Committee: Health and Wellbeing Board

Date: 30 September 2014

Wards: All

Subject: Merton Mental Health Needs Assessment

Lead officer: Dr. Kay Eilbert Director of Public Health

Lead member: Councillor Caroline Cooper-Marbiah, Cabinet Member for Adult Social Care and Health.

Forward Plan reference number:

Contact officer: Dr. Anjan Ghosh, Consultant in Public Health

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Recommendations:

A. That members of the Health and Wellbeing Board agree the two reports:

1. Merton Adult Mental Health Needs Assessment (MMHNA)

2. Supplementary Report on stakeholder event feedback

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The Merton Adult Mental Health Needs Assessment was commissioned by the Merton Health and Well Being Board (MHWBB) as part of the wider Merton Mental Health Review, to analyse current and future mental health needs to inform commissioning of health, well-being and social care services within Merton.

Executive summary of the MMHNA is included in the appendix 1.

2. DETAILS

The MMHNA (Merton Mental Health Needs Assessment) aims to:

- describe the size and nature of adult mental health conditions
- describe the nature and extent of health inequalities in both the distribution of mental health illnesses in the population, and in uptake of and access to services
- identify evidence-based interventions and best practice to tackle mental health issues
- describe current health and social care provision and how this compares with best practise interventions
- identify gaps in service provision and make recommendations about how to address them, particularly in relation to reducing health inequalities and inequity.

The MMHNA includes an in-depth data analysis, consultations with services users, carers and service providers, and a review of the literature.

A workshop was held on 28th July 2014, with service users, carers, voluntary sector and community organisations, and statutory organisations including key providers, commissioners and mental health professionals in Merton. Hosted by the London Borough of Merton (LBM) and NHS Merton Clinical Commissioning Group (MCCG) and facilitated by Merton Healthwatch, this event obtained views and facilitated discussion about the Merton Adult Mental Health Needs Assessment (MMHNA) findings. In addition to the recommendations from the MMHNA, feedback in this report will support the future commissioning of mental health services in the Borough.

3. NEXT STEPS

Following the agreement of the HWBB, the two reports will be uploaded on the Public Health Merton council web page. The recommendations and feedback from the reports will be utilised to inform the development of a commissioning plan by the Merton Clinical Commissioning Group, with support from Public Health Merton and other LBM partners.

It is planned to have regular workshops with users and carers regarding mental health services to ensure commissioners hear live messages, and progress on commissioning and service delivery is shared.

4. ALTERNATIVE OPTIONS

None

5. CONSULTATION UNDERTAKEN OR PROPOSED

A range of partner organisations participated in the development of the MMHNA through a Task and Finish Group. The MMHNA itself had a qualitative component which involved consultations with service users, carers and providers of mental health services. A large stakeholder event was held as well, in which the MMHNA recommendations were discussed and further feedback was obtained.

As mentioned earlier, an on-going programme of engagement with stakeholders is planned.

6. TIMETABLE

The next steps include the development of a commissioning plan and further stakeholder workshops. The timescales for this are to be determined.

7. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

Costs of the work was managed within existing budgets.

8. LEGAL AND STATUTORY IMPLICATIONS

None

9. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

None

10. CRIME AND DISORDER IMPLICATIONS

None

11. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None

12. BACKGROUND PAPERS

1. Full report of the Merton Adult Mental Health Needs Assessment
2. Report on the feedback from the stakeholder workshop

APPENDIX 1: EXECUTIVE SUMMARY OF THE MMHNA

Background

The Merton Adult Mental Health Needs Assessment was commissioned by the Merton Health and Well Being Board (MHWBB) as part of the wider Merton Mental Health Review, to analyse current and future mental health needs to inform commissioning of health, well-being and social care services within Merton.

Aims, objectives and methodology

The MMHNA (Merton Mental Health Needs Assessment) aims to:

- describe the size and nature of adult mental health conditions
- describe the nature and extent of health inequalities in both the distribution of mental health illnesses in the population, and in uptake of and access to services
- identify evidence-based interventions and best practice to tackle mental health issues
- describe current health and social care provision and how this compares with best practise interventions
- identify gaps in service provision and make recommendations about how to address them, particularly in relation to reducing health inequalities and inequity.

The MMHNA includes an in-depth data analysis, consultations with services users, carers and service providers, and a review of the literature.

The picture of adult mental health in Merton

Overall Merton does well on many measures of mental health. Merton CCG has lower spend and better outcomes for mental health overall. While the per capita spend on mental health in Merton is much lower than for other CCGs in our ONS cluster (Hounslow, Harrow, Ealing, Redbridge and Barnet) and England, the outcomes overall are good- suggesting that the investments are good value for money.

While Merton is a relatively young borough, the proportion of older people is going to increase. By 2017 there is forecast to be an increase of 2,900 people (11%) in the over 65 age group with an increase of around 1,500 in the over 90 age group[1]. Modelled prevalence indicates that the numbers of people with Common Mental Health Disorders (CMDs) and Severe Mental Illnesses (SMIs) will increase in the next five years, and so will the number of dementia cases. This will place constant and increasing demands on mental health services and underscores the importance of prevention work in mental health.

[1] Merton Joint Strategic Needs Assessment, 2013-14

Key points

Overall:

- Data suggests that there is under-diagnosis and/or under-recording of depression and dementia in primary care in Merton
- Where Merton is doing particularly well:
  - Recording the diagnosis of a mental health condition
  - Assigning patients to a mental health cluster
  - Having significantly lower A&E attendances for patients with psychiatric disorders
  - Having significantly lower number of bed days,
  - Having a significantly higher rate of carers of mental health clients receiving assessments
- Where Merton not doing so well:
  - Providing newly diagnosed depression patients with severity assessment at the outset of their treatment
  - Having a significantly lower rate than England average of recovery for IAPT treatment (percentage of people completing IAPT who have moved to recovery)
- Merton has a significantly higher than national average percentage of mental health service users that are in-patient in a psychiatric hospital and a significantly lower rate than England average, of people on Care Programme Approach (CPA)
- Merton also has a significantly lower rate of mental health clients receiving community, residential or nursing home care and a significantly lower rate of people in contact with specialist mental health services
- The number of people with mental health conditions is expected to increase in Merton over time for all conditions (Common Mental Disorders, Borderline Personality Disorder, Antisocial Personality Disorder, Psychotic Disorder, and Two or more psychiatric disorder)
- Merton CCG has the lowest reported prevalence of mental health disorders among SW London and statistically similar CCGs
- There are considerable variations in the prevalence of mental health conditions by GP practices and also comparing practices in East and West Merton
- Proportion of adults in contact with secondary mental health services living independently, with or without support is below the London average and the lowest among SW London boroughs. It is second lowest among statistical neighbours

For Common Mental Health Disorders (CMDs):

- Public Health England estimates that Merton has one of the highest percentages of 16-74 years olds estimated to have a common mental health disorder
- Merton has significantly lower than national averages for adults with depression known to GPs, new cases of depression; and lower than national average long term mental health problems, and depression and anxiety among GP survey respondents
- The rate of initial assessment of depression in Merton was significantly lower than the England average while the percentage of adults with a new diagnosis of depression with a follow-up assessment after 4-12 weeks was significantly higher
- Merton performs significantly lower than average at case finding for depression and has a significantly lower than average percentage of people with long term conditions visiting GP who felt that they have had enough support from local services in the last 6 months

For Severe Mental Illness (SMI):

- Merton has a significantly lower than average number of people with SMI known to GPs
- The rate of contact with services, and day care attendances are significantly lower than average
- Merton has a significantly higher than average percentage of mental health service users who were inpatients in a psychiatric hospital
- Schizophrenia emergency admission rate was significantly higher in Merton than the national average although the data quality had some concerns
- For the percentage of people in contact with mental health services with a crisis plan in place was significantly less in Merton compared with the England average
- Merton rates were significantly lower than the England averages for social care mental health clients receiving services during the year, mental health clients in residential or nursing care, mental health clients receiving home care during the year, and mental health clients receiving day care or day services
- 2012-13 QOF data suggests that there is room for improvement and considerable variance between GP practices overall and between practices in East and West Merton in terms of proxies for caring for the physical health of patients with schizophrenia

For dementia:

- The NHS dementia calculator gives the current diagnosis rate as 47% (2013/14) and a dementia gap of 1,057 cases for 2014/15
- In 2012-13, there were 870 Merton residents on the dementia register out of a total registered population of 217,803. This gives an overall GP recorded prevalence of 0.4% for Merton CCG. The England prevalence is 0.57%
- There is considerable variance between practices and East and West Merton for the observed to expected prevalence ratio

For mental health inequalities in Merton:

- Black ethnicities were over-represented in the in-patient population and Asians under-represented in both the in-patient and Community Mental Health Services (CMHS) populations. This could be indicative of the underlying risks of mental illnesses in different ethnicities- especially in the case of black ethnicities and/or more repeat admissions in this group, but in the case of Asians this very likely indicates an inequity in access, perhaps due to cultural taboos or other reasons
- A majority of in-patients and CMHS patients belonged to the most deprived areas of Merton and most patients came from East Merton
- The majority of patients from West Merton belonged to the least deprived areas
- In terms of referral rates to CMHS, white, black and other ethnicities have comparable referrals rates while the rate in Asians is statistically significantly much lower. For in-patients, Black ethnicities have the highest admission rates in Merton and this is statistically significantly different from admission rates for other ethnicities. Asians have the lowest rate and this too is statistically significantly different from admission rates in white and black ethnicities
- Apart from organic disorders where the least deprived patients have the highest proportion of cases, for all other the major diagnostic groups the more deprived patients have the higher proportion of cases, indicating a positive correlation between mental illnesses and deprivation

- In all the major primary diagnostic groups there are a higher proportion of patients from East Merton compared with West Merton

For patients in Merton:

- The three top causes for in-patient admission were schizophrenia, followed by psychoactive substances and then mood affective disorders
- The three top causes for CMHS referrals were mood affective disorders, followed by psychoactive substances and then schizophrenia
- Psychoactive substances were the second most common cause for both in-patient admissions and CMH patients in adults overall from 2008-13, as well as the second most common cause for admissions in working age adults. Additionally this category was the most common cause for referrals to CMH in working age adults. In both in-patient admissions and CMHS referrals for substance misuse, a significant majority were due alcohol

Qualitative data: Focus Groups and Semi-structured interviews

Qualitative work was undertaken to ascertain the experiences and views of adult mental health services users, carers and providers in Merton. The study took place between August and October 2013. In all 31 informants participated in the study.

For the most part, service users were critical of mental health services in the borough. This is by no means unusual and is typical of much of the user experience documented in the mental health literature.

Concerns raised in the study included the continuing attitudes towards mental illness, experience of care and cuts in services. Other issues included the closure of drop-in/day centres, perceived powerlessness to influence care and services dominated by a medical approach to treatment. Carers highlighted their lack of involvement in the decision making process. BAME service users and carers reported particular challenges which highlight the importance of developing cultural competence within mainstream services along with more targeted provision specifically. This is a priority for further investigation.

Key themes emerging from the experience of service users and carers included:

- relationships with health professionals and the need for more involvement and empowerment
- communication, including listening, talking and understanding
- cultural competence of the service
- comparisons with services in neighbouring boroughs, especially Sutton and Wandsworth, which are seen as providing better care and a wider range of services

What are the gaps in Merton?

1. **Equity issue: Under-representation of Asians and over-representation of black minority ethnic groups**
   Analysis of the data clearly indicates which groups are the most vulnerable in Merton and which groups needs to be therefore targeted more effectively. Black ethnicities are over-represented (in-patients) and Asians significantly under-represented (both in-patients and Community Mental Health Services-CMHS) in our mental health services. In the case of Asian communities this under-representation suggests inequity in access and cultural taboos and stigma associated with mental illness. In Black ethnicities the over-representation could be due to the underlying risks of mental illness in different ethnicities, but it is possible that a number of patients are being diagnosed later and with more severe symptoms, who could have otherwise been managed in the community. More targeted work is required with these communities and there is a need to develop services that are more accessible to BME groups- especially Asians.

2. **Services that address the dual diagnosis of substance misuse and mental ill-health and hidden harms**
   Psychoactive substances are the most common cause for community mental health referrals and the second most common cause for in-patient admissions in working age adults in Merton. The overwhelming majority of these were for alcohol related problems. The issue of dual diagnosis is a significant one for Merton - with so many admissions and referrals due to psychoactive substances, increased focus is required on prevention and early detection in addition to treatment. The 'hidden harms' aspects of this are likely to be considerable, i.e. the impact on children living with parent(s) with dual diagnosis. There could be potential safe-guarding risks, crime-related issues and a wider reputational risk to both London Borough of Merton and the NHS. The hidden harms aspect is not just about dual diagnosis but extends to parents with mental illnesses (and not substance misuse) as well.

3. **Personality disorders (PD)**
   Around 8-9% of all in-patient cases and patients in CMHS are seen because of personality disorders. Anecdotal evidence suggests that there are significant numbers of undiagnosed cases of PD in the community, and there needs to be more and better access to psychological treatment (DBT/MBT) for cases of PD and dual diagnosis with PD. Considerable preparatory work is required to get PD cases ready for such therapies.

4. **Primary care variation by practice, variable quality outcomes and under-diagnosis**
   Findings suggest that in primary care there is considerable variation by practice, variable quality of outcomes and under-diagnosis. The 2012-13 QOF data for both depression and dementia suggest that at primary care level, there is under-diagnosis of both in Merton, and that there is considerable variation between GP practices especially when comparing the GPs in East Merton (where the data indicates even more under-diagnosis) with those in West Merton.

   While the latest HSCIC data on further assessment of depression severity is reported for 2011-12 and is for Sutton and Merton PCT, it suggests that we have the lowest percentage of patients undergoing further assessment of depression in SW London, lower than some

statistical neighbours and lower than England. 2012-13 QOF data suggests considerable variation by GP practices in Merton, and that in East Merton especially for MH 17 - The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months, and MH 18 - The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the preceding 4 months- there are more practices which have low percentages compared to GP practices elsewhere in Merton.

NHS Dementia Prevalence Calculator indicates that the current detection rate of dementia in Merton is 47% (CQUIN data Q3 2013-14) which is better than many of our geographical and statistical neighbours but still means that there are estimated to be 1,057 undiagnosed dementia cases in Merton in 2014-15. There is an on-going refresh of the Merton dementia strategy to deal effectively with this.

5. **Primary Care management of the physical health of Merton residents with schizophrenia**

Findings suggest that more work is required to ensure the physical health of Merton residents with schizophrenia is better managed at primary care level. While emergency hospital admissions for schizophrenia in Merton are among the lowest in London and lower than all our SW London and statistical neighbours, the 2014 NEPHO SMI profile for Merton indicates that Merton has a significantly higher than average percentage of mental health service users who were inpatients in a psychiatric hospital and that Merton has a significantly higher than average (England) percentage of mental health service users who were inpatients in a psychiatric hospital. Local data indicates that admissions and referrals for schizophrenia are also increasing. This could be reflecting an increase in the prevalence of psychosis in Merton. HSCIC data indicates that in Merton the follow-up of non-attendance at annual review among patients with psychoses is among the lowest in SW London (especially considering that Kingston and Richmond PCTs achieved 100%), lower than Ealing and Harrow PCTs among statistical neighbours, and lower than England. For 2012-13 QOF indicators MH 16 (The percentage of patients aged from 25 to 64 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years) and MH19 (The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol: HDL ratio in the preceding 15 months) the GP practices in Merton do not perform very well and there is considerable variation between practices and by East-West Merton.

6. **Referrals to community mental health services**

In terms of referrals to community mental health services in Merton, 44% were from GPs & the next largest sources of referrals were internal (16%) and then Accident & Emergency services (12%). While it is encouraging that GP referrals were the highest, this could be improved further. Furthermore it appears that GPs in East Merton are making fewer referrals than West Merton GPs. There were fewer referrals from the Merton Local Authority (including Adult Social Care, Education & other departments) combined (2.6%) than Merton residents who self-referred (2.9%) . This perhaps indicates that more training and awareness raising is required for front-line staff (in all sectors including Metropolitan Police) on detecting the signs of mental ill health, local services and pathways, and how and where to refer someone to. The DH policy “No Health Without Mental Health” states

that frontline workers, across the full range of services, are to be trained to understand better about mental health, the principles of recovery and be able to tackle any stigma related to mental health[2].

7. **IAPT services**
   In terms of IAPT services, Merton has the lowest proportion of cases that moved to recovery in SW London and compared with the London average. From August 2012-August 2013, the recovery rate for Merton was 35.7% against a local target of 43% and a national target of 50%. This has been the case for some years as the NEPHO 2014 community MH profile indicates that in 2012/13 the IAPT recovery rate at 37.9% was significantly worse than England (45.9%). The percentage of referrals waiting less than 28 days for IAPT services are significantly lower than average but in contrast for waiting times greater than 90 days Merton has significantly higher than average percentages. This could mean that more referrals are waiting over 90 days than they are less than 28 days. Merton CCG is undertaking a specific project to look at the IAPT service and how it can be made more effective.

8. **Smoking and mental health**
   Smoking and mental health have very strong and significant links. SWLStG MH NHS Trust has had a CQUIN on smoking since 2010-11 and this ends in March 2014. Data provided by the Trust suggests that an effective smoking cessation service had been established although it was unclear from the data what the disaggregated figures for Merton were. This service is meant to be mainstreamed into SWLStG MHT but there is a risk to the service till it is assured that this has indeed happened.

9. **Gaps expressed by service users in consultations**
   Although the consultations in the qualitative study identified a variety of both positive and negative experiences of mental health services in Merton, the views expressed by service users and carers were for the most part critical. Service users' main concerns in this study were around continuing attitudes to mental illness, experience of care, and cuts in services. Their most prominently expressed issues with Merton's mental health provision were the loss of drop-in/day centres, perceived powerlessness in influencing their care and services that where dominated by a medical approach to treatment.

10. **Gaps expressed by carers in consultations**
    The most important issues for carers were their poor involvement in decisions about the care, properly informed sessions, providing support in the areas of training in managing specific situations. There is no up-to-date carer's strategy for Merton and this needs to be addressed. The triangle of care model must be sustained.

11. **Cultural competence of services**
    BME service users and carers reported particular challenges in different areas, exposing the importance of developing cultural competence within the mainstream services along with targeted provision specifically tailored to their unique needs. The data stated earlier,

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[2] Department of Health published a cross-government strategy on mental health "No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages" in 2011.

(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135457/dh_124058.pdf.pdf)

which shows that black ethnicities were over-represented and Asians significantly under-represented, back this expressed need. Furthermore this is specifically emphasized in the DH policy, "No Health without Mental Health"[3] and the implementation framework[4] which state that services should actively promote equality and must be accessible, acceptable, and culturally appropriate to all the communities. Public Bodies must meet their obligations under the Equality Act 2010.

Service providers offered insights into the main strategies they employed to deliver more user-responsive services. These were:

a. Adopting a more open and candid approach with users informed by the policy recommendations of the Francis report.
b. Established feedback and stepped complaints procedures
c. Developing different ways of working, and
d. Fostering partnership working.

Staff training and education underpinned all four approaches.

Health and social care recommendations

1. Promoting Mental Health and Wellbeing

1.1. **Promoting public mental health**

There is growing emphasis to promote mental wellbeing of the whole population, as well as an on-going commitment to reducing health inequalities in health (there are separate recommendations on health inequalities included in recommendation 4).

a. It is recommended that steps are taken to promote positive mental health and wellbeing and prevent mental ill-health, taking a life-course approach.

b. This encompasses taking a whole community approach to recovery, addressing factors that influence mental wellbeing for everyone, whether or not they have a diagnosis; and creating environments and cultures that support wellbeing from schools and colleges, to work places and on the streets.

1.2. **Smoking cessation and healthy lifestyles**

a. As of 31st March 2014, the CQUIN on smoking cessation services for SWLStG MHT will cease to exist. It must be ensured that the Trust embeds this service in line with NICE public health guidance PH48 and that an on-site stop smoking services continues to be provided.

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[3] Department of Health published a cross-government strategy on mental health "No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages" in 2011.

(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135457/dh_124058.pdf.pdf)

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156084/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf.pdf

b. Smoking cessation support to Merton residents with mental ill-health must also be provided by community-based and primary care service and mental health should be mainstreamed within general smoking prevention and cessation programmes in the borough.

c. It is recommended that all patients on GP Practice's SMI register who smoke should be routinely referred to LiveWell for smoking cessation advice.

d. It must be ensured that people with diagnosed mental illnesses, especially psychosis or schizophrenia and those taking antipsychotics are offered a combined healthy eating and physical activity programme by their mental healthcare provider[5].

e. The percentage of adults participating in recommended levels of physical activity is lower in Merton than the London and England averages and this percentage must be increased as the link between physical activity and mental health and wellbeing is well established.

1.3. **Promoting mental wellbeing early in life**

a. The most important opportunities for prevention of mental illness and promotion of mental health wellbeing lie in childhood, many of them in the context of the family. *The most important modifiable risk factor for mental health problems in childhood, and thus in adult life in general, is parenting*[6].

b. The key way to reduce risk in very early childhood is to promote healthy parenting focusing on the quality of parent-infant/child relationships, parenting styles including behaviour management, and infant and child nutrition (including breast-feeding and healthy eating). Parental mental illness and parental lifestyle behaviours such as smoking, and drug and alcohol misuse are important risk factors for childhood mental health problems[7].

c. Schools offer another important opportunity for promotion and prevention. School, school ethos, bullying and teacher wellbeing all have an influence on children's current and future mental health[8]. Mental health promotion programmes that can modify these factors, and also mitigate mental health problems initiated from within the family, must be provided in schools in Merton.

1.4. **Enabling more people with mental ill-health to remain in or move into work**

People with mental ill health frequently experience high levels of unemployment. Conversely people who are not in employment are more susceptible to mental ill health.

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[5] NICE Clinical Guideline CG 178: Psychosis and schizophrenia in adults: treatment and management, Feb 2014 http://www.nice.org.uk/nicemedia/live/14382/66534/66534.pdf

[6] http://www.fph.org.uk/parenting

[7] Göpfert M, Webster J, Seema MV, (eds). Parental psychiatric disorder: distressed parents and their families. Cambridge, CUP 2004

[8] Weare K. Promoting mental, emotional, and social health: a whole school approach. Psychology Press, 2000

For people with mental ill health who are unable to attend mainstream education, training or work, London Borough of Merton should ensure that commissioned services are effective in providing alternative educational or occupational activities according to their individual needs and capacity to engage with such activities, with an ultimate goal of returning to mainstream education, training or employment.

1.5. **Providing good quality housing**

a. There is an extensive body of academic, policy-related and community based literature that describes the powerful nature of housing as a social determinant of population health. The relationship that exists between poor housing (or a lack of housing) and poor mental and physical health is well-documented[9][10]. The spectrum of accommodation in Merton, from high to low dependency and independent accommodation for people with mental health need should be reviewed, in order to establish the current needs, to enable forward planning for the future provision of housing and support options for people with mental health needs.

b. LBM should consider how Merton can benefit from the Department of Health recently allocating up to £43 million from the Care and Support Specialised Housing (CASSH) Fund[11] to support the construction of a small number of housing projects for people with mental health problems or learning disabilities. These projects will be designed in close conjunction with mental health and learning disability policy experts and representatives of relevant charities. Their ambition is to receive bids from potential developers by 2015 and seeing some homes available by 2017.

1.6. **Workplace wellbeing**

a. All employers in Merton (including in LBM and MCCG) should be sensitive to the potential mental health issues underlying sickness absence. They should ensure adequate occupational health provision, and through employee assistance programmes, employees are supported to prevent the build-up of unmanageable stress, and healthy workplaces are actively promoted. Evidence states that workplace screening for depression and anxiety disorders is cost-effective, with the benefits gained through the reduction in levels of absenteeism, and improved productivity through reduction in presenteeism.

b. Public Health Merton is currently developing a Merton workforce strategy based on absence research that is looking at the reasons behind the sickness absence rates in the London Borough of Merton (Council). Work related stress comes up in the findings as an important reason. It is recommended that the findings of this report are taken into account while considering measures to create a healthy workplace.

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[9] Jacobs DE, Wilson J, Dixon SL, Smith J, Evens A. *The Relationship of Housing and Population Health: A 30-Year Retrospective Analysis Environmental Health Perspectives*. 2009;117(4):597–604

[10] Canadian Institute for Health Information. *Improving the Health of Canadians: Mental Health and Homelessness*. Ottawa: Canadian Institute for Health Information; 2007.

[11] Closing the gap: priorities for essential change in mental health, February 2014; Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

2. Parental and child mental health

The following generic recommendations are sourced from national policy documents[12] [13] and it is suggested that the Merton Local Safeguarding Children's Board (LSCB) partners should assure themselves and the LSCB that these are embedded in local practice.

2.1 **The Local Safeguarding Children's Board (LSCB) should assure that**:
Structures are in place for joint training and joint supervision to ensure that all children's and adult services practitioners working with families affected by mental health difficulties and/or drug and alcohol problems have a thorough understanding of the impact of these difficulties on children and the opportunity to reflect together on their joint responsibilities in tackling concerns.

2.2 **Adult mental health services should:**

a. increase awareness of the role of adult mental health professionals in safeguarding the children of adult service users.

b. orient early identification and assessment to ensure children and young people living with parental mental illness, learning disability, substance misuse and domestic violence, are not left in dangerous and abusive situations. Early identification depends on ensuring children and young people have opportunities to discuss their experiences with a trusted adult

c. review recording systems to ensure that information about children is set out clearly and in sufficient detail to establish children's needs and risks, to identify young carers and to assess whether there is a need for early support

d. collate data and report to the LSCB on the numbers of children affected by adult mental health difficulties

e. ensure that managers are aware of all cases in which adults with mental health difficulties have children, or where there are children in the household, and that all these cases have appropriate and recorded oversight.

2.3 **Commissioners of adult mental health services should:**

a. ensure that the role of adult mental health services in safeguarding and protecting children is set out comprehensively and explicitly in all relevant tender documents and in contracts

b. have systems in place to monitor the extent to which adult mental health services meet their responsibilities to safeguard and protect children

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[12] What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems; Ofsted March 2013, Ref no. 130066.

[13] Cleaver H, Unell I and Aldgate J; Children's Needs- Parenting Capacity, Child Abuse: Parental mental illness, learning disability, substance misuse, and domestic violence; 2nd Edition, TSO (The Stationery Office); Norwich, 2011.

c. Ensure stable funding for voluntary and community based programmes is required to provide the necessary long-term support to ensure children living with families with complex needs are safe

2.4 **Adult mental health services and drug and alcohol services should**:

a. ensure that practitioners consistently challenge decisions by children's social care to take no further action if in their judgement action is warranted, using escalation processes where necessary

b. review recording systems to ensure that children and young people who are undertaking inappropriate caring responsibilities for parents or siblings are identified, and that their needs are explicitly considered and referred for support when necessary

c. ensure that adult assessments consider the need for early support for parents, carers and children and that action is taken to put this in place.

2.5 **Local authorities (Adult and Child Social Services), mental health services and drug and alcohol services should:**

Ensure that staff liaise with each other and agree a joint plan of action when parents or carers do not attend appointments with adult services.

2.6 **Local authorities (Adult and Child Social Services) and mental health services should**:

a. improve the quality of assessments of the impact of mental health difficulties on children, ensuring that children's social workers and adult mental health practitioners work together to assess and agree effective action plans

b. review arrangements for discharging patients from hospitals to ensure that discharge meetings involve children's social workers where appropriate; that the needs of the children are considered and that discharge plans set out clearly when/if parents or carers will be ready to resume the care of their children.

3. Tackling Dementia in Merton

3.1. **Supporting the Dementia Hub**

With the launch of the Dementia Hub in Merton[14] it must be ensured that relevant services are aware of this centre and how patients with dementia can be referred to it. This is particularly applicable to GP practices as GPs have a pivotal role to play in the early detection and referral of residents of Merton with dementia.

3.2. **Dementia awareness and training**

Dementia awareness and training sessions with relevant services, especially in primary care must be organised in a rolling programme that is repeated at regular intervals.

3.3. **Dementia strategy refresh**

[14] http://www.alzheimers.org.uk/site/custom_scripts/branch.php?branch=true&branchCode=13596&areaBC=EALO

The current five year dementia strategy (for Sutton and Merton) which is due to end in 2015, must be refreshed to reflect the current organisational changes in health and social care, and the dementia strategy implementation plan must be updated.

3.4. **Preventing dementia**

Awareness must be raised of evidence-based measures to prevent dementia (the six pillars of a brain-healthy lifestyle: regular exercise, healthy diet, mental stimulation, quality sleep, stress management and an active social life[15]) to relevant services, professionals and lay public in Merton. Community-based projects or pilots to prevent dementia and promote dementia awareness should be considered.

4. Improving services for people with a dual diagnosis of substance misuse and mental ill-health

4.1. **Early identification of dual diagnosis and prevention work**

Developing &/or strengthening services should be considered, to ensure that dual diagnosis of substance misuse and mental ill health is identified early and that there are clear eligibility criteria, referral and care pathways, and robust outcome measures for dual diagnosis

4.2. **Joint service provision and pathways for dual diagnosis**

a. Joint commissioning of mental health and drug or alcohol services needs to become the norm in the areas of general health, mental health, substance misuse (including alcohol), social care, education, community safety, crime (including domestic violence) and safeguarding in both children and adults, linking promotion and prevention much more closely with treatment and care for substance use and mental health.

b. To ensure 4.2a above, all contracts with providers need to stipulate effective joint working and clear pathways, to meet the needs of people with co-existing mental health needs and substance misuse problems.

4.3. **"Hidden harms" of substance misuse**

LBM is planning a needs assessment on Hidden Harm in Merton. It is recommended that appropriate services are jointly developed; to tackle hidden harm and support this needs assessment, considering its recommendations in the development of this work. A dual diagnosis in one or both parents or caregivers has significant impacts on children living with them. The hidden harms aspect is not just about dual diagnosis but extends to parents with mental illnesses (and not substance misuse) as well.

4.4. **Personality disorders (PD)- with and without dual diagnosis**

Around 8-9% of all in-patient cases and patients in CMHS are seen because of personality disorders. Anecdotal evidence suggests that there are significant numbers of undiagnosed cases of PD in the community, and there needs to be more and better access to psychological treatment (DBT/MBT) for cases of PD and dual diagnosis with PD. Considerable preparatory work is required to get PD cases ready for such therapies.

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[15] http://www.helpguide.org/elder/alzheimers_prevention_slowing_down_treatment.htm

5. Addressing Health inequalities and inequity

5.1. **Black and Minority Ethnic groups**

The findings from this report indicate that black communities are over-represented in in-patient services (but not in CMHS) and Asians are significantly under-represented in both in-patient and community mental health services. A range of early intervention and support services should be considered that are culturally sensitive to Merton's BME groups that promote mental health wellbeing and reduce stigma. The services should be targeted and outcome specific.

5.2. **Local care pathways**

It should be ensured that local care pathways promote access to the services by wider communities including socially excluded groups such as black and minority ethnic groups, older people, those in prison or in contact with the criminal justice system and ex-service personnel.

5.3. **Services for older people**

a. It has been estimated that at any given time in a typical 500-bed district general hospital, 220 beds are occupied by older people with mental health problems: 102 with dementia and 96 with depression[16]. Services and pathways should be developed to address the specific needs of older adults in Merton and these services should be appropriate for this age group, helping to reduce the demand on acute beds by increasing care for the frail and elderly in community settings, providing a holistic assessment in the community, and ensuring that both mental and physical health are addressed..

b. Rather than the current generic system in Merton, a specialist liaison psychiatry service for older people based in acute hospitals could be developed. Mental health liaison services can help increase productivity in acute hospitals by improving older people's clinical outcomes while reducing length of stay and re-admission rates[17].

c. Development in this area should be linked with the on-going integration work in Merton under the Better Care Fund.

6. Improving engagement with and support for service users and carers

6.1. **Education and Training of front-line staff**

It must be ensured that frontline workers, across the full range of services, are trained to understand better about mental health, the principles of recovery and are able to tackle any stigma related to mental health. Furthermore training must be provided on the

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[16] Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H, Seymour J (2009). The Need to Tackle Age Discrimination in Mental Health: A compendium of evidence. London: Faculty of Old Age Psychiatry, Royal College of Psychiatrists. Available at: www.rcpsych.ac.uk/pdf/Royal%20College%20of%20Psychiatrists%20%20The%20Need%20to%20Tackle%20Age%20Discrimination%20in%20Mental%20Health%20Services%20-%20Oct09.pdf

[17] Naylor C, Bell A (2010); Mental Health And The Productivity Challenge, Improving quality and value for money; The King's Fund and Centre for Mental Health.

services that exist in Merton, the care pathways and how to refer a person to the appropriate mental health services.

6.2. **Education and Training of healthcare professionals in primary care**
Healthcare professionals in primary care including GPs need training and education in order to better recognise mental ill health, engage and support patients on this, and accord parity of esteem to mental ill health. Consultations with service users revealed that primary care professionals were perceived by some to have an inadequate understanding of mental illness, and service users reporting a negative experience on the whole.

6.3. **Carer needs**
Consultations with carers revealed that pro-active information-sharing and guidance, their involvement in decisions about the care provided, properly informed sessions and providing support/training in managing specific conditions were the most important issues for them. Feedback from the carers indicated that these arrangements and provisions were not as good as they needed to be. It needs to be ensured that these provisions are improved for carers. There is no up-to-date carer's strategy for Merton and this needs to be addressed. The triangle of care model must be sustained.

6.4. **Enabling access to services for Merton residents with mental health conditions**
Service users and carers in our consultations felt that not having the Freedom Pass severely limited their ability to get around and could contribute to a worsening of their problems. Many mental health service users are not in employment or on low incomes and they struggle with the cost of transport. It is recommended that the London Borough of Merton takes steps to enable Merton residents with mental ill-health to access services that are so vital for their wellbeing, bearing in mind that the Freedom Pass is no longer available.

7. Primary care and IAPT services

7.1. **Variation in quality and under-diagnosis in Primary Care**
Variations in quality and under-diagnosis need to be understood in greater depth (i.e. how much is due to differences in coding and how much is actual) and minimised in primary care, particularly in GP practices in East Merton. In the consultations in this needs assessment both service users and carers expressed the view that health services continue to give less attention to mental illnesses than to physical illnesses and primary care professionals had an inadequate understanding of mental illness. Health professionals in primary care (including GPs) need training and education in order to better recognise mental ill health, engage and support patients on this, and accord parity of esteem to mental ill health.

7.2. **Physical health of Merton residents with mental ill-health**
The physical health of Merton residents with mental health conditions needs to be monitored regularly. NICE guidance CG 178 recommends that GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and

then at least annually. The physical health of patients with schizophrenia in particular needs to be better managed in Primary Care.

7.3. **Transfer of care from secondary to primary care**
The transition between secondary care and primary care in relation to all mental illnesses but specially schizophrenia must be well managed.

7.4. **Primary Care integration**
There must be more integration of mental health related services in primary care between health, social care, housing, employment, legal services and community services. This includes greater integration between physical and mental health, and the early identification of illness and comorbidity, reduced stigma, and social inclusion.

7.5. **Psychological therapies**
There are a number of issues around the current IAPT service that are being addressed by the Merton CCG. These include consistently low recovery rates against local and national targets, and the profile of cases being seen tending to belong to the more severe spectrum of mental disorders. Merton CCG is undertaking a specific programme of work that is reviewing the IAPT service and considering how to make it more effective.

8. Improving rehabilitation and stepped down provision

8.1. There is a need to undertake a more detailed piece of work to understand the current step-down provision from acute services when patients are well enough to be discharged from an acute bed but not well enough to live independently at home. This work will help to consider alternative options and to design a provision that is fit for purpose, mindful of the principle of “Right Care at the Right Place” and commissioning services closer to home and in the least restrictive environment.

8.2. Co-ordinated working with LB Merton will be required to understand the demand and capacity for step-down placements for social care needs, including housing.

9. Areas where more research required

While this report covers a wide expanse of issues pertinent to adult mental health in Merton, there are some areas that are not covered and need more work. These areas are learning disabilities, the interface between children and adult mental health services (especially the transition) and in general there is need for a CAMHS health needs assessment.

Beyond the MMHNA: Next steps

The MMHNA will be reported to the MHWBB in September 2014, and form part of the evidence base for commissioning future mental health services for Merton residents.

A workshop was held with service users, carers, voluntary sector and community organisations, and statutory organisations including key providers, commissioners and mental health professionals in Merton. Hosted by the LBM and MCCG and facilitated by Merton Healthwatch, this workshop obtained views and facilitated discussion about the MMHNA findings. Feedback from participants (see supplementary report) will also support the future commissioning of mental health services in the Borough.

It is planned to have regular workshops with users and carers regarding mental health services to ensure commissioners hear live messages, and progress on commissioning and service delivery is shared.