the following distribution in terms of area of residence across the county for the period 2011-2016.
Hospital admissions for intentional self-harm, standardised admission ratio 2012/13 – 2016/17
Middle Level Super Output Area – MSOA (Boundaries 2011).

In addition to admissions from parts of Northampton, Kettering and Corby, the map above shows high levels of admission for self harm from Queensway, Irthlingborough, Raunds, and parts of Daventry district, including Abbey North and South and parts of Drayton as well as parts of South Northamptonshire including Harpole and Grange and Heyfords and Bugbrooke.

Rates of admissions for 10-24 year olds are increasing and in both genders. Increases could reflect an increasing burden but also may reflect improved data collection or differences in coding or local pathways of care.

Further analysis of admissions was undertaken in 2018 looking at the last 5 years of admissions, a summary can be found here. This analysis allows for higher risk groups to be identified locally and highlights the marked differences geographically and by patient characteristics. More research on local patterns is needed particularly in those areas identified with greater prevalence or where rates differ from the average pattern.
Suicide:
The age standardised suicide rate, presented as a three year average, shows that the Northamptonshire rate is not significantly different to the England average from 2001-03 to date.

The prevalence of suicide in Northamptonshire broadly mirrors the prevalence in England as a whole and in the East Midlands Region, although there is some variation in the prevalence of suicide across the county.

(Northamptonshire Suicide Prevention Strategy 2017-20).

Percentage of suicide by usual place of residence by District, 2009-2016
source: ONS 2017

Data shows that suicide rates are higher in Corby and Kettering in 2014-16, and that men are more at risk than women, but rates in women are increasing”.

The reasons that lead to someone taking their own life may be extremely complex, but it is important to note that deaths from intentional self-harm are most prevalent (49% of all deaths from suicide) in those aged between 41 and 60 years old, more specifically those aged 50-59 years. When looking at prevalence by 5 year age bands, Northamptonshire appears to have a higher number of older people dying from intentional self-harm than might be expected by the national average.

Six years of Primary Care Mortality Database (PCMD) data (April 2011 to March 2017) indicate that in Northamptonshire the prevalence of deaths from intentional self-harm appear to be higher among a slightly older cohort; 49% of all deaths from suicide in the county are in those aged between 41 and 60 years old.
The population group with the highest suicide rate in England and Northamptonshire is middle aged men. There may be a number of factors influencing this, including higher rates of risk factors such as alcohol misuse, economic pressures, unemployment or redundancy and debt and sometimes this may be thought to be the outcome of a reluctance to ask for help among this group.

**Refining our understanding of the impact of deprivation**

As noted above, levels of deprivation are significantly associated with prevalence of mental health disorders. People living in more deprived areas are likely to have higher levels of mental health conditions and higher need for services.

This overview section provides brief information about deprivation across the county, and subsequent sections of this Health Needs Assessment will cross reference this with what is known about (self-assessed) mental wellbeing as reported in the Northamptonshire Mental Wellbeing Survey (2016) to provide a more nuanced picture of the relationship between deprivation and mental wellbeing at a borough and district level.

In Northamptonshire, 69 (16.4%) of the county’s 422 LSOAs fall within the top 20% most deprived LSOAs in England. The three most deprived LSOAs in the county are:

- Northampton 011A Billing Aquadrome and Bellinge area
- Northampton 021F Railway Station, St Peters Way and Industrial Estates area
- Corby 006G Kingswood Oakley Road area

The least deprived is South Northamptonshire 009B North Brackley.

Looking at the seven domains of the IMD, the following LSOAs are in the top 100 most deprived LSOAs in England for their particular domain:

- Northampton 021F Railway Station, part of Town Centre, St Peters Way and Industrial Estates area (ranked 17th nationally in the Crime Domain)
- Northampton 015C Racecourse area (ranked 39th nationally in the Crime Domain)
- Northampton 011A Billing Aquadrome and Bellinge area (ranked 50th nationally in the Barriers to Housing Domain)
- Corby 006D Kingswood (ranked 88th nationally in the Education, Skills & Training Domain)

Within Northamptonshire, the deprived population is made up of a higher proportion of children and non-White British residents than the less deprived areas of the county.

The variation across the county in terms of areas of deprivation, with Northampton and Corby having the highest concentration of the most deprived Lower Super Output Areas with regards to health deprivation and disability is illustrated in the map below.
It is worth noting that 14 Lower Super Output Areas (LSOAs) in Northamptonshire fall within the 10% most deprived in England (Income Deprivation Affecting Older People Index 2015). Of these 14 LSOAs, 9 are in Northampton, with 2 in Kettering, 2 in Wellingborough and 1 in Corby.

In relation to children, 26 LSOAs in Northamptonshire fall within the 10% most deprived LSOAs in England in the 2015 Income Deprivation Affecting Children Index, half are in Northampton and 15% apiece in Wellingborough and Corby (ONS, IMD 2015).
Deprivation and perceived mental wellbeing

The Northamptonshire Mental Wellbeing Survey (42), which was conducted in 2015, set out to provide a ‘general diagnosis’ of the level of mental wellbeing both at the County and District levels using the Warwick Edinburgh Mental Wellbeing Scale (developed to enable the measurement of mental wellbeing) and used alongside segmentation data to assess the relationship between deprivation and mental wellbeing.

Further details about the Mental Wellbeing Survey can be found here.

The Mental Wellbeing Survey (42) suggested that,

“Actions to improve mental wellbeing should be focused on these respondents with the lowest wellbeing scores. Reflecting Marmot’s “Social Gradient”, the association between mental wellbeing and deprivation, risky lifestyle behaviours and associated health inequalities is clear here. There is considerable scope to improve the mental wellbeing of this core group and influence positive behaviour change and improve physical health. This will have the longer-term impact of improving a range of health outcomes”.

The map below shows the percentage of respondents in the lowest mental wellbeing quartile by MSOA. The percentages have been divided into five ranges with the highest percentage in red and the lowest in yellow.

NB: These do not indicate statistically significant differences as only 11 of the 91 MSOAs shown have significantly higher percentages, and 10 have significantly lower percentages, than Northamptonshire as a whole.

The Survey recommended that a key focus for action and intervention should be the quarter of Northamptonshire residents who have a WEMWBS score of 49 or lower; the threshold score below which the quarter of Northamptonshire residents with the poorest mental wellbeing are to be found.
Additional considerations

Importance of considering perinatal mental health
Research suggests that perinatal mental health problems interfere with the relational environment for the infant and therefore compromise the healthy emotional, cognitive and even physical development of the child, with serious long-term consequences (43).

Overlap between long-term conditions and mental health problems
People with long-term physical health conditions – the most frequent users of health care services – commonly experience mental health problems such as depression and anxiety, or dementia in the case of older people. As a result of these co-morbid problems, the prognosis for their long-term condition and the quality of life they experience can both deteriorate markedly (44).

Overall, research evidence suggests that at least 30 per cent of all people with a long-term condition also have a mental health problem (44). Researchers at the King’s Fund have represented this relationship in the graphic below:

Figure 7: Relationship between long term conditions and mental health problems

The King’s Fund and Centre for Mental Health (2012) (44)

There is also evidence that the relationship between having multiple long-term conditions and experiencing psychological distress is exacerbated by socio-economic deprivation in two ways. First, a greater proportion of people in poorer areas have multiple long-term conditions. Second, the effect of this multi-morbidity on mental health is stronger when deprivation is also present.

Data about people living with long term conditions in Northamptonshire
There is evidence that people with a long-term physical health condition are two to three times more likely to develop mental conditions, particularly depression and anxiety. Data from the patient survey below shows the proportion of people who responded to the survey and reported having a long standing health condition (45).
Figure 8: Percentages of patients with long term conditions identified from GP profiles in Northamptonshire

![Graph showing percentages of patients with long term conditions in Northamptonshire over years.](image)


<table>
<thead>
<tr>
<th>Period</th>
<th>Count</th>
<th>Value</th>
<th>Lower CI</th>
<th>Upper CI</th>
<th>England</th>
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<td>6,586</td>
<td>52.9*</td>
<td>-</td>
<td>-</td>
<td>53.1</td>
</tr>
<tr>
<td>2012/13</td>
<td>6,239</td>
<td>52.6*</td>
<td>-</td>
<td>-</td>
<td>53.5</td>
</tr>
<tr>
<td>2013/14</td>
<td>5,938</td>
<td>53.7*</td>
<td>-</td>
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<td>2014/15</td>
<td>5,800</td>
<td>55.6*</td>
<td>-</td>
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<tr>
<td>2015/16</td>
<td>5,391</td>
<td>52.1*</td>
<td>-</td>
<td>-</td>
<td>53.2</td>
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<tr>
<td>2016/17</td>
<td>5,415</td>
<td>53.1*</td>
<td>-</td>
<td>-</td>
<td>53.5</td>
</tr>
</tbody>
</table>

Source: Dh, GP patient survey


**Working age population in Northamptonshire claiming out of work benefits**

The role of work in promotion of mental health and well-being is important, as it is a key determinant of self-esteem, identity, sense of fulfilment and opportunities for social interaction. The evidence shows that those in work experience better mental health than those not in work (46).

National research has noted that people in Great Britain who are unemployed are between four and ten times more likely to develop anxiety and depression (47).

Marmot and colleagues have noted the beneficial effects of “good work” in their review of health inequalities in England (2010). ‘Good work’ means having not only a work environment that is safe but also having a sense of security, autonomy, good line management and communication within an organisation. For the majority of people being in ‘good work’ is better for their health than being out of work (48).

The map below shows that there are wards with relatively high levels of people claiming out of work benefits in Northampton, Kettering, Corby, and Wellingborough.
Older adults

People living longer is a cause for celebration, but older people can more vulnerable to mental health problems according to evidence that has been collated by the Mental Health Foundation. They cite research that suggests depression affects around 22% of men and 28% of women aged 65 years and over (49), yet it is estimated that 85% of older people with depression receive no help at all from the NHS (50).

Overall, the Mental Health Foundation suggest that there are 5 key factors that affect the mental health and wellbeing of older people: discrimination, participation in meaningful activity, relationships, physical health and poverty. These factors will be noted below in relation to the recommended action plan to promote mental health and mental wellbeing in Northamptonshire.

Details about overcrowding in Northamptonshire

People living in overcrowded housing are likely to experience higher rates of respiratory disease, tuberculosis, meningitis and gastric conditions, and such conditions are likely to have a negative impact on their mental health (51).
Percentage of households with one or more rooms too few, reported in 2011 Census.
Middle Level Super Output Area – MSOA (Boundaries 2011).

The map above shows distinct areas of over crowded households across Northampton, and in parts of Wellingborough, Daventry and Kettering, and a small area of Brackley South.

Social isolation and loneliness
Social isolation describes the state of having inadequate quantity and quality of social relationships, while loneliness is an emotional perception that can be experienced by people regardless of the extent of their social network (52).

Both have negative consequences for health and wellbeing. A meta-analysis of nine longitudinal studies found that social isolation and loneliness are associated with 50% excess risk of coronary heart disease, which is broadly similar to the excess risk associated with work-related stress (53).

Loneliness can have a negative effect on our health, with studies reporting an association with higher blood pressures, compromised immune system function and increased stress hormones. The cumulative effect means that being lonely can be as bad for your health as being a smoker (54)(55).

The English Longitudinal Study of Ageing (ELSA) asked respondents for their thoughts and feelings regarding social interactions and feeling lonely. The study found that the two points in life where feelings of social isolation and loneliness are most likely during adolescence and during old age.
Figure 9: Proportion of people who report feeling lonely in their daily life, by age group, 2014-2015 in Great Britain

![Percentage reporting high levels of loneliness](0 to 1 out of 10)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage Reporting High Levels</th>
<th>Percentage Reporting Very Low Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 to 64</td>
<td>14.8%</td>
<td>55.7%</td>
</tr>
<tr>
<td>65 to 79</td>
<td>14.5%</td>
<td>62.4%</td>
</tr>
<tr>
<td>80 and above</td>
<td>29.2%</td>
<td>43.4%</td>
</tr>
</tbody>
</table>


Notes:
1. Adults aged 16 and over were asked “On a scale where 0 is not at all lonely and 10 is extremely lonely, how lonely do you feel in your daily life?”.
2. Responses were grouped into those who reported high levels of loneliness (those who rated their loneliness between 6 and 10), those who reported low to medium levels of loneliness (those who rated their loneliness between 2 and 5) and those who reported very low levels of loneliness (those who rated their loneliness at 0 or 1).

Socio-Economic Isolation by LSOA in Northamptonshire

The report “Social Isolation in Northamptonshire” (2015) (56) provided extensive analysis of available data, and produced some valuable insights into the experiences of local residents.

The report noted that there were “hotspots” for loneliness in all the major urban areas of the county, particularly Northampton. It might be expected that people living in more rural locations would be more at risk of isolation and loneliness but this is only true in the East and South of Northamptonshire.

The report concluded that older people in urban environments are most at risk of feeling isolated and lonely, rather than people living in more rural communities. It observed that the main societal factors that contribute to a sense of isolation, are crime, and a fear of crime, and a lack of community brought about by housing stock that promotes transience rather than a long term residency.

The report suggests that a focus on crime reduction in areas where older people are likely to feel isolated would help people in this situation find ways to improve their social life without the fear of crime or anti social behaviour. Older people living in areas with high proportions of social housing
and rented accommodation are more likely to feel lonely or isolated than those living in areas with higher levels of owner occupation. Targeting activities at older people in these areas could help to rebuild the community networks for these residents that have been lost over time.

Local data about black and minority ethnic communities
The relationship between inequalities related to socio-economic status and protected characteristics and poor mental health is two-way: experiencing disadvantage and adversity increases the risk of mental health problems and experiencing mental health problems increases the risk of experiencing disadvantage (5).

Mental health problems can create a spiral of adversity where related factors such as employment, income and relationships are impacted, and these things in turn are known to compound and entrench mental health problems (5).

Research suggests that some Black and Ethnic Minority groups are also more likely to experience a mental health problem, irrespective of socio-economic status (57).

In addition, people Black and ethnic Minority groups are less likely to have their mental health problems detected by their GP (58).

Figure 10: Graphic showing ethnicity information of Northamptonshire residents based on 2011 Census data

Map of distribution of Black and Minority ethnic populations across Northamptonshire.

Source Local Health 2018.

The map above shows that the distribution of Black and Minority Ethnic communities is focused on key urban areas in Northampton, Wellingborough, and Corby, as well as to a slightly lesser extent, parts of Kettering, Rushden, and Daventry district.

**Note about mental ill health**

Details about the prevalence of mental ill health, and of the usage of mental health services in Northamptonshire, is being captured in the revised Joint Strategic Needs Assessment chapter regarding mental Health, and so is not reproduced in this document.

**Protective factors for mental health in Northamptonshire**

Protective factors support or increase the development of individual level attributes such as coping abilities, self-efficacy and resilience, and the ability to learn and to develop social skills – all of which may encourage healthy behaviours and mental health and wellbeing. These attributes contribute to the ability to have control over one’s life. Research suggests that a sense of “control” is a key mediator in the relationship between social position and health (18).

In addition to these attributes being supportive of good mental health, research suggests that mental wellbeing and resilience are themselves protective factors for physical health, as they reduce the prevalence of risky behaviours such as heavy drinking, illegal drug use, smoking and unhealthy
food choices which are often used as coping and management mechanisms in the absence of other support (S).

The following indicators are taken from the Mental Health JSNA toolkit which collates public health data on the Fingertips website to provide a local summary.

### Table 3: Protective factors

<table>
<thead>
<tr>
<th>Protective factors</th>
<th>Northamptonshire</th>
<th>Trend</th>
<th>Local RAG</th>
<th>Corby</th>
<th>Daventry</th>
<th>East Northants</th>
<th>Kettering</th>
<th>Northampton</th>
<th>South Northants</th>
<th>Wellingborough</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCSEs achieved A*-C: % of pupils (2015/16)</td>
<td>54.2</td>
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<td></td>
<td></td>
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<tr>
<td>Average attainment 8 score (2016/17)</td>
<td>44.7</td>
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<tr>
<td>Employment - % of population aged 16-64 (2017/18)</td>
<td>76.4</td>
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<tr>
<td>Enough physical activity: % of population age 19+ (2016/17)</td>
<td>63.6</td>
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PHE Source - [https://fingertips.phe.org.uk/](https://fingertips.phe.org.uk/)

Stable and appropriate employment is a factor in maintaining good mental health. The data suggests that for most of the county, the level of employment and long term unemployment are similar to the national average, although for Daventry, Kettering and South Northants the trend data for employment is showing a significant decline.

Physical activity levels in adults across the county as a whole do not compare well to national average, and there is a worsening trend in Corby and Wellingborough.

**Cross referencing risk factors and protective factors with findings of Northamptonshire Mental Wellbeing Survey 2016:**

- “Generally speaking, the average mental wellbeing levels of Northamptonshire residents are higher than the UK population. Lower wellbeing levels have been observed in Northampton and Wellingborough; these two boroughs also have a high proportion of residents living in the most deprived neighbourhoods”. p2

- “The survey results also show that Northamptonshire has a higher WEMWBS mean score (53.3) than the UK (51.6). Corby, despite being one of the more deprived boroughs/districts within Northamptonshire, has the highest WEMWBS score (55.1)”. p2
• “Actions to improve mental wellbeing should be focused on these respondents with the lowest WEMWBS scores. Reflecting Marmot’s “Social Gradient”, the association between mental wellbeing and deprivation, risky lifestyle behaviours and associated health inequalities is clear”. p17

• “Underpinning this is social deprivation, unemployment, lower educational attainment, lower skill employment and uptake of benefits. These factors are likely to have a considerable impact on personal relationships, emotional resilience, levels of community capacity and support, and overall levels of mental wellbeing”. p36

• “Corby, despite being one of the more deprived and ‘less healthy’ boroughs/districts in the County, has appeared to have higher wellbeing than the Northamptonshire average in terms of the WEMWBS, ONS anxious yesterday and NEF social trust measure”. p 82
5. **Recommendations for promoting mental wellbeing across the life course:**

These will be structured around the Faculty of Public Health recommendations in “Better Mental Health for All (2016), using their “Universal, selective or indicated” prevention model (as per diagram below):

**Figure 11: Prevention Model**

Better Mental Health for All: A Public Health Approach to Mental Health Improvement (2016)  
London: Faculty of Public Health and Mental Health Foundation. Pp 3

**General approach**

The principles underlying public mental health are not dissimilar from those underpinning any public health approach (18).

Six principles that are especially important can be summarised as follows:

1. Interventions which focus on the positive have added value over those which focus on finding or preventing the negative. Promoting mental wellbeing moves the focus away from illness and is central to an individual’s resilience, social purpose, autonomy and ability to make life choices.

2. The social, economic, cultural and environmental determinants of mental health need to be considered and addressed. Different interventions can potentiate (increase power/effect) each other.

3. A proportionate universalism approach which addresses whole population mental wellbeing promotion and provides additional support for high risk groups is the optimum approach.

4. Engagement, both community and individual is central to public mental health. The former is concerned with building on assets and involving communities in framing the issues and the solutions, the latter with developing individual strengths and resilience.
(5) Since personal risk and protective factors are determined in early childhood, primarily in the context of family relationships, a life course approach is essential.

(6) A truly multidisciplinary and inter-sectoral approach must be adopted as no one discipline has all the knowledge or power to effect the required level of change.

NB: The following recommendations are based on the risk and protective factors identified above, and seek to build on existing local resources, investments and plans.

**Children**

**Perinatal**

As noted above, research suggests that the key way to reduce risk in very early childhood is to promote healthy parenting focusing on the quality of parent-infant/child relationships, parenting styles including behaviour management, and infant and child nutrition (including breast-feeding and healthy eating).

**Recommendation:**
Given the specific risk factor identified for Northamptonshire in the Public Health England data set of smoking at time of pregnancy, it is recommended that focused smoking cessation support to pregnant women smokers is provided as part of an holistic package of perinatal support.

At the programmatic level, research suggests interventions to support parents can deliver benefits to their mental health, support children’s social and emotional development and reduce behavioural problems (17).

**Recommendation:**
The Children and Young People (CYP) Action Plan includes a commitment to implement the Incredible Years programme, as well as improving prevention and early intervention for families. This aligns well with many of the risk factors identified above, and consideration could be given to the merit of other parenting support programmes as well as other interventions already proposed in the CYP Action Plan and in the Future in Mind Local Transformation Action Plan would fit well to the following proposed structure of “universal” and “targeted” interventions. For example, building on existing commitments:

**Universal offer**
- Expanding services to support breastfeeding, including immediate telephone and signposting support on discharge from hospital and a volunteer peer support programme
- Support training of the multi-disciplinary workforce to implement the Five to Thrive programme
- Improve emotional wellbeing support for Children and Young People; including the implementation of the Future in Mind programme in line with the Five Year Forward View
- Promote Ask Norman site has prevention focus and content included in update
- Promote Talk Out Loud anti-stigma group and Youth Counselling Services.
- 0-19 School Nursing Service includes promotion of student wellbeing, and wellbeing sessions are offered to schools to promote positive mental health and emotional resilience.
Targeted offer

- Implementation of the Adverse Childhood Experiences report recommendations via the Health and Wellbeing Board
- Focus on mental wellbeing of looked after children, (linked to Priority 5 of Future in Mind action plan)
- Focused mental wellbeing support for children in need due to abuse, neglect or family dysfunction
- Build on work already undertaken in the Northamptonshire Self-Harm Care Pathway to develop prevention focus, and use insight from existing multi-agency network and geographical mapping shown above.
- Based on analysis in the HNA above, develop place based interventions with children in areas of deprivation – esp in Northampton, Corby, Wellingborough and Kettering.
- In light of the inequalities noted in this HNA, to note and support the implementation of the Northamptonshire SEND strategy 2018 – 2020 which identifies priorities across three main areas:
  - Meeting the needs of children and young people, in whatever setting, as early and as quickly as possible;
  - Progress the co-location of children services to improve collaborative working and planning around the needs of the family.
  - Scope, plan and implement the Children’s Health Digital Strategy as part of the Five Year Forward View in partnership with all providers and commissioners; requiring support from the LDR.

Adults

As noted above, good mental health is vital to overall health, and is associated with better productivity, is a protective factor for some physical health conditions, and is a vital asset for dealing with life’s stresses. Good mental health is not just the absence of a mental health problem, but having the ability to think, feel and act in a way that allows us to enjoy life and deal with the challenges it presents (4).

The Faculty of Public Health have provided a useful synthesis of available research and made recommendations about how best to deliver both “Universal” and “Targeted” interventions. In addition to which, Public Health England have analysed the available research and produced an update of guidance about Return on Investment of various programme and approaches to promoting mental wellbeing.

Based on the analysis of the current situation in Northamptonshire described above, the recommendations arising from the Mental Wellbeing Survey (2016), and the activity currently taking place via the Mental Health Transformation Board, the following interventions are recommended:

Universal

- To use social media and other avenues to disseminate universal public mental health messages such as those promoted in the “5 Ways to Wellbeing” and “Action for Happiness”
  **NB: References to be included here.**
- Consider promotion of physical activity and linkage with local social prescribing initiative
- Extend existing Workplace health programme to promote mental health and initiatives to help adults at risk of stress, anxiety and depression
Consider promoting Mindfulness, amplifying existing local initiatives including Learn2b and local groups, incl tai chi and yoga, and using national resources incl apps here.

Consider use of volunteering / timebanking and enhancing / promoting existing local initiatives.

Targeted

- Arising from action points noted in Northamptonshire Mental Wellbeing Survey 2016, targeted action in relation to the quarter of Northamptonshire residents who have a WEMWBS score of 49 or lower. (See Mental Wellbeing Survey report for further details).
- Arising from the Northamptonshire Social Isolation report (2015) noted above, a focus on crime reduction in areas where older people are likely to feel isolated would help people in this situation find ways to improve their social life without the fear of crime or anti social behaviour. Older people living in areas with high proportions of social housing and rented accommodation are more likely to feel lonely or isolated than those living in areas with higher levels of owner occupation. Targeting activities at older people in these areas could help to rebuild the community networks for these residents that have been lost over time.
- Initiatives to identify and support people who have self-harmed and are potentially suicidal. (as noted above in Children’s recommendations section, geographically focused on areas of deprivation and linked to hospital admissions data
- Consider and consult on how best to integrate mental health support into the pathways and interventions for people with long term physical health problems e.g. diabetes and heart disease
- Promote Community Safety partnership action plans, especially in those urban areas noted above – Northampton, Kettering, Corby and Daventry.
- Financial advice services for people with debt problems located in primary care (geographically focused on areas of deprivation). In addition to this, to promote financial advice and energy efficiency advice to people in areas of fuel poverty, linking with local countywide initiatives, and targeting geographic areas highlighted above.
- Based on Faculty of Public Health recommendations, promote mental health literacy training to frontline housing and advice workers to help individuals and families to secure and sustain appropriate accommodation, manage debt and maximise their incomes.

For further research and consideration

Further investigation into what it is about Corby which enables it apparently to ‘buck the trend’ on certain mental wellbeing measures, but noting recent suicide data which is worse than national and regional averages, and shows a worsening trend.

- Consider approaches for supporting older people in relation to their mental wellbeing, e.g. linking to reducing social isolation, explore the case for expanding a “men in sheds” initiative targeted in areas of deprivation and social isolation for older men, building on the experience of existing schemes such as that in Northampton (NB: and focusing on areas identified in Social Isolation report)
- NB: Options for older women to be considered too – possibility of having this as a discussion point with Concordat group
In addition to the above, actions arising from the Kerslake report (re rapid response and provision of appropriate counselling support) at the location of large scale “Emergency Incidents” should be included in any action plan.

References:


4. Mental Health Foundation. Surviving or Thriving: The state of the UKs mental health. London: Mental Health Foundation; 2017

5. Better Mental Health for All: A Public Health Approach to Mental Health Improvement (2016) London: Faculty of Public Health and Mental Health Foundation


42. Northamptonshire Mental Wellbeing Survey (2015) Northamptonshire Analysis


Additional references consulted:


Department of Education (2018)

Department of Education (2018)
Characteristics of Children in Need 2016-17.


Mental Health Foundation (2016): Mental Health and prevention; taking local action. London; Mental Health Foundation

Appendix 1.

Note about Health Needs Assessment

Health Needs Assessment (HNA) is a systematic method of reviewing the health issues faced by a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities. (1)

The purpose of undertaking a Health Needs Assessment is:

1. To better meet need and demand

By gathering the information needed to re-focus local public health strategies and, in combination with local service re-design programmes (e.g. as overseen by the Mental Health Transformation Board), to change services where necessary, to meet need and demand.

2. To focus on integration

An HNA reviews needs and maps services in an integrated fashion including related services and services delivered by other providers – the basis for integrated planning of service delivery.

3. To understand the local picture

The HNA process provides a baseline of need and current service content and configuration against which it is possible to evaluate and measure the progress of any changes that are implemented.

4. To identify barriers to access and opportunities for overcoming them

A HNA provides an in-depth analysis and understanding of the needs of the local population and facilitates better access to information and services.

5. To help allocate scarce resources to best meet need

Information collected during a HNA will help commissioners and service providers focus resources effectively and efficiently and inform prioritisation when there are conflicting demands. In the absence of a needs assessment there is a danger that services in historical locations bear no resemblance to current patterns of need.

6. To engage your stakeholders

Appendix 2

Linked strategies and workstreams

- Suicide Prevention Strategy (2017)
- Mental Health Transformation Strategies (Adults and Children)
- Adverse Childhood Events – local action plan.
- STP/ Northamptonshire Health and Care Partnership Mental Health workstream
- Northamptonshire Physical Activity Strategy
- Local Depression pathway (in development)