CHAPTER 1: INTRODUCTION

Private: Information that contains a small amount of sensitive data which is essential to communicate with an individual but doesn't require to be sent via secure methods.

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1 INTRODUCTION

1.1 The burden of mental health problems

1.1.1 Prevalence

Mental health problems start early in life. Half of all mental health problems would have been established by the age of 14, rising to 75% by age 24 (NHS Digital, 2016). Together with substance misuse, mental illness accounts for 21.3% of the total burden of disease in England (Office for Health Improvement and Disparities, 2022).

Mental health problems are common, with 1 in 6 adults reporting a common mental health disorder, such as anxiety, and there are close to 551,000 people in England with more severe mental illness (SMI) such as schizophrenia or bipolar disorder (Office for Health Improvement and Disparities, 2022).

Mental ill health is the single largest cause of disability in the UK, contributing up to 22.8% of the total burden, compared to 15.9% for cancer and 16.2% for cardiovascular disease (Office for Health Improvement and Disparities, 2022). The Mental Health Foundation found that across the UK there were 10.3 million recorded instances of mental ill health over a one-year period, and the third most common cause of disability was depression (McDaid, et al., 2022).

The following are some the facts relating to mental health in England (Department of Health, 2011):

- At least one in four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time.
- One in ten children aged between 5 and 16 years has a mental health problem, and many continue to have mental health problems into adulthood.
- Half of those with lifetime mental health problems first experience symptoms by the age of 14, and three-quarters before their mid-20s.
- Self-harming in young people is not uncommon (10–13% of 15–16-year-olds have self-harmed).
- Almost half of all adults will experience at least one episode of depression during their lifetime.
- One in ten new mothers experiences postnatal depression.
- About one in 100 people has a severe mental health problem.
- Some 60% of adults living in hostels have a personality disorder.
- Some 90% of all prisoners are estimated to have a diagnosable mental health problem (including personality disorder) and/or a substance misuse problem.

Mental health disorders are the fourth contributor of DALYS in Wokingham, which is approximately 8% of the total. Alzheimer's disease and other dementia contributes a further 3%. When focussing on YLD, mental health disorders are second, just below musculoskeletal disorders in terms of their contribution to total YLD, with 15% of YLD attributable to mental disorders. Alzheimer's disease and other dementia contributes a further 1.5% (Global Burden of Disease Collaborative Network, 2021).

1.1.2 Economic cost

Mental health problems cost the UK economy at least £117.9 billion annually and is equivalent to around 5% of the UK's GDP. Almost three quarters of the cost (72%) is due to the lost productivity of people living with mental health conditions and costs incurred by unpaid informal carers who take on a great deal of responsibility in providing mental health support in our communities (McDaid, et al., 2022). In England, poor mental health is estimated to carry an economic and social cost of £105 billion a year (Office for Health Improvement and Disparities, 2022)

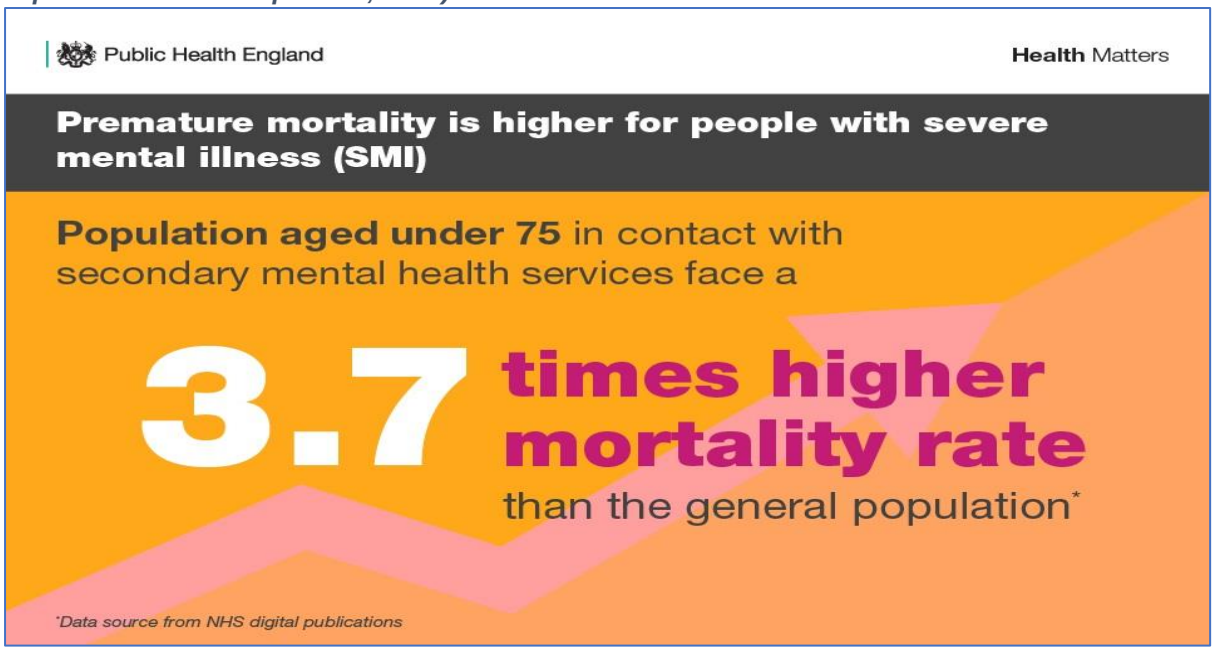
1.1.3 Outcomes for people with mental health problems

Mental health problems are often hidden, stigma is still widespread, and many people are not receiving support to access services (Office for Health Improvement and Disparities, 2022).

An adult (aged 15 to 74) with a serious mental illness is 1.8 times more likely to have 3 or more physical health conditions when compared to the general population, and a young adult (aged 15 to 34) with SMI is 5.1 times more likely to have 3 or more physical health conditions than the general population (Office for Health Improvement and Disparities, 2022)

People with severe mental illness (SMI) such as bipolar disorder or schizophrenia have a life expectancy up to 20 years less than the general population, and the gap is widening. This is mostly from preventable physical health problems, such as cardiovascular disease. It is estimated that for people with SMI, 2 in 3 deaths are due to physical illnesses and can be prevented with those in contact with secondary mental health services aged under 75 years experiencing 3.7 time higher mortality rate compared with the general population (Figure 1.1) (Office for Health Improvement and Disparities, 2022).

Figure 1.1: Severe mental health illness and premature mortality ((Office for Health Improvement and Disparities, 2022)



1.2 The scope of the needs assessment

The needs assessment focuses on mental health needs in adults aged 18 years or older but some of the data presented covers those in the younger age group as we do not have all data separately reported for those aged 18 years or older.

1.3 Methods

The methods used for the needs assessment are outlined below:

- A review available evidence base on mental health problems prevalence and outcomes was done to set the context regarding the importance of mental health disorders, their impact on the affected population and relevant outcomes.
- Relevant national and local policies were reviewed and cited where relevant and appropriate to explain any observed patterns in the data at both local and national levels.
- Analyses of local data were done to describe mental health disorder prevalence, service use and related outcomes if they were available
- Where local data were not available, modelling of local prevalence based on national prevalence figures was done if appropriate.

Data sources include:

- Fingertips: Mental Health, Dementia and Neurology - this was the main data source for most of the chapters.
- Office for National Statistics (ONS) 2011 Census and 2020 Mid-year population estimates. This was used in modelling prevalence figures
- QOF data of relevant mental health conditions – this supplemented data obtained from fingertips
- Access to Psychological Therapies (IAPT) data – was used to describe treatment outcomes for common mental health disorders (CMD)
- Local data obtained from Connected Care portal provided by Frimley ICS System Insights – this was used to describe prevalence by gender, deprivation level and ethnicity where available.

Potential limitations associated with the approach used include:

- Data reported may not reflect the current situation e.g., some of the information reported were based on 2011 census data
- Limited local service data made it difficult to assess service gaps
- Lack person-level data hindered detailed analysis to identify factors that may be associated with local mental health problem prevalence and outcomes
- Crude rates were reported for many of the indicators and be confounded by other factors such as age, sex and socio-economic factors
- There was limited information at both national and local levels on mental health experiences among marginalised and deprived communities. Overall summary mental health indicators may still obscure local inequalities.

- There may be inconsistencies in figures shown in the various chapters. This is most likely due to different sources from which these were derived and different time periods.

In spite of these potential limitations, the needs assessment provides a robust summary of the mental health experiences of the local population which can inform strategies and policies to improve mental health of the population.

1.4 Chapters included in the needs assessment

The following are the chapters included in the needs assessment:

- Chapter 1: Introduction (the current document).
- Chapter 2: Common Mental Health Disorders (CMD)
- Chapter 3: Severe and Enduring Mental Health Illness (SMI)
- Chapter 4: Suicide and Self-Harm
- Chapter 5: Substance Use and Addiction
- Chapter 6: Living with Dementia
- Chapter 7: Mental Health needs in the Vulnerable Groups and Inequalities
- Chapter 8: Covid-19 and Mental Health

There are crossovers in the various chapters. If required, the reader is recommended to refer to the relevant chapter(s) for further details on specific issues.

1.5 Cost-effective interventions to prevent mental health problems across the life course

Though this needs assessment is on adults aged 18 years of older, early intervention during childhood and perinatal period can have a significant impact on mental health in adulthood, and as result a life-course approach is recommended.

The summary below has been adapted from a 2022 Mental Health Foundation (McDaid, et al., 2022). Where appropriate original reference sources used in the report are also cited.

1.5.1 Perinatal and maternal mental health

1.5.1.1 Mental Health Training for Health Visitors

Between 10% and 20% of women experience perinatal depressive symptoms. The lifetime costs from a societal perspective of perinatal depression and perinatal anxiety alone, to both mother and child, have been estimated to be £75,728 and £34,811 respectively.

Several economic evaluations have indicated that measures to prevent and/or intervene early in perinatal depression are cost-effective and can reduce the number of women who experience this. These include health visitor-provided counselling and/or psychological therapies, primary care screening and treatment for depression and telephone peer support

1.5.2 Children and young people

1.5.2.1 Parenting programmes

'Parenting programmes' is a term used to describe a range of interventions for parents, which are often delivered to a group. They aim to support parents to

strengthen their relationships with their children and foster their child's emotional and social skills development.

There is good evidence parenting programmes can help promote positive mental health and reduce the risk of poor emotional development for children. Universal programmes for all the relevant population, as well as targeted programmes for parents and their children at risk of mental health problems have been shown to be effective.

There is a growing number of studies that show parenting programmes are cost-effective, reporting up to £15.80 can be saved on spending in the long-term for every £1 spent on delivering the programme. A large study showed that the "Incredible Years" parenting programme could save £4.57 for every £1 spent among children who benefitted from the programme over a 30-year follow up period (Gardner, et al., 2017).

1.5.2.2 Anti-bullying programmes

Persistent bullying can adversely affect mental health at all ages; but most initiatives that have looked at ways to counter this issue have focused on impacts on young people. Young people who are frequently bullied are more than 2.5 times more likely than other young people to use mental health services, both in childhood and adolescence. Even in midlife, up to age 50, people who have been bullied have a 30% higher likelihood of using services compared to their non-bullied peers.

There is strong evidence that measures targeted at all pupils within a school can reduce bullying and have positive benefits for mental health. It has been found that if the impact of anti-bullying programme known as KiVa were applied to UK children aged between the ages of 7 and 11, an additional four in every 100 children could avoid sustained bullying, saving £1.58 for every £1 spent over those four years. When the costs associated with bullying up to the age of 50 were considered, long-term saving increases to £7.52 per £1 spent.

1.5.2.3 Exercise

Though research on their cost-effectiveness is limited, exercise interventions can also be protective of mental health. For example, a Swedish study which delivered twice weekly dance classes to teenage girls with high levels of stress was found to be cost-effective through reducing their use of school health services.

1.5.3 Working-Age Adults

1.5.3.1 Brief psychological interventions

There is evidence that different types of psychological support can help prevent episodes of depression among adults. For example:

- A Dutch study found that self-help manuals on mood management, supplemented by six telephone consultations with a 'prevention worker', were associated with a reduced risk of depression and reduced costs associated with depression for society.
- A German study found that a mindfulness based mental health promotion programme had a 95% chance of being cost effective.

- There is some evidence that brief psychological interventions are effective in preventing other forms of mental health difficulty, such as anxiety. However, more research on their cost-effectiveness for preventing other mental health conditions is required.

1.5.3.2 Workplace interventions

There is a strong case for investing in mental health prevention in the workplace. Poor mental health contributes to reduced productivity at work, greater likelihood of sickness absence, and a higher probability of being unemployed

A review found that, on average, for every £1 invested in mental health interventions in the workplace, £5 is saved. Other reviews have also highlighted the potential benefits of interventions targeted at stress and the symptoms of conditions such as depression and anxiety. The greatest savings were seen in programmes that improved the knowledge of line managers and workers of risks for mental health, as well as the provision of personalised exercise programmes.

1.5.3.3 People living with long term physical health conditions

People living with long term physical health conditions are at an increased risk of experiencing mental health difficulties. There is evidence that psychological interventions can reduce their risk of experiencing these and are also cost-effective.

For example, studies have found that brief psychological support, in the form of CBT or mindfulness-based therapy, either delivered online or face-to-face can prevent depression and/or anxiety among people with cancer and are cost-effective. However, not all studies have found such positive results. For example, the use of stepped care, including a guided self-help course and problem-solving therapy, was not found to be cost-effective in preventing depression in adults with diabetes and/or coronary heart disease (Pols, et al., 2017) (van Dijk, et al., 2021) and more research is therefore required.

1.5.3.4 Older Adults

At least 12% of older people in high-income countries are affected by clinically significant levels of depression at any one time and in the UK, around a third of those aged over 50 years report feeling lonely. There is growing evidence to suggest that interventions which tackle loneliness and isolation in older people can be protective of both their physical and mental health. For example, group-based social participation interventions are recommended by the National Institute of Health and Care Excellence guidance on promoting the mental wellbeing and independence of older people. This guidance is supported by a review which includes several interventions that have been delivered in a UK context. One of these studies found that a 14-week professionally led community choir group for women aged over 60 years was associated with a significant improvement in quality of life after six months among those who had attended the group, compared with those who had not. Depression and anxiety were also significantly lower among this group after three months, and remained lower at six months, although this difference was no longer statistically significant. The intervention was found to have a 60% probability of being cost-effective. However, it must be noted that many of the studies exploring interventions to reduce loneliness in older adults are small in size and scope, and

more empirical studies are needed to determine their cost-effectiveness in different settings.

1.5.3.5 Suicide and self-harm prevention

The human and economic costs associated with suicide and self-harm, much of which is linked to poor mental health, are vast. The most effective suicide prevention measure remains restricting access to lethal means of harm, for example reducing easy access to excessive amounts of paracetamol, safety measures on bridges, and the introduction of enhanced injury prevention measures in vehicles. While there are few economic evaluations of these measures, there is evidence that they are cost-effective. There is also evidence that other suicide-prevention strategies, which include public mental health campaigns, training for primary care and other service gatekeepers, and appropriate support to deal with depression, are highly likely to be cost-effective.

Studies in England have indicated that better use of psychosocial assessment when people present to hospital following self-harm is likely to be cost-effective in the prevention of subsequent self-harm and suicide. This is in part because of reduced costs to health services, the police and local government services. However, these analyses are conservative, as they did not include the substantial long-term consequences and costs of self-harm to individuals and their families.

1.6 Acronyms used in the various chapters of the needs assessment

- AMHP: Approved Mental health Practitioner
- APMS: Adult Psychiatric Morbidity Survey
- ASMR: Age-standardised mortality rate
- BDD: Body Dysmorphic Disorder
- BHFT: Berkshire Healthcare NHS Foundation Trust
- CBT: Cognitive Behavioural Therapy
- CCG: Clinical Commissioning Group
- CI: Confidence interval
- CMD: Common Mental Health Disorder
- CMHT: Adult Community Mental Health Team
- CPE: Common Point of Entry
- CQC: Care Quality Commission
- FGM: Female genital mutilation
- GAD: Generalised anxiety disorder
- IAPT: Access to Psychological Therapies
- ICS: Integrated Care System
- ICU: Intensive Care Unit
- JCPMH: Joint Commissioning Panel for Mental Health
- LGBT: Lesbian, Gay, Bisexual, Trans
- LGBTIQ+: Lesbian, Gay, Bisexual, Trans, Intersex, Queer or Questioning
- MCST: Maintenance Cognitive Stimulation Therapy
- NDTMS: National Drug Treatment Monitoring System
- NEET: Not in employment, education, or training
- NHS: National Health Service

- NICE: National Institute for Health and Care Excellence
- OCD: Obsessive-compulsive disorder
- OCU: Opiate and/or crack user
- OHID: Office for Health Improvement and Disparities
- ONS: Office for National Statistics
- OSFED: Other specified feeding or eating disorder
- PCN: Primary Care Network
- PHE: Public Health England
- PLWD: People Living with Dementia
- PND: Postnatal depression
- PTSD: Post-traumatic stress disorder
- QOF: Quality and Outcomes Framework
- SAD: Seasonal affective disorder
- SMI: Severe Mental Health Illness
- UKHSA: UK Health Security Agency
- VCS: Voluntary and Community Sector
- WBC: Wokingham Borough Council
- WHO: World Health Organisation
- WRC: The Wokingham Recovery College
- YPWD: Younger people living with Dementia Berkshire

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