Mental Health Joint Strategic Needs Assessment

Presentation to Cumbria Mental Health Care Stream Board

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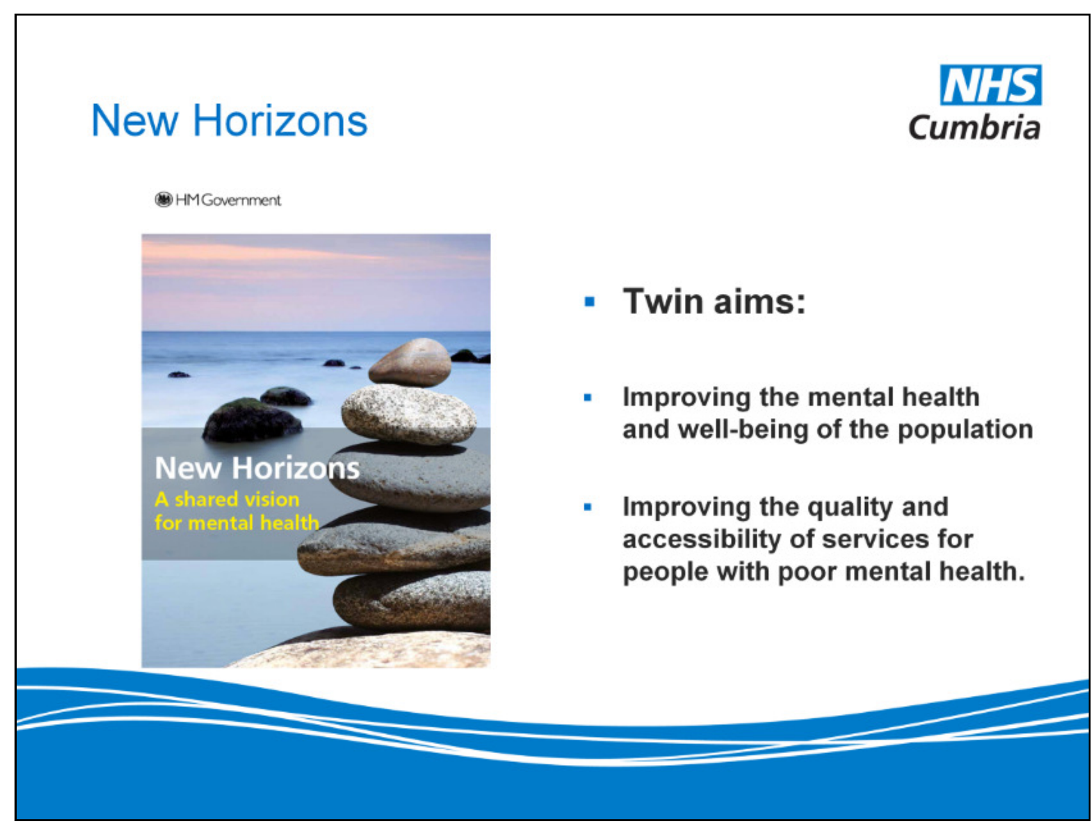
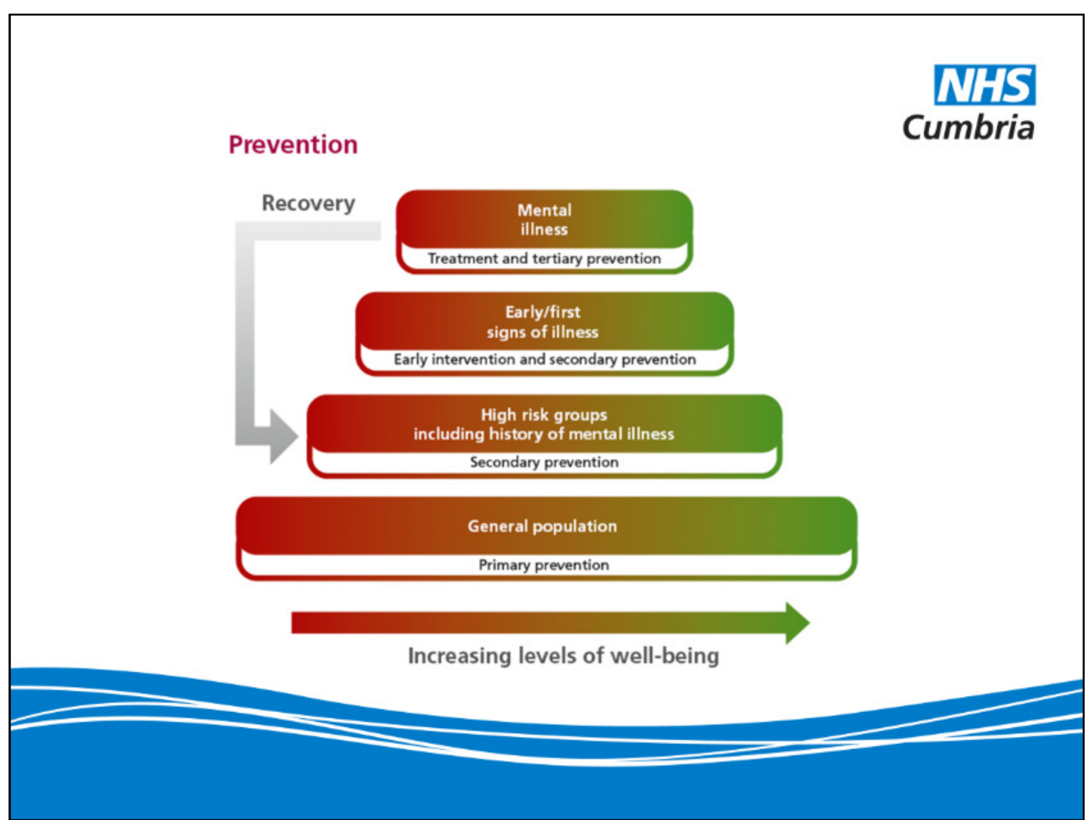
25 May 2010



Context for this work –

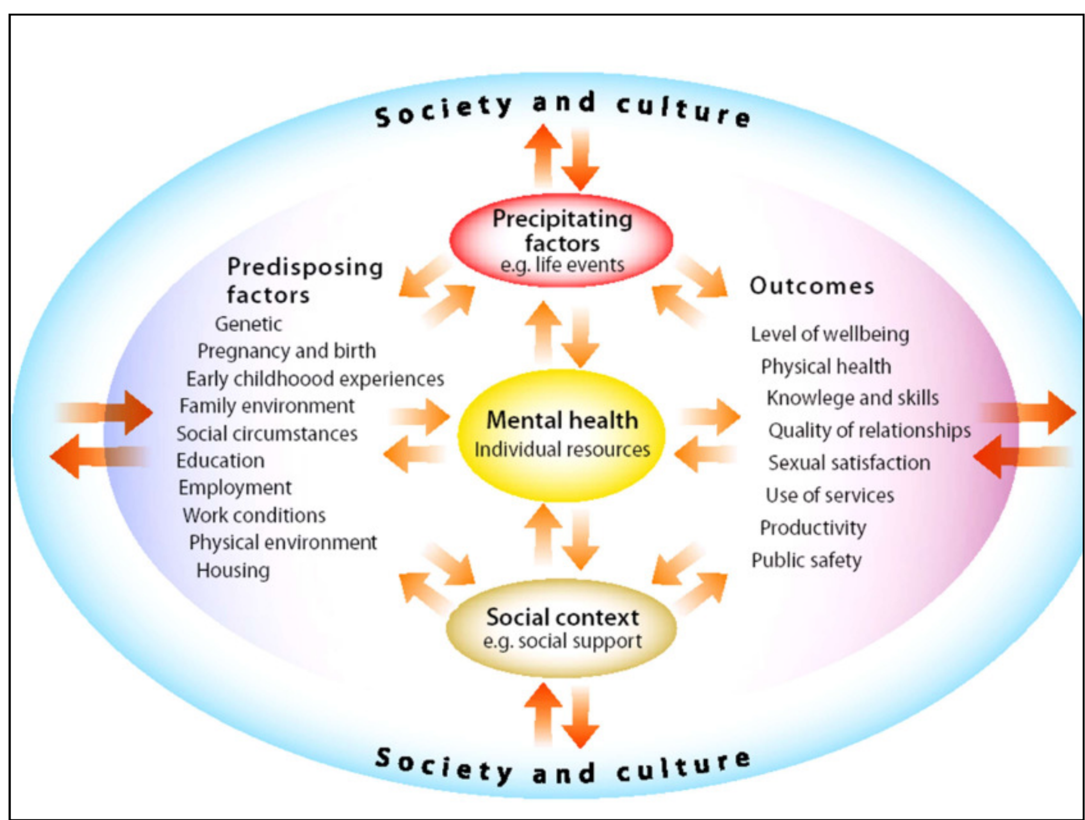
New cross government mental health strategy for England Dec 2009

Twin aims…



New horizons is about improving the mental health and well-being of the population as well as improving the quality and accessibility of services for people with poor mental health

New Horizons Focuses on prevention and early intervention maximising people's mental well being and recovery including when they are experiencing mental health problems



Starting point – a social model of mental health

This representation of the causal factors and outcomes associated with MH – from the Foresight mental health project report, 2008

So what's the role of needs assessments?

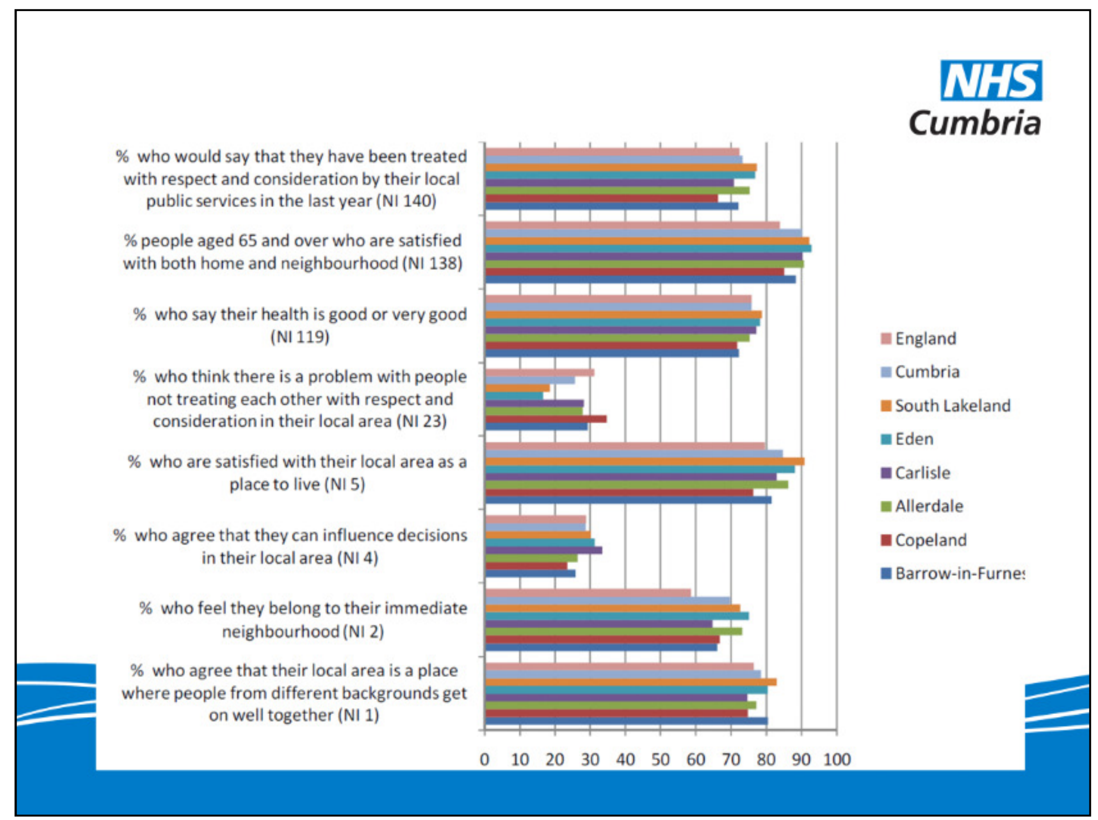
In my experience, needs assessments play a crucial role at the interface between government policy and the frontline in generating a shared understanding of priorities for action to improve health and creating opportunities for integrated strategy, commissioning and frontline work.

As the diagram sets out, JSNA involves bringing together relevant data and evidence about patterns of health and its determinants, current services, the views and experiences of the public, professionals and other stakeholders and research evidence of what works.

‘There can be no health without mental health’

Well-being is described in *New Horizons* as:

‘A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment’.



England's Place Survey 2008 provides information for each local authority area on people's perceptions of their community and services they receive. Several questions give an indication of levels of well-being in our communities: perceptions about how well people from different backgrounds get on together and whether they treat each other with respect, how satisfied they are with their local area, and whether they feel they can influence decisions and belong to a local area.

Overall, Cumbria tends to do better than England on these measures. However within Cumbria there are large differences. The more socially disadvantaged areas tend to fare less well compared to Eden and South Lakeland. Barrow-in-Furness is a noticeable exception. Considering it has the highest level of deprivation in Cumbria, it scores relatively well on most of these measures. Copeland has the lowest reported levels for several indicators including whether people of different backgrounds get on together, whether people feel they can influence decisions, whether people treat each other with respect and overall satisfaction.

In order to better understand levels of well-being and the factors, or determinants, which may either enhance or reduce well-being, a survey was undertaken in 2009 across the North West of England

Warwick and Edinburgh Mental Wellbeing (WEMWBS) Scale

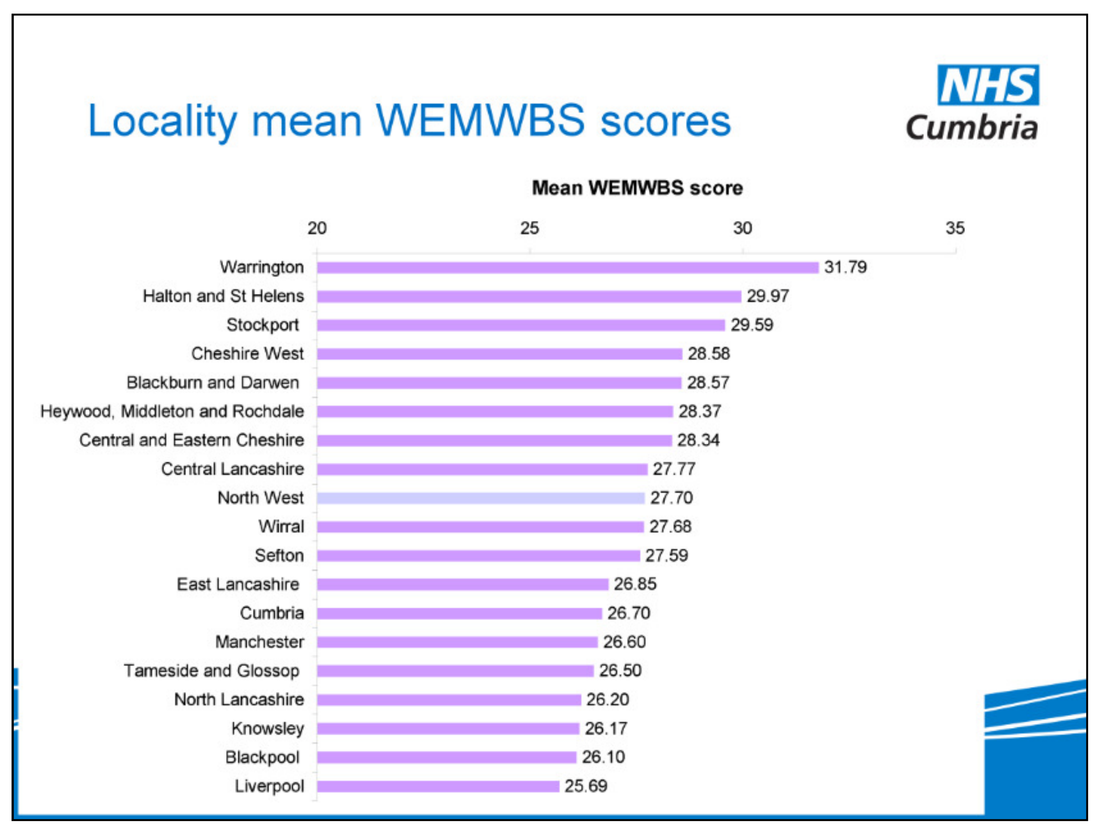
NHS Cumbria

	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future					
I've been feeling useful					
I've been feeling relaxed					
I've been dealing with problems well					
I've been thinking clearly					
I've been feeling close to other people					
I've been able to make up my own mind about things					

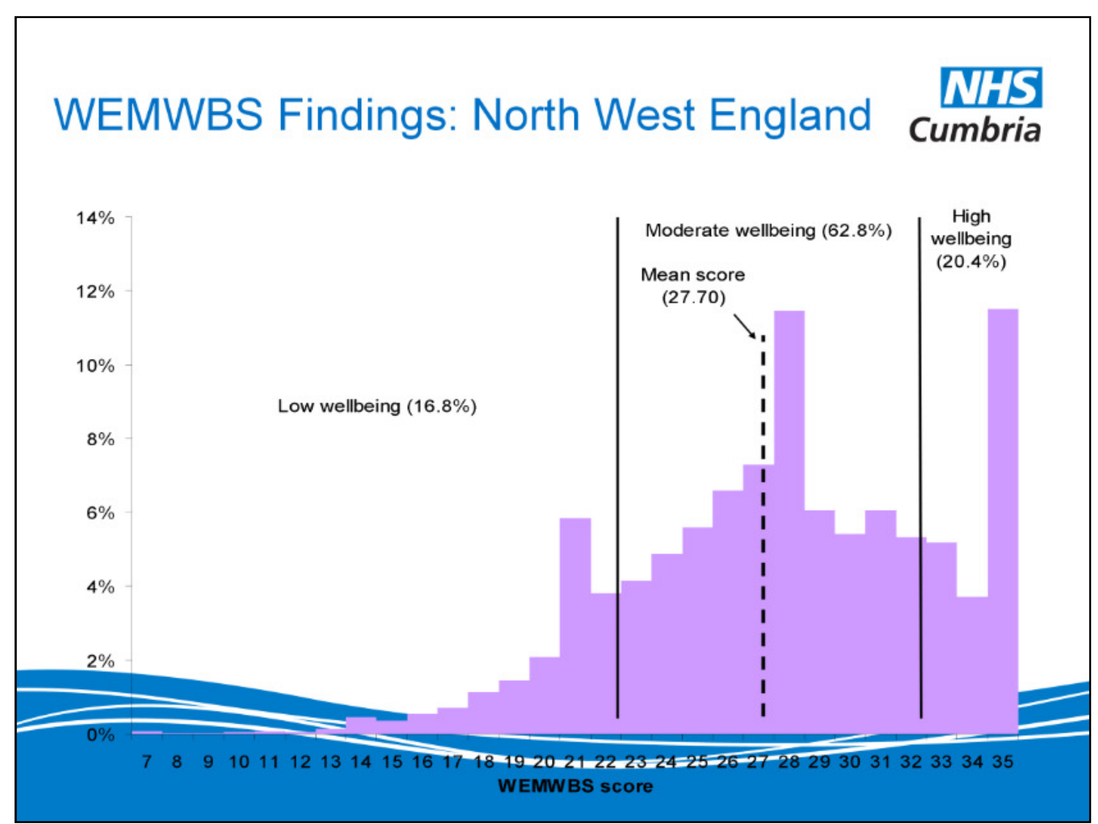
The survey used the Warwick Edinburgh Mental Wellbeing scale (WEMWBS).

This scale is made up of seven items that cover two dimensions of mental wellbeing: how people feel (pleasure) and being able to function positively. Each statement has a five point scoring system, with responses ranging from 'none of the time' through to 'all of the time'. The highest possible score is therefore 35.

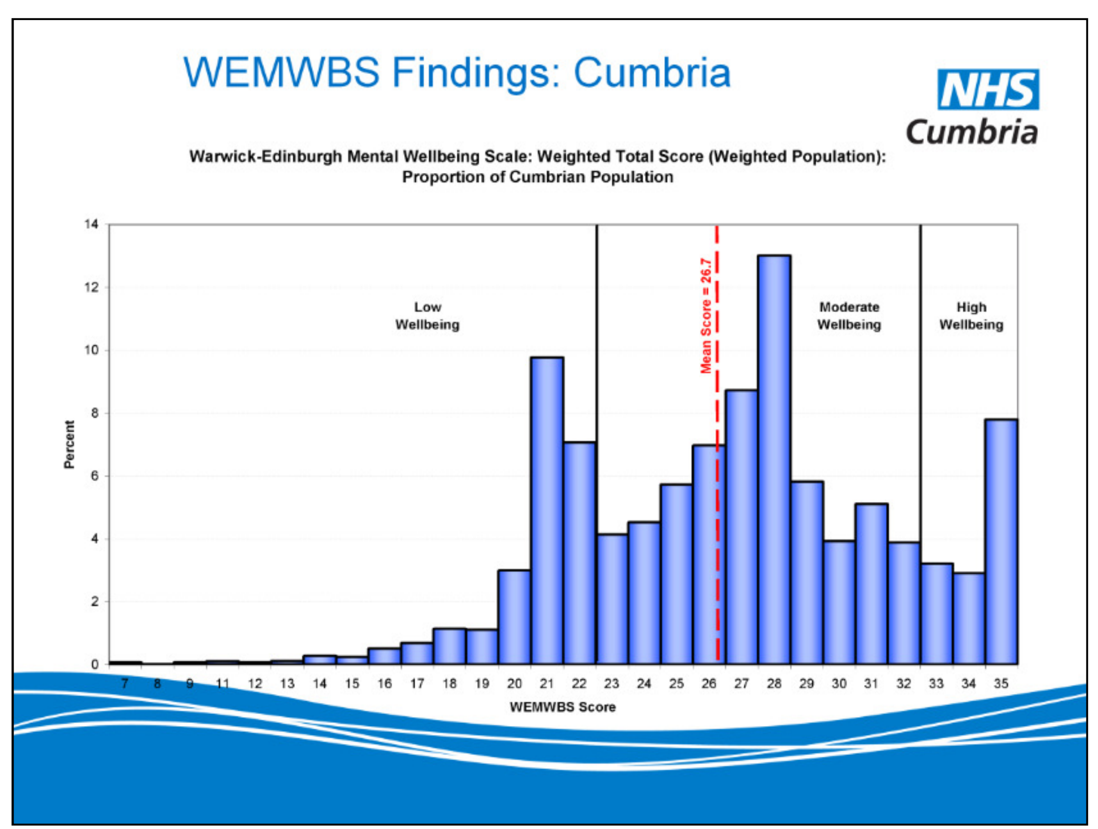
The survey not only provides a population measure of positive mental health using the Warwick and Edinburgh Scale, but also captures information on some of the major determinants of mental wellbeing. The include the place where people live and people's feelings and relationships. Health was measured using a subjective measure, rather than a medical diagnosis. Aspects of lifestyle and significant life events were captured. The survey includes the financial, employment and education situations of individuals. It also contained demographic information.



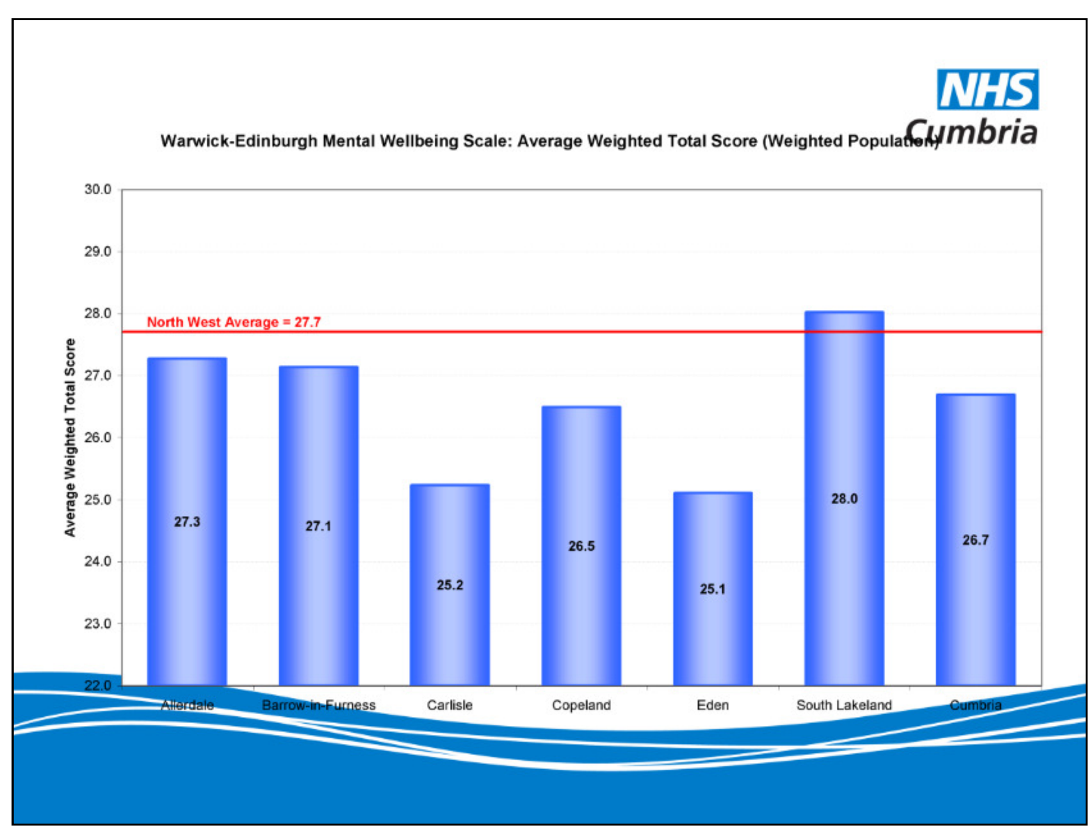
This survey results provide us with a new baseline allowing us to compare well-being across Cumbria's districts and with other local authorities in the region.



The survey revealed a mean WEMWBS score for the North West of 27.7 out of a maximum possible score of 35.



Cumbria's mean score of 26.7 placed it just below the regional average. 13.9% of Cumbria's population had high levels of mental wellbeing (score of 33 and above (i.e. one standard deviation above the NW mean)), 61.9% had moderate (23-32) and 24.2% had low levels of mental wellbeing (score of 22 and below (i.e. one standard deviation below the NW mean)).



Results by district in Cumbria show that only South Lakeland had a mean score above the regional average. Survey participants in Eden had the lowest mean well-being score, at 25.1 out of 35.

Why Eden? More respondents than expected answered ‘some of the time’ and fewer answered ‘all the time’ on all WEMWBS questions

There is a strong association between answering ‘some of the time’ and reporting worries about money (answers to ‘able to ask someone for help if in financial difficulty and need to borrow £100’ and ‘worried about money during the last few weeks’).

Weaker association with satisfaction with personal relationships and being retired

Eden residents are likely to have lived a bit less long than other Cumbria residents, but this does not correlate with WEMWBS

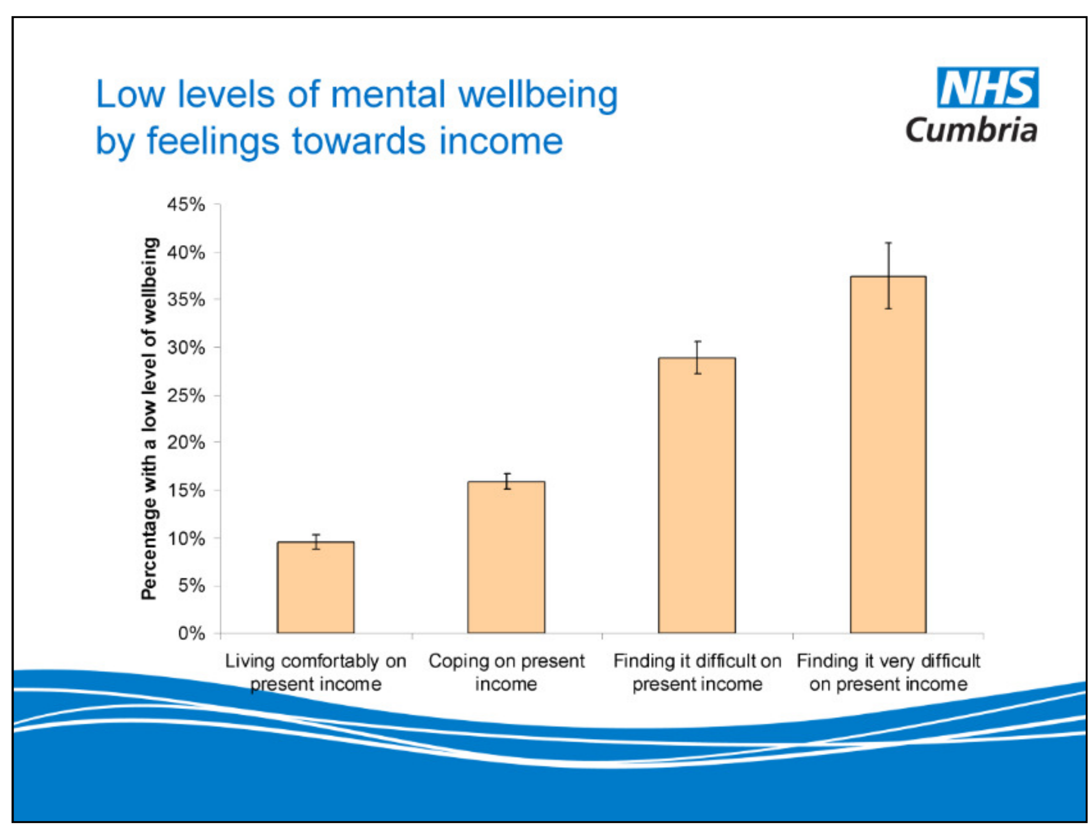
Design artefact???

Mental wellbeing distribution: North West

NHS Cumbria

- **Gender – there is no difference between men and women**
- **Age – mental wellbeing is highest among 25-39 year olds, then decreases and is significantly lower among 40-54 year olds**
- **Deprivation – mental wellbeing reduces as deprivation increases**
- **Ethnicity – mental wellbeing lower amongst white than non-white**
- **Health - strong associations between physical health, lifestyle and mental wellbeing**
- **Work – mental wellbeing higher in those in full-time employment or education or self employed and lower in permanently sick or disabled**
- **Place - mental wellbeing higher if lived 10 years or more in local area; satisified with local area; sense of belonging; affect decisions; feel safe**
- **Relationships - strong relationships and good social networks are strongly associated with high levels of mental wellbeing**
- **Money worries - mental wellbeing lower if money worries**

More interesting perhaps, the survey enables us to make correlations between wellbeing and its determinants



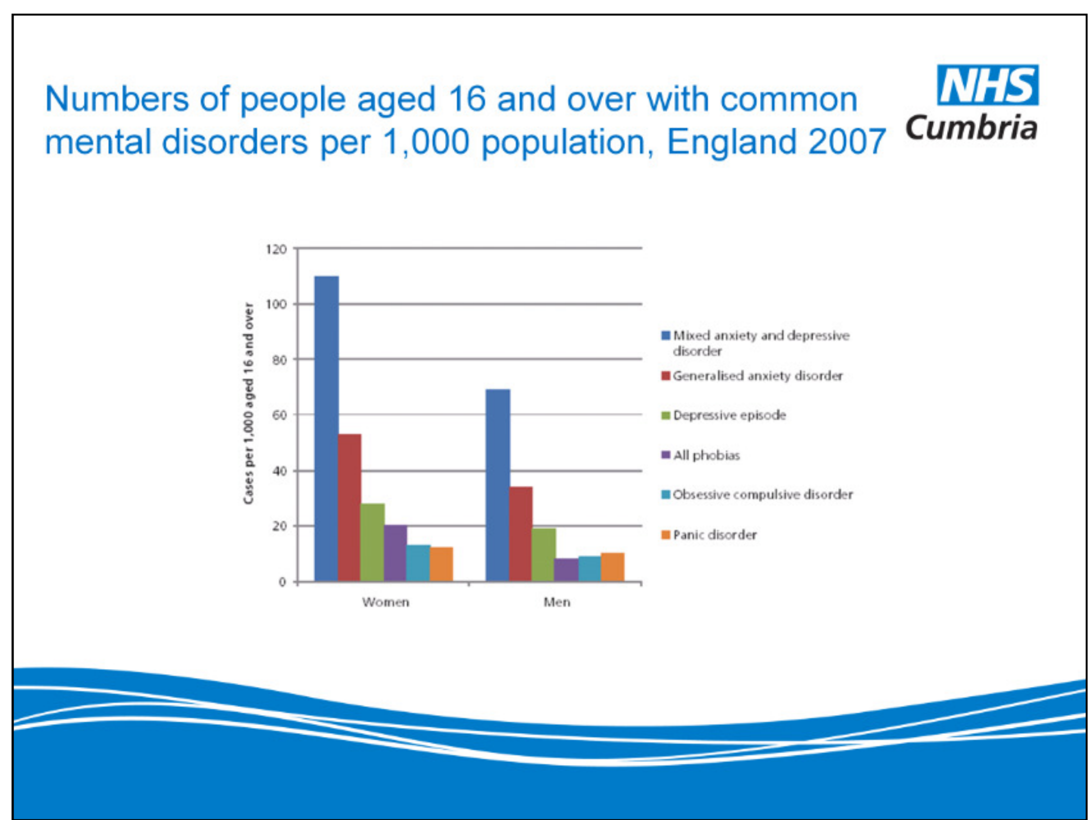
Those who feel they are finding it difficult or very difficult to live on their present income are more likely to have significantly lower wellbeing than those who are comfortable or coping

Some key facts about mental ill-health

- Mental ill-health is common – one in four people will experience a mental health problem at some point in their lives
- One in six of the UK adult population experiences mental ill health at any one time
- Mental illness accounts for over 20% of the total burden of disease in the UK, more than cardiovascular disease or cancer
- 10% of children have a mental health problem
- Half of all mental illness (excluding dementias) starts by age 14
- Depression and anxiety are the most common mental disorders (CMD)
- The prevalence of CMDs increased from 15.5% in 1993 to 17.6% in 2007
- Women are more likely than men to have a CMD (19.7% vs 12.5%)
- Rates of CMDs vary with age and are less frequent over the age of 75 (12.2% women, 6.3% men)
- Rates are higher in areas of deprivation
- Dementias affect 5% of people aged over 65 and 20% aged over 80
- 10% of new mothers suffer from post natal depression
- 4% of the population have a personality disorder
- The prevalence of psychotic disorder is 0.4% (women: 0.5%; men, 0.3%)
- 24% of the adult population have a hazardous pattern of drinking, 6% are dependent on alcohol, 3% on illegal drugs and 21% on tobacco

Moving now from mental wellbeing to mental ill-health

These facts won't be a surprise to most of you = though possibly for people not involved in MH



Main source for prevalence data : Adult psychiatric morbidity for England, 2007

Current and projected patterns of well-being and mental health in Cumbria

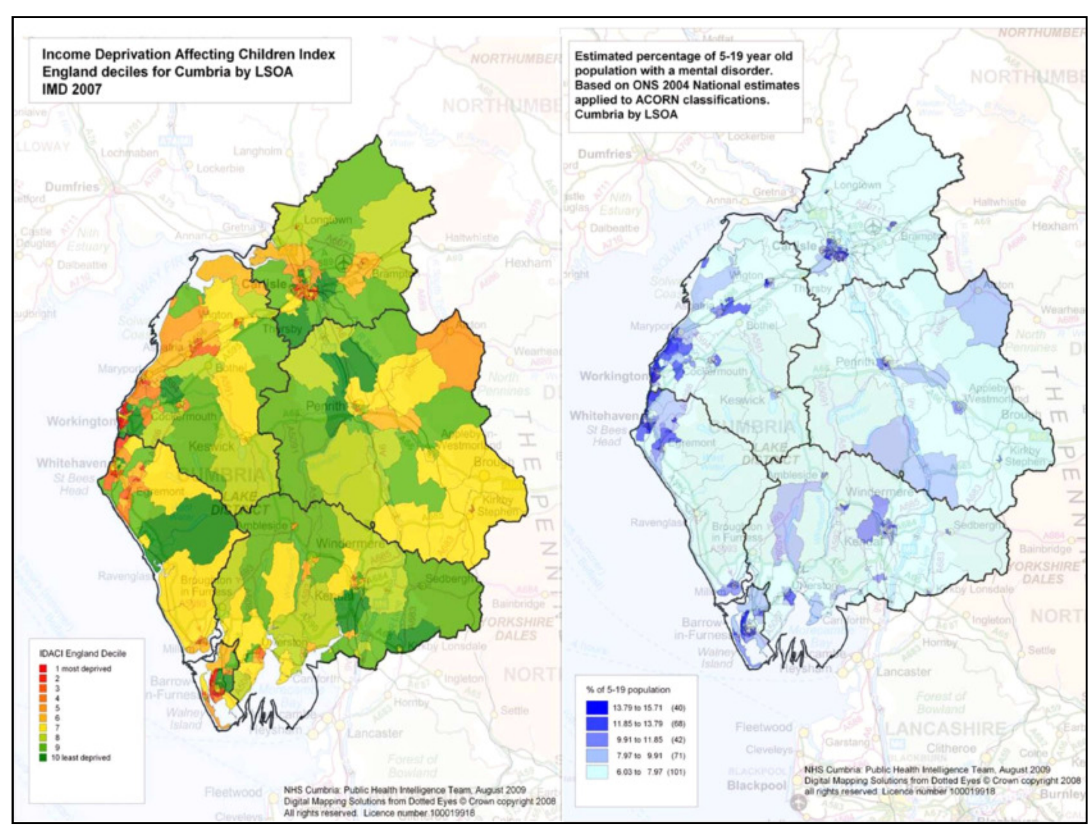
Children and Young people

- 25,000 children < 5 years
- 112,000 children < 20 years (predicted decrease in 0-19s of 3,700 between 2006-2031)
- ~18,000-30,000 0-19s at risk of poor MH due to preventable social, economic & family conditions (18,000 living in low income households;15,000 living in workless households; 8,500 eligible for free school meals; 5,000 who feel there are no adults they can trust; 5,000 with low self esteem)
- **~ 10,700 aged under 20 with diagnosable mental disorder**
- ~ 3,600 children with mental disorders living in the 20% most deprived areas in Cumbria
- ~ 1,000 people children with autistic spectrum disorders
- High hospital admissions of children for self harm
- (~ 140/year)
- High alcohol use amongst children
- ~ 9,000 children affected by parental alcohol misuse and ~2,500 by parental drug use

Adults

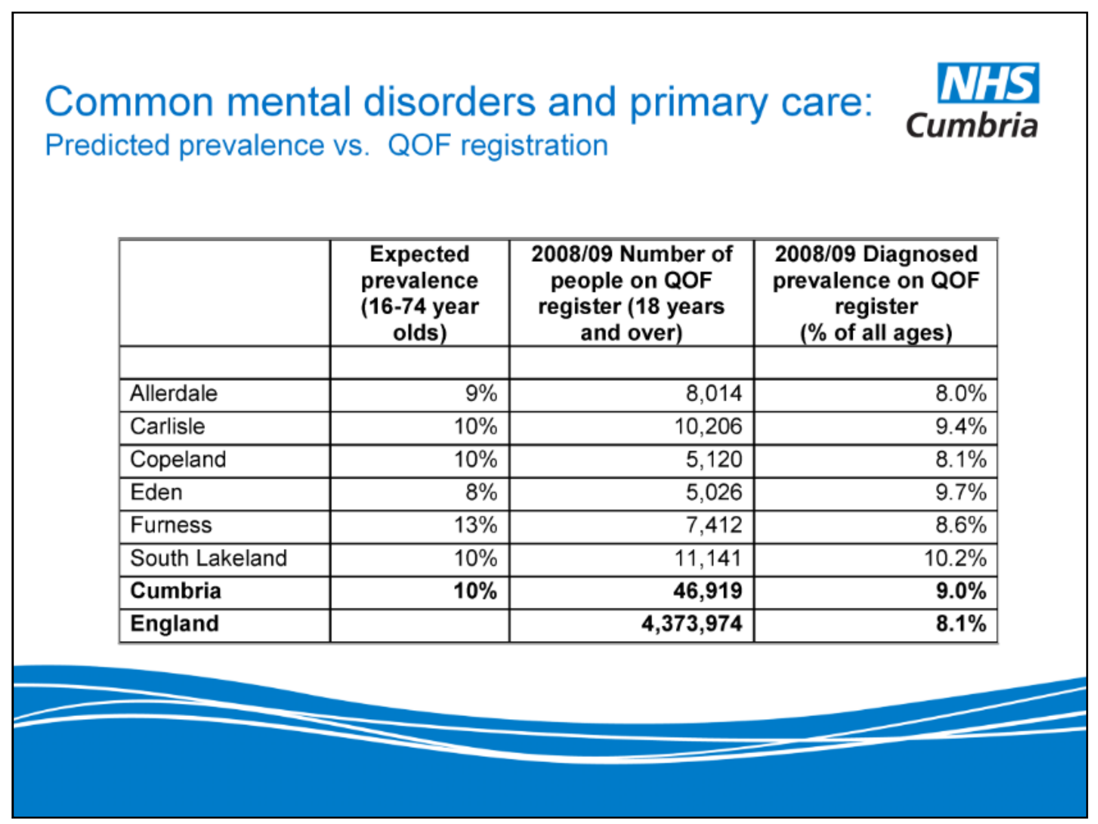
- 385,000 adults aged 20+ (predicted decrease in working age adults of 4,000 and increase in 65+ of 70,000 between 2006-2031)
- ~ 63,000 on low incomes
- ~30,000 out of work
- ~ 10,000 incapacity benefit for MH problem
- ~ 800 gypsy and travellers, up to 80% with MH problems
- **~ 45-66,000 adults with common MH disorders**
- ~ 7,000 adults with dementia
- ~ 2,000 adults with psychosis
- ~ 3,000 adults with personality disorders
- ~ 4,000 adults with autistic spectrum disorders
- ~ 4,000 adults with bipolar disorders
- ~ 700 women with major to severe post natal depression (up to 40% of mothers in deprived areas)
- High alcohol related morbidity and mortality
- High hospital admissions of adults for self harm (~ 900/year)
- ~ 50 suicides

So what do needs assessments tell us about exposure to risk of mental illness in adults and children in CUmbria? Some facts and figures:



What this slide – from CYP NA - tells us is that Poverty and deprivation are the most important determinants of mental health – on the left a map of income deprivation affecting children, on the right the **PREDICTED prevalence of mental disorders extrapolated from a 2004 ONS survey of mental disorders in children.**

The map of common mental disorders in adults shows similar results – as with most health conditions, mental health is strongly correlated to deprivation.



	Expected prevalence (16-74 year olds)	2008/09 Number of people on QOF register (18 years and over)	2008/09 Diagnosed prevalence on QOF register (% of all ages)
Allerdale	9%	8,014	8.0%
Carlisle	10%	10,206	9.4%
Copeland	10%	5,120	8.1%
Eden	8%	5,026	9.7%
Furness	13%	7,412	8.6%
South Lakeland	10%	11,141	10.2%
Cumbria	**10%**	**46,919**	**9.0%**
England		**4,373,974**	**8.1%**

NEXT 2 SLIDES ARE ABOUT PRIAMRY CARE AND MH

This slide is an example of PREDICTED PREVALENCE VS PRIMARY CARE PREVALENCE/QOF activity

Now to compare predicted numbers (from the national survey data) with numbers on GP registers.

This is an example of the kind of information that the needs assessment provides us with, it concerns the diagnosis of common mental disorders in primary care.

It shows the number of people on GP depression registers by district in Cumbria and the proportion of the total practice population, alongside the expected weighted prevalence in that population (Glover, 2008 – derived from adult psychiatric morbidity survey). There are higher than expected numbers of people recorded with a diagnosis of depression in the more affluent district of Eden (+1.7%) and fewer than expected in the more socially disadvantaged districts of Allerdale, Copeland, Carlisle, and Barrow (-4.4%) , where the actual prevalence is likely to be higher.

This could relate to several factors. The diagnosed prevalence may be a true reflection of actual prevalence of depression. This hypothesis would be compatible with the findings of the North West Mental Health and Well Being Survey 2009. The diagnosed prevalence may not be a good proxy measure of true prevalence, due to sources of bias, including differences in the recording of this information, or differences in treatment seeking behaviour or in clinical practice according to where people live. This would be consistent with the *inverse care law* whereby those most in need of services are least likely to access them.

Psychosis and primary care :

Predicted prevalence vs. QOF registration

NHS Cumbria

Locality	Estimated number of people with probable psychosis (16-74 years)	Estimated prevalence of probable psychosis (%) (16-74 years)	2008/09 Number of people on QOF register (all ages)	2008/09 Diagnosed prevalence on QOF register (all ages)
Allerdale	414	0.6	768	0.8%
Carlisle	473	0.6	1,014	0.9%
Copeland	293	0.5	521	0.8%
Eden	164	0.4	343	0.7%
Furness	388	0.7	740	0.9%
South Lakeland	325	0.4	738	0.7%
Cumbria	**2,056**	**0.5**	**4,124**	**0.8%**
England		**0.5**	**406,075**	**0.7%**

General practices keep a register of all people with a diagnosis of psychosis, schizophrenia or bipolar affective disorder (MH 8) as part of the QOF. 2008/09 data indicates that there were about 4,100 people on these registers in Cumbria giving a practice prevalence of 0.8%. This is noticeably higher than the prevalence given in the APMS survey of probable psychosis of 0.5%, a finding repeated for the national figures. This may reflect the intermittent nature of psychotic disorders or/as well as differences in diagnosis, definition, age groups (QOF includes all ages) and data accuracy. In addition, bipolar affective disorder is included in the QOF figures and so the findings are not directly comparable.

The table shows the number of people included on these registers by local authority district along with the average for Cumbria and England

Cumbria Partnership NHS Foundation Trust

Primary Care Mental Health team distribution vs. need

NHS Cumbria

Locality	Predicted number with CMD	GP population over 16	Predicted prevalence	Distribution of current workforce according to need		Actual distribution of current workforce		Difference
				WTE	% of total	WTE	% of total	
Allerdale	9995	74494	13%	14.1	16%	15.9	15%	1.7
Carlisle	12655	91730	14%	17.9	20%	19.5	25%	1.6
Copeland	6652	49046	14%	9.4	11%	9.8	13%	0.4
Eden	6487	53710	12%	9.2	10%	8.1	8%	-1.1
Furness	15323	87287	18%	21.7	25%	19.9	20%	-1.8
South Lakes	10771	75888	14%	15.2	17%	14.4	19%	-0.8
Cumbria	61883	432155	14%	87.5	100%	87.5	100%	

THIS IS FROM PRESENTATION TO BOARD RE WORKFORCE AND IAPT =

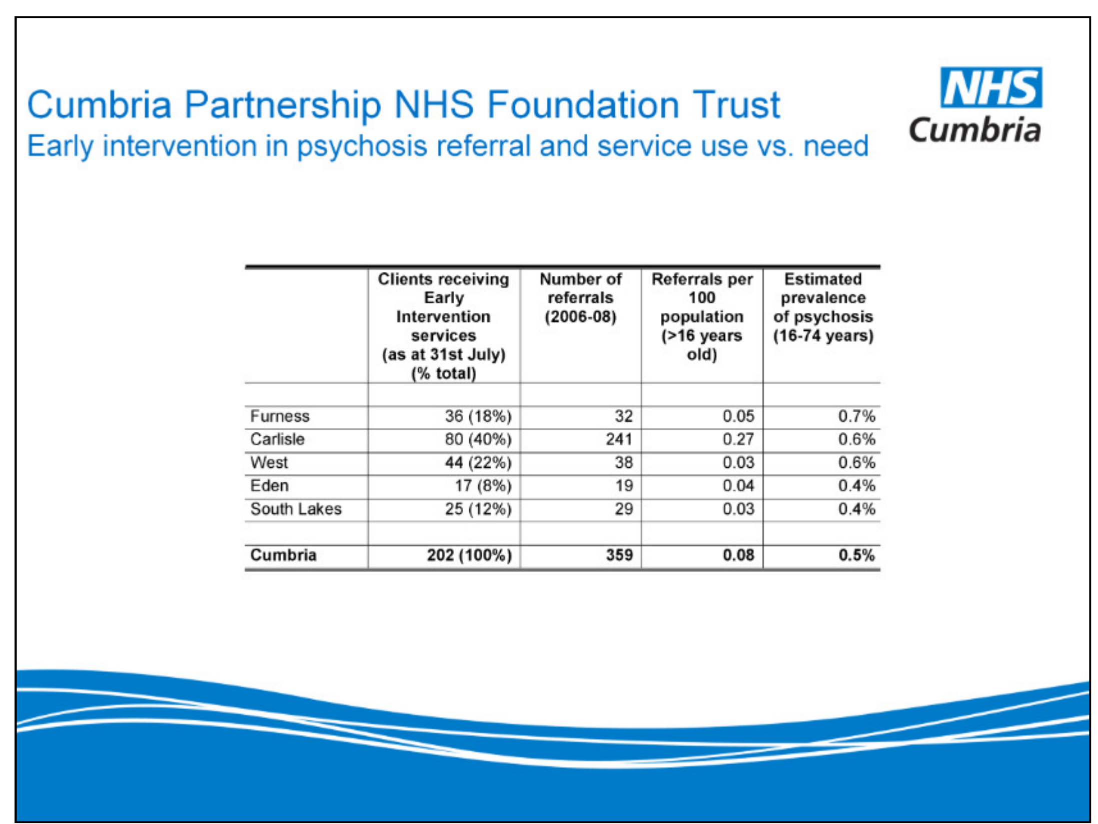
THIS IS A GOOD EXAMPLE OF HOW NEEDS ASSESSMENT IS BEING USED TO SHIFT RESOURCE ACCORDING TO NEED (MOSTLY DEPRIVATION) FIRST STEP HAS TAKEN ESTIMATED PREVALENCE DATA INTO ACCOUNT IN ITS SERVICE DESIGN.

There are an estimated 61883 people with a CMD over the age of 16 in Cumbria. The prevalence CMD is likely to vary between 12% in Eden and 18% in Furness.

The current workforce of 87.5 WTE would be sufficient to provide access to psychological therapies for 35% of these 61883 people in a year.

For this level of access to remain consistent across each locality these 87.5 WTE should be distributed as shown in the table below.

This indicates that the distribution of the workforce is lower than required in Furness and to a lesser extent in Eden and South Lakes localities.



	Clients receiving Early Intervention services (as at 31st July) (% total)	Number of referrals (2006-08)	Referrals per 100 population (>16 years old)	Estimated prevalence of psychosis (16-74 years)
Furness	36 (18%)	32	0.05	0.7%
Carlisle	80 (40%)	241	0.27	0.6%
West	44 (22%)	38	0.03	0.6%
Eden	17 (8%)	19	0.04	0.4%
South Lakes	25 (12%)	29	0.03	0.4%
Cumbria	**202 (100%)**	**359**	**0.08**	**0.5%**

THIS IS ANOTHER EXAMPLE OF HOW TE NEEDS ASSESMENT HIGHLIGHTS POSSIBLE EQUITY OF ACCESS ISSUES

THE TABLE shows the number of people using the early intervention in psychosis *service* in each locality as at July 2009 and the number of referrals (2006-08) compared with the expected level of psychosis in each locality population. This shows that use of this service varies considerably between areas, with most referrals occurring in Carlisle and largest caseload there too.

There is therefore a need to increase the equity of access to this service.

Nb I HAVEN’T INCLUDED ANYTHING ELSE ON CPFT ACTIVITY – THE DATA QUALITY WAS SO POOR = cf improvement plan below

m

Public engagement and user involvement
key issues

- **Need for a directory of statutory and voluntary services, to enable:**
  - Better knowledge and hence access to and uptake of services including 'social prescribing' services, either through professional referral or self referral.
  - Identification of gaps and inequities in existing services.
  - The directory would complement and be linked to other important strands of the mental health strategy, including: social prescribing; assets based approaches; self management; personalised care; pathways development; communications and training.
- **Training of professionals and 'gatekeepers', public education and communication:** to address isolation arising from public perceptions of mental health problems: primarily lack of understanding, not knowing what to say and fear of 'contagion' of mental health problems. Professionals – whether health or other sectors – did not always seem to understand 'what its like to be in my shoes': Saying 'how are you'? would make a difference.
- **Access to support in time of crisis**: 24 hour access to professional care; scope for volunteer involvement?
- **Open access to high quality recovery focused support**, both 'service based' (e.g. Croftlands, MIND, community gym) and 'community based' (scope to develop community buddying schemes, whether face to face, telephone based, or virtual).
- **Support for people bereaved through suicide:** could include both access to appropriate professional support and development of peer support groups (e.g. SOBS).
- **Management of transitions** from young people's to adult services and from adult to older adult services.
- **Specific issues of hard to reach communities**

The engagement process for the mental health needs assessment was built on good practice in public engagement. It was co-developed with Cumbria Mental Health Group and consisted primarily of:

Facilitated sessions within 18 established locality meetings of CMHG and one CMG meeting.

A survey of mental health service users and carers carried out by the Targeted Community Engagement Programme.

'Horizon scanning' through one to one contacts with, and a stakeholder event bring together, stakeholders with an interest in public engagement and asset mapping for mental health (CMHG; CMG; Cumbria mental health third sector provider forum; NHS Cumbria engagement team and public health team, including team member working on gypsy and traveller health issues; Cumbria DAAT; Cumbria Local Involvement Network, LINk; Cumbria County Council community programmes and community development workers and neighbourhood development team; Cumbria Equality Resource Centre; Churches Together in Cumbria; GPs with an interest in mental health; Cumbria Suicide Prevention Reference Group; and Cumbria Dementia Strategy lead).

What would high quality services and interventions look like?

Main sources:

- New Horizons (DH, 2009) - www.dh.gov.uk/newhorizons
- National Mental Health Development Unit, NMHDU[1]- www.nmhdu.org.uk
- Foresight Mental Capital and Wellbeing Project (2008) - www.foresight.gov.uk
- Bacon, N et al (2010) The state of happiness: can public policy shape people's wellbeing and resilience? The Young Foundation - www.youngfoundation.org
- Royal College of Psychiatrists, in particular its policy section, and the College Centre for Quality Improvement - www.rcpsych.ac.uk
- Relevant NICE guidance - www.nice.org.uk

Fourth element of needs assessment

we looked at evidence, guidance and innovative practice concerning public mental health, models of mental health care services and evidence concerning specific conditions and priority groups

Completed NICE guidance

- Antenatal and postnatal mental health
- Antenatal care
- Antisocial personality disorder
- Anxiety
- Attention deficit hyperactivity disorder (ADHD)
- Bipolar disorder
- Borderline personality disorder (BPD)
- Dementia
- Depression (replaced by CG90)
- Depression in adults (update)
- Depression in children and young people
- Depression with a chronic physical health problem
- Drug misuse: opioid detoxification
- Drug misuse: psychosocial interventions
- Eating disorders
- Medicines adherence
- Obsessive compulsive disorder (OCD) and body dismorphic disorder (BDD)
- Post-traumatic stress disorder (PTSD)
- Schizophrenia (replaced by CG82)
- Schizophrenia (update)
- Self-harm
- Violence
- When to suspect child maltreatment

What can be done to improve mental health and promote wellbeing?
(***Confident communities, brighter futures, 2010)***

- Use a life course approach to ensure a positive start in life and healthy adult and older years. With such an approach, people develop and share skills to *continue learning* and have *positive social relationships* throughout life.
- Build strength, safety and resilience: *address inequalities* and ensure *safety and* security at individual, relationship, community and environmental levels.
- Promote mental wellbeing through productive healthy working conditions (cf NICE Public Health Guidance 22, 2009)
- Develop sustainable, connected communities: create socially inclusive communities that promote *social networks* and *environmental engagement.*
- Integrate physical and mental health: develop *a holistic view of well-being* that encompasses both physical and mental health, reduce health-risk behaviour and *promote physical activity.*
- Promote purpose and participation to enhance positive well-being through a balance of physical and mental activity, relaxation, generating a positive outlook, *creativity* and *purposeful community activity.*

Wise Buys for Mental Health: children and young people

- Universal routine enquiry and targeted treatment for *women at risk of depression* with home visiting therapist for post natal depression, as part of a package of measures to improve peri-natal mental health.
- Universal assessment of potential parenting problems and targeted *early intervention programmes for common parenting problems*, including school-based learning.
- Early interventions with individual home based programmes for conduct disorders.
- Whole school approaches to build the emotional resilience of children and young people.
- Implementation of initiatives to prevent, identify and respond to emotional, physical and/or sexual abuse.

Now to how we persuade our chief executives and directors of finance to invest in prevention.

I think we would all agree that everyone has the right to the best physical and mental health that society can afford.

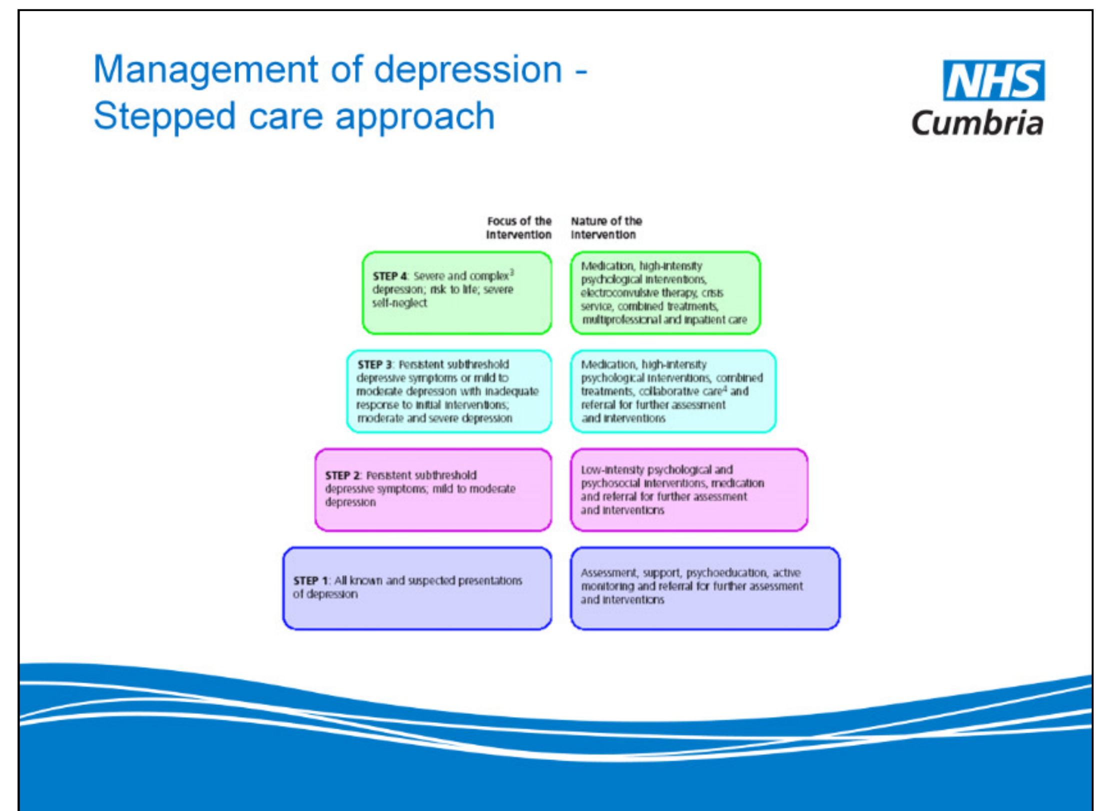
But research also shows that there is an economic case for mental health promotion, illness prevention and the creation of well-being.

For example, Targeted Parenting Programmes for children with conduct disorder cost £639-3,839 but a total cost of a child with conduct disorder is £70,000 by 28 years of age.

Among the 10 most cost effective interventions for mental health, five concern CYP. They are:

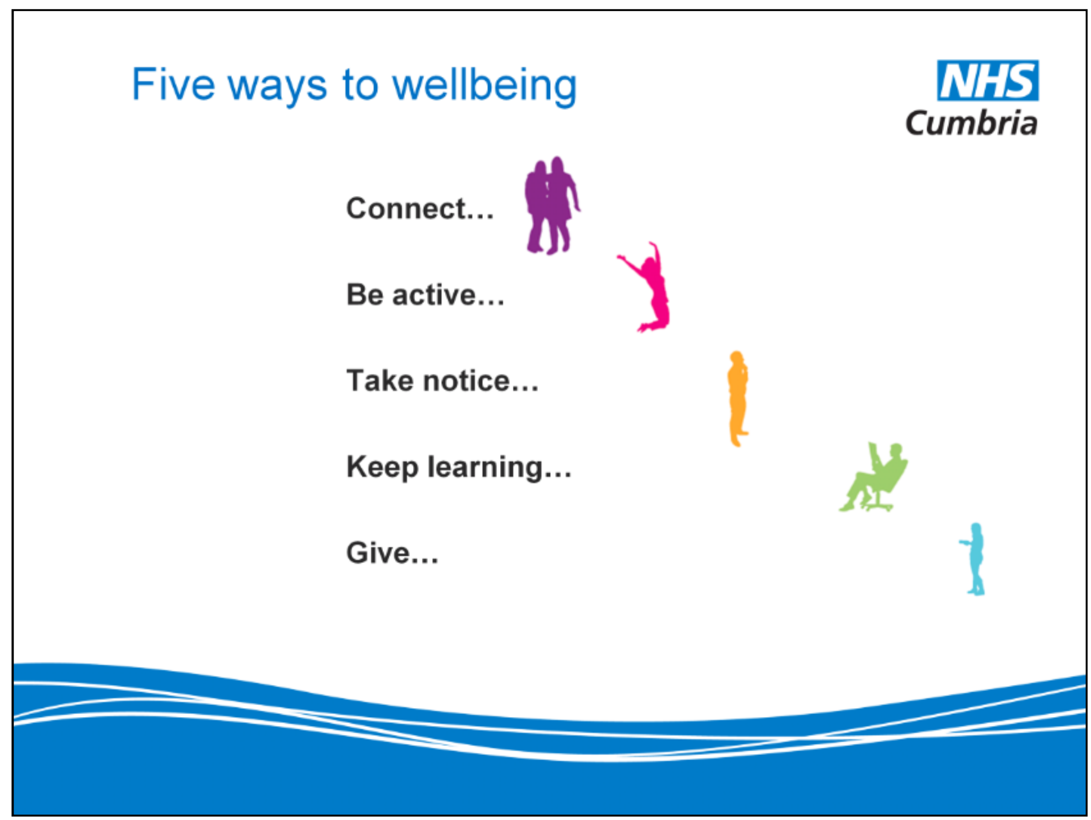
Wise Buys for Mental Health: adults

- Interventions, delivered through '*social prescribing*', to increase social support, to strengthen psychosocial skills and to access resources which protect wellbeing
- Integrate physical and mental well-being through universal access to lifestyle programmes to reduce smoking alcohol use, substance use, and obesity.
- Improve working lives by early intervention to reduce risks of unemployment
- Ensure access to psychological therapies, including CBT, for people with long term conditions, disabilities and carers.
- Early intervention and targeted approaches for high risk groups, including suicide reduction programmes



Model adopted by IAPT

Stepped care provides a framework in which the provision of services can be organised to support patients, carers and healthcare professionals to identify and access the most effective, but least intrusive, intervention appropriate to a person’s needs. If a person does not benefit from that intervention, or declines an intervention, they should be offered an appropriate intervention from the next step. The intervention given in stepped care models ranges from ‘low intensity’ to ‘high intensity’. Patients generally have access to treatments on lower steps before receiving treatments from higher steps. Stepped care has the potential for deriving the greatest benefit from available therapeutic resources



And these are things that people can do themselves to increase WB – assets based approach!

Part of Foresight Mental Capital and Wellbeing Project

New Economics Foundation – 5 evidence based ways to improve well-being

About individuals but also about their interactions in a social context – linked to the determinants of mental health

The Foresight Mental Capital and Wellbeing project commissioned the New Economics Foundation to gather evidence on actions that people could take themselves to improve their well-being. They estimated that life expectancy could be extended by 7.5 years by building the following actions - or '***five ways to wellbeing'*** - into daily life. New Horizons sets out the government's intention to build a public campaign based on these messages.