Thurrock Joint Strategic Needs Assessment for Common Mental Health Disorders – Executive Summary

Authors:

Funmi Worrell, Strategic Lead Public Health

Maria Payne, Senior Programme Manager Health Intelligence

Tim Elwell-Sutton, Assistant Director and Consultant in Public Health

February 2018

Acknowledgements

With thanks to all those who have helped us with this document. We particularly thank Jane Itangata (TCCG), Karen Balthasar, Kelly Clarke, Kareema Olaleye, Nicola Smith, Kevin Malone, Sarah Hurlock, Katie Clark (TCCG), Mandy Moore, Ian Kennard and Kim James (Healthwatch Thurrock) for their hard work in providing data and helping to pull together this JSNA product.

Key findings and recommendations

Findings	Summary Recommendations
System Fragmentation The current mental health prevention and treatment system is highly fragmented with a large number of services operating at different levels and commissioned in parallel	**Integration of commissioning:** Plans for joint commissioning across health and social care in Thurrock should include integration of mental health commissioning between the local authority and CCG. Joint commissioning should be used as a platform to drive the integration of services around the individual. **Integrated Service Delivery**: The development of new models of care provides a huge opportunity to try doing thing differently. Mental health needs to be integrated into the delivery of new models of primary care and wellbeing teams delivering social care in the community. There are also important opportunities to integrate services addressing the social determinants of mental health such as housing and employment into these new models of care.
Under-diagnosis A large proportion of those with mental ill health are never diagnosed or treated. Depression is particularly poorly diagnosed and there is wide variation between GP practices in the extent of case finding.	**Reduce unwarranted variation between GP practices in case finding**. Building on the work of the GP practice profiles produced by the public health team there is an opportunity to reduce variation and find the 8000+ people estimated to have undiagnosed depression in Thurrock. **Make better use of depression screening.** There is a strong evidence base to support the use of depression screening amongst front-line staff working with high risk groups (e.g. use by social workers or health professionals in long term condition clinics). Current use of this tool appears to be minimal and is not consistently monitored. Joint work between the local authority and CCG is needed to promote this.

Key findings and recommendations

Findings	Summary Recommendations
Quality of Care Even when people are identified as having a mental illness they are often not referred for treatment or their treatment is not in line with the highest quality standards.	**Reducing unwarranted variation between GP practices.** Variation in referrals into IAPT services and reviews of newly diagnosed depression are examples of two quality standards which could be improved through joint working between GP practices and the public health team. **Commissioners working to improve standards**. Redesign of CCG-commissioned services of some existing services is underway and standards are expected to improve. This must be monitored closely by commissioners. **Improve quality of service data.** Commissioners in the local authority and CCG are working with providers to improve the quality of the service data they receive. New indicators need to be designed with are meaningful and focussed on patient outcomes, including wider social outcomes.
Risks Associated with Mental Health There are well-known wider health risks associated with mental health including high rates of smoking, obesity and long-term conditions (LTCs).	**Improve understanding of links between mental health and LTCs**. Feedback from residents with LTCs suggests that clinicians do not always appreciate these connections. Education of health professionals would be beneficial. **Promote smoking cessation in those with serious mental illness**. Work is ongoing between public health and mental health provider services to promote smoking cessation even in in-patient settings. This needs to be brought to completion and monitored. **Promote referral of mental health patients into healthy lifestyles services commissioned by public health**.

Background

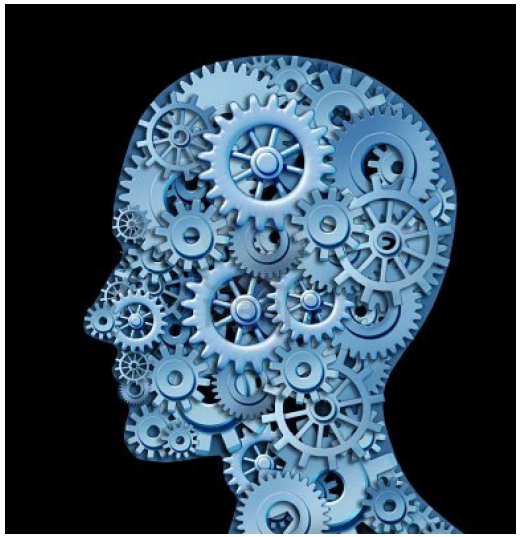
Abbreviations

CMHDs	Common Mental Disorders
SMIs	Severe Mental Illnesses
IAPT	Improving Access to Psychological Therapies
EIP	Early Intervention in Psychosis
PTSD	
OCD	
MH	Mental Health
JSNA	Joint Strategic Needs Assessment
APMS	Adult Psychiatric Morbidity Survey
CMS-NOS	Common Mental Disorder – Not Otherwise Specified
GAD	Generalised Anxiety Disorder

Definitions

Common Mental Disorders (CMHDs)	Includes: depression, anxiety, panic disorder, obsessive-compulsive disorder (OCD), phobias, post-traumatic stress disorder (PTSD). CMHDs do not generally exist in isolation to each other. Mixed anxiety and depression being the most commonly diagnosed CMHD.
Serious Mental Illnesses (SMIs)	Includes conditions characterised by psychosis (losing touch with reality) or requiring high levels of care. Two of the most common are: schizophrenia and bipolar disorder (manic depression). Also known as *Severe* Mental Illness.
Improving Access to Psychological Therapies (IAPT)	A national programme to increase the availability of 'talking therapies' on the NHS. IAPT is primarily for people who have mild to moderate mental health difficulties.
Early Intervention in Psychosis (EIP)	Early Intervention in Psychosis (EIIP) teams provide specialist treatment and care for people who have signs of psychosis. The teams are made up of a number of different health and social care professionals.

Background



Purpose and Scope

This JSNA aims to:

- Understand the full estimated level of need
- Understand the variation in access and quality of treatment
- Identify mental health priorities for Thurrock

It includes both Common Mental Health Disorders (CMHDs) and Serious Mental Illness (SMI)

> *Mental health is "a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to made a contribution to her or his community."*
>
> World Health Organization

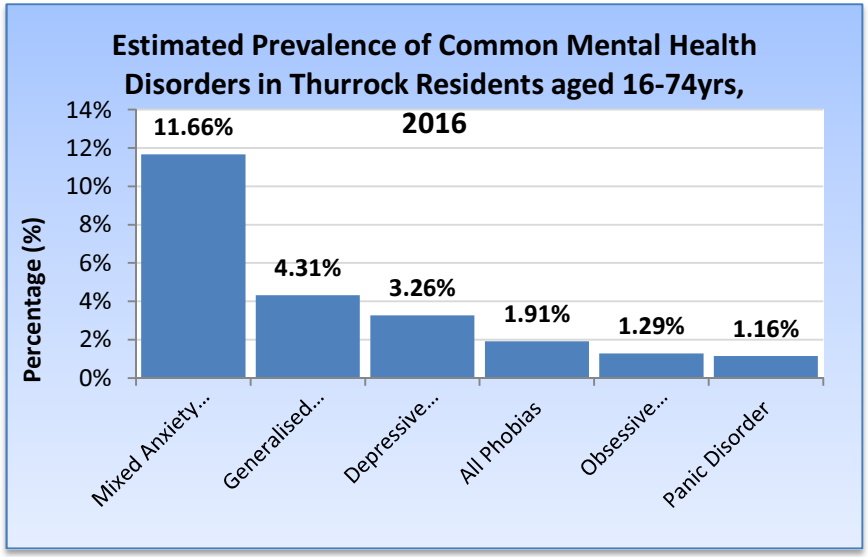
There is a growing recognition of how common mental health disorders are. Mental health disorders are the leading cause of disability worldwide (WHO)and one in four people in the UK will experience a mental health disorder at some point in their lives. While the document focuses on adults, this is an issue which exists across the life course. We know that many adult mental health disorders begin in childhood and that up to half of them could be averted with effective childhood interventions (COI, 2011).

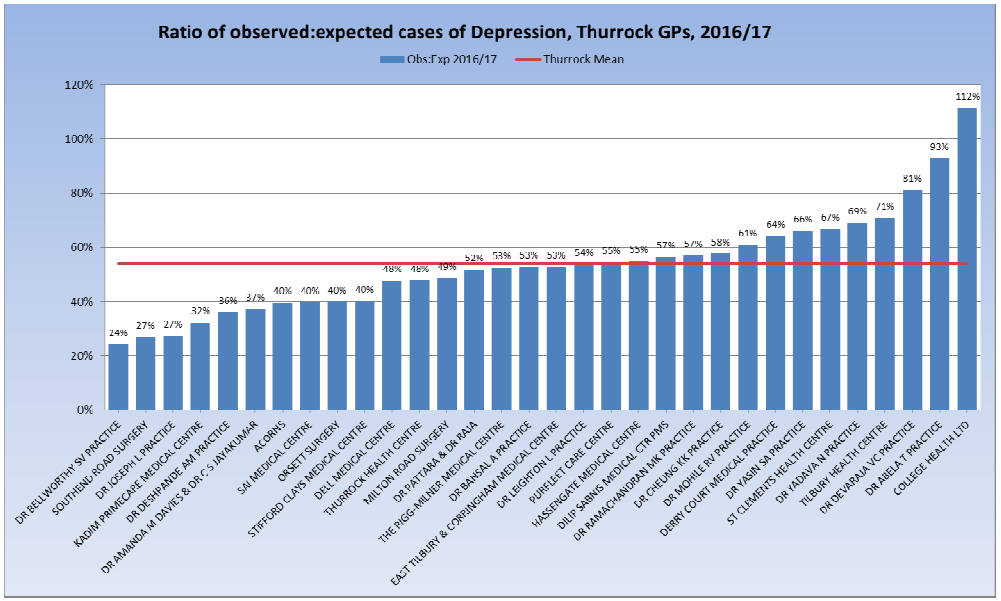
Historically, mental health disorders has been severely stigmatised. As a result many mental health problems have gone unrecognised and untreated, mental health treatment has been treated in a separate silo from physical health and has suffered from a lack of investment. This JSNA aims to improve our understanding and build a better system.

Who is affected? The scale of the problem

Prevalence of Common Mental Health Disorders

- One in four people will be affected by mental illness at some point in their lives
- Up to 15% of the population are affected by CMHDs at any one time at any one time
- Mixed Anxiety and depression is the most common CMHD, estimated to affect 11.66% of adults in Thurrock.





Diagnosis of depression

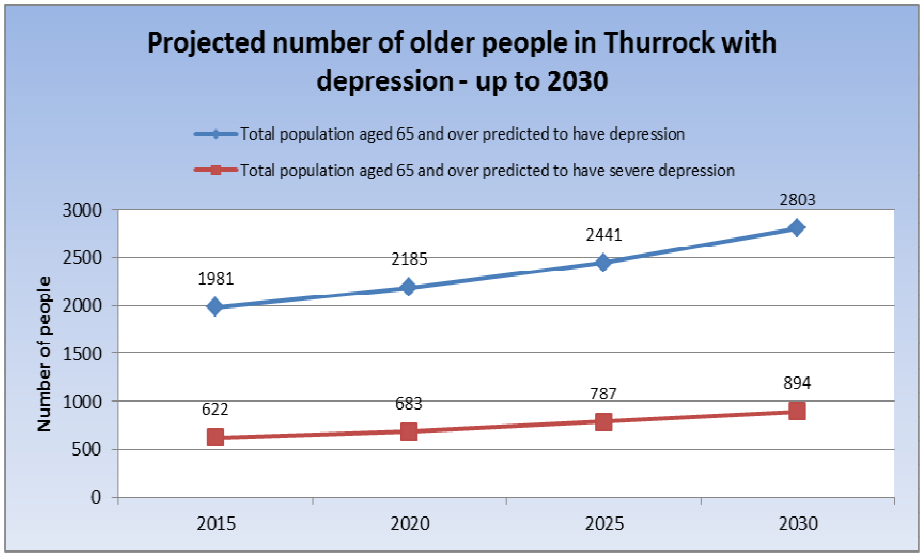
- Many people with mental illness are never diagnosed or, therefore, offered treatment.
- For example, it is estimated that there are 8,628 people in Thurrock with undiagnosed depression.
- There is huge variation in the diagnosis of depression between GP practices in Thurrock. This suggests that some practices are better than others at spotting and diagnosing depression.

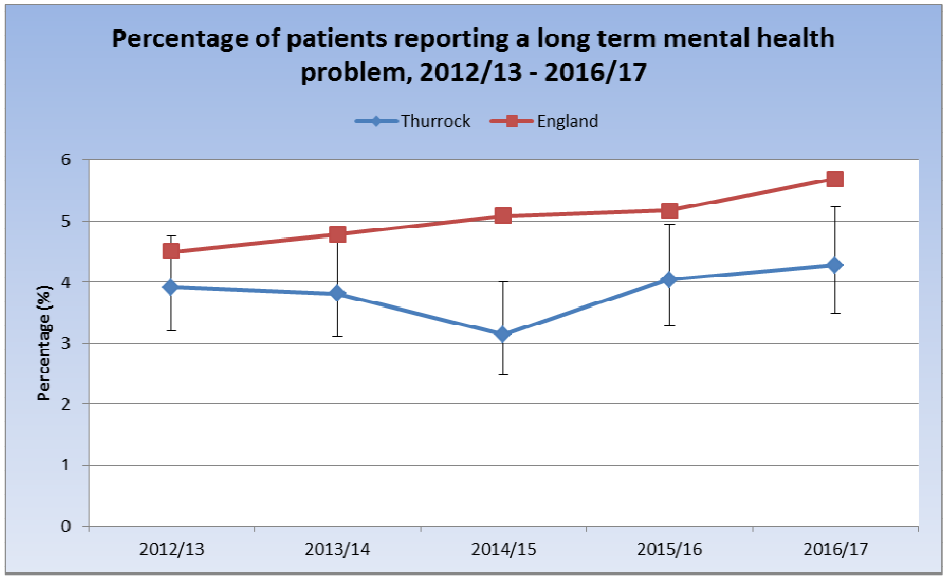
Key point: There is a huge opportunity to identify and treat thousands of people with undiagnosed mental illness

Who is affected? Trends

Trends in Long Term Mental Health

- Nationally, the proportion of people reporting that they have a long term mental health condition is on the rise.
- Rates in Thurrock are slightly below the national level but the upward trends appears to be affecting Thurrock too.
- More positively, other data show that the proportion of adults reporting low levels of happiness declined in Thurrock from just over 12% in 2011/12 to under 10% in 2016/17. This suggests that rates of mental illness may be increasing partly due to greater recognition of mental health issues and that rates of increasing illness is not necessarily incompatible with improvements in quality of life.





Projecting trends into the future

- Estimates made by the Projecting Adult Needs and Services Information (PANSI) suggest that the number of adults with a CMHD in Thurrock will increase by 10% between 2015 and 2030.
- Increases are likely to be steeper in the older population. For example, the number of older people (65+) with depression is likely to increase from 1,981 to 2,803 between 2015 and 2030

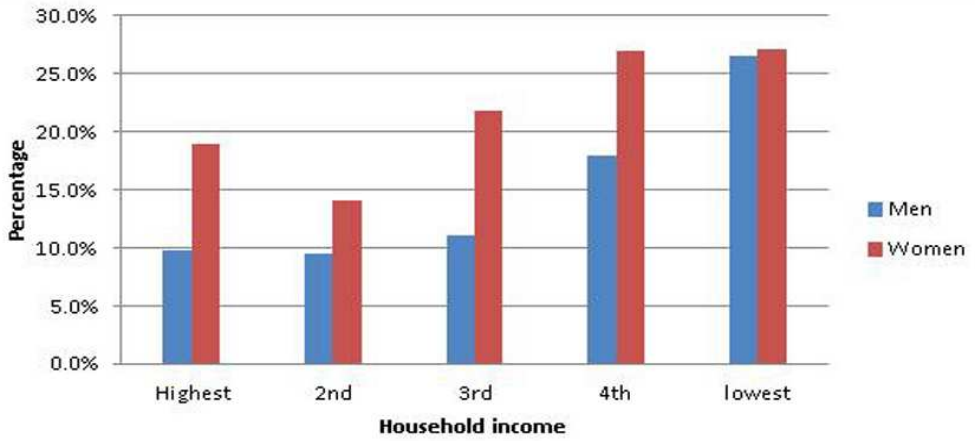
Key Point: the number of people affected by mental illness is growing, particularly in vulnerable groups such as older people. Some of this may be due to better recognition of mental illness.

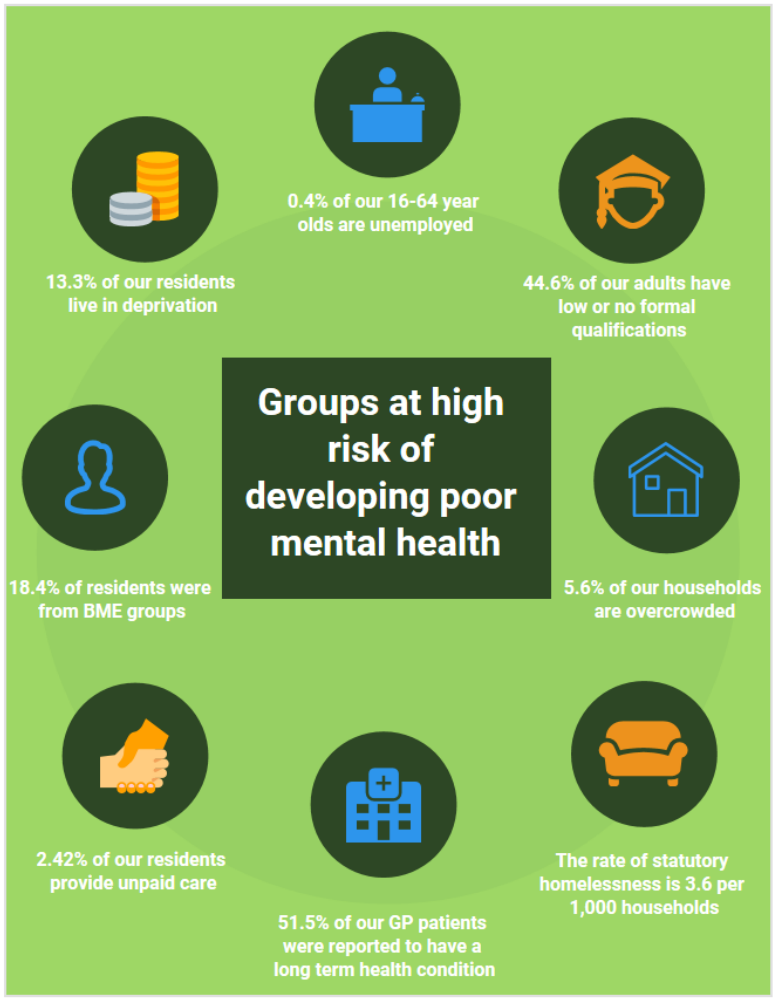
Who is affected by MH? High risk groups

High Risk Groups

- The causes of poor mental health are complex; however it is known that there are specific groups at high risk of mental health illness.
- Some of the key risk groups are shown in the infographic to the right.
- The strong association between income and mental health is illustrated by the chart below, using national data.
- Some people fit into several of the risk categories shown here. They are at particularly high risk of having poor mental health.
- There is also evidence of intergenerational cycles in mental health. Children whose parents have mental illness are, themselves, more likely to suffer from poor mental health.
- Other factors protect against mental illness: especially employment and strong community connections.

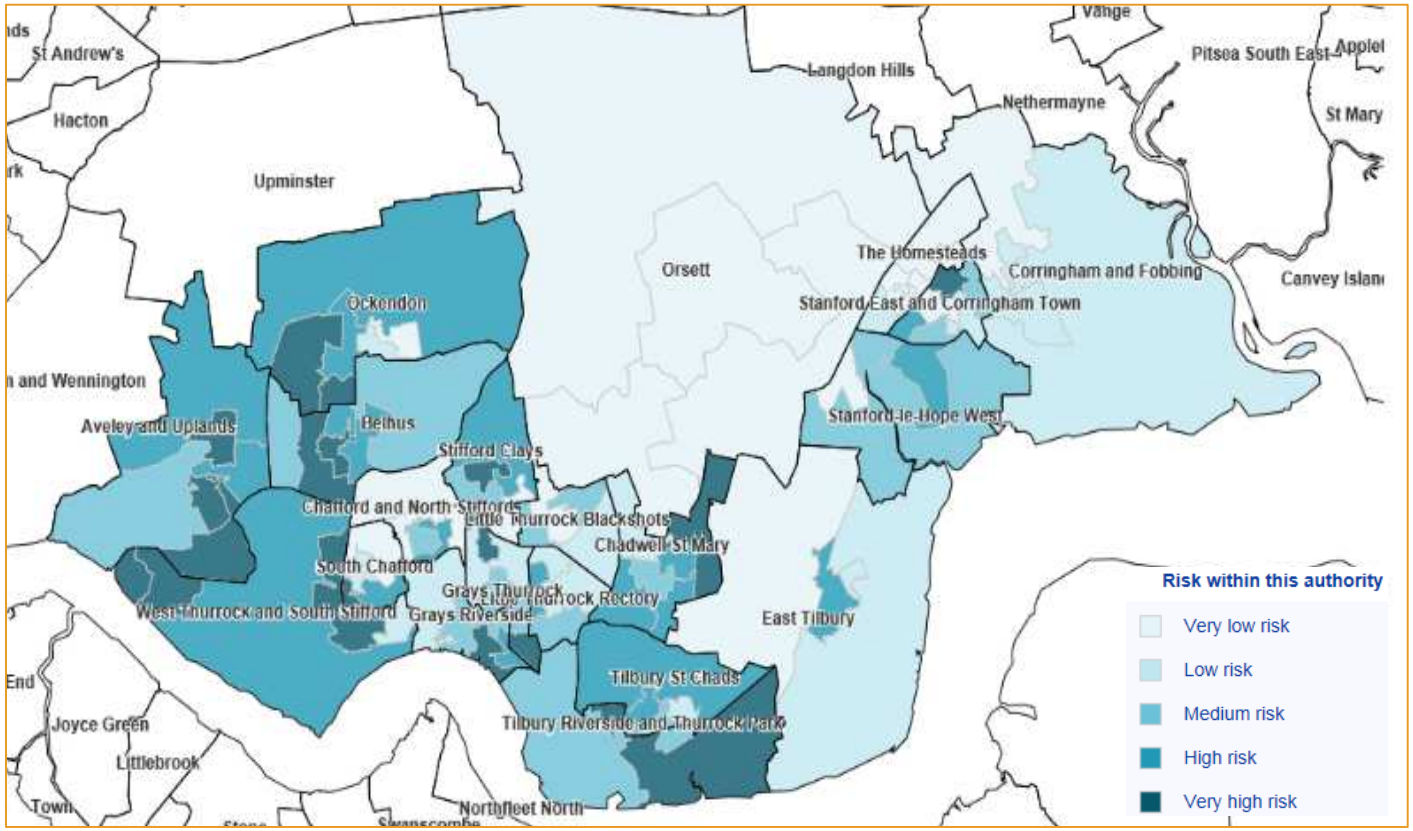
Common mental health disorders by household income and gender, 2011.





Who is affected? High risk groups

Part of Thurrock by relative risk of older people likely to feel loneliness.



Source: Age UK

Social Isolation

- There are strong links between the older community and depression.
- 40% of older people living in nursing/care services suffer depression in comparison to those living in their own homes with contact maintained with their families (Mental Health Taskforce, 2016).
- The map to the left illustrates the geographical patterning of social isolation in Thurrock, using analysis done by Age UK.
- There is a strong link between social isolation and deprivation.

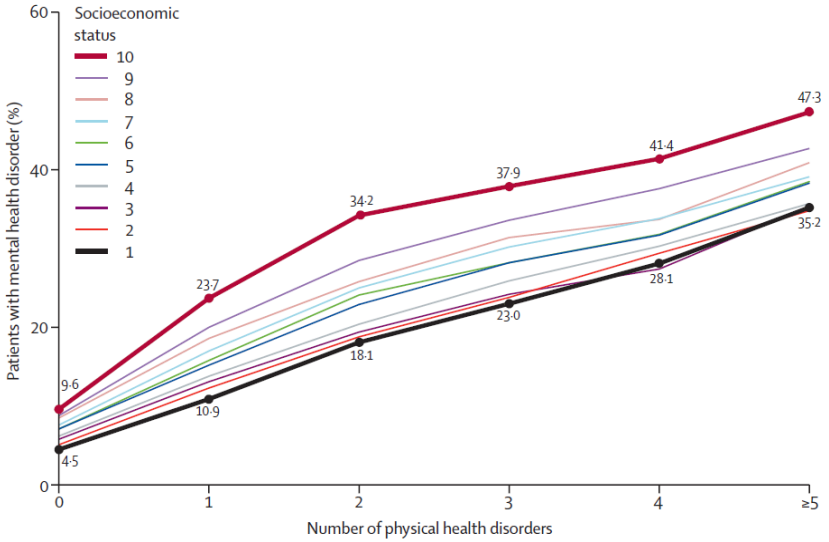
Key point: strong family and community connections are a strong protective factor against mental illness.

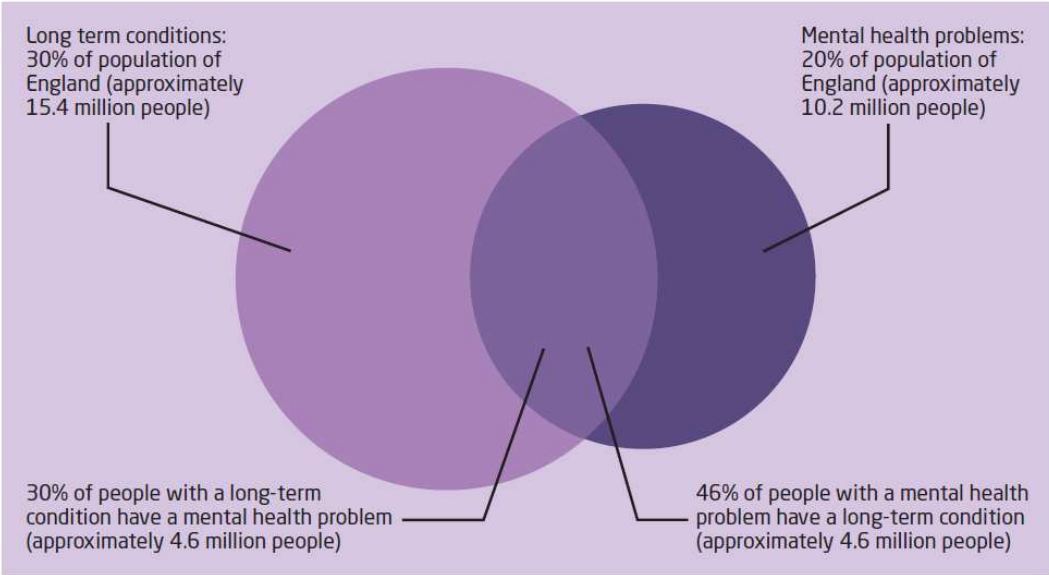
What are the causes and consequences of poor mental health?

Interactions with physical health

Mental health interacts with physical health and health-related behaviours in complex ways. Poor physical health can increase the risk of mental illness, such as depression, while being depressed may also make physical health worse. This can create a vicious cycle. Conversely, it is possible for a virtuous cycle to be created through interventions and services which address both physical and mental health.

Relationship between mental health and physical co-morbidity, 2012.





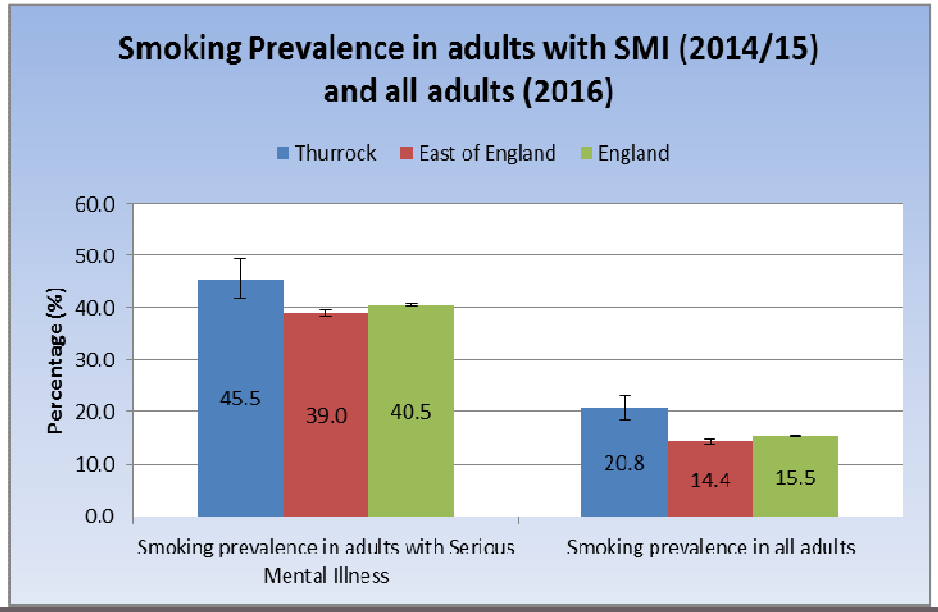
Long Term Conditions (LTCs)

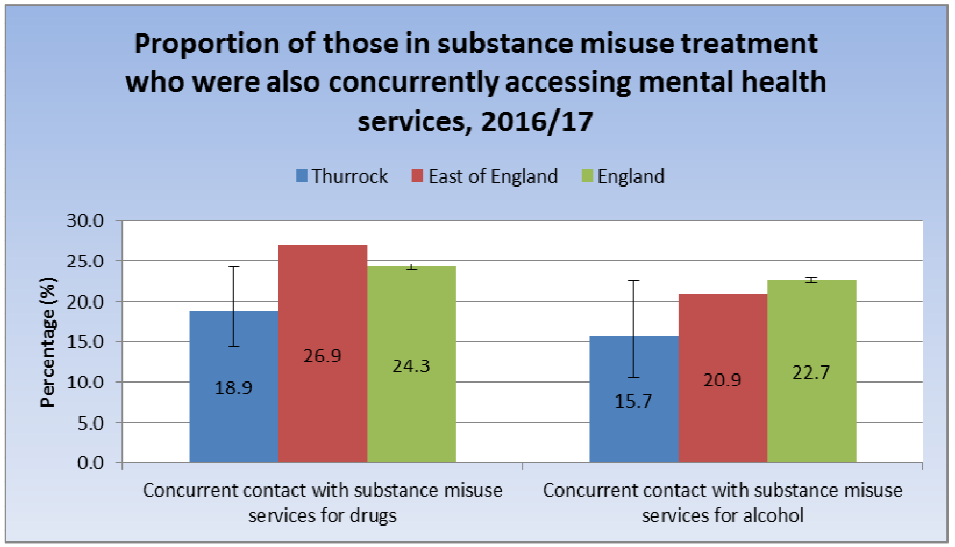
- The presence of poor mental health increases the average cost of NHS service use by each person with a long-term condition from approximately £3,910 to £5,670 a year
- 30% of people with a long-term physical health problem also had a mental health problem and 46% of people with a mental health problem also had a long-term physical health (see above)
- People with two or more long-term conditions are seven times more likely to have depression than people without a long-term condition (Moussavi *et al* 2007).

What are the causes and consequences of poor mental health?

Other key interactions with mental health

- A high proportion of people misusing drugs and alcohol also suffer from mental illness (see top right)
- There is a strong association between obesity and poor mental health. The rising rates of obesity in the Thurrock population mean that the co-occurrence of obesity and mental illness will become increasingly common (see bottom right)
- Those with serious mental illness have extremely high rates of smoking (see bottom left)





Percentage of patients estimated to be obese and experiencing a CMHD in Thurrock 2016-2026

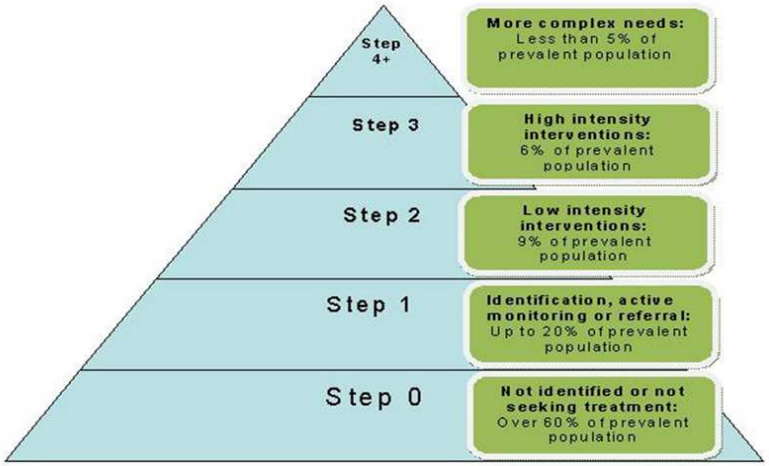
	% patients estimated to be obese in 2016	% patients estimated to be obese in 2026	Additional Number of Obese patients
Neurotic Disorder	28.3%	33.5%	2000
Personality Disorder	28.5%	34.1%	555
Psychotic Disorder	28.5%	33.9%	69
Dementia	28 %	32.7%	211

What services exist? Overview

The Mental Health Care System

- The treatment of mental illness occurs in a wide range of settings including: General Practice, IAPT (Improving Access to Psychological Therapies), hospitals, community services and specialist mental health hospital services. It is a fragmented and often confusing system for the public.
- Traditionally, the system has been divided into tiers, as represented by the diagram below which also shows the proportions of those likely to use different levels of service.
- The infographic to the right gives some key figures on the treatment of mental health in Thurrock.

Estimated proportion of the prevalent population with common mental health disorders who will enter each step of care – National Picture

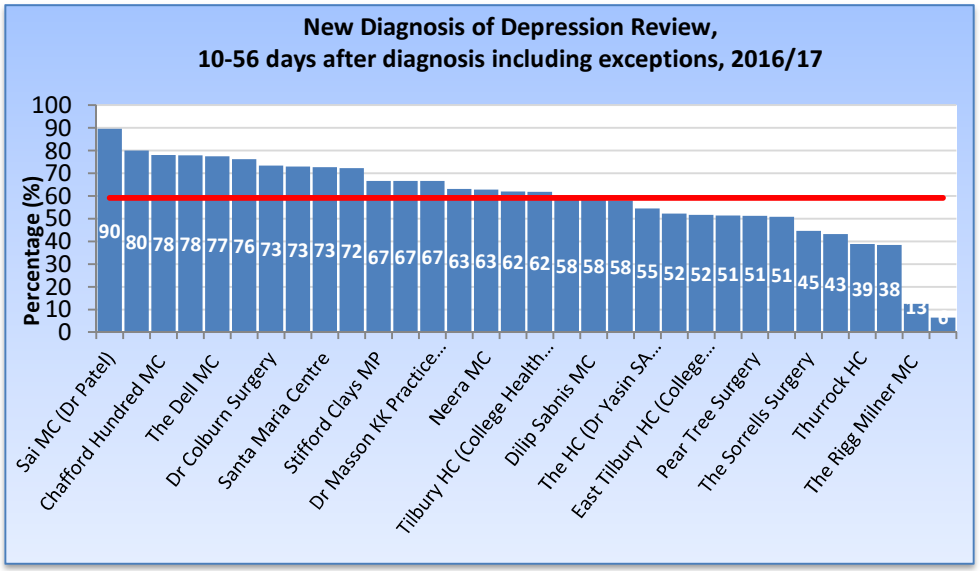


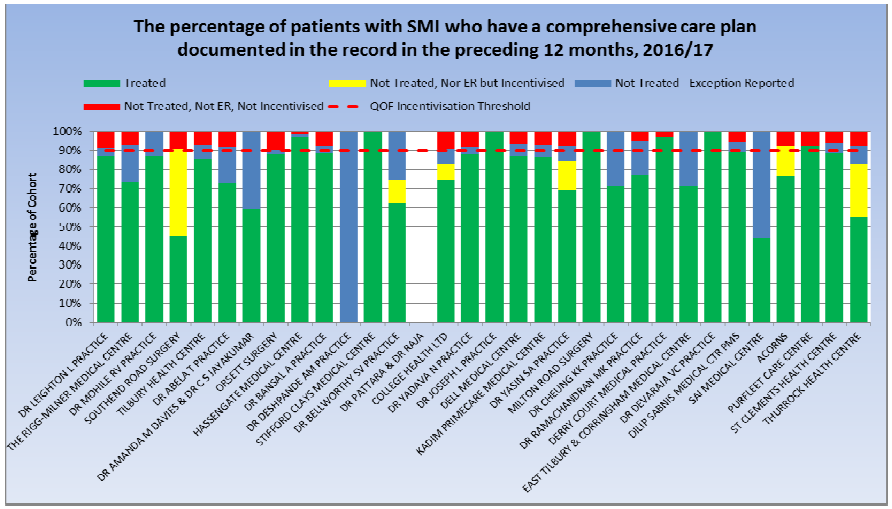
Source - NICE

What services exist? Primary care

Treatment in General Practice

- It is clear that there is huge variation between practices in the rate at which they identify and treat common mental health problems such as depression (see above);
- However, it is also clear that for those who are diagnosed, the type and quality of treatment they receive may vary significantly between practices. For example, the 10 – 56 day review after diagnosis (a national guideline) is very variable (see right).
- Similarly the treatment of Serious Mental Illness varies significantly between practices (see below).





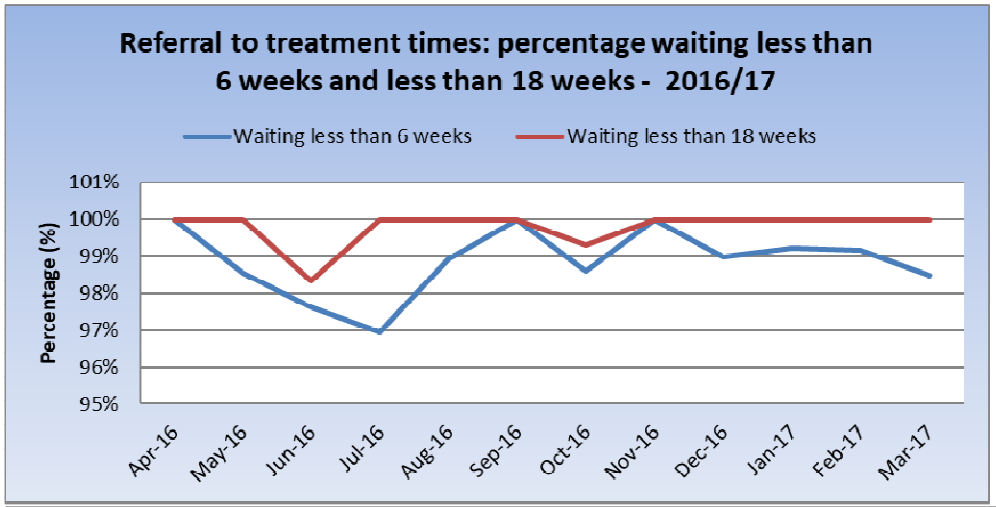
Key Point

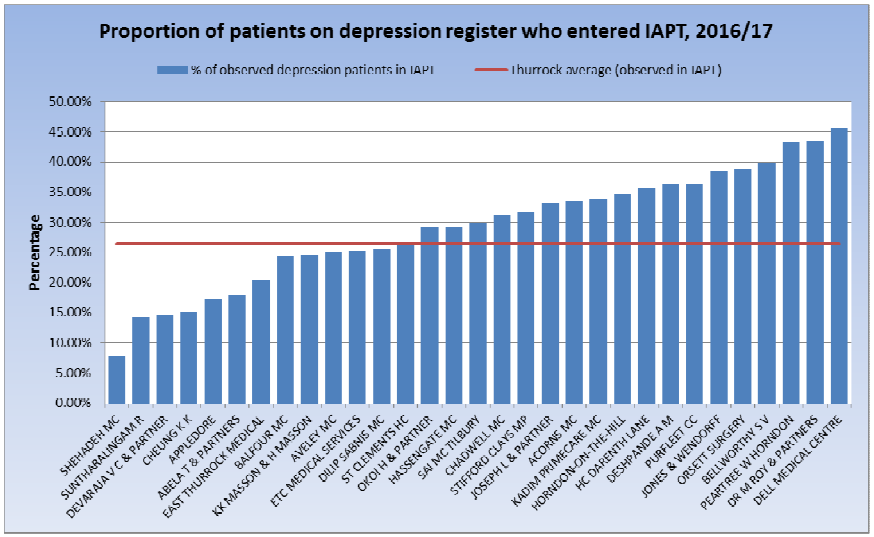
In addition to variations in identification of mental illness there are wide, and preventable, variations in the treatment and management of mental illness in primary care. More could be done to ensure that all patients receive the highest quality of care.

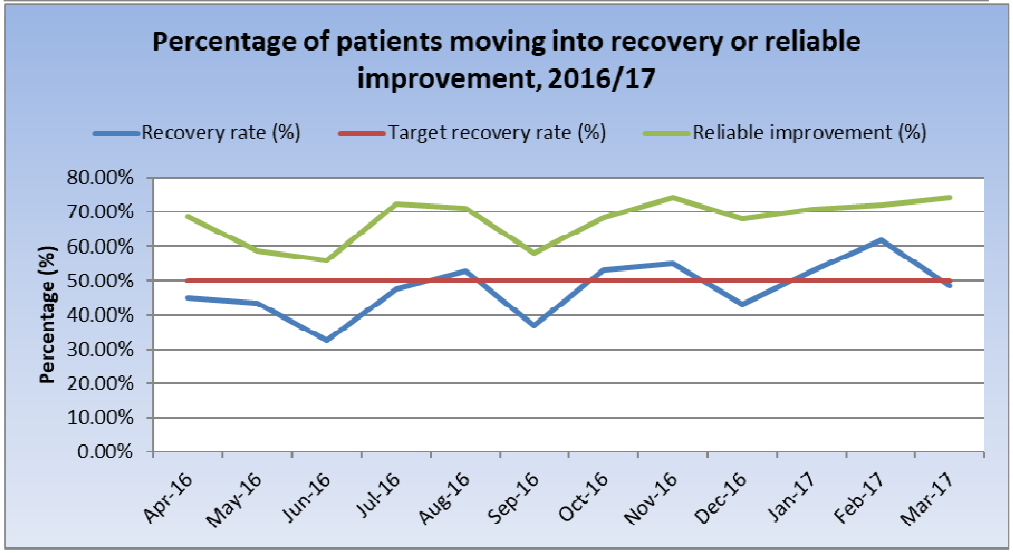
What services exist? Primary care

IAPT

- The current IAPT service is providing high quality generally surpassing national targets for waiting times (top right);
- Though there is scope for improvement, the recovery rates for those who complete IAPT treatment are generally good and appear to have been improving over time;
- However, there are is wide variation between GP practices in the proportion of those identified as having depression who enter IAPT treatment. This suggests that a significant number of people who would benefit from IAPT are not accessing it. The reasons for this need to be investigated further but variation by practice suggests that referral may be a key factor.







What services exist? Integrating primary and community Care

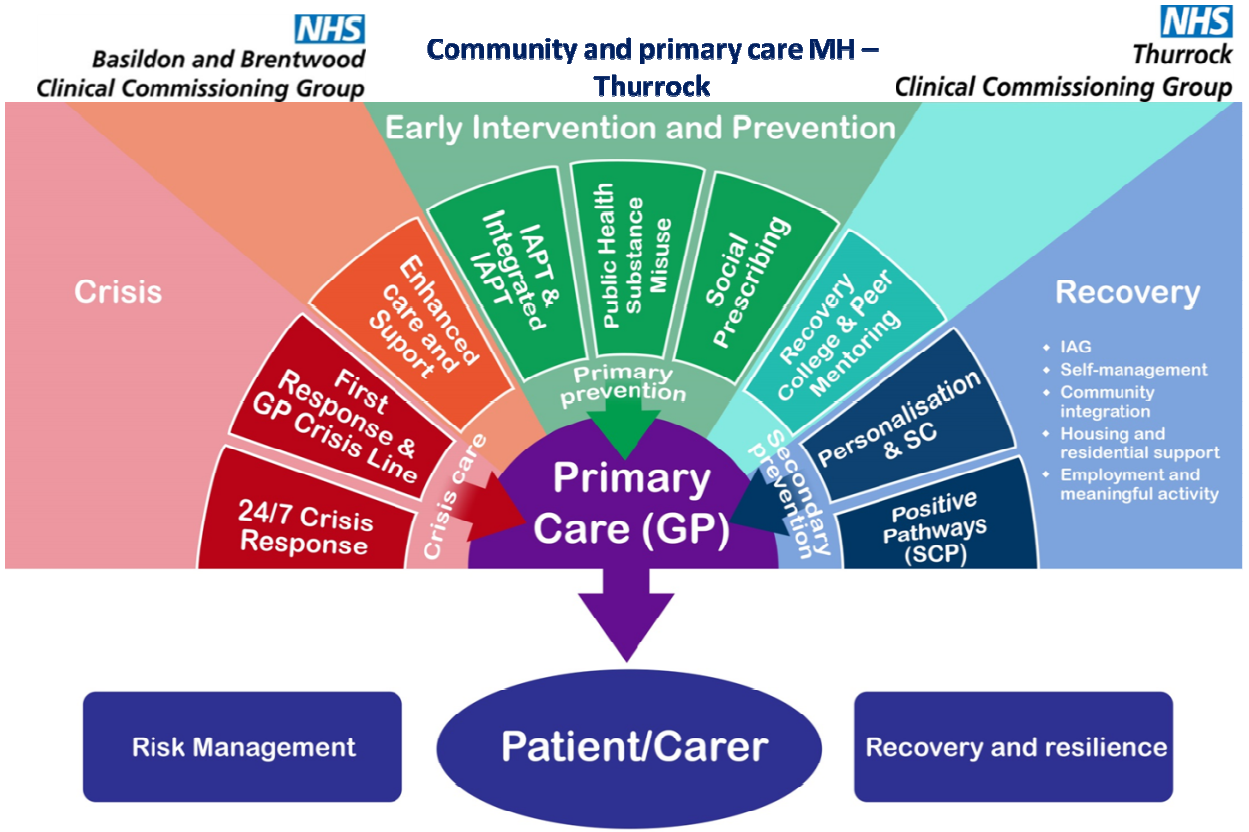
The integration agenda

The current fragmentation of services is recognised by commissioners and a programme of integration work (Thurrock Mental Health Transformation) is underway.

The vision for this work is represented diagrammatically on the right.

A clinical leadership and oversight group has been established to drive this agenda forward with the specific aims of:

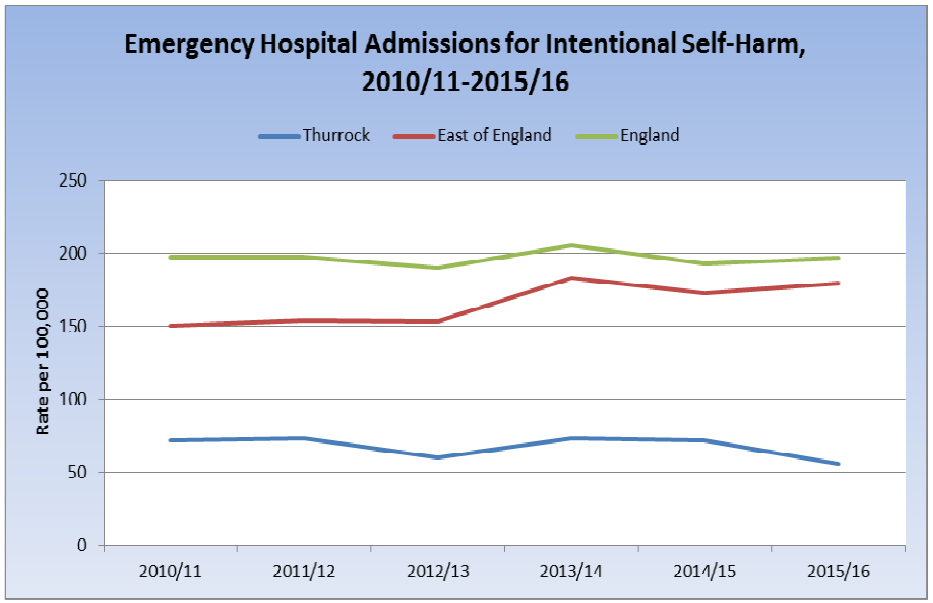
- Improving urgent and emergency care
- Integrating social, mental and physical health and providing care closer to home
- Promoting good mental health and preventing poor mental health



What services exist? Secondary care

A&E and self-harm

- When mental health conditions are not identified or appropriately treated in the community, patients attend A&E when they reach a crisis point. These attendances can be seen, to some extent, as reflecting the effectiveness of the wider mental health treatment system.
- The table below shows that 43.1% of mental health service users attend A&E, twice as many as patients without mental health problems.
- Better identification and treatment (e.g. more extensive use of IAPT) has the potential to reduce demand on A&E.
- One area of particular concern is emergency admissions due to self harm (see right). The low numbers found in Thurrock are likely due to problems with data collection and coding practices. This means that the true extent of this problem is currently unknown.



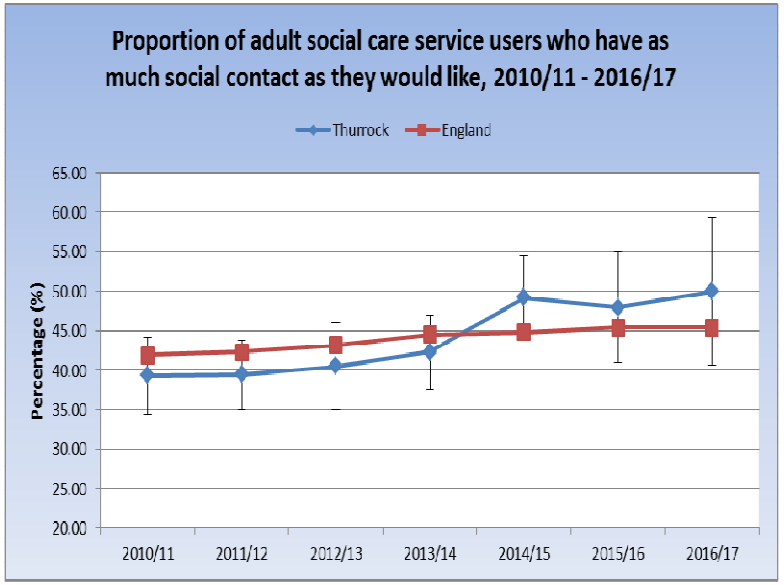
Attendance by Mental Health service users (aged 18+), 2012-13.

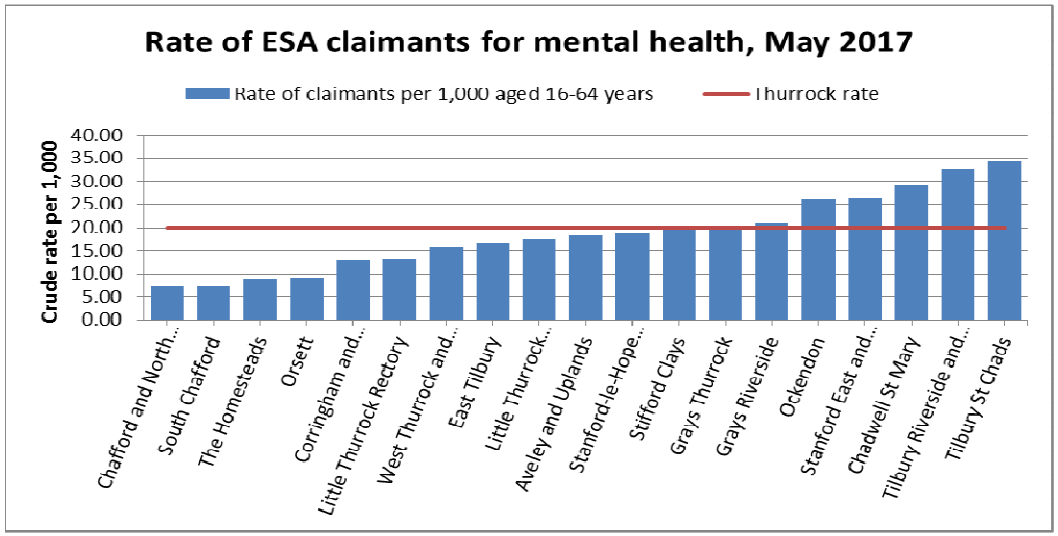
Patients who accessed A&E services at least once 2012/13	Average number of A&E attendances per patient	Percentage accessing A&E services (at least once)
All Patients	1.56	21.3%
Non-MH Service users	1.49	20.6%
MH Service users	2.43	43.1%

What services exist? Social care

Mental health in social care users

- Users of social care services are generally at high risk of having poor mental health. As explored previously, there are strong links between the social and physical health problems which lead people to need social care support and mental illness. As a result the Council's Adult Social Care Service commissions a range of mental health programmes and works closely with NHS treatment services.
- Mental illness can be a primary reason for social care utilisation or a secondary issue.
- 54% of those accessing social care for mental health conditions are aged 65 and over.
- Poor mental health is a common cause of people being unable to work (see below).
- 37 per 1000 residents (3.7%) in Belhus claim ESA payments due to mental health conditions; this represents a large proportion of people who would benefit from improved mental health, if employed.





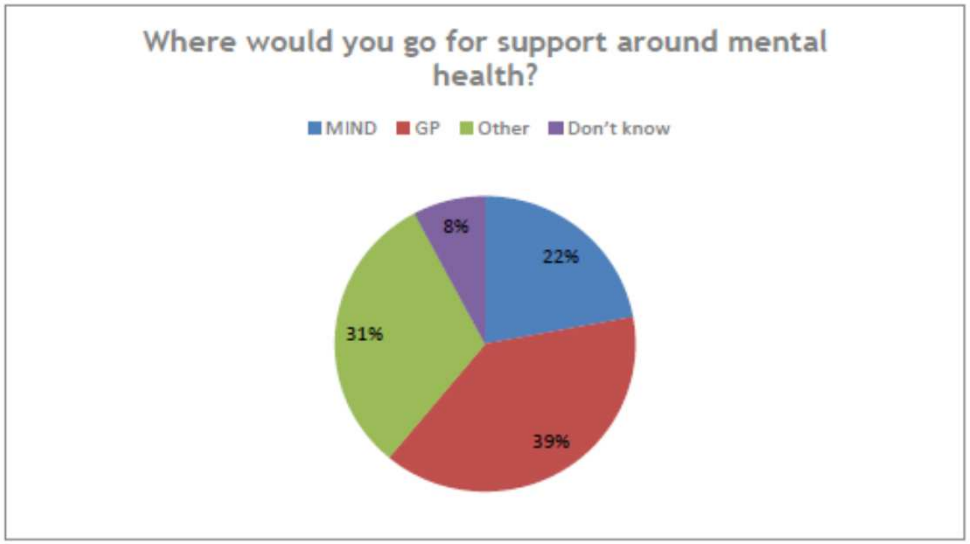
Opportunities for integration

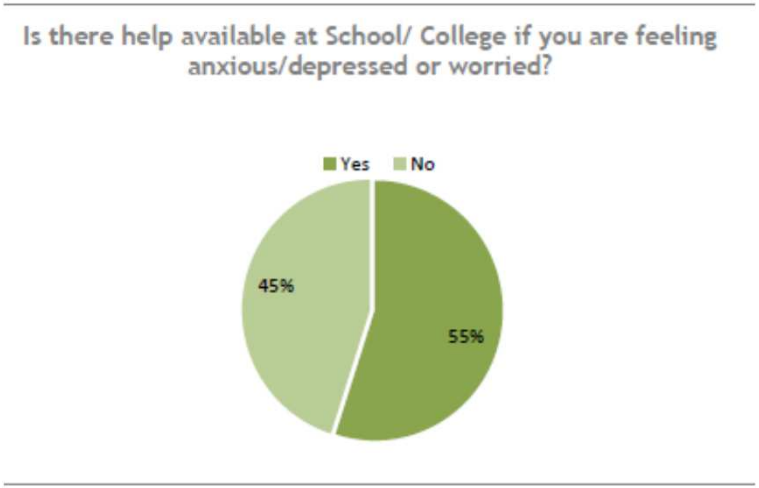
- The existing cooperation between local authority and NHS commissioners could and should be deepened in future;
- The establishment of new Wellbeing Teams to deliver social care in the community is an opportunity to learn lessons about operational integration of mental health support for vulnerable residents. There are opportunities for prevention, identification and treatment of services.

What do residents think of mental health issues in Thurrock?

Mental health in social care users

- Healthwatch Thurrock is an independent Health and Social Care service organisation that represents the people of Thurrock.
- As part of Thurrock Health and Wellbeing Strategy, Healthwatch was asked to engage with the community in Thurrock and ask them questions around emotional health and wellbeing linked Goal C: Better Emotional Health and Wellbeing. The four themes were:
    1. Give parents the support they need
    2. Improve children's emotional health and wellbeing
    3. Reduce social isolation and loneliness
    4. Improve the identification and treatment of depression, particularly in high risk groups





Where would you go for help with mental health problems?

Category	Number	Proportion (%)
GP	28	28
Family support	22	22
School support	21	21
Healthcare services	11	11
Friend support	8	8
Unsure	3	3
A quier place eg bedroom	2	2
on-line support	2	2
Outside school/college clubs	2	2
Totals	99	100

What do residents think of mental health issues in Thurrock?

Recommendations made by Healthwatch

Give parents the support they need	Improve children's emotional health and wellbeing
- Increase awareness of support for parents and children who have disabilities and make it easier to access - Provide disability support group	- Ensure that activities such as youth clubs, groups and sports for young people are equitable across the Borough - Consider subsidising activities for young people - Colleges and schools to raise the profile of the support they offer

Reducing social isolation and loneliness	Improve the identification and treatment of depression in high risk groups
- Publication of local community activities as many people do not know what is going on. - Continue to strengthen social relationships an opportunities for community connection (E.g. through LACs) - Work on how to strengthen relationships between communities and health and social care agencies	- Counselling services should be able to recognise and understand the links between LTCs and mental health. The Stroke Group felt that counsellors often did not understand that having a LTC can be the main cause of depression.