August 2015

Improving mental health and wellbeing in North West London

Case for Change

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WORKING TOGETHER FOR MENTAL HEALTH AND WELLBEING IN NW LONDON

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This paper has a bold ambition: to describe the aspirations for mental health and wellbeing in North West London; to identify the issues that we face in meeting our aspirations and ambitions; and to simply and clearly set out what must happen next for us to make progress.

Its purpose is to help us to agree how we move forward; it cannot hope to describe every issue or satisfy every interest or point of view. It is, by its nature, an identification of the common ground; the shared foundations on which we can build a better future for mental health and wellbeing for the people of North West London.

1.1 Introduction: our mental health and wellbeing

Our mental health matters. To each of us, our mental health – and that of our family, friends and colleagues – is vital. It is the very essence of our human experience – our sense of who we are, what matters to us, and how we relate to others and the world around us. Whether you call it wellbeing, contentedness, or happiness – that feeling of choice and life lived well is what most of us strive for each day. We all aim to build a life that we find fulfilling whether that includes loving relationships, happy homes, fulfilling work, meaningful activity, or any of the myriad other ways we can achieve satisfaction.

That old adage – that we don't value our health until we lose it – is more perfectly applied to our mental health. Not only do we not value it, too many of us actively reject the belief that mental health is something that is relevant to us all – and that each of us has varying mental health, better or worse, yet ever-present. Indeed, mental health and illness are used as a way to divide the majority from the minority, not as something that unites us in the very essence of our being.

Mental health needs can affect any of us – children, young people, adults, and older people. Our vulnerability will depend on a number of factors including our resilience to deal with increasing life stressors. Mental illness can be a distressing and debilitating experience, both for us as individuals, our family, friends and others in our lives. When these feelings are combined with physical ill health,

the effect can be devastating – drawing together to create a downward spiral. The effects of dementia and Alzheimer's can cause devastation to entire lives. It is precisely because the impact of mental illness can be so great that treatment, care and support, particularly if provided early, can make such a difference.

Risk factors for mental health needs include a family history, socioeconomic inequalities, debt, smoking during pregnancy, adversity particularly exposure to violence and abuse during childhood, substance misuse, lack of education, unemployment, isolation and inadequate housing.[1] Prevention of mental health needs can occur by addressing some of these factors. Certain groups are disproportionately affected by such factors which in turn require targeted approaches.

Likewise promotion of activities and factors that impact positively on our overall wellbeing can help build resilience to cope with life and maintain wellness.

Throughout North West London there are examples of excellent care – ranging from leading-edge innovations in clinical treatment to the very best examples of holistic support. Care and support are often at their best precisely when they bring together the NHS, local authorities, the third sector and peer support. However, only a minority of our communities receive any treatment, which in turn has broad impacts and associated economic costs.

Various factors promote our wellbeing including good attachment with our parents and carers early in life, educational attainment, meaningful activities and employment, social connectedness, feeling in control, physical activity, resilience and good quality housing. Interventions which promote such factors also promote our wellbeing.

Londoners in our part of the capital often live good and full lives. Recent survey results[2] show that over 90% have good levels of wellbeing. Yet the contrasts can be sharp, with 10% of adults living in London experiencing poor wellbeing. The largest proportion of this group are people who have a mental health need. Many of us find ourselves profoundly alone, with no meaningful conversation with another person this day, this week or even this month. Action is needed to promote wellbeing and target prevention of mental health needs.

[1] *WHO: Social Determinants of Mental Health, 2014*

[2] *Measuring National Well-being: Life in the UK, 2014*

1.2 Our aspiration

We have high ambitions for better mental health and wellbeing for every person living in North West London. We want North West London to be a place where people say:

> "My wellbeing and happiness is valued - I am supported to stay well and thrive"
> "As soon as I am struggling, appropriate and timely help is available"
> "The care and support I receive is joined-up, sensitive to my own needs and my personal beliefs. It's delivered at the place that's right for me and the people that matter to me"

Underpinning this vision is a set of principles:

- My life is important, I am part of my community and I have opportunity, choice and control.
- My wellbeing and mental health is valued equally to my physical health.
- I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing.
- My care is seamless across different services, and in the most appropriate setting.
- I feel valued and supported to stay well throughout my life

Now is *not* the moment to describe at great length North West London's successes, celebrated though they should be. The voice of services users has been amplified through transitioning to a "co-production" approach. Moving more care to the community, particularly primary care, through Primary Care Plus, has reduced inpatient care in Mental Health hospitals by almost ten per-cent[3]. Standardised acute psychiatric liaison services are now in place at every NWL hospital. Many fewer patients are sent away from home for out-of-area treatments that dislocate them from the people that matter in their lives and are expensive. These successes matter in one sense only: they should give us confidence that we can make future improvements to care because we have done so in the past. We also know that prevention is better than cure and there are a range of cost effective interventions which could prevent people from developing mental health needs and promote mental wellbeing.

Here, now, in this moment, we are impatient. We are anxious for improvement. We want to focus on what needs to be better in the future rather than to be reminded of what has been done in the past. As you will discover below, there is much work to be done. And all of us are keen to get on with doing it.

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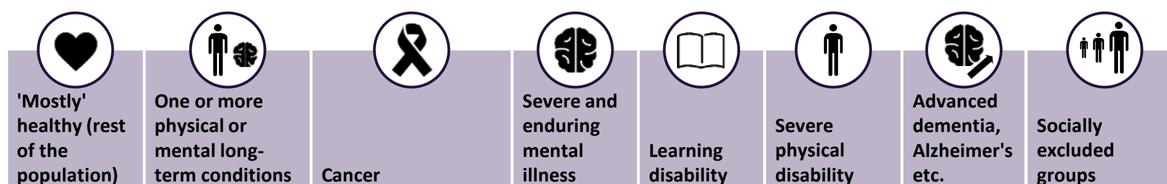
[3] *Health and social care information centre, Hospital Episode Statistics, Admitted Patient Care, England - 2009-14*

1.3 This paper

This paper is our case for promoting wellbeing, improving coverage of interventions to prevent mental health needs and for treating mental illness by changing the way that mental health services are provided in North West London. Below, we set out the major issues that we face – and the 12 ambitions that we must sign up to if we are to meet our aspirations. In the weeks and months ahead, we will develop proposals to deliver on these aspirations – and plan to set about the hard graft of making lasting improvements to care and support.

The Like Minded programme set out with a commitment to work with our partners across North West London and build on the good work that already exists – as a basis for an honest shared understanding of where we can do better. We used the approach developed locally and now applied across London to consider different, distinct population groups and their specific needs – across all ages, as set out in the figure below:



With the knowledge that no-one exists in a 'box' we also captured people's thoughts on the transition points between different needs – and in this way were able to understand themes which were positive, or challenging across our North West London population.

As well as talking to people (service users, staff, voluntary sector and the wider public) across our boroughs about their experiences we also looked at a range of information:

- mapping what services and support is currently available
- looking at what data we have on current services and our health and wellbeing more generally – and how we compare to the rest of London
- gathering together a sense of 'what good looks like' from local beacons of good practice – and also other work across London, the UK and more widely.

This paper briefly describes and organises the issues and accompanying challenges and ambitions. It does not set out the full breadth and depth of analysis that has been undertaken in the programme to date, which are published and available for review online (see http://www.healthiernorthwestlondon.nhs.uk/mental-health).

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2.1 Issue one: awareness and attitudes to the scale and significance of mental health needs in North West London

One of the main personal factors impacting on our overall wellbeing is the presence of a mental health need. Our mental health has a great impact on our ability to achieve our goals, whether this is to live happy and fulfilling lives, have good social relationships, to contribute positively to society or other personal aspirations.

Mental Health needs affect more people than cancer. They affect more people than heart disease or stroke. They affects more people than diabetes[4]. Over the course of a year, almost one in four people will have a diagnosable mental illness[5]. Perhaps the person in the queue with us at the checkout. Three of the children in the class with our child. Thirteen people on the bus with us in the morning; maybe a hundred on the same tube train.   But for example , only a quarter of people with anxiety and depression receive treatment[6] compared to more than 90% of people with diabetes[7].

Depression and anxiety are by far the most common, affecting around one in six of the adult population in London[8]. In North West London, self-reported prevalence of anxiety and depression[9] in 2014 was above the national average in Westminster, West London and Hammersmith and Fulham. Estimates suggest that depression and anxiety disorders may rise steeply in the next decade.[10] At the same time,

- 7% of London's population have an eating disorder,
- 1 in 20 adults have a personality disorder,
- 1% are registered with their GP as having a psychotic disorder such as schizophrenia, bipolar disorder or other psychoses[11].
- approximately 25,000 children[12] experience mental health needs. Indeed, nearly half of all lifetime mental health needs arise by the age of 14[13].

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4 How mental illness loses out in the NHS, Centre for economic performance mental health group, 2012

5 McManus, Meltzer, Brugha, Bebbington, Jenkins. Adult psychiatric morbidity in England, 2009: Results of a household survey: The Information Centre for Health and Social Care, 2009.

6 McManus et al, 2009

7 McShane M, Strathdee G, 'Valuing Mental and Physical Health Together Equally,' Presentation to NHSE; November 2013

8 London Mental Health: The invisible costs of mental ill health, Greater London Authority, 2014

9 GP Patient Survey, NHS England 2015

10 PHE Common Mental Disorders Profiling Tool, 2015

11 London Mental Health: The invisible costs of mental ill health, Greater London Authority, 2014

12 Better Health for London, London Health Commission, 2014

13 Kim-Cohen J, Caspi A, Moffitt T et al. Prior juvenile diagnoses in adults with mental disorder. Archives of General Psychiatry 60: 709–717; Kessler R, Berglund P, Demler O et al. (2005) lifetime prevalence and age-of-onset distributions of dsM-Iv disorders in the national comorbidity survey Replication. Archives of General Psychiatry 62: 593–602, 2003

Mental illness is experienced by our family, it is experienced by our friends, it is experienced by our colleagues – and it's experienced by ourselves. Mental illness is both normal for everyone and yet invisible to many of us at the same time. Despite the large proportion of the population affected by mental health needs, only a minority of people nationally receive any treatment[14]). In North West London, we estimate that two-out-of-three people living with mental health needs are not known to health services[15].

The risks of developing mental health needs in adults and older people varies by age, sex and ethnicity. Some parts of North West London have higher levels of factors impacting on mental ill health such as large proportion of ethnic minorities, deprivation, low levels of education, unemployment, substance misuse, violence and crime, social isolation and homelessness.

Just like physical health, there are significant inequalities in mental health. It is perhaps little surprise that families that live in poverty are more likely to have mental health needs. Similarly, people with mental health needs are more likely to live in poverty too[16].

Inequalities are both a cause and outcome of mental health needs (Campion et al, 2013). There is an important intergenerational effect: children whose parents have mental illness and do not receive appropriate support are five times more likely to experience mental illness themselves[17]. North West London has some of the wealthiest and some of the most deprived boroughs in the capital. It is little surprise then, that the incidence of mental illness varies sharply, with child and adolescent mental health needs three times as common in deprived areas compared to the least deprived parts of the city[18].

Too many of us face mental illness alone, afraid of the stigma of speaking up, or not understanding what support could be available – or trusting that it will be. We don't talk, think, or act enough on our mental health and wellbeing. How can it be that something that matters so much and affects so many, is so poorly understood? The first step is for us to assess the level, impact and cost of local unmet need in treatment and prevention of mental ill health and promotion of wellbeing.

We need to make improvements to services that people access already and to work in partnership to ensure that universal services such as schools, hospitals, criminal justice, housing and workplaces, are more accepting, more knowledgeable, more supportive to people who are experiencing mental ill health needs. We need to work with these services to ensure at a basic level that they do not inadvertently become places where further harm is done.

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14 McManus et al, 2009

15 Prevalence for all conditions: QoF 2013/14; Expected prevalence: Depression and Anxiety: Psychiatry survey, 2007; SEMI: LSE Centre for Economic Performance

16 *Campion J, Bhugra D, Bailey S, Marmot M (2013) Inequality and mental disorder: opportunities for action. The Lancet 382: 183-184*

17 *Meltzer H, Gatward R, Corbin T et al (2003). Persistence, onset, risk factors and outcomes of childhood mental disorders. London: The Stationery Office*

18 *Green et al: Mental Health of Children and Young People in Great Britian, 2005 ONS*

Naturally, we give our support to London-wide and national initiatives (such as Time to Change) to create parity of esteem between mental and physical health, to encourage more open and tolerant attitudes, and to de-stigmatise both the experience of mental health needs and care and support for people who experience them.

Ambition 1: We will ensure that mental health needs are better understood and more openly talked about and improve the experience of universal services for people with mental health needs in NWL

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2.2 Issue two: the promotion of wellbeing, resilience and prevention of mental health needs for people in North West London

Our sense of wellbeing is necessarily subjective. The Commission on Wellbeing and Policy, chaired by Lord Gus O'Donnell, defines wellbeing as "*perceived* happiness and life satisfaction". Amartya Sen – who won the Nobel prize for his work on welfare economics – pushes the concept further, and describes how wellbeing must take into account the extent to which individuals have freedom of choice and how far society allows them to "enhance their capabilities and to flourish".

As a result, the concept of wellbeing includes a broad range of things that contribute to happiness and life satisfaction. These range from attachment and early life experiences to successful personal relationships, employment satisfying work or something meaningful to do, choice, fulfilling education, good quality housing and an active old age with a purpose in life.

Whilst the causes of mental illness are sometimes poorly understood, evidence shows a range of risk factors for mental health needs include genetic predisposition and environmental factors such as socioeconomic inequalities, adversity such as violence and abuse, debt, as well as loneliness and isolation[19].

The opportunities to improve wellbeing and mental health are found mainly in the places where most people spend most of their time. For children and young people, such places are schools and further education providers. There is a significant opportunity to work with schools to promote mental wellbeing and resilience. Addressing risk factors and promoting protective factors at an early age both prevents a proportion of mental health needs from arising, promotes wellbeing and resilience.

For the majority of the adult population, the workplace represents an important opportunity. Mental health in the workplace is being championed across the capital by the Greater London Authority, as a result of the London Health Commission report 'Better Health for London' (October 2014). This reinforces national efforts driven and coordinated by the Department of Work and Pensions, for example the Working Capital programme. If all the organisations across North West London involved in this work signed up to the Healthy Workplace Charter[20] the impact would be significant. And speaking with honesty, the NHS, for example, has a poor track record of promoting either the physical or mental health of its employees. We have, therefore, much more to learn than to teach.

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19 Campion J, Bhui K, Bhugra D (2012) European Psychiatric Association (EPA) guidance on prevention of mental disorder. European Psychiatry 27: 68-80

20 https://www.london.gov.uk/priorities/health/focus-issues/london-healthy-workplace-charter

There is a huge opportunity to improve mental health and wellbeing for older people. Older people are typically frequently in contact with both health and social care – these are people that are usually known to us. We also know that many older people feel lonely and socially isolated – and that loneliness is detrimental to both health and wellbeing. Over time, loneliness and isolation can lead to mental health needs such as depression or anxiety[21].

Older, housebound people are particularly vulnerable, but other life events such as becoming a carer can make it hard to make time to socialise or carry on with hobbies or interests. The number of carers who reported feeling lonely across NWL boroughs is particularly high in some boroughs and varies from a quarter in Brent to half of all carers in Harrow (compared to 36% in London as a whole)[22].

There is potential for the health and care system to identify people who are lonely and connect them to opportunities for positive, substantive, social interactions. There is a particularly important role for the third sector and for peer-led support groups in confronting loneliness. Though there have been positive efforts, there is huge untapped potential outside the public health and care system. For relatively small levels of investment, a huge return can be achieved by partnering closely with the third sector. Furthermore, peer-support represents an essential part of mental health support and should be considered a core part of what happens, not a 'nice to have'.

Ambition 2: We will improve wellbeing and resilience, and prevent mental health needs for people in North West London, by supporting people in the workplace, building resilience in children and young people and reducing loneliness for older people.

21 Griffin J. The Lonely Society, 2010. Mental Health Foundation www.mentalhealthfoundation.ork.uk

22 PHE Fingertips fingertips.phe.gov.uk

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2.3 Issue three: the quality of care, coverage and outcomes for people with serious, long-term mental health needs

As the name suggests, serious, long-term mental health needs can have a devastating impact on lives, tearing apart the things that matter most –your place in the world, relationships with family, friends and colleagues, and the sense of purpose– whether in education, work or pastimes. At the same time, when affected we can lead the life we choose. All of us are more than a diagnosis.

Around 23,600 people in North West London have been diagnosed with schizophrenia, bipolar disorder and/or psychosis (approximately 1% of the total population) is around double that of the national average[23]. Around 60% of people diagnosed with a serious mental illness such as schizophrenia or having experienced psychosis are cared for solely in primary care[24].

Mental health and substance misuse problems are major public health and social issues. Studies suggest that dual diagnosis may affect between 30 and 70% of those presenting to health and social care settings[25]. In North West London, there is a great variation across the borough in people accessing both mental health services and substance misuse services; it ranges from 13% of people in Hounslow accessing mental health services and alcohol treatment services to as high as 52% in Hillingdon[26].

Outcomes for people are often poor. For example, rapid step-down from inpatient crisis care is known to result in better outcomes: there are wide disparities in North West London – in many boroughs, half of all patients are still in crisis care after 9 months, whereas in others fewer than one-sixth are[27].

Social outcomes of people known to secondary care are often worse than the general population; only 8-10% are employed and only half live in settled accommodation.[28] Further work is needed to support people with serious mental illness to live independently in the community. Pathways for recovery and enablement should be holistic and integrated across the whole health and care economy and include working with local authority and voluntary sector services that promote independence such as leisure, employment schemes, befriending interventions etc.

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23 Quality and Outcomes Framework (QOF) for April 2013 - March 2014

24 QoF 2013/14

25 Reference: Crome, I, Chambers, P. (2009) The relationship between dual diagnosis: substance misuse and dealing with mental health issues. SCIE Research briefing 30. Available from: http://www.scie.org.uk/publications/briefings/briefing30/

26 PHE National Treatment Agency, 2013/14

27 Cluster and patient data January 2014 to September 2014 for CNWL and WLMHT

28 Adult Social Care Outcomes Framework, 2013

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Whether we have long-term needs or a short term episode of mental health needs, when we experience, or are close to experiencing, a mental health crisis, there should be services available to provide urgent help and care at short notice which are responsive and easy to navigate.

For routine specialist care, the normal wait for people who have experienced a psychotic episode is two weeks; in some boroughs it is closer to four weeks [29]. Elsewhere in England, one week is the norm. The contrast with physical health services is sharp and stark – access points and pathways are generally clear and well structured; the same cannot be said for mental health services which can be over-complicated and confusing. This is all the more so at a time of crisis, and especially for those with little or no prior contact with mental health services (such as friends and family of first onset patients).

The defining characteristics for this group are their *needs* not their diagnosis. There are two broad dimensions on which needs are defined – complexity and duration.

Complexity can come in many different forms. Examples would include relapsing/remitting serious mental health needs such as schizophrenia, recurrent long-term depression, complex interactions between mental and physical conditions, complex social factors ranging from homelessness to being a carer, severe forms of personality disorders. Complexity is much more than a clinical concept.

Conversely a given diagnosis does not always imply complexity. For example a large proportion of young people experiencing their first psychotic episode will make good recovery if treatment is accessed early[30]. Work is underway in North West London to improve Early Intervention in Psychosis – but there is more that can be done. An evidence base exists for even earlier support – during what is known as the prodrome phase, when an early symptom (or set of symptoms) can indicate the start of a disease before specific symptoms occur.

Being cared for in primary care settings does not by default mean that an individual's needs are not complex. In the case of people with depression treated by normally 'effective' means, a substantial minority still fail to meet the criteria for recovery. Depression can become complex and chronic with people reporting continuing symptoms of depression and accompanying distress about these symptoms (increased duration of need).

Similarly, reflecting duration of need, many serious mental illness are relapsing and remitting in their character which means that through excellent care and support, the amount of time that people feel well can increase, improving quality of life. Levels of resilience are typically lower than the general

29 CNWL and WLMHT referral data with first contact January 2014 to September 2014

30 Rethinking Mental Illness: Lost Generation, 2013

population. The goal for this group of people is to support the holistic concept of recovery –focusing care on finding meaningful activities, ensure good housing is maintained, promoting independent living and building the resilience of people with mental illness, not just on treating or managing their symptoms. This can be done through joint working with local authorities and other community organisations that can reach far out outside the usual care settings.

15% of people who experience an episode of psychosis will lead a chronic course experiencing repeated relapses and being substantially handicapped by their condition and 10 will die mainly by their own hand[31]. Reflecting the intensive needs of these individuals, they account for the vast majority of mental health expenditure – indicatively more than 80% of specialist contacts, nearly 90% of inpatient bed days, and 80% of spend by the mental health trusts. Furthermore, they also require support from local authorities, housing, employment, the third sector, and, regrettably, the police and criminal justice system.

There is significant room to improve the quality of care that is provided. Today, no boroughs meet all of the NICE guidelines for psychosis treatment. Patient satisfaction hovers around the London average. People tend to spend longer in inpatient facilities than in other parts of London and nationally. We need to make sure we have the right balance of inpatient beds and community teams. There is a huge opportunity, therefore, to completely redesign and strengthen community-based care through clarified pathways and a new care and support model.

Whilst we focus throughout our strategy on the need to support wellbeing promotion and prevention of mental health needs, for many people who experience serious and long-term mental health needs these result from an experience of trauma – often early in life. Whilst more can be done to address these causes of trauma, we cannot aim to prevent or reduce the severity of all illness – we need our current services to work differently with service users and with other agencies.

Essential features might include transformed peer support, much better support for GPs, first class rapid response both for crisis and to stabilise people, and stronger community based support – wrapped around the needs of the individual and working jointly across organisational divides – social care, health, voluntary sector, employment and housing teams and drawing on the assets of the individual themselves and the community. It is vital that the care model that is designed is placed within – and connected to – the North West London environment.

31 http://www.livingwithschizophreniauk.org/advice-sheets/recovery-strategies-for-schizophrenia/

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The result of a better, higher quality, more connected and more consistent model of care and support should be that people remain stable for longer, and exacerbations are less acute as well as less frequent – and that the quality of life for people is made better. It should also lower the demand for inpatient care, and by doing so, help the overall system to achieve sustainability.

Ambition 3: We will clarify and simplify the pathways for people with serious, long-term mental health needs

Ambition 4: We will develop new community-based care and support models that will improve the quality of care and outcomes for people with serious, long-term mental health needs

Ambition 5: We will rebalance resources from inpatient facilities to innovative community based support

2.4 Issue four: identification of common mental health needs and access to good quality care

Common mental illnesses are experienced by nearly a quarter of a million people living in North West London. This includes depression and anxiety, social anxiety, post-traumatic stress disorder and obsessive-compulsive disorder. People with serious mental health problems die on average 20 years earlier than the general population[32]. For people who have a physical long-term condition, having depression increases mortality by at least 45%. [33]Importantly, the suicide rate – though low overall – is 20 times higher for this group than for the rest of the population[34]. The impact is wider than on health – mental health is the most significant cause of lost workdays across England[35].

Many of us in North West London get no access to the care that we need. There are huge variations between expected rates of mental illness, rates of diagnosis, and rates of treatment. When we develop a common mental illness we often do not seek help from healthcare services or if we do mental health needs are not detected. We know there are particular groups who are even less likely to have needs diagnosed – and indeed to access services. Undiagnosed depression is one of the main risk factors for suicide. Suicide rates per 100,000 population in North West London boroughs vary greatly with the rates in Hammersmith & Fulham and Westminster higher than the London and national average.[36]

Better access is a common theme in feedback from local residents but can also be a complicated issue. With barriers to access not solely relating to services, but also to complex factors such as stigma within the service and artificial gateways requiring certain diagnose or behaviours to enable eligibility to then access care. Our services need to consider the reasons why people may choose not to access them, and how this informs how services could be differently delivered.

The result is that as many as two-thirds of people with common mental illnesses are receiving no care whatsoever (versus a quarter of people with a physical illness not receiving care)[37]. With steadily declining expenditure on primary care overall, this is perhaps to be expected. It should remain shocking.

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32 Brown S, Kim M, Mitchell C and Inskip H (2010) Twenty-five year mortality of a community cohort with schizophrenia. British Journal of Psychiatry 196: 116–121; Parks J, Svendsen d, singer P et al. (2006) Morbidity and Mortality in People with Serious Mental Illness, 13th technical report. Alexandria, Virginia: National Association of State Mental health Program Directors.

33 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

34 Lepine, Biley: The increasing burden of depression. Neuropsychiatr. Dis Treat 2011, 7(Suppl 1): 3-7

35 No health without mental health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages; 2nd February 2011

36 PHE Fingertips, 2013

37 *Campion (2015) Mental health needs assessment for North West London. Draft 22-6-15. South London and Maudsley NHS Foundation Trust*

For those whose mental health needs are detected, there are drug and psychotherapeutic treatments that are effective for many people at both shortening the duration of the disorder and in reducing the likelihood of relapse. Nonetheless, the quality of primary mental health care for people who are diagnosed with common mental health needs is not always good enough.

Failure to diagnose or late diagnosis and lack of provision of timely access to short term therapies and supported self-care can lead to deterioration and poor outcomes. Typically, people in North West London get poorer care than can be found in other parts of London. For example, just two boroughs achieve the London average for post-diagnosis review (and the London average itself is poor)[38]. Of the eight CCGs in North West London, only Hammersmith and Fulham meets the national target of 15% access to IAPT (Improving Access to Psychological Therapies) services and 50% recovery rate for those people using the service[39].

Going further, many people who use services have pointed out that there ought to be a broader range of offers than just IAPT – and that IAPT services themselves must be more flexible. Treatment and care must take into account people's needs and preferences. Models of care where clinical teams work alongside the voluntary sector and engage as equals with people who have a lived experience of common mental health needs, in peer support roles, provide less rigid and more person-centred support – for example our Primary Care Mental Health services in Westminster and Kensington & Chelsea, Queen's Park and Paddington work with Mind and Depression Alliance respectively. As the London Health Commission described, there are potentially promising avenues in digital mental health support, building on the success of the "Big White Wall" – which is already available in some areas of North West London, such as Hounslow.

Ambition 6: We will improve identification of depression and anxiety recognising that many people may not be engaged with any services at present

Ambition 7: We will improve the quantity, quality and diversity of non-pharmacological therapies for people experiencing depression and anxiety

[38] *Public Health England Local Profiles*

[39] *Public Health England Local Profiles*

2.5 Issue five: mental health needs of Children and Young people are often neglected

The needs of North West London's **children and young people** have for too long been neglected. There are approximately 25,000 children in our part of the capital with mental health needs, of whom more than 8,000 require more specialist interventions[40]. Children and young people have been relatively underserved by the system for too long. Despite the fact that around half of all mental health needs in adults emerges by the age of 14, and three-quarters of lifetime mental health disorders have their first onset before the age of 18, fewer than 10% of CCG mental health spend is invested in their care.[41] There is a compelling case to prioritise their needs.

Parental unemployment is associated with several fold increased risk of mental ill health in their children[42]. The proportion of children living in households with no adults in employment ranges across NWL from 9.6% in Hounslow to 28% in the Westminster borough; a total of 57,480 households across North West London[43].

Our childhood and experiences in our early years have a significant effect on our adult lives. Many mental health needs in adulthood show their first signs in childhood and, if left untreated, can develop into conditions which need regular care throughout adult life.

We know that there is variation across our boroughs of children likely to have conduct disorder (e.g. 5.4% in Harrow to 8.3% in Brent)[44]. This is important because ignoring conduct disorder in childhood has repercussions for the individual and society more broadly. The annual cost of crime by adults who had conduct disorder and sub-threshold conduct disorder during childhood and adolescence varies from £147.4m in Kensington & Chelsea to £452m in Brent[45].

We can sometimes end up focusing on those children with complex and serious needs - which whilst important can mean we miss opportunities to highlight and support those children where early intervention within families could dramatically improve their life chances. Frequently it is our schools, health visitors, school nursing services and GPs who have contact with children with early signs of mental health needs – unfortunately it is also our Youth Offending Teams, social care and acute emergency services that interact with these vulnerable children and young people, where the early opportunities to intervene are missed. This is not due to lack of good will – there are many highly skilled and highly valued staff working with children and young people who want to make a

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[40] *Public Health England Fingertips*

[41] *NHSE, 2014*

[42] *Royal College of Psychiatrists Position Statement: No Health without Public Mental Health, PS4/2010*

[43] *Office of National Statistics, 2012*

[44] *PHE Fingertips fingertips.phe.gov.uk*

45 SCMH, 2009

real and lasting difference to their lives but there are barriers in the system itself which prevent change.

There is a terrific opportunity to work with schools to improve mental health and resilience – and indeed many of our schools, despite the challenges of increasingly pressurised curricula, ensure that wellbeing is a part of the school experience. Speaking with partners working in education, eating disorders are a significant issue that schools attempt to address through their work on resilience and wellbeing. Whilst eating disorders are not restricted to children and young people – the drive for improvements centres on the younger population. Nationally admissions relating to eating disorders continue to rise (8% from 2011/12-2012/13)[46]. Additionally funding is being provided across England to improve services locally.

In 2014 the national Children and Young People's Mental Health and Wellbeing Taskforce sought to identify the problems which stop us from providing excellent mental health care for young people. The publication of the national strategy (Future in Mind) in February 2015 has galvinised teams working with children to articulate how we improve our formal Child and Adolescent Mental Health Services, but also improve how our whole system builds resilience, prevents needs developing and supports a range of growing issues (such as mounting rates of eating disorders and self-harm).

Whilst the national strategy means we can access additional funding, this is also about considering children and young people as a real priority for system-wide focus, to improve immediate experiences, but also to set them up for lives which are meaningful and fulfilling.

Ambition 8: We will ensure that implementation the national strategy responds to our specific local needs – and the variation in access and outcomes across NWL for all children and young people

[46] *HSIC, January 2014*

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2.6 Issue six: the quality of care for other population groups with specific needs

The intensity of needs of a relatively small group of people with serious, long-term mental health needs combined with the enormous scale of the challenge of common mental illnesses means that particular groups have been relatively underserved. Our work has identified four groups with defined needs that require significant improvements. These include the following:

- Expecting and new mothers (perinatal)
- People with learning disabilities
- People who are homeless and other underserved groups
- People with dementia

Improvements are required to the care for each of these groups. We now – briefly – explore some of the issues faced.

The early years of life have the power and potential to shape whole lives – for both mothers, infants and children. For example, depression affects more than 1,000 **expecting and new mothers** in Ealing and many thousands across North West London as a whole[47]. Tragically, suicide remains a leading cause of death for expecting and new mothers. Furthermore, when mothers become mentally unwell it increases the likelihood that children will experience behavioural, social or learning difficulties and fail to fulfil their potential. Work is presently underway to implement new perinatal models of care across all 8 boroughs.

People with **learning disabilities** often have mental health needs too. Nationally, 2.2% of the population have learning disabilities. What is often overlooked is the intensity of mental health needs of this population group. Not only do 25-40% have a diagnosable mental illness, the prevalence of schizophrenia is three times that of the general population[48]. Often, people with learning disabilities will already have support from social services or carers or both, making the case for more integrated care even more compelling. Services must be designed to meet their needs – with better, clearer communication and appropriate training so that care is tailored in the right way.

North West London has some of the highest rates of **homelessness** and rough sleeping in Britain (this is particular concentrated in Westminster). Studies have demonstrated that nearly half of all homeless people suffer from mental health needs (45% prevalence) though this may be understated. The homeless population has a life expectancy of only 43-47 years, compared with 80-84 for the general population, and is more afflicted by mental ill health than any other population group. Often, homelessness reflects not only unfortunate circumstances, but a crisis in an individual’s ability to cope with life’s challenges.

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[47] *Gavin et al, 2005*

[48] *Smiley 2005*

People who are homeless often have the most intense needs in addition to their need for accommodation: 12% of participants diagnosed with mental health issues also reported drug and alcohol issues.[49] This is exacerbated by the fact that often the homeless cannot manage their own conditions, due to a combination of chaotic lives, low literacy, poor access to care, and, regrettably, often hostility from health professionals. This makes it much more likely that care is provided at A&E or the hospital, which is both inefficient, costly, and degrades their quality of care. We will work with the London-wide programme to improve mental health care for people who are homeless.

When considering the needs of the homeless, specialist voluntary sector partners suggested that the needs of many hard to reach groups have wider ranging similarities – for example there is considerable overlap in the needs of sex workers, people with mental health needs who use drugs and alcohol or indeed BME communities. The issues around access, stigma and acceptance by universal services are critical. In North West London our providers report particular challenges in relation to the impact of immigration and a transient population.

A rising challenge for every part of the country – where North West London is no exception – is **dementia**. As of March 2015, 10,000 people on GP registers had diagnosis of dementia compared to 15,115 people estimated to have dementia locally. Over the recent years, diagnosis of dementia in GP practices has increased however the latest data suggest an overall diagnosis gap of 34%[50].

Work is presently underway to implement a NWL Dementia Framework, which is a new model of service based on national guidance and best practice – but tailored to local requirements. What is clear is that diagnosis rates are rising (partly as a result of primary care financial incentives) and as a result, significant effort must now be invested in ensuring that more accurate diagnosis is followed up with best practice interventions.

Ambition 9: We will make targeted improvements to the care and support for underserved groups within existing services

Ambition 10: We will identify which care and support models need to change and how, so that we can improve care for underserved groups

[49] *http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf*

[50] *NHS England Dementia Prevalence Calculator, March 2015*

2.7 Issue seven: the relationship between mental health and physical health

The NHS has historically created a separate institutional, legal and regulatory framework for mental healthcare. Yet just as the health delivery system has been divided, the health of any individual is indivisible.

In 2014, the life expectancy of a man who has experienced psychosis was 65 – 14 years less than the average, and the same as the typical life expectancy for a man in 1954[51]. This is because people with mental health needs are at higher risk of developing significant, preventable physical health problems.

The largest single preventable cause of death in England is tobacco smoking and this is even more so for people with mental health needs who smoke at much higher rates. 42% of all cigarettes smoked in North West London are smoked by people who have a mental health need[52]. Despite the existence of effective interventions to address physical illness and prevent it, such as smoking cessation, monitoring of physical health is often inadequate.

People with schizophrenia are twice as likely to die from cardiovascular disease and three times more likely to die from respiratory disease and the single biggest risk factor for these physical conditions are smoking followed by obesity and lack of exercise. These shocking facts demand that we are pioneers in making improvements to the physical health of people with serious, long-term mental health needs. The crucial need is to fully integrate physical health services into a single care and support model for people with serious, long-term mental health needs.

Similarly, too many people with long-term conditions do not have their mental health needs properly taken into account. The observation is often made that mental health "is a co-morbidity of many long-term conditions". This is hardly surprising: being sick for any period of time is not an enjoyable experience. It can feel terribly disempowering, and all too easy to focus on what an individual can no longer do, with particular issues around employment, mobility, and social isolation. Providing high quality holistic care means empowering us as individuals and enabling everyone to focus on what they can do.

Mental health needs are associated with poorer physical health in general - those with long-term conditions are two to three times more likely to have a mental health need than the general population [53]. Mental health and wellbeing can affect physical health outcomes – depressed co-

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[51] *Better Health for London, London Health Commission, 2014*

[52] *McManus et al, 2010*

[53] *De Hert M, Correll CU, Bobes J, Cetkovich-Bakmas M, Cohen D, Asai I, Detraux J, Gautam S, Möller HJ, Ndetei DM, Newcomer JW, Uwakwe R, Leucht S (2011a). 'Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care'. World Psychiatry, vol 10, no 1, pp 52–77.*

morbid patients are three times more likely to be non-compliant with treatment recommendations than non-depressed patients[54]. It is estimated that £1 in every £8 spent on treating a long-term condition is linked to a co-morbid mental health needs[55].

This is why mental health is an integral part of the whole systems integrated care programme. The question is how to build upon the lessons from the early adopters in the programme and to spread and scale changes across North West London.

Ambition 11: We will fully integrate physical health into the care and support model for people with mental health needs

Ambition 12: We will build upon, spread and scale the lessons learned from the whole systems early adopters in mental health care for people with long-term physical health conditions

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[54] *DiMatteo et al: Depression is a risk factor for non-compliance with medical treatment: meta analysis of the effect of anxiety and depression on patient adherence. Arch Intern Med, 2000*

[55] *Naylor et al: Long Term Conditions and Mental Health King's Fund 2012*

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2.8 Issue eight: our systems hinder integrated care

When we look across the systems in North West London, it becomes all too apparent that too often they hinder rather than help to deliver high quality care. There are a set of enablers for better care that need to be put in place if North West London is to achieve its aspirations. In this section, we focus on those enablers that are more specific to mental health (where they are the same as physical health, they are captured in the whole systems programme).

The first focus must be on **workforce**. There are three broad areas where progress is necessary. First, we must make sure that the mental health workforce is sufficient. This includes peer support workers, psychiatrists and general practitioners, for example. Second, we must systematically develop the broader mental health workforce – in particular, to think about how we can improve the skills and capabilities of our talented third sector partners and, crucially, of those offering peer support. This may take the form of sharing between different parts of the third sector (some of whom are more skilled than others) as well as targeted training to improve peer support services. Third, we must ensure that those working in other parts of the health and care system – and beyond it such as the police, schools, housing – have appropriate training and awareness of mental health issues.

The second area that needs urgent attention is **information**. There is a paucity of information in mental health that serves, over the long-term, to fundamentally harm the interests of the sector. Outcomes are often not well-defined nor measured. Neither, in many cases, is activity. The information set for community-based services is particularly sparse. Though significant investments have been made in recent years, the sector as a whole is playing catch-up to its cousins in physical health. We have an opportunity to revolutionise the approach to data and information – by placing a sharp focus on measuring the things that really matter.

A related issue to information is **payments**. Today, the payment system does not promote integrated care; it hinders it. Much of the work that has been developed in the whole systems programme more widely has the potential to have huge impact in mental health. For example, consolidating the budget for mental and physical health could enable completely different care models that are much more holistic in their character. The programme should be at the forefront of holistic capitated or personalised budgets – building on recent initiatives in both the NHS and local authorities.

Finally, we know that the mental health **estate** faces even more fragmentation and chronic under-investment that the physical health estate. Reports from the Department of Health, NHS England and Monitor have demonstrated this. Furthermore, evidence has shown that the environment that people are cared in has a significant impact on their recovery. We must look at how the estate can be rationalised and upgraded – a process that must proceed in parallel.

Ambition 13: How can we ensure that our systems help rather than hinder integrated care

3. What's next?

The goal of this document is to build a consensus that the right issues and ambitions have been identified, and that work should commence or accelerate to address them. Nonetheless, it will be necessary to approach the different issues and ambitions in different ways, reflecting the unique circumstances of each of them. We will maintain the importance of co-production; working with service users – the people who access the services we seek to improve – to harness critical experience, creativity and ingenuity and improve care.

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