Mental health and wellbeing in the Lancashire sub-region

Part 3 – Gap analysis, priorities and recommendations

2011

Intelligence for Healthy Lancashire (JSNA)

NHS Central Lancashire NHS East Lancashire NHS North Lancashire NHS Blackburn with Darwen NHS Blackpool

Lancashire County Council

Blackburn with Darwen Borough Council

Blackpool Council – Building a better community for all

Lancashire Public Health Network

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Introduction and methodology

Introduction

This report represents the third in a series of reports that make up a joint strategic needs assessment on mental health and wellbeing in Lancashire. The previous two reports in the series are published on the JSNA web pages:

- Part 1 – demography and epidemiology
- Part 2 – services and investment

It is intended that further reports will provide Mosaic profiling and mapping of referrals and caseload for mental health services across Lancashire.

Methodology

The analysis included in the first two parts of the reports was conducted during 2011/12. On Wednesday 30th March 2011 the Mental Health and Wellbeing JSNA reference group were assembled for a full day workshop in Preston to receive presentations on the results of the analysis. The purpose of the event was two-fold:

1. To agree the key issues identified by the analysis, highlighting any flaws in the data and further intelligence to be included.
2. To agree on the implications for commissioning and recommendations.

The analysis was split into three sections based around the step model of mental health services (included in the appendix). The workshop attendees were split into three groups to consider the analysis and the recommendations:

- Steps 1 and 2: determinants of mental health and mild to moderate mental health problems
- Steps 3 to 5: moderate to severe mental health problems, severe and enduring mental health problems that can be supported in the community and severe mental health problems that cannot be supported in the community.
- Groups with particular needs: children and young people, older people, prisoners and those on probation, learning disabilities and others with protected characteristics.

The results of that workshop and further consultation with the reference group, have informed the contents of this report.

Report structure

The remainder of this report is structured as detailed above.

Steps 1 and 2: determinants of wellbeing and mild to moderate mental health problems

Introduction

Steps 1 and 2 focus on the whole community of Lancashire as it relates to the determinants of wellbeing such as health and exercise, satisfaction with personal circumstances, perceived safety locally, lifelong learning and environmental factors. Interventions to influence this level of mental health and wellbeing need would focus on prevention and early intervention such as mental health promotion, community development, social prescribing, counselling and social and carer support

Recommendations and priorities

The importance of promoting Well-being

- Wellbeing is the one of the strongest determinants of an individual's health; it fundamentally affects behaviour, social cohesion, social inclusion and prosperity
- Adopt the Living Well across local communities approach. The principle of this approach is that there will be no lasting reduction in inequalities unless we create the conditions across local communities that support wellbeing and enable people to live well.
- This includes the 'Year of Health and Wellbeing', which will then be extended to '2020 - a **Decade of Health and Wellbeing**', by which partners agree to:
- Commit to taking action to improve the Health and wellbeing of staff and customers
- Commit to adopting and integrating the 5 Ways to Wellbeing into their organisations and services they provide.
- Commit to using the 2011/2020 Logo and website address on all future publicity materials and communications
- The Five Ways to Well-being are:

Connect with the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the

cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.

Be active. Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.

Take notice. Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters.

Keep learning. Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun.

Give. Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.

Mental Health and the Economy

- Because of the economic climate, rising unemployment etc, we need increased focus on debt advice, relationship support, and programmes to improve and rebuild confidence and self-esteem.

- Likewise, employers should be encouraged to adopt good mental health practice in the workplace, through HSE standards on stress, healthy workplace award schemes etc.

- Employers and education need to work together to determine the future skills required in the workforce and develop programmes aimed at those most excluded from the workforce to build those skills. Community learning pathways to get people who are unemployed into local community learning and on into college or work placements need to be created. These programmes should be focused on areas of highest unemployment.

Mental Health and NHS Care

- GPs and their staff need more knowledge of mental health and the social determinants of mental health.

- We need mechanisms for GPs to be aware of and access support for patients within their local communities – e.g. Help Direct clinics in GP practices.

- Much greater emphasis needs to be placed on the physical health needs of people with mental health problems, and the mental health of people with physical health problems – screening assessments, integrating mental health into physical health care pathways, training for medical and psychiatric staff, joint working etc.

- Target early interventions at the most at risk segments of the population. This includes tenants in social housing flats on estates at risk of serious social problems; families with varied structures living on low rise social housing estates and transient singles, poorly supported by family and neighbours. See our full segmentation profiling report for more information and advice on the best ways to make contact with the at-risk groups.

- Ensure equity of access to services by carrying out equity audits. Current data suggests that some demographic groups in Lancashire may not be accessing the services they need. The reasons for this need to be investigated.

Step 1-2 Services

- **Health literacy -** Recognise that Health literacy is a social determinant of health and equally, is socially determined. Higher levels of health literacy enable individuals to participate more fully in society and to exert a higher degree of control over daily events. Health literacy is about empowering individuals and communities to move to a point where they are fully equipped with the knowledge and skills to take part in health related decision making, access to services and have a better quality of life. People who can particularly benefit from developing health literacy skills include adults who are unemployed, on benefits or in low skilled employment; people at risk of social exclusion, prisoners and offenders. Ensure that Health Literacy is a key to building health equity delivering a programme of health promotion within community settings and workforce development.

- Co-location of services – many front line advice and liaison services could be deployed more effectively if co-located. This increases access, raises public awareness, reduces stigma and increases inter-agency collaboration and partnership working. Examples of services that could be co-located – Help Direct, tax and benefit advice, welfare rights, local council access points, voluntary sector, debt advice, etc

- We need more creative ways of engaging with people most excluded from 'traditional' methods of support, particularly younger men, unemployed, low level drug users, in touch with criminal justice, BME etc.

- Develop community capacity by using **ABCD Approach.** Asset-Based Community Development (ABCD) is a large and growing movement that considers local assets as the primary building blocks of sustainable community development. Building on the skills of local residents, the power of local associations, and the supportive functions of local institutions, asset-based community development draws upon existing community strengths to build stronger, more sustainable communities for the future. ABCD moves away from the traditional assessment of communities in terms of needs, issues and deficits and instead focuses on talents, capacity, skills and opportunities.

- Implement **Peer mentorship** initiatives to stimulate co–production of well-being services. Peer mentoring has value from the perspective of addressing the mental processes that are assumed to underlie successful behaviour change and by paying attention to the role of external circumstances, be they physical, social, or economic.

- Mentors will be able to contextualise and articulate the Five Ways and the choices around intended action in a linguistically and culturally appropriate way for their peer group. Peer

mentors will, by virtue of having similar experiences, understand the external circumstances which impact on behaviour for that peer group.

- A “caseworker” model should be developed for working with people who are repeat attenders to GP, A&E and who have complex and multiple needs. The caseworker role would be to streamline and manage a person’s care in the way a CPA care coordinator does, and by ensuring care is better organised, targeted and effective, would improve mental health and reduce costs of complex care packages.

- Commissioning decisions should be made on the basis of health outcomes, not health processes or clinical systems. If an intervention improves mental health and wellbeing, it is a valid for NHS/LA commissioning. This will encourage innovation and good practice, particularly where focusing on those most excluded.

Steps 3 to 5: moderate to severe mental health problems and severe and enduring mental health problems

Introduction

Steps 3 to 5 of the mental health services model include moderate to severe mental health problems, severe and enduring mental health problems that can be supported in the community and severe mental health problems that cannot be supported in the community. Interventions to support people with these needs will be primarily NHS services. They will include psychological interventions through Primary Care, specialist care including medication and combined treatments and inpatient care providing enhanced treatments in specialist environments.

Recommendations and priorities

Common mental health disorders

- To consider ethnicity and other protected characteristics in performance and activity monitoring (will be required under Equality Delivery System by all NHS organisations)

Self harm and suicide

- Collect information about who is referring to A & E for MH assessment and why – how appropriate (review currently being undertaken by LCFT).
- Ensure that the function of Crisis Teams is clear to referring agencies – including GPs – to ensure appropriate use of the service.
- Need a consistent approach to Suicide Audit across all 5 PCTs and an overarching Suicide Prevention plan which involve all partners and reflect local need. A county-wide Suicide Prevention Group has been convened to oversee the annual Suicide Audits (pan-Lancashire) implement the recommendations from the National Strategy (due to be published January 2012). This includes specific self-harm work.

Severe mental health problems

- Develop integrated pathways for peri-natal mental health (some regional work just completed around this) Are personality and anti-social disorders addressed in Criminal Justice review?
- Develop integrated pathways for weight management which address emotional issues around weight – cCBT and other therapeutic interventions within an integrated lifestyle service.

- Develop integrated lifestyle programmes that take a whole-person and community approach to improving physical and mental health, providing a tailored approach for individuals facing multiple challenges to improve overall wellbeing. The report *Illness to Wellness,* encourages a shift in organisational approaches to wellness rather than illness, including services such as weight management. This is in line with NICE Guidance *Obesity and Mental Health* that advocates that intervention strategies should consider both the physical and mental health of patients. Work is underway to run a pilot Wellness Service in Blackpool in 2012.

- **Conduct a geo-demographic survey of caseloads across county using LCFT data - conclusions**

- Need to develop consistent pathways around early intervention and transition into other services – also crisis prevention and pre-clinical interventions – work to be undertaken in partnership with LCFT around collaborative involvement in further development of their internal care pathways.

Issues to consider

- Transition issues are consistently prevalent – across ages and 'steps' of care and services ie. – EIS to CMHT, CAMHS to adult – adult to older adult. – Would a life-course budget be the answer? (eg. CAMHS monies sitting in overall MH budget rather than Children and Young People stream) - need to cross reference with children and YP JSNA

- **Clarify definition of STaR worker roles -** In Blackpool a STaR worker focuses directly on the needs of the service user to support them to reach their full potential and recover within their own community environment. Working as part of a team with clear direction and support from a responsible Mental Health Practitioner, they provide long term support to service users who have severe and enduring mental health problems across the Blackpool area (who are currently supported by Primary Care Mental Health services). Within the LCC footprint, the definition for the STaR workers is ever changing. The emphasis of the STaR is now on the Recovery aspect of the role. This is to promote independence and ordinary lives by engaging Service Users in enabling activities. The current emphasis would be around vocational pathways. This would ask Service Users to consider their responsibilities towards gainful employment. Employment means many things to many people but it would essentially ask Service Users to work towards a meaningful use of time. There will be specific pieces of work which an STaR worker would undertake such as bus work to increase someones ability to get out and about. STaR workers in the Recovery Service will

be working within the structure of a Support Time and Recovery assessment (STAR) which identifies the areas of someone's life which if changed can result in more fulfilling lives.

- Ensure an equitable spread of performance monitoring capacity for the county and a consistent approach - ? MINDSET minimum dataset or other

Groups with particular needs

Introduction

Groups with particular mental health and wellbeing needs include children and young people, older people, prisoners and those on probation, learning disabilities and others with protected characteristics. Although for the most part they should be supported through mainstream services, it is important to ensure that such services are accessible and appropriate to these groups.

Recommendations and priorities

Children and young people

- Reducing services for children and young people due to the projected reductions in the population will be a false economy as it is well understood that there is an invest to save principle at work. Investing in children's mental health prevents mental health problems in later life, which tend to be more costly.
- Transition remains a key area of need and there is a transition group working on this who should be able to provide intelligence. ASD and ADHD transitions are specifically problematic as there are no services for young people to transfer into. This is being addressed via a separate JSNA for relating to Learning Disabilities.
- Analysis of overall investment in mental health services suggests high levels of investment in adults' services but low levels of investment in children's and older peoples services. This is likely to be a result of the NSF which focused on adult mental health.
- Whatever way the future funding goes, the pathway needs to be joined up.
- Mental health and children's pathways need to be joined up – emotional and mental health and wellbeing.
- Encourage Think family approaches - early intervention into maternal mental health to prevent impacts on children
- Children's Public Mental Health plans need to include Parenting skills programmes and focus on early intervention
- Measuring outcomes from universal and preventative services – identifying methods to do that for CAMHS will be important
- Further intelligence about young people and self harm - TIIG

- Review evidence from evaluation of TAMHS to inform recommendations for provision of school emotional health support.
- School nursing may be being commissioned by Public Health Lancashire – explore opportunities for how this service may be used to influence mental health in children and young people.
- Children Looked After nurses currently do not look after care leavers – is there an opportunity to expand the service so that they do?

Issues to consider

- Staffing levels have reduced further since the last CAMHS mapping

Older people

Dementia is one of the leading causes of disability in older adults and barriers to dementia diagnosis and management are an increasingly recognised problem across primary care. The English National Dementia Strategy (NDS) (DH, 2009) highlighted this and the need for improvements, to ensure more efficient screening and diagnosis, better care pathways, and enhanced outcomes for the patients and families.

In 2009 the National Audit Office (NAO) conducted a National Survey of General Practitioners across England to examine the facilitators and mechanisms necessary for the successful implementation of the National Dementia Strategy. In 2011, NHS Blackpool conducted a similar survey of local GPs. The findings corroborate those of the NAO 2009 survey, suggesting a training need and a need to bring improvements across all levels of dementia care. It is highly evident that work is needed to contribute towards the development and implementation of local care pathways and education programmes that are tailored towards GPs' needs and requirements, supporting recommendations set out in the National Dementia Strategy.

Inequalities Identified

The gravest inequalities identified in this hypothesis, and therefore those which should command the attention of commissioners include:

- The inequality in income between affluent older people and the poor is a powerful threat to social cohesion – hidden because older people don't riot. Benefit take up amongst older people may well be regarded as a priority, as well as more focussed advice (and help) for younger people to prepare financially for old age.

- The difference in life expectancy for those over 65, especially in deprived areas is considerable. The poor die a lot younger than the rich. Public Health priorities such smoking and obesity contribute to this, but other aspects of poverty make this worse: fuel poverty for instance and mal and under nutrition. There is also a considerable difference in male and female life expectancy, fuelled partly by lifelong male underuse of medical services. The imbalance in health and social care service responses to men and women is greater than the population differential.

- Sensory impairments, arthritis, osteoporosis and especially mental health problems amongst older people are not attacked with the vigour that other conditions are and appear very low on society's radar. Access to and the accessibility of GPs may be a problem.

- The reduction in 'social capital' (neighbourliness, contribution to society by voluntary action, membership of groups, friendship affiliations and so on) across communities condemns more older people than in the past to isolation and possibly depression and other mental illness than previously. The move away from institutional treatments and institutional care, use of speedy, time limited more efficient treatments and more people living longer, alone, in their own homes potentially exacerbates this.

Potential Opportunities and questions

- The increase in numbers of relatively affluent, non working people in their sixties and seventies, a proportion of whom will be keen to contribute to society offers considerable opportunities to enhance social capital and support the more disabled. Community engagement strategies may have a crucial role to play in enhancing the quality of life of older people helping communities offer support to their own.

- Model the impact on health and wellbeing to poor older people made if they were to receive improved incomes via improved welfare benefits – making fuel bills less pressing, travel and improved social life more possible, additional comforts affordable.

Mental health and Older People

Achievement and maintenance of good mental health are prerequisites for a fulfilling later life. Mental health has been defined as

"the emotional and spiritual resilience which enables us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own, and others', dignity and worth." **Health Education Authority**

For older people in particular, physical health and mental health are inextricably linked. Discrimination on the basis of age and mental health, in both direct and indirect forms, presents a major risk factor to older people's well-being and needs to be challenged and eradicated. The importance of health promotion in later life should not be diminished by stereotypical views on older people's frailty and dependence.

Planning Public Mental Health

Promotion of good mental health needs to be planned across the whole of life. It should incorporate both physical health and mental well-being and be targeted at both the whole population of older people as well as those who have mental health problems. Health promotion should be seen as a continuum that includes maintaining good mental health, preventing problems, care and treatment, and recovery. Depression, the most common mental health problem of later life, can have a better treatment outcome when local partners work together.

Challenges to older people's mental health

Certain transition points may challenge older people's resilience and coping mechanisms, for example retirement, moving home, going into hospital, and life events involving change and loss such as bereavement or illness. However, the cumulative effect of day-to-day problems can also challenge the mental health of older people. Low-level preventative services, such as help with housework, gardening, laundry, and home maintenance and repairs, can help improve people's quality of life and keep them independent.

A call for evidence for the Inquiry into Mental Health and Well-being in Later Life, a joint project between Age Concern and The Mental Health Foundation, demonstrated five themes to be of particular relevance for mental health and well-being in later life. These were:

- public attitudes,
- staying active,
- social networks,
- standards of living,
- physical health.

These factors are important whether the person is physically and mentally well or unwell, living at home or in care, and whether or not they are caregivers themselves.

Evidence base - Key messages

Local issues to be addressed for the promotion of older people's mental health, both for the general population and also for at-risk groups. This should include attention to the needs of carers of people with mental health problems. Local suicide prevention strategies should incorporate actions directed at the older population where suicide risk is high.

The strategy should cover the following areas:

- Information provision - Older people and staff from health and care providers should have easy access to information about the range of health promotion and leisure activities offered locally, and options for transport. (Such as Help Direct)

- Physical health - Older people benefit from physical exercise - whether in a gym or digging the garden - improved diet and nutrition, not smoking or drinking too much. They should be supported in these healthy lifestyle choices with information and suggestions on where to get further advice. Older people with mental health problems should be offered, and where necessary enabled to use, mainstream health promotion and disease prevention programmes in the same way as other people, without discrimination or bars to access. Local partners should ensure appropriate take up of mainstream health promotion and disease prevention activities amongst people with mental health problems, which may involve NHS trainers and community matrons.

- **Public attitudes - Local partners should take a lead in combating the dual negative stereotypes of mental illness and ageing and in promoting positive attitudes. Training is required for all staff across community services. Staff need to use language that it is non-discriminatory, inclusive and positive. The contribution of older people to their communities and society should be celebrated and the media used effectively in this.**

- Staying active - Staying mentally and physically active gives a sense of purpose and personal worth to people, as well as enabling people to make an effective contribution to their communities. Participating in valued activities can also provide an opportunity for social contact. Hobbies and leisure activities, lifelong learning, as well as volunteering, employment, and engagement in the development or delivery of local services should all be supported.

- Social networks - Older people may suffer from isolation from a variety of causes such as bereavement, dispersed family, lack of occupation, insufficient financial resources, poor

transport services and the impact of poor health. Partners should ensure that older people in all settings can choose from and participate in a diverse range of stimulating one-to-one and/or group activities.

- Standards of living - All people need financial security and older people, especially those with mental health problems, can be particularly vulnerable. Retirement and pension planning, advice on benefits and other financial issues should be available. The opportunities to provide benefits advice in health and social care settings should be explored. Adequate housing and low-level preventative services improve quality of life.

People in Prison

- Develop a clear blueprint for the delivery of mental health services in prison, including appropriate external support and governance, and internal integration with other prison staff and services.
- In addition to in-reach services, the provision of designated, structured primary care mental health services is essential, including the provision of psychological therapies within primary care and access to self-help programmes.
- Recognise that care and support for those with mental and emotional needs should not be seen as the exclusive province of mental health professionals but requires a holistic approach, as part of a model of a 'healthy prison' – (one where prisoners are safe, treated respectfully, able to engage in purposeful activity, and prepared for resettlement.)
- Robust communication/liaison pathways between mental health services and other agencies, including departments within the prison service itself, is also indicated – for example, education, offending behaviour programmes, and drug and alcohol treatment programmes.
- Reception screening appears to be failing to pick up the extent or diversity of need. This is partly because it is not always done by appropriately skilled staff. But it is also partly because the screen itself is not sensitive enough to pick up real, and particularly unacknowledged, need. Use PGQ – 9 or GHQ12?
- The collation of information regarding all services in the prisons providing mental health care at all levels is needed in order to establish a clear picture of what is currently provided.
- There is a clear need for a range of mental health staff with expertise in the area of intellectual disability, in order to provide clinical assessment, support for some individuals within the prison, and consultation to other staff.
- Clear liaison and referral mechanisms between existing and any new services which are developed.

- Prison staff should have access to good quality training in working with people with mental health problems, intellectual disability and personality disorder, to enable them to recognise these conditions and to support those who have them, as well as to enable them to manage such prisoners within the prison environment.
- Clearly defined mechanisms for prison staff to access consultation with mental health services within the prison are essential. Training alone is insufficient to bring about a sustained benefit; prison staff need to be able to discuss with mental health practitioners those prisoners they have identified who may need further assessment, or to consult about the management and support of those who are already known to mental health services.
- For those prisoners who return to the community with mental health needs clearly defined under the Care Programme Approach (CPA) there are pathways to support continuity of care post-release. Liaison with local services and with families/carers may also be indicated for some other prisoners who have identified mental health needs and mechanisms for this should be considered.