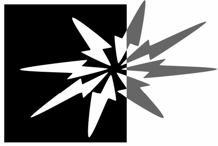
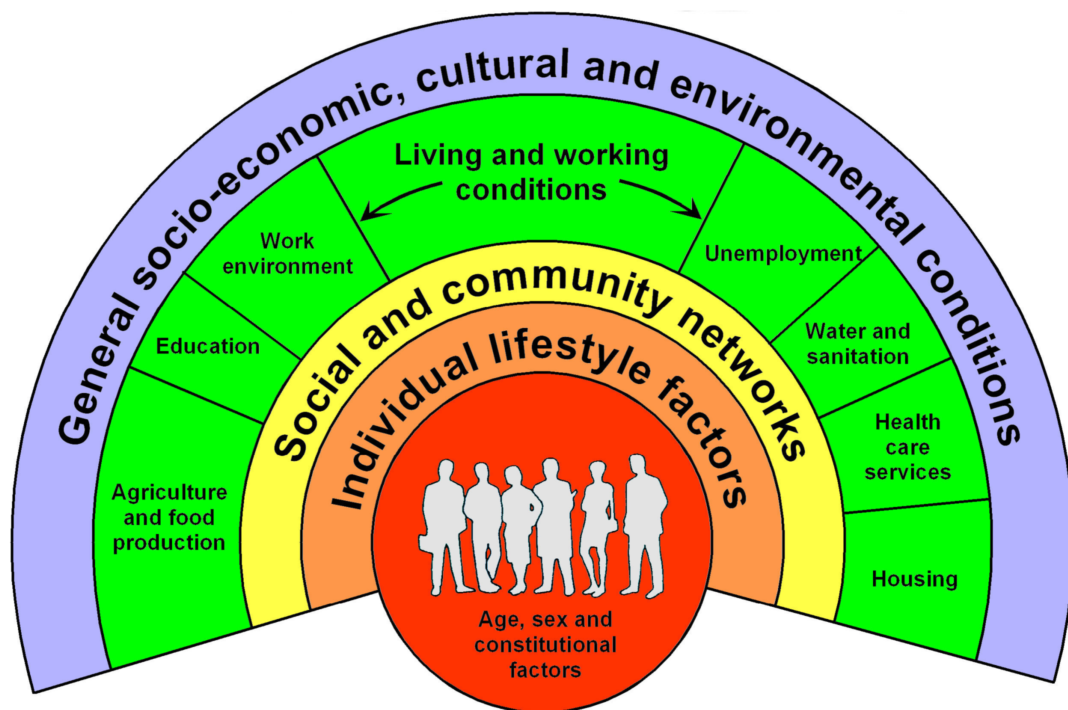


Health: Everyone's Business (2010)



Source: Dahlgren and Whitehead, 1991

A REPORT OF THE OVERVIEW AND SCRUTINY COMMITTEE

March 2011

www.haringey.gov.uk

Chair's Foreword

I am pleased to present the report of the second 'Health: Everyone's Business' event on tackling health inequalities in Haringey. The Scrutiny Committee became involved in health inequalities back in 2008 when we hosted the first of these events in order to raise awareness of the importance of working together across the partnership to tackle health inequalities in the borough.

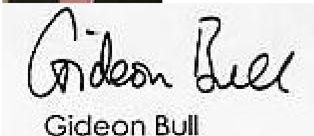
Although commonly considered factors such as access to and use of health care services have an impact on health and well-being, they are also determined by individual circumstances and the local environment. Factors such as where people live, income, education, life experiences, behaviours and choices and relationships with friends and family all have an impact.

All of these health determinants can be influenced by the work of the local authority and its partners. This is why I believe that it is crucial to work openly and collaboratively with all our partner agencies and the third sector, particularly as Haringey, in common with other local authorities, assumes responsibility for Public Health in the borough.

I would like to thank all of those stakeholders who attended this very interesting event, as well as Officers both in the Council and in Public Health and also the Well-Being Partnership Board who worked jointly with the Overview and Scrutiny Committee to make the event a success.

I would particularly like to thank Dr Lynne Friedli who attended as our key note speaker and presented the attendees with some very thought provoking information.

I look forward to working further on this challenging yet very important topic.



For further information:

Melanie Ponomarenko/Jodie Szwedzinski
Policy, Intelligence and Partnerships
7th Floor River Park House
High Road
Wood Green N22 4HQ
Tel: 020 8489 2933/2405
Email: Melanie.Ponomarenko@haringey.gov.uk
Jodie.Szwedzinski@haringey.gov.uk

Contents

Executive Summary	Page 4
Recommendations	Page 5
Health: Everyone's Business	Page 5
National and Local Policy Context	Page 6
Social Prescribing	Page 11
Mental Health	Page 11
Tobacco Control	Page 17
Physical Activity	Page 22

Appendices

Appendix A – Attendees	Page 27
Appendix B - Case Studies	Page 29
Appendix C – End notes	Page 39
Appendix D – Presentation by Dr Lynne Friedli	Separate document
Appendix E - Marmot Indicators for Haringey	Separate document

1. Executive Summary

1.1. Overview and scrutiny has a specific role in relation health inequalities as part of its health scrutiny powers. These powers have been used regularly in looking at inequality in terms of access to healthcare. Following an external audit by Grant Thornton the Overview and Scrutiny Committee held its first 'Health: Everyone's Business' event in 2008. This event highlighted the wider determinants of health and their links to health inequalities as well as emphasising the role that each Thematic Board under the Haringey Strategic Partnership has in tackling health inequalities in Haringey.

1.2. Since this event the Overview and Scrutiny Committee have continued to be actively involved in work around health inequalities, and were commended on this work by the Health Inequalities National Support Team in their feedback in 2009.

1.3. In late 2010 the Overview and Scrutiny Committee, in conjunction with the Well-Being Partnership Board, held a follow up event focusing on three specific areas where it is felt there are significant health inequalities in the borough and where the Committee felt value could be added by it's involvement along with a range of other stakeholders. Dr Lynne Friedli attended as the key speaker.

1.4. This event focused on three areas:
- Mental Health
- Tobacco Control
- Physical Activity

1.5. These areas formed the focus of group discussions with the following questions.

- What should we as a partnership be doing that we aren't doing?
- What could we as a partnership be doing differently?

1.6. In response to the above questions key messages were collated from each group. These include:

Mental Health:
- Increased community education of mental health and further support for children with mental health issues
- Prevention
- Increased community education and support of mental health

Tobacco Control:
- Advantages of brief interventions
- Ethnic and cultural targeting according to prevalence
- Support/Social networks

Physical Activity:
- Walking-based initiatives
- Interventions targeting children
- Closer partnership working with providers of sport/physical activity initiatives

1.7. This report provides best practice examples and cost effective interventions linked to the key messages of the event.

2. Recommendations

1. That the OSC hold a further 'Health: Everyone's Business' event in 2011/2012.

2. That the Health Inequalities Cross Party Working Group note this report and utilise it as part of their evidence base.

3. So that awareness of the Health Inequalities agenda is embedded in all of Haringey's policies and services, the report should be distributed to all heads of business units, appropriate partner agencies and third sector organisations.

4. That the appropriate partnership group identify what is already being done locally to tackle health inequalities and consider where best practice identified in this paper may apply.

3. Health: Everyone's Business

3.1. Overview and scrutiny has a specific role in relation health inequalities as part of its health scrutiny powers. These powers have been used regularly in looking at inequality in terms of access to healthcare. Following an external audit by Grant Thornton the Overview and Scrutiny Committee held its first 'Health: Everyone's Business' event in 2008. This event highlighted the wider determinants of health and their links to health inequalities as well as emphasising the role that each Thematic Board under the Haringey Strategic Partnership has in tackling health inequalities in Haringey.

3.2. Since this event the Overview and Scrutiny Committee have continued to be actively involved in work around health inequalities, and were commended on this work by the Health Inequalities National Support Team in their feedback in 2009.

3.3. In late 2010 the Overview and Scrutiny Committee, in conjunction with the Well-Being Partnership Board, held a follow up event focusing on three specific areas where it is felt there are significant health inequalities in the borough and where the Committee felt value could be added by it's involvement along with a range of other stakeholders. Dr Lynne Friedli attended as the key speaker.

3.4. This event focused on three areas:
- Mental Health
- Tobacco Control
- Physical Activity

3.5. These areas formed the focus of group discussions with the following questions.

- What should we as a partnership be doing that we aren't doing?
- What could we as a partnership be doing differently?

3.6. In response to the above questions key messages were collated from each group and these have been further explored in the main body of this report by way of best practice examples. The report provides further information on cost

effective interventions. The report also provides an overview of the demographics and health inequalities associated with each of the above areas. It should be noted that the best practice examples are only a sample of best practice available and a starting point for further investigation.

4. National and Local Policy Context

4.1. Healthy Lives, Healthy People - Public Health White Paper

4.1.1. The White Paper sets out the Government's long-term vision for the future of public health in England. The aim is to create a 'wellness' service (Public Health England) and to strengthen both national and local leadership.

4.1.2. The paper aims to strengthen both national and local leadership by having directors of public health, employed by local authorities and jointly appointed with Public Health England. Their role will be to lead on driving health improvement locally.

4.1.3. Responding to the challenges set out in Professor Sir Michael Marmot's powerful Fair Society, Healthy Lives report, the White Paper includes a proposal for a new, health premium that will reward progress on specific public health outcomes.

4.1.4. The premium is intending to fight health inequalities thus formally recognising disadvantaged areas which face the greatest challenges, and will therefore receive a greater premium for progress made.

4.1.5. Local authorities will deploy resources to improve health and well-being in their communities using ring-fenced health improvement budgets allocated by the Department of Health and based on a formula grant for each area.

4.2. Marmot review- 'Fair Society, Healthy Lives'

4.2.1. The government has expressed its commitment to reducing health inequalities. In 2010 The Marmot review; *'Fair Society, Healthy Lives'* was published in response to the request made by the former Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The strategy includes policies and interventions that address the social determinants of health inequalities. Key messages delivered from the review were:

1. The reduction of health inequalities is reliant on fairness and social justice being achieved. Evidence suggests that in England, many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.
2. Further evidence points to the fact that there is a social gradient in health – the lower a person's social position, the worse his or her health. Therefore our effort should also be focused on reducing the gradient in health.
3. The review also reaffirms the point that health inequalities result from social inequalities. Therefore tackling health inequalities requires action across all the social determinants of health.
4. The reduction in the steepness of the social gradient in health should include actions which are universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is called proportionate universalism. Therefore

showing that focusing solely on the most disadvantaged will not reduce health inequalities sufficiently.

5. There is also an emphasis on the fact that action taken to reduce health inequalities will benefit society in many ways. Benefits like economic benefits in reducing losses from illness associated with health inequalities, which account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.
6. Statements were made to stress the point that economic growth is not the most important measure of our country's success. The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.
7. Reducing health inequalities will require action on six policy objectives (See below)
8. Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies.
9. Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

4.2.2. The review also identified 6 evidenced based policy objectives for action most likely to have the greatest impact on reducing the gap in health inequalities long-term:

1. Give every child the best start in life
2. Enable all children young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

4.3. Marmot indicators for Local Authorities in England

4.3.1. To mark the one year anniversary since the publication of 'Fair Society, Healthy Lives' the London Health Observatory and Marmot Review Team have produced baseline figures for some key indicators of the social determinants of health, health outcomes and social inequality that correspond, as closely as is currently possible, to the indicators proposed in Fair Society, Healthy Lives*:*

- Male life expectancy
- Female life expectancy
- Slope index of inequality (SII) for male life expectancy
- Slope index of inequality (SII) for female life expectancy
- Slope index of inequality (SII) for male disability-free life expectancy
- Slope index of inequality (SII) for female disability-free life expectancy
- Children achieving a good level of development at age 5
- Young people who are not in education, employment or training (NEET)
- People in households in receipt of means-tested benefits

- Slope index of inequality for people in households in receipt of means-tested benefits

The Haringey Indictor set can be found at Appendix E

4.4. London Health Inequalities Strategy

4.4.1. The first London Health Inequalities Strategy was published in March 2010 and provides the framework for action. The strategy is due to be refreshed every four years. The London Health Inequalities Strategy recognises there is a social gradient in health – the lower a person's social position, the worse his or her health. The strategy aims to diminish the steepness of the social gradient so that the health gaps between all Londoners are lessened.

4.4.2. The Mayor's strategic objectives for reducing health inequalities in London are to:

1. Empower individual Londoners and their communities to improve health and well being
2. Improve access to London's health and social care services, particularly for Londoners who have poorer health outcomes.
3. Reduce income inequalities and minimise the negative health consequences of relative poverty.
4. Increase opportunities for people to access the potential benefits of work and other forms of activity.
5. Develop and promote London as a healthy place for all – from homes to neighbourhoods and the city as a whole.

4.5. The London Health Inequalities Strategy – First Steps to Delivery to 2012

4.5.1. Sets out agreed actions to prioritise to 2012 against the thirty high-level commitments which form the bedrock of the strategy. It summarises the first steps already identified with partners to be further built upon over the coming months.

4.5.2. This includes first steps such as:

- Encouraging regional and local organisations to review the extent of their current focus on health inequalities in strategy development, investment and programme planning and in prioritisation – key partners mentions include Overview and Scrutiny Committees.
- Engaging regional and local scrutiny leads in joint work to increase their focus on reducing health inequalities throughout their scrutiny plans and investigations.
- Tackle street trading of illicit tobacco, and the illegal sale of tobacco and alcohol, through use of existing effective interventions, and encourage widespread adoption.
- Generate a planned communication programme to increase positive attention on health issues, starting with HIV and mental health (in order to reduce stigma).
- Work with NHS to scale up approaches to building capacity in Voluntary and Community Sector to deliver physical activity services.

4.6. Health Inequalities National Support Team (HINST)

4.6.1. The Department of Health Inequalities National Support Team (HINST) visit took place in Haringey from the 5th to the 9th October 2009. The National Support Team (NST) held several stakeholder events to understand the local context and assess barriers to and opportunities for making progress at a population level. A number of high level recommendations were made, and following the visit an action plan was developed an approved by the Cabinet member of Adult and Social Care and by the Department of Health. Key recommendations from the visit included:

1. Undertake further analysis quantifying the number of lives that need to be saved and assessment of the necessary scale and reach of interventions required to reduce mortality rates to sustain progress towards the 2010 mortality targets and address inequalities within Haringey.
2. Develop detailed delivery plans informed by the above analysis, equity audit and social marketing.
3. Develop a culture of data and analysis underpinning all strategic and commissioning decisions, as part of a whole systems approach to addressing health inequalities.
4. Establish clear local clinical and practitioner leadership in Cardiovascular Disease (CVD), Stroke, and Cancer.
5. Continue to focus intensively on improving the quality of primary care across the 3 levels of support, and build a partnership approach to case-finding.
6. Take a partnership approach to the development of commissioning groups relating to the contributing factors to health inequalities and the development of improved patient pathways.
7. NHS Haringey should fully integrate its strategic and operational community engagement work internally and with other partners.
8. Continue the development of the Well-Being Partnership Board and the Haringey Strategic Partnership structures in relation to locality working, engagement of the Voluntary Community Services (VCS) and the broader healthy communities' agenda.
9. Ensure specific initiatives are developed and implemented to embed

4.7. Infant Mortality National Support Team (IMNST)

4.7.1. The Department of Health Infant Mortality National Support Team (IMNST) visited Haringey in January 2010. The Team identified examples of good practice and strengths in Haringey, and also made a series of recommendations to be taken forward in the revised partnership Haringey Infant Mortality Strategy.

The IMNST identified the top 5 take home messages for Haringey:

1. Vision and Strategy
In order to keep the vision relevant and maintain momentum:

- NHS Haringey and partners to consider how they can communicate to all staff who contribute to the Infant Mortality Strategy regarding their role and responsibility, and progress on reducing infant mortality.
- Build on the commitment to increase the focus on early intervention and prevention and its critical role in implementation of the Infant Mortality Strategy

2. Commissioning

- The Children's Trust Joint Commissioning Group to explore and develop opportunities to strengthen commissioning arrangements with respect to universal and targeted interventions.

3. Communications
Further strengthen:

- Communication across and between organisations in Haringey
- Communication with the many and diverse population groups and individuals.

4. Community Engagement

- Adopt a strategic approach that integrates the efforts and resources of Haringey Council and NHS Haringey. The risk factors for infant mortality should be embedded in this approach.

5. Workforce, Capacity and Training
A small task and finish group to be established led by Haringey Children's Trust, to:

- Identify where skills need updating and develop training plans
- Spread the existing good practice in Haringey in relation to skill mix and stratification of resources i.e. matching the right skill to the particular needs of the population and service.
- Ensure that the workforce resource is allocated according to local need and priorities.

4.8. Haringey

4.8.1. Haringey has a significant history in tackling health inequalities and continues to address these at every level across the borough. Tackling health inequalities has been integral to the production of several key strategies and plans in Haringey over several years. The Sustainable Community Strategy is the overarching strategy of the Haringey Strategic Partnership, examples of other key strategies and plans include: Sustainable Community Strategy[1], Well-being Strategic Framework, Children and Young People's Plan, Community Safety Strategy, Housing Strategies, Greenest Borough Strategy and Regeneration Strategy, Safer for all, NHS Strategic Plan, Life Expectancy Action Plan, Infant Mortality Action Plan, Report of the visit of the National Support Team of the Department of Health. These existing plans will form components that will shape the future health inequalities strategy. Haringey needs assessments and local information for example Haringey Our Place and Joint Strategic Needs Assessment should inform local strategies.

4.9. Health Inequalities Cross Party Working Group

4.9.1. A Health Inequalities Cross Party Working Group has been set up in order to determine the priority areas to be addressed in the health and wellbeing strategy in order to reduce health inequalities in Haringey.

4.9.2. The proposed objectives of this group are:

- "Evidence base – consider current priorities for tackling health inequalities and identify gaps in knowledge.
- Resources - Identify areas where resources are available and those where programmes have ended as funding has been withdrawn.
- Priorities – determine the priorities on which to focus, ensuring they are integrated with Council policies.
- Recommendations – Make proposals to CAB
- Action – Participate in ensuring that Group's work informs the development of the Health and Well Being Strategy."[2]

5. Social Prescribing

5.1. The advantages of social prescribing emerged as a cross-cutting issue in each of the group sessions. Participants felt that social prescribing could be applied for a wide range of lifestyle choices.

5.2. There is also good evidence of effectiveness in relation to alcohol, where a review of six published studies suggests that between 5 and 10 minutes of advice from GPs to patients with harmful alcohol consumption leads to reductions in consumption of around 25-35% at follow-up six months or a year later[3].

5.3. While the evidence in relation to diet and exercise is less strong, in all these areas only a very low level of effectiveness is needed to make the intervention cost-effective, given the scale of potential benefits and the very modest cost of GP advice.

6. Mental Health

6.1. Key themes which emerged from the Mental Health groups were

- Increased community education of mental health and further support for children with mental health issues
- Prevention
- Increased community education and support of mental health

6.2. **Demographics**

6.2.1. Haringey has a high burden of mental illness and the needs of east and west Haringey are reflected by their demographic differences. There are more patients with dementia in West Haringey which has a greater proportion of older people. In the East of Haringey there are more people with common mental illnesses. It is likely that both dementia and common mental illnesses (particularly depression) are under-diagnosed.

6.2.2. The mental health problems are related to a variety of socio-economic conditions and within east Haringey there are greater levels of deprivation,

poorer housing and a wider variety of socioeconomic groups which lead to greater health inequalities.

6.2.3. In 2010 Haringey was the 13th most deprived borough in England and the 4th most deprived borough in London[4]. Deprivation is not evenly distributed across the borough with areas in the east of the borough experiencing much higher levels of deprivation than the west. Psychiatric morbidity (including anxiety, depression, schizophrenia and psychotic disorders) is known to be associated with social deprivation. Social deprivation is also known to result in longer duration of illness episode, higher risk of relapse, poorer treatment response and clinical outcome.

6.2.4. In Feb 2011, 6.9% (10,159) of the working age population were claiming Job Seekers Allowance (JSA). This includes 7.9% of all working age males and 4.7% of working age females. All three rates are the third highest in London. Unemployment affects mental health especially anxiety and depression, and increases the risk of suicide and self-harm. Unemployment is not evenly distributed across the borough. In Feb 2011, 11.6% (1026) of the working age population in Northumberland Park were claiming JSA. This is the highest ward in London. Duration of unemployment is also an important predictor of psychiatric morbidity. In August 2010, 79.6% of Haringey residents claiming Income Support had been claiming for over 2 years.

6.2.5. Housing and homelessness is an important determinant of mental health. Higher prevalence of mental illness has been found in homeless people or in people in insecure accommodation. Haringey is tackling a serious homelessness challenge. As at 31st December 2009 there were 3,800 households in temporary accommodation. This had reduced to 3,547 by 31st March 2010, a reduction of 22% on 2008/09.

6.3. Key Health Inequalities

6.3.1. Mental health in black and minority ethnic groups

6.3.1.1. Some black and minority ethnic groups have a higher risk of suicide, psychotic illness and hospital admissions. It is likely that there is significant under-diagnosis in this group of patients due to a variety of cultural and social factors. There is evidence that Black Caribbean ethnic groups are at higher risk of being admitted to psychiatric hospital than White ethnic groups. In Haringey 9.5% of residents are of Black Caribbean origin. This proportion is higher than that predicted for London and nationally.

6.3.2. Dementia and depression in older patients

6.3.2.1. Older people make up a significant percentage of Haringey's population. According to the 2009 ONS Mid-Year Estimates, it was estimated there were 21,200 people aged 65+ in Haringey, making up approximately 9.4% of the total population.

6.3.2.2. Depression in elderly people is most often related to social isolation, lower levels of deprivation and chronic medical problems. In Haringey, 2,363 people aged 65+ are predicted to have depression and 741 predicted to have severe depression by 2030.

6.3.2.3. According The Audit Commission's 'Forget me Not' report, one quarter of people aged 85 and over will develop dementia. By 2030, it is estimated that 1,796 people aged 65+ in Haringey will have dementia.

6.3.3. **Refugees and Asylum Seekers**

6.3.3.1. There is evidence that refugees and asylum seekers are especially vulnerable to psychiatric disorders including depression, suicide and post-traumatic stress disorder. It is estimated that between 25 and 30,000 refugees and asylum seekers live in Haringey. This group also has more complex needs and often have more difficulty accessing health services than the general population.

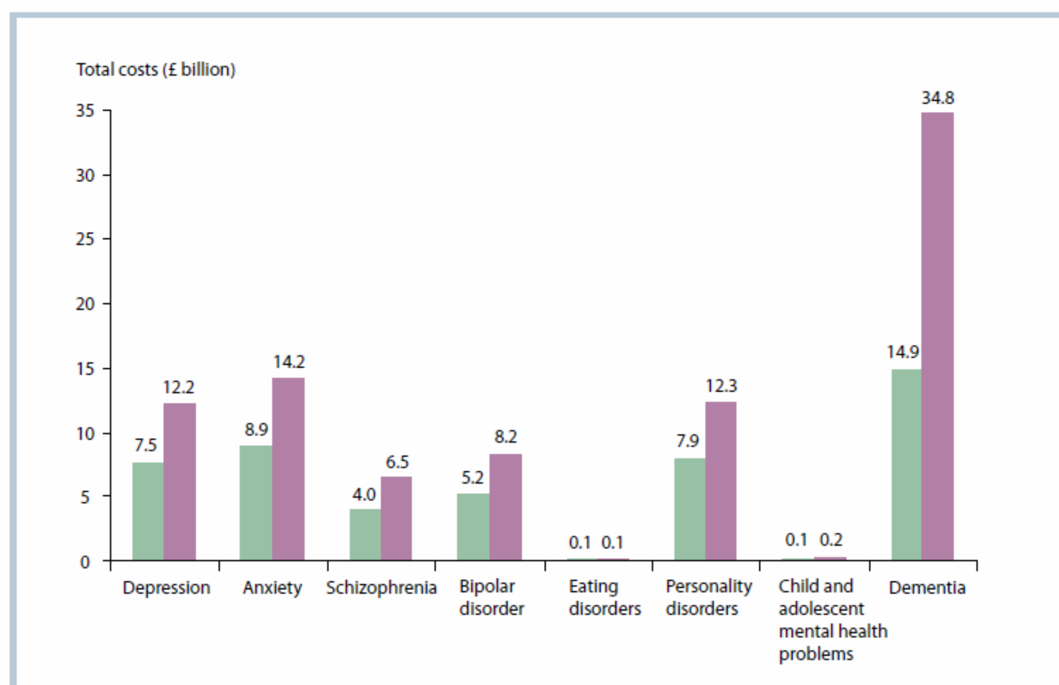
6.3.4. **Mental health care for people with substance misuse problems**

6.3.4.1. There is an established link between mental illness and substance misuse. There are a number of crack and opiate users in Haringey; the latest estimated prevalence is 2,666. A significant majority use crack (80%; 2,141) but, partly due to our specialist stimulant service Eban, commissioned in 2007, Haringey had the sixth highest proportion of crack users in treatment between 2006/07-2008/09 in London (NTA:2010). The estimate for opiate users in 2008/09 was 1,936. This data, suggests that a poly use of crack and opiates is common, a trend by no means unique in comparison to the rest of London. Problem drug use mirrors geographical deprivation with most residing in the more deprived and densely populated north east of the borough, higher levels of mental ill health and poor housing conditions, and a higher likelihood of involvement in acquisitive crime. At least 60 different nationalities were represented in treatment last year and a vast majority were non white British (65%). Women made up a quarter of the drug treatment population in 2008-9, a proportion on par with national and regional averages.

6.3.5. **Projected costs of poor mental health**

6.3.5.1. Figure 1 below is adapted from a report published three years ago that looked at how the costs of mental health problems might change over a 20-year period. For each of eight mental health disorders (depression, anxiety, schizophrenia, bipolar disorder, eating disorders, personality disorders, child and adolescent mental health problems, and dementia), Figure 1 shows the costs of mental health problems in 2007 and the expected costs in 2026 if treatment and support arrangements remain unchanged, and if impacts on, for example, employment patterns also remain unchanged. The projections also assume that the proportion of mental health needs that are recognized and treated remains the same. The projections clearly show a substantial increase in the impact of mental health problems on the economy under current treatment and care arrangements. It is debatable whether such an increase would be widely seen as affordable.

Figure 1: Current and projected future costs by mental health disorder, England 2007, 2026



Source: McCrone, Dhanasiri, Patel, Knapp, Lawton-Smith. *Paying The Price*. London: King's Fund, 2008.

6.4. Examples of Best Practice based on the workshop key messages

Increased community education of mental health and further support for children with mental health issues

6.4.1. Parenting interventions for the prevention of persistent conduct disorders (For further details see Appendix C)

Conduct disorders are the most common childhood psychiatric disorders, with a UK prevalence of 4.9% for children aged 5–10 years.[5] The condition leads on to adulthood antisocial personality disorder in about 50% of cases, and is associated with a wide range of adverse long-term outcomes, particularly delinquency and criminality.[6]

The intervention

Parenting programmes can be targeted at parents of children with, or at risk of, developing conduct disorder, and are designed to improve parenting styles and parent-child relationships. Reviews have found parent training to have positive effects on children's behaviour. [7]

Key points

- Parenting programmes are cost-saving to the public sector, and to the NHS alone, over the long term, with the main benefits accruing to the NHS and criminal justice system.
- When the wider costs of crime are included, total gross savings over 25 years exceed the average cost of the intervention by a factor of around 8 to 1.

Prevention

6.4.2. Workplace screening for depression and anxiety disorders (For further details see Appendix C)

Substantial economic costs arise for employers from productivity losses due to depression and anxiety in the workforce.

The intervention

Workplace-based enhanced depression care consists of completion of a screening questionnaire by employees, followed by care management for those found to be suffering from, or at risk of developing, depression and/or anxiety disorders. Those identified as being at risk of depression or anxiety disorders are offered a course of cognitive behavioural therapy (CBT) delivered in six sessions over 12 weeks.

Key points

- The intervention is cost-saving from the perspectives of both business and the health system, on the assumption that all costs are borne by business.
- The costs of the intervention are more than outweighed by gains to business due to a reduction in both presenteeism and levels of absenteeism.
- Public sector employers also have the potential to benefit from investing in universal workplace depression and anxiety screening interventions.

6.4.3. Debt and mental health (For further details see Appendix C)

Research has demonstrated a link between debt and mental health; individuals who initially have no mental health problems but find themselves having unmanageable debts within a 12-month period have a 33% higher risk of developing depression and anxiety-related problems compared to the general population who do not experience financial problems.[8]

The intervention

For the general population, contact with face-to-face advice services is associated with a 56% likelihood of debt becoming manageable,[9] while telephone services achieve 47%[10]. In comparison, around one-third of problem debt may be resolved without any intervention.

Key points

- In nearly all modelled scenarios, at least one type of debt management intervention has better outcomes and lower costs over a two-year period compared to no action.
- For greatest cost-effectiveness, careful consideration needs to be given to models of financing and to the mix between face-to-face, telephone and web-based provision.

6.4.4. Collaborative care for depression in individuals with Type II diabetes (For further details see Appendix C)

Depression is commonly associated with chronic physical health problems. NICE has estimated that 20% of individuals with a chronic physical problem are likely to have depression,[11] while US data indicate that 13% of all new cases of Type II diabetes will also have clinical depression.[12]

The intervention

The model assessed the economic case for investing in six months of collaborative care in England for patients with newly diagnosed cases of Type II diabetes who screen positive for depression, compared with care as usual.

Key points

- The intervention is cost-effective after two years, but has high net additional costs in the short term due to implementation costs.

- A wider-ranging analysis is merited to demonstrate the potential longer-term savings in health and social care costs due to reduced complications of diabetes.

6.4.5. **Increased community education and support of mental health**

Good support networks and social support are well recognised as important for preventing mental health problems. NICE, in a review of public health interventions to promote positive mental health and prevent mental health disorders among adults, emphasizes the importance of social support.[13] In particular, they noted that trust in the community has been found to predict psychological distress[14]. As such, interventions aimed at promoting mental health could focus on building trust in the community

Community mental health services can improve the social support of isolated and excluded people in the community through 'befriending' or 'one-to-one support' services. Local authorities can assist these organisations in making the community aware of their services. Local authorities can also assist by supporting local community events such as street parties where people can get to know their neighbours. Supported access to information involves primary care staff providing details about voluntary agencies, self-help groups, leisure, sporting, cultural and educational activities within the community (Blastock et al, 2005).

6.4.6. **Befriending of older adults (For further details see Appendix C)**

Befriending initiatives, often delivered by volunteers, provide an ‘upstream’ intervention that is potentially of value both to the person being befriended and the ‘befriender’. For those receiving the intervention, particularly older people, it promotes social inclusion and reduces loneliness;[15] for the befriender, there is the personal satisfaction of contributing to the local community by offering support and skills. Specific potential benefits include the improved mental well-being of the person receiving the intervention, a reduced risk of depression, and associated savings in health care costs.

The intervention

In a typical befriending intervention, a befriender visits a person in their home, usually on a one-to-one basis, where that individual has requested and agreed to such a contact. The intervention is not usually structured and nor does it have formally-defined goals. Instead an informal, natural relationship develops between the participants, who will usually have been matched for interests and preferences.

Key points

• Befriending interventions are unlikely to achieve cost savings to the public purse, but they do improve an individual’s quality of life at a low cost.

• The targeting of at-risk groups (e.g. older people discharged from hospital or mothers at risk of post-natal depression) would potentially offer better returns on an investment in befriending, and this could be explored through further research.

7. Tobacco Control

7.1. Key themes which emerged from the Tobacco control group were:

- Brief interventions
- Ethnic and cultural targeting according to prevalence
- Support/Social networks

7.2. Smoking tobacco is the single greatest preventable cause of ill health and premature mortality in the UK. It is also the primary reason for the gap in life expectancy between socio-economic groups. It has long since been acknowledged by national bodies that smoking is harmful to the nation's health and that targeted methods are needed to help people stop smoking. These have included the Tobacco control legislation that prevented smoking in public places in 2007 (extended to include mental health services in 2008).

7.3. Reducing prevalence is a key priority in improving the health of the population in Haringey, particularly in the more deprived areas where smoking rates tend to be higher.

7.4. **Cost and deaths related to smoking**

7.4.1. It has been estimated that smoking costs the health service over £5 billion per year.

7.4.2. The report Tobacco in London: the preventable burden indicated that in Haringey in 2001 there were 260 deaths related to smoking and 1,120 hospital admissions, at a cost of nearly £2.6m[16].

7.4.3. From 2006-08 there were 195 deaths related to smoking. This was 203 deaths per 100,000 persons aged 35 years and over, a similar rate to the England rate at 207 per 100,000.

7.4.4. Women who smoke during pregnancy have an elevated risk of miscarriage, complications, preterm birth and low birth-weight[17], and exposure to smoke after birth is a cause of health problems including sudden infant death syndrome[18].

7.4.5. The evidence base on smoking cessation is substantial. Cost-effectiveness studies indicate that the cost per quality-adjusted life year (QALY) gained of smoking cessation interventions is in the range of £174 to £873.246 Given that NICE's threshold for cost-effectiveness is between £20,000 and £30,000 per QALY, it is clear that smoking cessation is highly cost-effective. Interventions in healthcare settings, including brief interventions by GPs, pharmacological therapies and nicotine replacement, are known to be effective, but are not covered here because of their limited relevance to local authorities.

7.5. **Key Health Inequalities:**

7.5.1. Smoking is currently the principal avoidable cause of premature death and ill health in England and a major cause of health inequalities. Reducing prevalence of smoking is therefore a key priority in improving the health of the population in Haringey, particularly in the more deprived boroughs, where smoking rates tend to be higher.

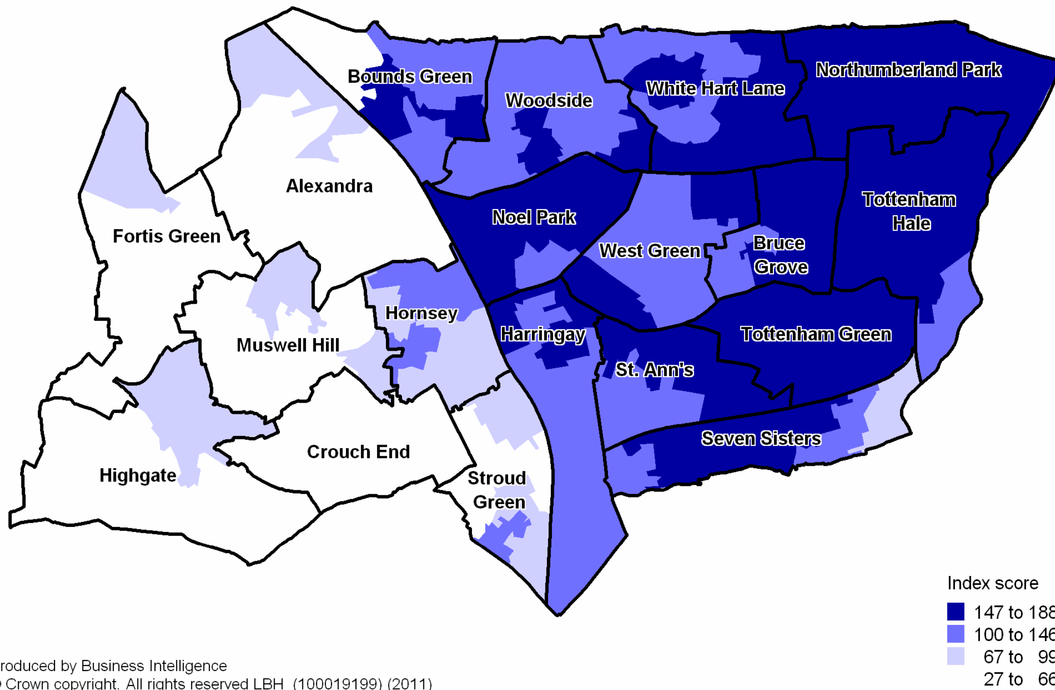
7.5.2. There were 260 deaths related to smoking between 2006 and 2008, with 1,120 hospital admissions, at a cost of nearly £2.6million.

7.5.3. Modelled smoking prevalence data derived from the Health Survey for England (2006/08), predicts that Haringey has a current smoking prevalence of 24.1%, compared with 20.8% in London and 22.2% in England. The figures for 2003/05 were released to Middle Super Output Area (MSOA) level. Highest smoking prevalence of between 29% and 33% was predicted for MSOAs in Noel Park, Tottenham Green, Northumberland Park, Tottenham Hale and White Hart Lane.

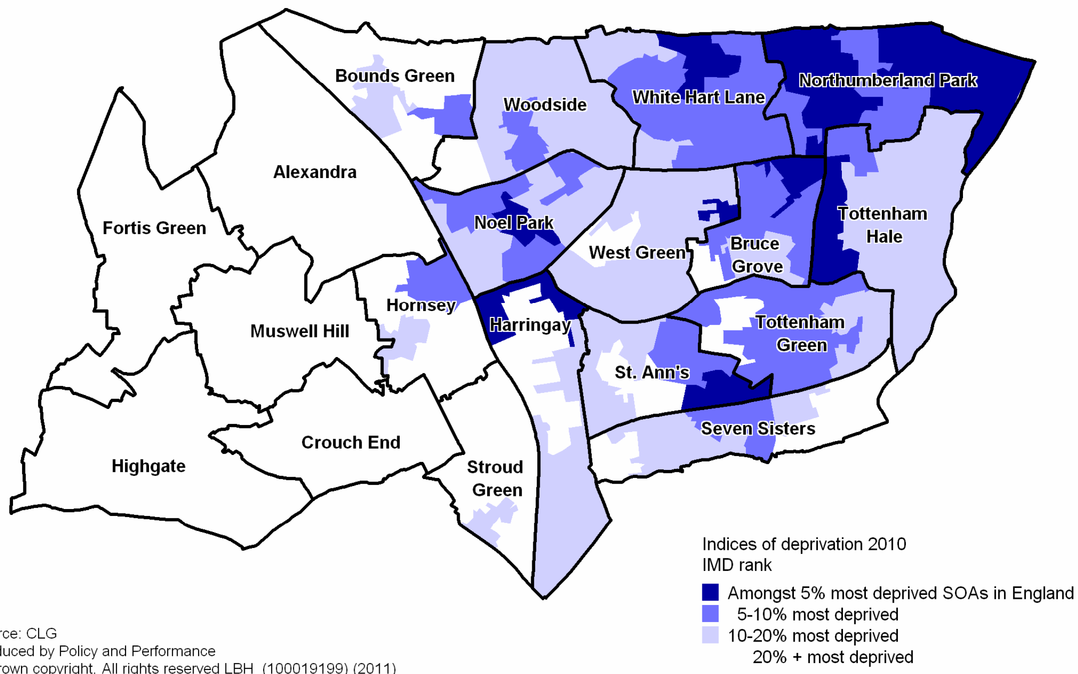
7.5.4. 17.7% of residents registered with a GP in Haringey were recorded as smokers as at March 2009. Smoking rates were lowest in the West Neighbourhood (15.4%) and highest in the North East Neighbourhood (19.9%).

7.5.5. Smoking rates vary considerably between ethnic groups and between men and women within those groups. The Health Survey for England suggests people from the Black African, Indian, Pakistani, Bangladeshi and Chinese minority ethnic groups are less likely to be current smokers than England as a whole, whereas Irish respondents are more likely to be current smokers[19]. However, it should be noted that these estimates do not reflect the ethnic diversity within Haringey and the complex relationship between ethnicity and smoking prevalence. More accurate local estimates of smoking behaviour are required to better understand needs relating to this important health determinant. The Association of Public Health Observatories (APHO) has released a technical briefing on this issue[20].

Map A – showing likelihood of residents to be heavy smokers as mapped by Super Output areas.



Map B – Indices of Deprivation by Super Output area



7.5.6. As can be seen from the above two maps, those living in the more deprived areas of the borough are more likely to be heavy smokers than those living in the less deprived areas of the borough.

7.6. Smoking quit rates

7.6.1. In 2008/09 3,282 persons in Haringey set a smoking quit date, with a success rate of 59% (1,939 persons) at the four-week follow-up. These success rates are higher than London (47%) and England (50%) averages.

7.6.2. Haringey have an active Tobacco Control Alliance that is committed and active in reducing the impact of smoking on health inequalities. The alliance is formed from partners in the Haringey Strategic Partnership and monitors and evaluates the local Tobacco Control Strategy running from 2009-2012. There are five objectives for the Tobacco Control Strategy:

- Increase support for smokers who want to stop smoking;
- Increase the number of smoke-free environments;
- Increase awareness and understanding of tobacco use and health;
- Reduce access to tobacco products; and
- Make sure developments are informed, co-ordinated and supported by a trained workforce.

N.B the Delivery Plan is due to be revisited in light of reduced resources.

7.7. Examples of best practice

7.7.1. Brief interventions

7.7.1.1. Brief interventions are acknowledged to be effective for smoking cessation involve opportunistic advice, discussion, negotiation or encouragement and referral to more intensive treatment, where appropriate. They are delivered by a range of primary and community care professionals, typically in less than 10 minutes. The package provided depends on a number of factors including the individual's willingness to quit, how acceptable they find the intervention and previous methods they have used. It may include one or more of the following:

- simple opportunistic advice
- an assessment of the individual's commitment to quit
- pharmacotherapy and/or behavioural support
- self-help material
- referral to more intensive support such as the NHS Stop Smoking Service[21].

7.7.1.2. There is robust evidence to suggest that advice from GPs can have a beneficial effect on lifestyle behaviours. Much of this relates to smoking, where there is evidence to show that simple, brief, unsolicited advice from GPs is effective in increasing rates of smoking cessation[22] and is extremely cost-effective, mainly because it is so cheap: a typical 10-minute GP consultation cost £21 in 2005/06[23].

7.7.2. Social Networks

7.7.2.1. Individually focused approaches such as advice and counselling are effective in promoting smoking cessation, although they are less suited to prevention. Family-based interventions may be effective in preventing the uptake of smoking by children and young people, although the evidence is mixed.

7.7.2.2. Community-based interventions offer social support to people wishing to quit smoking, disseminate messages about prevention, and may also promote access to other services. Such interventions are usually multi-component and may include media campaigns, campaigns to restrict tobacco availability, interventions in schools and workplaces, and increasing access to therapies such as nicotine replacement. The evidence on such programmes indicates that some are effective in reducing smoking, although many such programmes have not been successful, and the most extensive and most rigorously evaluated programmes have found little or no evidence of effectiveness. Actively engaging and mobilising communities may increase the chances of success. Targeted community-based interventions are promising for decreasing smoking in low-income and disadvantaged areas.

7.7.2.3. Interventions in workplaces may be of particular interest to local authorities as a means to improve the health and wellbeing of their own employees, which may result in substantial efficiency savings; in addition, such programmes may form part of broader community strategies. However, although individually oriented interventions such as counselling are effective in workplace settings, comprehensive workplace strategies, such as those involving environmental changes or incentives, are less successful.

7.7.3. **Environmental and policy change**

7.7.3.1. Environmental and policy changes for smoking may take a variety of forms. Restricting the sale of tobacco products to minors may reduce smoking among young people, although enforcing such restrictions consistently is challenging.

7.7.4. **Media campaigns**

7.7.4.1. Media campaigns can combine a variety of multiple types of media, such as TV, radio and national newspaper advertising. They can be used alone to encourage and support quit attempts or combined with other activities at a local or regional levels[24].

7.7.5. **Cultural and Ethnic targeting based on local prevalence data**

7.7.5.1. NICE guidance[25] recommends that services should aim to treat at least 5% of the estimated local population of people who smoke or use tobacco in any form each year.

7.7.5.2. There is no evidence to suggest that mainstream interventions proven to be effective with white smokers should not be successful with BME groups. The key is to *improve accessibility*. It seems likely that the simplest way is to make mainstream services more accessible. However, considering local circumstances and community views, it may be appropriate and cost effective to produce specific targeted services[26].

8. Physical Activity

8.1. Key themes from group discussion were:

- Walking-based initiatives
- Interventions targeting children
- Closer partnership working with providers of sport/physical activity initiatives.

8.2. Physical activity levels are low nationally, with only 21.9% of adults participating in moderate intensity sport and active recreation on at least 3 days per week for at least 30 minutes. Participation levels in London and Haringey are 20.9% and 21.3% respectively (Active People Survey 3). The Health Survey for England (2002) found that only two-thirds of boys and girls aged 2-11 years achieve the recommended levels of physical activity. However, in girls this activity declines steadily from 10 years of age to about half by the age of 15. Based on locally held data, this year's results for the Borough wide survey of Primary schools indicate that whilst 93% of pupils were evaluated as achieving the required 2 hours of quality PE time, 24% of pupils in year 6 were obese.

8.3. The current physical activity recommendation for adults to achieve health benefits is to undertake 30 minutes of at least moderate intensity physical activity on at least 5 or more days of the week. Children and young people should achieve a total of 60 minutes of at least moderate intensity physical activity each day.

8.4. Participation in regular physical activity can help to prevent and manage a range of long term conditions or disorders including obesity, stroke, coronary heart disease (CHD), type II diabetes, some cancers and mental health. Physical inactivity is a major risk factor for the development of a number of long term conditions and is one of the leading causes of death in developed countries. It has been estimated that it is responsible for an estimated 22-23% of CHD, 16-17% of colon cancer, 15% of diabetes, 12-13% of strokes and 11% of breast cancer.

8.5. **Key Health Inequalities**

8.5.1. In the UK there are significant inequalities in levels of physical activity in relation to age, gender, ethnicity and disability, and corresponding inequalities in health. For example, in Haringey white adult populations are more active than non-white adults, men tend to be more active than women, younger people are more active than their older counterparts and activity levels are lower in those who have a limiting illness or disability.

8.5.2. The data also indicates that there is a very strong correlation between participation and social class. Within Haringey, people in the lower socio-economic groups are less active than those in the higher socioeconomic groups , at levels of 14.4% and 24.6% respectively. Such evidence exists for some long term conditions, e.g. CHD and cancer which, indicate that increases in physical activity levels in lower socioeconomic groups could help offset such gradients. For example, circulatory disease (includes heart disease and stroke) is a leading cause of premature mortality in Haringey. These deaths are not evenly distributed across Haringey, with higher rates observed in the East of the borough compared to the West. This suggests that there are differences in prevalence of disease and disease risk factors (including physical inactivity), in addition to the management of circulatory disease in different areas of the borough.

8.6. Best Practice - Adults

8.6.1. The evidence on effective strategies for increasing physical activity across all age groups is limited. The National Institute for Health and Clinical Excellence[27] produced guidance on methods used to increase the physical activity levels of the adult population. Four commonly used methods were selected, namely brief interventions in primary care, exercise referral schemes (ERSs), pedometers and community based exercise programmes for walking and cycling.

8.6.2. Brief interventions in primary care refer to a broad range of approaches including opportunistic advice, discussion, negotiation or encouragement. The delivery of these interventions may vary greatly in that they may involve giving basic advice to more lengthy person centred approaches. ERSs are programmes that direct individuals to a service that offers an assessment, a tailored physical activity programme, monitoring of progress and follow up. These programmes may require attendance at a facility such as a leisure centre. Pedometers were assessed regarding their effectiveness in increasing activity levels. Walking and cycling programmes were defined as organised walks or cycle rides.

8.6.3. NICE concluded that there was insufficient evidence to support the use of pedometers, walking and cycling schemes and ERSs to increase physical activity. However, In March 2007, in response to NICE guidance on ERSs, the Department of Health[28] issued a statement (best practice guidance) on this topic to clarify the opinion regarding the commissioning of ERSs in England, designed to be read in conjunction with NICE (2006) guidance. DH guidance stated that commissioners, practitioners and policy makers should continue to provide high quality ERSs for their local population where they address the medical management of conditions, such as type 2 diabetes, obesity and osteoporosis or aim to prevent or improve individual health conditions (e.g. falls prevention). The DH ended their statement urging that these schemes continue to be provided in accordance with the National Quality Assurance Framework for exercise referral in England[29].

8.6.4. However, there was evidence that brief interventions were effective in increasing activity levels. NICE recommend that practitioners should identify inactive patients, assessed using the DH general practitioner physical activity questionnaire (GPPAQ)[30], and advise them of the current recommendations for physical activity. They further recommend that advice should be delivered using a personRcentred approach and should be complemented with written information about the benefits of physical activity. In addition, NICE recommend that patients should be followed up over a period of three to six months.

8.7. Children

8.7.1. In 2009, NICE[31] produced guidance on promoting physical activity for children and young people up to the age of 18.

8.7.2. National Campaign

- At a national policy level NICE recommends the delivery of a long-term (minimum 5 years) national campaign to promote physical activity among children and young people, which should be integrated with and support

other national health campaigns and strategies to increase participation in play, physical activity and reduce obesity.

8.7.3. **High level policy and strategy to raise awareness of the importance of physical activity**

- NICE recommend that the needs of children and young people to be physically active be addressed through JSNA, local development and planning frameworks, sustainable community plans and strategies and through children and young people's plans. These should be coordinated through a local strategy to increase physical activity.

8.7.4. **Local strategic planning**

- NICE recommend the development of physical activity plans which include identifying local children and young people who are amongst the least active and involving them in the planning and delivery of physical activity opportunities. It is also recommended that different groups of children, young people and their families be consulted on a regular basis to gain insight into what helps or prevents them from being physically active. This information should be used to increase opportunities for children and young people to be physically active and to plan programmes which tackle inequalities in provision.

- It is also recommended that consideration is given to the planning and provision of spaces and facilities, with a particular focus on ensuring physical activity facilities are suitable for those from lower socioeconomic groups, those from minority ethnic groups and those who have a disability. School facilities should be made available to children and young people before, during and after the school day, at weekends and during school holidays. Public parks and facilities should be actively promoted as well as more non-traditional spaces as places where children and young people can be physically active. Town planners should make provisions for children, young people and their families to be physically active in urban settings. Facilities and spaces should meet safety standards. Lastly, all proposals for signs restricting physical activity in public spaces should be assessed to judge their potential effect on physical activity levels.

- Local transport plans should aim to increase the number of children and young people who regularly cycle, walk and use other modes of physically active travel, making provision for those with a disability or impaired mobility. Assistance should be given to develop, implement and promote school travel plans. In addition, local transport and school travel plans should be aligned with other local authority plans which may impact on physical activity.

8.7.5. **Local Organisations: planning, delivery and training**

- Factors which affect physical activity participation should be identified through regularly consulting with children, young people and their families. Physical activity sessions should be delivered by those who have achieved the relevant sector standards/skills or qualifications for working with children. Continuing professional development should be provided for these staff. Education institutions should be identified to deliver multi-component physical activity programmes and multi-component physical activity programmes should be developed. Opportunities, facilities and

equipment should be available to encourage children (up to 11 years) to develop movement skill. Girls and young women (11-18 years) should be supported to become more physically active through, for example, consulting with them on their preferences for physical activities, barriers to participation should be addressed and school-based activities should be made available, and multi-component physical activity programmes developed. Active and sustainable school travel plans should be developed.

8.7.6. **Local practitioners: delivery**

- Children up to the age of 11 years should be helped to be active through the provision of a range of indoor and outdoor physical activities, including in pre-school establishments; during playtimes, lunch breaks at school and as part of extra-curricular and extended school provision and during leisure time within the community and private sector. In addition, girls and young women (11-18 years) should be helped to be more active through, for example, the use of appropriate role models, encouraging a dress code that minimises concerns regarding body image, help those who are amongst the least active towards gradual full participation and support those of all abilities to participate in an inclusive and non-judgemental way, with the focus on enjoyment and personal development rather an on the evaluation of performance.

Appendices

Appendix A – Attendees

Cllr Bull	Chair of Overview and Scrutiny
Cllr Winskill	Scrutiny (Well-being Lead)
Cllr Dogus	Cabinet Member for Adult and Community Services
Cllr Gorrie	Leader of the Liberal Democrats
Cllr Basu	Councillor
Cllr Erskine	Councillor
Cllr Scott	Councillor
Cllr Waters	Councillor
Cllr Goldberg	Cabinet Member for Finance and Sustainability
Cllr Mallett	Cabinet Member for Planning and Regeneration
Cllr Watson	Councillor
Cllr Wilson	Councillor
Cllr Weber	Councillor
Cllr Newton	Councillor
Kevin Crompton	Chief Executive of Haringey Council
Marion Morris	Drug & Alcohol Action Strategic Manager
Dr Therese Shaw	Clinical Director, BEH Mental Health Trust
Gina Taylor	Middlesex University, School of Health and Social Sciences
Stephen Wish	Polar Bear Mental Health Charity
Cathy Herman	Non Executive Director, NHS Haringey
John Morris	Assistant Director, Recreation
Paul Ely	Policy and Development Manager, Recreation Services
Naeem Sheikh	Chief Executive, Haringey Association of Voluntary and Community Organisation
Helena Pugh	Corporate Head of Policy
Mun Thong Phung	Director of Adult, Culture and Community Services
Susan Otiti	Interim Joint Director of Public Health
Diana Edmonds	Assistant Director, Culture, Libraries and Learning
Eve Pelekanos	Head of Policy & Performance
Helena Kania	Haringey LINk Chair
Rob Mack	Scrutiny Officer
Fiona Wright	Associate Director of Public Health
Mobola Alex-Oni	Public Health
Barbara Nicholls	Head of Commissioning (Adults)

Leo Atkins	Head of Healthy Communities Programme
Robert Edmonds	Director, Age Concern Haringey
John Ota	Community Services, NHS Haringey
Anastasia Georgiou	Mental Health Charity Polar Bear Community
Jodie Szwedzinski	Policy Officer
Melanie Ponomarenko	Scrutiny Officer
Mike Davis	Participation Manager
Tamara Djuretic	Associate Director of Public Health
Vanessa Bogle	Senior Public Health Commissioning Strategist
Michael Fox	Chairman, Barnet, Enfield & Haringey MH NHS Trust
Laura Copolovici	Polar Bear Community
Dimitrie Copolovici	Polar Bear Community
Gloria Salmon	NHS Haringey
Patrick Morreau	Age Concern Haringey
Anna Jozefwicz	Health Worker, Children and Young People, Haringey Council
Stephen Deitch	NHS Haringey
Marlon James	Project Worker - Community Health Workers
Yvonne Denny	Parent Governor
Pam Moffat	LINk
Ify Adenuga	Crucial Steps
Mary Connolly	Partnership Manager
Chris Giles	Whittington NHS Trust
Janet Alldred	Barnet, Enfield and Haringey Mental Health Trust
Olivia Darby	HAVCO

Appendix One: Best Practice taken from Mental health promotion and mental illness prevention: The economic case, January 2011

Parenting interventions for the prevention of persistent conduct disorders

Context
Conduct disorders are the most common childhood psychiatric disorders, with a UK prevalence of 4.9% for children aged 5–10 years.[32] The condition leads on to adulthood antisocial personality disorder in about 50% of cases, and is associated with a wide range of adverse long-term outcomes, particularly delinquency and criminality.[33]
The costs to society are high, with average potential savings from early intervention previously estimated at £150,000 per case.[34] Costs falling on the public sector are distributed across many agencies and are around ten times higher than for children with no conduct problems.[35] The cost of conduct disorder-related crime in England may be as high as £22.5bn a year, and £1.1–1.9m over the lifetime of a single prolific offender.[36]

Intervention
Parenting programmes can be targeted at parents of children with, or at risk of, developing conduct disorder, and are designed to improve parenting styles and parent-child relationships. Reviews have found parent training to have positive effects on children's behaviour, and that benefits remain one year later. [37] Longer term studies show sustained effects but lack control groups; cost-effectiveness data are limited, but health and social services costs were found to reduce over time in one trial.[38] Without intervention, conduct disorder will persist in about 50% of children.[39]

The median cost of an 8–12 week group-based parenting programme is estimated at £952 per family, while that of individual interventions is £2,078.vii Assuming 80% of people receive group-based interventions and 20% individual interventions, in line with NICE guidance, the average cost of the intervention works out at £1,177 per family. An important ingredient of success in the design and implementation of these programmes is maximising the engagement of 'at-risk' families, as there is evidence that some services suffer from low rates of take-up and high rates of drop-out.

Impact
The model looks at the costs/savings for 5-year-old children with conduct disorder whose parents attend a parenting programme, and estimates the impact to age 30 compared to no intervention. It is assumed that the intervention decreases the chance that early onset conduct disorder will persist into adulthood, thus avoiding high costs to society. Among those whose parents complete the programme, 33% of children improve to 'no problems', and 5% improve to moderate conduct problems; however, behaviour changes are not sustained beyond one year for 50% of children who initially improve.

Table 1: Gross pay-offs from parenting interventions at age 5, per child with conduct disorder (2008/09 prices)

	Age 6 (£)	Age 7–16 (£)	Age 17+ (£)	Total (£)
NHS	-168	-912	-197	-1,278
Social services	-24	-29	-14	-67
Education	-132	-304	0	-437
Criminal justice system	0	-1,247	-340	-1,588
Public sector total	**-324**	**-2,493**	**-551**	**-3,368**
Voluntary sector	-3	-6	-5	-15
Victim costs (crime)	0	-3,361	-810	-4,171
Lost output (crime)	0	-995	-232	-1,227
Other crime costs	0	-377	-129	-506
Other sectors/individuals total	**-3**	**-4,740**	**-1,176**	**-5,919**
Total	-328	-7,233	-1,727	-9,288

Table 1 shows that total gross savings over 25 years amount to £9,288 per child and thus exceed the average cost of the intervention by a factor of around 8 to 1. Savings to the public sector come to £3,368 per child, including £1,278 accruing to the NHS. Under the assumptions made, the intervention will provide a positive return to the public sector in year 8, and to the NHS in year 14, after the intervention. No benefits are assumed from a range of other potential wider impacts such as improved employment prospects, reduced adult mental health issues, and improved outcomes for the child's family and peers; these are likely to be substantial, making the intervention an even better investment.

Further details: Eva-Maria Bonin (e.bonin@lse.ac.uk)

Workplace screening for depression and anxiety disorders

Context
Substantial potential economic costs arise for employers from productivity losses due to depression and anxiety in the workforce. The main costs occur due to staff absenteeism and presenteeism (lost productivity while at work). From the perspective of the public purse, failure to intervene also risks higher future health and social care costs.

It is estimated that the average annual cost of lost employment in England attributable to an employee with depression is £7,230, and £6,850 for anxiety (2005/06 prices).

The proposed intervention
Workplace-based enhanced depression care consists of completion by employees of a screening questionnaire, followed by care management for those found to be suffering from, or at risk of developing, depression and/or anxiety disorders. Those identified as being at risk of depression or anxiety disorders are offered a course of cognitive behavioural therapy (CBT) delivered in six sessions over 12 weeks. In a similar approach in Australia, productivity improvements outweighed the costs of the intervention.[40]

Initial Costs
It is estimated that £30.90 (at 2009 prices) covers the cost of facilitating the completion of the screening questionnaire, follow-up assessment to confirm depression, and care management costs.[41] For those identified as being at risk, the cost of six sessions of face-to-face CBT is £240. Computerised CBT courses are cheaper, but may be less effective, with less known about their longer-term effectiveness.

Impact
The model assesses the cost-effectiveness of a workplace-based intervention for depression and anxiety disorders, and whether it reduces sickness, absenteeism and presenteeism, compared with no intervention.

The target population is a hypothetical cohort of working age individuals in a white collar enterprise with 500 full time equivalent employees, all of whom are screened. The cost/savings impact is addressed from the perspective of the health system (including personal social services) and business, with the enterprise bearing the total costs of the intervention. It assumes that only two-thirds of employees offered CBT as a result of screening will make use of this treatment. It is estimated that the reduction in presenteeism as a result of successful intervention is equivalent to an extra 2.6 hours of work per week.iv In year 1 it is assumed that this benefit is seen only in the 36 weeks after the completion of the CBT course. If depression and anxiety orders are averted, then 27.3 days of absenteeism per annum associated with these disorders will be avoided.

Conservatively, the model assumes that health and personal social services costs relating to depression and anxiety only occur in year 2.
The results show that from a business perspective the intervention appears cost-saving, despite the cost of screening all employees (Table 6). Benefits are gained through both a reduction in the level of absenteeism and improved levels of workplace productivity through a reduction in presenteeism. However, the impact may differ across industries; the case may be less strong where staff turnover is high and skill requirements low. From a health and personal social services perspective the model is cost-saving, assuming the costs of the programme are indeed borne by the enterprise.

Table 6: Total net costs/pay-offs from business and societal perspectives for a company with 500 employees (2009 prices)

	Year 1 (£)	Year 2 (£)
Intervention cost	20,676	0
Health (including social care)	0	-10,522
Absenteeism (productivity losses)	-17,508	-23,006
Presenteeism (productivity losses)	-22,868	-30,050
Total	-19,700	-63,578

Further details: David McDaid (d.mcdaid@lse.ac.uk)

Debt and mental health

Context

Even before the current global financial crisis, it was estimated that 8% of the population had serious financial problems and another 9% showed signs of financial stress.[42] These problems have wide-ranging implications.
In particular, research has demonstrated a link between debt and mental health; individuals who initially have no mental health problems but find themselves having unmanageable debts within a 12-month period have a 33% higher risk of developing depression and anxiety-related problems compared to the general population who do not experience financial problems.[43]

The vast majority of these mental health problems take the form of depression and anxiety-related disorders.

These conditions are associated with significant costs arising from health service use, legal fees, debt recovery and lost productivity. On average, the lost employment costs of each case of poor mental health are £11,432 per annum, while the annual costs of health and social service use are £1,508.[44]
Only about half of all people with debt problems seek advice,[45] and without intervention almost two-thirds of people with unmanageable debt problems will still face such problems 12 months later.

Intervention

The current evidence suggests that there is potential for debt advice interventions to alleviate financial debt, and hence reduce mental health problems resulting from debt. For the general population, contact with face-to-face advice services is associated with a 56% likelihood of debt becoming manageable,[46] while telephone services achieve 47%[47]. In comparison, around one-third of problem debt may be resolved without any intervention.
The costs of this type of intervention vary significantly, depending on whether it is through face-to-face, telephone or internet-based services. The Department for Business, Innovation and Skills suggests expenditure of £250 per client for face-to-face debt advice; telephone and internet-based services are cheaper. Funding for debt advice comes from a range of sources including government, NHS, charities and creditors.

Impact

The model explores the cost-effectiveness of different types of debt advice services targeted at working age adults without mental health problems. It follows a hypothetical cohort of people at risk of unmanageable debt over a 24-month period, and looks at the impact of subsequent debt-related mental health problems (depression and anxiety) on costs to the health, social care and legal systems, and from lost productivity due to reduced employment. Legal and debt advice costs are assumed to fall in year 1, while other costs fall mostly in year 2.

A range of scenarios was explored in models. Even under conservative assumptions, investment in debt advice services can both lower expected costs and reduce the risk of developing mental health problems. The intervention appears to be cost-effective from most societal and public expenditure perspectives. However, face-to-face services will only be the most cost-effective option if a high proportion of the costs of providing the service is recovered from creditors. This is feasible: one major not-for-profit debt advice service covers more than 90% of its costs in this way. In other scenarios, where cost

recovery is lower, either telephone or web-delivered services will be most cost-effective. Table 8 shows the impact on costs/savings of face-to-face intervention for a hypothetical population of 100,000, compared with no intervention, assuming that one third of the cost of the debt advice is borne by the NHS, with the rest paid for by creditors.

Table 8: Impact on costs/pay-offs of face-to-face debt intervention (with NHS paying one-third of the costs of the debt advice services) (2009 prices)

	Year 1 (£)	Year 2 (£)	Year 3 (£)	Year 4 (£)	Year 5 (£)
Health and social care	151,512	-13,209	-13,017	-12,829	-12,643
Legal	-87,908	-	-	-	-
Productivity losses	-7,827	-100,128	-98,677	-97,426	-95,837
Net costs/pay-offs	55,777	-113,336	-111,694	-110,075	-108,480

In practice, this type of intervention could be targeted at specific groups who may be particularly vulnerable to financial debt and mental health problems, for example low-income communities.

Further details: Martin Knapp (m.knapp@lse.ac.uk)

Collaborative care for depression in individuals with Type II diabetes

Context

Depression is commonly associated with chronic physical health problems. NICE has estimated that 20% of individuals with a chronic physical problem are likely to have depression,[48] while US data indicate that 13% of all new cases of Type II diabetes will also have clinical depression.[49]

These patterns are important as evidence shows that co-morbid depression exacerbates the complications and adverse consequences of diabetes, in part because patients may more poorly manage their diabetes. Not only does this increase the risk of disability and premature mortality, it also has substantial economic consequences. In the UK, compared to people with diabetes alone, individuals with co-morbid depression and diabetes are four times more likely to have difficulties in self-managing their health and seven times more likely to have days off work.[50] In the US, health care costs for those with severe depression and diabetes are almost double those with diabetes alone.[51]

Intervention

'Collaborative care' can be delivered in a primary care setting to individuals with co-morbid diabetes and depression. Like 'usual care', collaborative care includes GP advice and care, the use of antidepressants and cognitive behavioural therapy (CBT) for some patients. The difference is that for collaborative care a GP practice nurse acts as a case manager for patients receiving care; GPs also incur additional time costs liaising with practice nurses.
Using a NICE analysis, it is estimated that the total cost of six months of collaborative care is £682, compared with £346 for usual care. A two-year evaluation in the US found that, on average, collaborative care achieved an additional 115 depression-free days per individual; total medical costs were higher in year 1, but there were cost savings in year 2.[52]

Impact

The model assessed the economic case for investing in six months of collaborative care in England for patients with newly diagnosed cases of Type II diabetes who screen positive for depression, compared with care as usual.
The costs associated with screening are not included in the baseline model; we were given expert advice that in GP care all individuals with diabetes would already be screened for depression. The analysis assumed that 20% of patients under collaborative care would receive CBT, compared with 15% of the usual care group. Existing data on the cost-effectiveness of CBT were used to estimate the impact on health care and productivity losses.

Table 11 shows the estimated costs/savings for 119,150 new cases of Type II diabetes in England in 2009, assuming 20% screen positive for co-morbid depression. Completing and successfully responding to collaborative care leads to an additional 117,850 depression-free days in year 1 and 111,860 depression-free days in year 2. According to the model, the intervention results in substantial additional net costs in year 1 due to the costs of the treatment. In year 2, however, there are net savings for the health and social care system due to lower costs associated with depression in the intervention group, plus further benefits from reduced productivity losses. Using a lower 13% rate of co-morbid diabetes and depression, total net costs in year 1 would be more than £4.5m, while net savings in year 2 would be more than £450,000. The study also estimated the incremental cost per Quality-Adjusted Life Year (QALY) gained, which over two years was £3,614. This is highly cost-effective in an English context.

These estimates of the potential benefits are, however, very conservative. The model does not factor in productivity losses due to premature mortality, nor further quality of life gains associated with avoidance of the complications of diabetes, such as amputations, heart disease and renal failure. Nor does the analysis include long-term cost savings from reduced complications. These are potentially substantial: research in 2003 showed that for diabetes-relates cases the average initial health care costs of an amputation were £8,500 and for a non-fatal myocardial infarction £4,000.[53] If, on average, costs of just £150 per year could be avoided for the intervention group then investment in collaborative care would overall be cost-saving from a health and social care perspective after just two years.
Further details: David McDaid (d.mcdaid@lse.ac.uk)

Table 11: Costs/pay-offs of collaborative care for new cases of Type II diabetes screened positive for depression in England (2009 prices)

Table 11: Costs/pay-offs of collaborative care for new cases of Type II diabetes screened positive for depression in England (2009 prices)

	Year 1 (£)	Year 2 (£)
Health and social care	7,298,860	-385,240
Productivity losses	-331,170	-314,330
Net cost/pay-off	6,967,690	-699,570

Befriending of older adults

Context

Befriending initiatives, often delivered by volunteers, provide an ‘upstream’ intervention that is potentially of value both to the person being befriended and the ‘befriender’. For those receiving the intervention, particularly older people, it promotes social inclusion and reduces loneliness;[54] for the befriender, there is the personal satisfaction of contributing to the local community by offering support and skills. Specific potential benefits include the improved mental well-being of the person receiving the intervention, a reduced risk of depression, and associated savings in health care costs.

Intervention

In a typical befriending intervention, a befriender visits a person in their home, usually on a one-to-one basis, where that individual has requested and agreed to such a contact. The intervention is not usually structured and nor does it have formally-defined goals. Instead an informal, natural relationship develops between the participants, who will usually have been matched for interests and preferences. This relationship facilitates improved mental health, reduced loneliness and greater social inclusion. A recent research review confirmed that, compared with usual care and support (which may mean no intervention at all), befriending has a modest but significant effect on depressive symptoms, at least in the short term.[55] Another evaluation showed decreased depression and anxiety in 5% of people receiving socio-emotional interventions, including befriending.[56]
The contact is generally for an hour per week or fortnight. The cost to public services of 12 hours of befriending contact is estimated at £85, based on the lower end of the cost range for befriending interventions.[57]

Impact

The model looked at the cost-effectiveness of befriending interventions in terms of the reduction in depressive symptoms and the consequent decline in the use of health services by the recipient of the intervention. The intervention is assumed to be targeted at lonely and isolated individuals aged over 50. The analysis included costs/savings associated with the use of mental health services, primary care, hospital services and medication; home helps, but no other social care services, were included. The model did not
factor in any benefits to the befriender.

Using existing estimates of savings associated with reduced treatment of depression,[58] the model found total gross cost savings to the NHS were around £40 (at 2008/9 prices) in year 1 for every £85 invested in the
intervention. Thus, befriending schemes do not appear to be cost-saving from a public expenditure perspective.

If the analysis includes the quality of life benefits associated with reduced depressive symptoms, then befriending schemes have the potential to create further improvements worth £270 per person and are likely to be cost-effective with an incremental cost effectiveness ratio (ICER) of around £2,900.
Further details: Annette Bauer (a.bauer@lse.ac.uk)

Case study: Tower Hamlets

A successful Stop Smoking Service targeted specifically at the Bangladeshi community

The Bangladeshi Stop Tobacco Project

This was set up following publication of *Smoking Kills* and the completion of primary research indicating the need for a local BME tobacco programme. National surveys have reported that smoking prevalence in Bangladeshi men is around 40% and research in Tower Hamlets has shown that 49% of local Bangladeshi women chew tobacco in paan (a leaf wrapping which can contain spices as well as tobacco). One third of the population of Tower Hamlets is of Bangladeshi origin. Few Bangladeshi men set quit dates with the NHS Stop Smoking Services or successfully stop smoking.

The project aims to tackle barriers to accessing tobacco use by addressing language and cultural sensitivities. It has developed a community-oriented approach to address the needs of the Bangladeshi residents. It actively seeks feedback from the community and uses this to enrich the service delivery model.

The expectation is that clients will be contacted and supported in locations and ways that help them to feel most at ease. This includes:

- being supported by a gender specific project worker
- providing home visits to women and the elderly
- holding regular drop-in sessions
- using language of preference
- offering support, understanding, and Nicotine Replacement Therapy.

The project accepts referrals from GPs, practice nurses and other health professionals. There is a 24 hour client recruitment telephone line, which is advertised through leaflets and a website. It also gains clients and publicity by participating in local community events.

There have been positive results, with the project achieving higher quit rates than the national average (63–66% through 2004–06) in what tends to be regarded as a ‘hard to reach’ group.

Case study: Islington

Engaging the Turkish community, and using alternative settings for treatment

Turkish stop smoking project

This project was established in March 2000 to provide community based smoking education and Stop Smoking support to the Turkish speaking communities of Camden and Islington. Its key objectives were:

- to develop culturally appropriate stop smoking resources
- to develop Stop Smoking services to both individuals and groups
- to identify innovative ways of encouraging smokers to quit
- to advertise services to the community

It was launched in the 3 main Turkish Community Organisations within the London borough of Islington: IMECE (Turkish Speaking Women’s Group), TEG (Turkish Education Group) and Turkish Cypriot Community Centre. Research into the Turkish communities in Camden & Islington indicated that 57% of the adult population smokes

an average of 17 cigarettes a day (Camden and Islington Health 1996). This is higher than the national average of 28% (DOH 1998).

Each organisation employed a part-time Stop Smoking advisor who worked 6 hours per week, making a total of 18 hours per week. The advisors accessed clients in community settings other than primary care and adopted a pro-active approach taking services directly to the clients rather than waiting for clients to approach the service. Due to the Advisors' knowledge of local communities, the publicity was targeted at key areas within the community, where many Turkish-speaking people congregate (e.g. Turkish cafes, events etc).

Brief opportunistic advice was offered to smokers who the advisers saw on a casual basis. This may have been through a planned health or community event or discussions with individuals at community centres. The advisers also provided one-to-one behavioural support and made recommendations about Stop Smoking aids.

In 2001, the first Stop Smoking clinic for Turkish speakers was launched to provide intensive group support to smokers who wished to stop smoking. A health centre location for the clinic was chosen for the convenience of the community and was in easy travelling distance to where Turkish communities live.

Leaflets, posters, cards and other stop smoking resources were translated into Turkish. Many resources included cartoon designs, which were found to be popular amongst the Turkish community. A Turkish freephone telephone line was also provided, which allowed clients increased access to the service.

Results

The success rates of clients attending one-to-one sessions and group clinics were similar to those of mainstream Stop Smoking Services. One stop smoking group was run every 3 months from February 2001. The overall success rate of 4-week quitters who attended the clinic was 63%.

This outcome is viewed by the organisers as a great achievement when taking into account the perception that Turkish speaking communities will achieve lower success rates.

Appendix C – End notes

[1] Sustainable Community Strategy
[2] Health Inequalities Cross Party Working Group, Haringey Council, 2011
[3] Anderson, 1993
[4] Based on average scores of Super Output Areas.
[5] Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005) *Mental Health of Children and Young People in Great Britain*, 2004. Basingstoke: Palgrave Macmillan.
[6] Richardson J, Joughin C (2002) *Parent Training Programmes for the Management of Young Children with Conduct Disorders: Findings from Research*. London: Gaskell.
[7] Dretzke J, Davenport C, Frew et al (2009) The clinical effectiveness of different parenting programmes for children with conduct problems: a systematic review of randomised controlled trials. Child and Adolescent Psychiatry and Mental Health 3:7. Lundahl B, Risser H, Lovejoy M (2006) A meta-analysis of parent training: moderators and follow-up effects. Clinical Psychology Review 26:86–104.

[8] Skapinakis P, Weich, S et al (2006) Socio-economic position and common mental disorders. Longitudinal study in the general population in the UK. *British Journal of Psychiatry* 189:109–117.
[9]Williams K, Sansom A (2007) *Twelve Months Later: Does Advice Help? The Impact of Debt Advice: Advice Agency Client Study*. London: Ministry of Justice.
[10] Pleasence P,k Balmer NJ (2007) Changing fortunes: results from a randomised trial of the offer of debt advice in England and Wales. Journal of Empirical Legal Studies 4:465-475.
[11] NICE (2009) Depression in Adults with Chronic Physical Health Problem: Treatment and Management. London: NICE.
[12] Katon WJ, Von Korff M, Lin EHB et al (2004) The Pathways study: a randomized trial of collaborative care in patients with diabetes and depression. *Archives of General Psychiatry* 61:1042–1049.
[13] National Institute for Health and Clinical Excellence (2007). Public health interventions to promote positive mental health and prevent mental health disorders among adults. London: NICE.
[14] Berry, H.L., Rickwood, D. J. (2000) Measuring social capital at the individual level: personal social capital, values and psychological distress. International Journal of Mental Health Promotion, 2, 35-44.
[15] Cacioppo JT, Hughes ME, Waite LJ, Hawkley LC, Thisted RA (2006) Loneliness as a specific risk factor for depressive symptoms: cross-sectional and longitudinal analysis. *Psychology and Aging* 26:140–151.
[16] Tobacco in London: The preventable burden. www.lho.org.uk/viewResource.aspx?id=8716
[17] Jaddoe, V.W. et al., (2008), Active and passive maternal smoking during pregnancy and the risks of low birthweight and preterm birth: the Generation R Study, *Paediatric and Perinatal Epidemiology*, 22, pp. 162-171
[18] Fleming, P., and Blair, P.S., (2007), Sudden Infant Death Syndrome and parental smoking, *Early Human Development* 83, pp. 721-725
[19] National Statistics, Health Survey for England 2004. The health of minority ethnic groups. 2006
[20] Measuring smoking prevalence in local populations http://www.apho.org.uk/resource/item.aspx?RID=87192
[21] Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities, NICE, 2008
[22] Law and Tang, 1995
[23] Curtis and Netten, 2006
[24] The Need for Effective Mass Media Public Education Campaigns As Part of Comprehensive Tobacco Control Programs, www.stopsmokingcampains.org, 2007
[25] Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities, NICE, 2008
[26] Working with Black and Minority Ethnic Communities: A guide for Stop Smoking Service managers, Department for Communities and Local Government
[27] National Institute for Health and Clinical Excellence. (2006). *Four commonly used methods to increase physical activity.* http://www.nice.org.uk/Guidance/PH2
[28] Department of Health. (2007).*Department of Health statement on exercise referral (2007).* *http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072689*
[29] Department of Health. (2001). *Exercise Referral Systems: A national quality assurance framework.* Department of Health. London.

[30] Department of Health. (2006). *The General Practice Physical Activity Questionnaire (GPPAQ).* Gateway reference 6746. Department of Health. London.
[31] National Institute for Health and Clinical Excellent. (2009). http://guidance.nice.org.uk/PH17/QuickRefGuide/pdf/English

[32] Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005) *Mental Health of Children and Young People in Great Britain*, 2004. Basingstoke: Palgrave Macmillan.
[33] Richardson J, Joughin C (2002) *Parent Training Programmes for the Management of Young Children with Conduct Disorders: Findings from Research*. London: Gaskell.
[34] Friedli L, Parsonage M (2007) *Mental Health Promotion: Building an Economic Case*. Belfast: Northern Ireland Association for Mental Health.
[35] Scott S, Knapp M, Henderson J, Maughan B (2001) Financial cost of social exclusion : follow up study of antisocial children into adulthood. *British Medical Journal* 323:191–194.
[36] Sainsbury Centre for Mental Health (2009) The Chance of a Lifetime: Preventing Early Conduct Problems and Reducing Crime. London: Sainsbury Centre for Mental Health.
[37] Dretzke J, Davenport C, Frew et al (2009) The clinical effectiveness of different parenting programmes for children with conduct problems: a systematic review of randomised controlled trials. Child and Adolescent Psychiatry and Mental Health 3:7. Lundahl B, Risser H, Lovejoy M (2006) A meta-analysis of parent training: moderators and follow-up effects. Clinical Psychology Review 26:86–104.
[38] Bywater T, Hutchings J, Daley D et al (2009) Long-term effectiveness of a parenting intervention for children at risk of developing conduct disorder. British Journal of Psychiatry 195:318–324.
[39] Puig-Peiro R, Stevens M, Beecham J (2010) The costs and characteristics of the parenting programmes in the NAPP Commissioners' Toolkit. London: Personal Social Services Research Unit, LSE.

[40] Hilton M (2007) Assessing the Financial Return on Investment of Good Management Strategies and the WORC Project. Brisbane: University of Queensland.
[41] Wang PS, Patrick A, Avorn J et al (2006) The costs and benefits of enhanced depression care to employers. *Archives of General Psychiatry* 63:1345–1353.
[42] Fearnley J (2007) Gauging Demand for Free to Access Money Advice: a Discussion Paper. London: Money Advice Trust.
[43] Skapinakis P, Weich, S et al (2006) Socio-economic position and common mental disorders. Longitudinal study in the general population in the UK. *British Journal of Psychiatry* 189:109–117.
[44] McCrone P, Dhanasiri,S et al (2008) Paying the Price. The Cost of Mental Health Care in England to 2026. London: Kings Fund.
[45] Pleasence P, Buck A et al (2004) *Causes of Action: Civil Law and Social Justice*. London: Legal Services Commission.
[46]Williams K, Sansom A (2007) *Twelve Months Later: Does Advice Help? The Impact of Debt Advice: Advice Agency Client Study*. London: Ministry of Justice.

[48] NICE (2009) Depression in Adults with Chronic Physical Health Problem: Treatment and Management. London: NICE.
[49] Katon WJ, Von Korff M, Lin EHB et al (2004) The Pathways study: a randomized trial of collaborative care in patients with diabetes and depression. *Archives of General Psychiatry* 61:1042–1049.

[50] Lloyd CE (2010) Diabetes and mental health: the problem of co-morbidity. *Diabetic Medicine* 27:853–854.
[51] Das Munshi J, Stewart R, Ismail K et al (2007) Diabetes, common mental disorders, and disability: findings from the UK National Psychiatric Morbidity Survey. *Psychosomatic Medicine* 69:543–550.
[52] Simon GE, Katon W, Lin EHB et al (2007) Cost effectiveness of systematic depression treatment among people with diabetes mellitus. *Archives of General Psychiatry* 64:65–72.
[53] Clarke P, Gray A, Legood R, Briggs A, Holman R (2003) The impact of diabetes-related complications on healthcare costs: results from the United Kingdom Prospective Diabetes Study. *Diabetic Medicine* 20:442–450.
[54] Cacioppo JT, Hughes ME, Waite LJ, Hawkley LC, Thisted RA (2006) Loneliness as a specific risk factor for depressive symptoms: cross-sectional and longitudinal analysis. *Psychology and Aging* 26:140–151.
[55] Mead N, Lester H, Chew-Graham C, Gask L, Bower P (2010) Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis. *British Journal of Psychiatry* 196:96–101.
[56] Department of Health (2009) *Partnerships for Older People Projects Final Report*. London: Department of Health.
[57] Knapp M. Henderson C, Perkins M, Roman A (2009) *Brighter Futures Group final report* (unpublished). Maidstone: Kent County Council.
[58] Beecham J, Knapp M, Fernandez JL et al (2008) *Age Discrimination in Mental Health Services, Discussion Paper*. London: PSSRU, LSE.