Report to the Middlesbrough Health Scrutiny Committee on Mental Health and Wellbeing

1. Introduction

1.1. The purpose of this briefing is to highlight key issues in relation to mental health and wellbeing that the Health Scrutiny Committee may wish to consider during its review.

1.2. Historically, the mental health agenda has tended to focus on the problems associated with mental health diseases and conditions. As such, *good* mental health was often defined as the absence of a mental health condition. However, the World Health Organisation (WHO) defines mental health as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. In other words, it is a positive state of being and fundamental to overall health.

1.3. The WHO European Declaration on Mental Health (2005) states “There is no health without mental health. Mental health is central to the human, social and economic capital of nations and should therefore be considered as an integral and essential part of other public policy areas such as human rights, social care, education and employment. Mental health and mental well being are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens.”

1.4. A key national policy document was the National Service Framework for Mental Health, published in 1999. The NSF addressed the mental health needs of working age adults up to 65 and set out national standards; national service models; local action and national underpinning programmes for implementation; as well as a series of national milestones to assure progress. Local Implementation Teams (LITs) were established to coordinate and lead on the work required to deliver the mental health NSF. More recently, improving mental health was identified as a national priority and one of the six priorities for action in the White Paper *Choosing Health* (2006).

1.5. One of the broad aims of the Middlesbrough Community Strategy (currently being re-written) is to improve the lives of people living in Middlesbrough. The health, happiness and well-being of the people in Middlesbrough are critical to achieving this vision.

2. Mental health disorders

2.1. There are, however, significant challenges to improving the mental health and well-being of the Middlesbrough population since mental problems are very common. Estimating the prevalence of common mental health conditions is not straightforward and relies upon estimates and modelling from national surveys such as the National Psychiatric Morbidity Survey.

2.2. It is estimated that at any one time, 16% of adults aged 16 to 74 have a neurotic disorder such as depression, anxiety, panic attacks, phobias, obsessive compulsive disorders or a combination of two or more - in other words, one in six of the population. More serious psychotic disorders are much less common, affecting approximately 4 per 1000 adults aged 16-64.

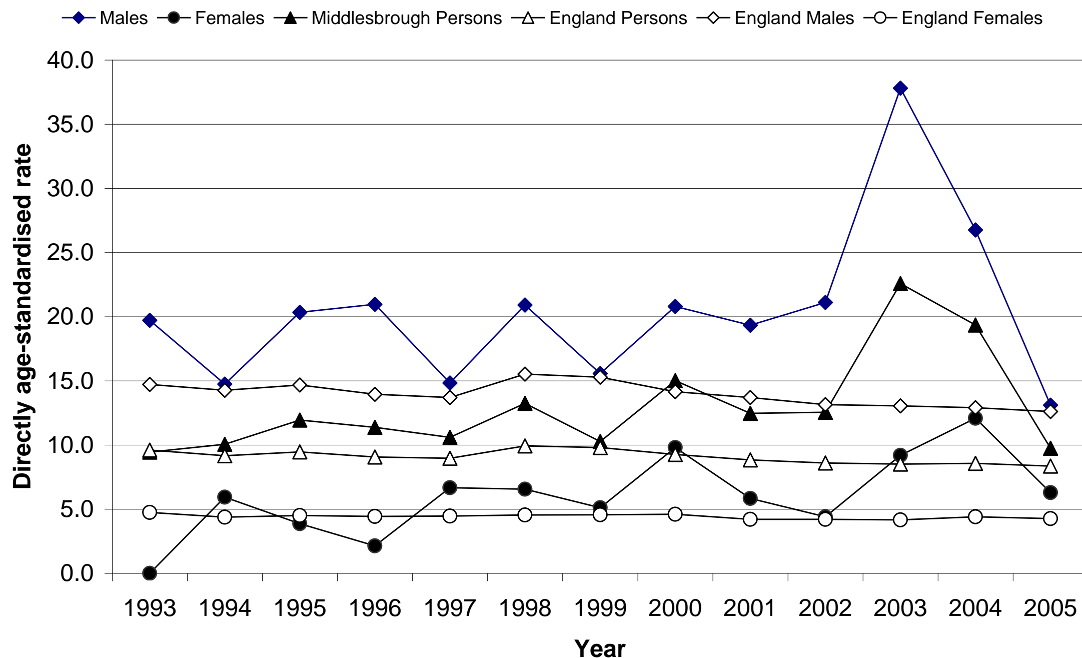
2.3. Mental health problems in older people (over 65s) are also very common. It is estimated that up to 40% of GP attendees, 50% of general hospital patients, and 60% of care home residents suffer from a common mental health problem. The trend in the death rate from suicide and undetermined injury is often used as a proxy indicator for population mental health. Suicide rates are highest among 20-24 year olds and ranks consistently as one of the leading causes of death for adolescents between 15 and 19 years of age. In young people aged 15-24 years, suicide accounts for approximately 30% of all deaths.

2.4. Deaths in young people are also strongly patterned by socio-economic status and account for almost quarter of the gap in life expectancy between those living in the most disadvantaged areas and those living in the most affluent areas.

2.5. Suicides rates are also patterned according to socioeconomic status. The suicide rate among men aged 20- 24 in social class V is four times as high as that in men in social class I. The relationship between socio-economic status and suicide is likely to be mediated through a number of different factors such as poor housing, unemployment, social fragmentation and living alone. Nationally, suicide rates have been declining in all age groups. Between 1994 and 2004, across Middlesbrough, there has been a steady rise in the number of suicides in men. However, within the last 2 years the number of suicides has fallen. Whilst this may be too early to indicate a long term trend, the early data is promising.

2.6. The following table describes the trends over time for suicides and undetermined injury (i.e. open verdict).

Figure 1: Suicides and undetermined deaths for Middlesbrough and England, males and female, 1994-2006



2.7. The following table provides *estimates* of the number of people with common mental health conditions in Middlesbrough.

Condition	Estimated Number	Middlesbrough rate per 100,000
Any neurotic disorder	19,883	198.1
All phobias	2,367	23.6
Depressive episode	3,669	36.6
Generalised anxiety disorder	5,641	56.2
Mixed anxiety depression	10,158	101.2
Obsessive compulsive disorder	1,176	11.7
Panic disorder	1,097	10.9

Source: Mental Public Health Observatory, 2006

3. Mental Health and Wider Determinants

3.1. More recently, the North East Public Health Observatory (NEPHO) has published a comprehensive assessment of mental need in the northern region.[1] The report should be commended to the Health Scrutiny Committee for further consideration and presents a wide range of data on the factors which can give rise to poor mental health, the mental health status of populations, provision of

[1] http://www.nepho.org.uk/mho/publications/indications

interventions of care for mental illness, service user experience and traditional outcomes such as suicide.

3.2. In summary, mental health conditions are strongly associated with socio-economic deprivation and the association between rates of mental illness and other factors such as poverty, unemployment and social isolation is well established. The following table summarises the evidence and rationale presented in the NEPHO document on the risks, protective factors and wider determinants of mental health and wellbeing.

Risks, Protective Factors and Wider Determinants of Mental Health *Summarised from Indications of Public Health in the English Regions: Mental Health*	
Deprivation	People with a neurotic disorder are more likely to belong to socioeconomic class V and least likely to belong to socioeconomic class I. Higher prevalence of mental health disorders among children of families from lower socioeconomic groups.
Employment	Unemployment is associated with social exclusion, which has a number of adverse effects, including reduced psychological wellbeing, and a greater incidence of self harm, depression and anxiety. Two-thirds of men under 35 who commit suicide are unemployed. There is considerable evidence to support the beneficial effects of employment on an individual's mental health. Employment can protect a person's mental health by boosting confidence and self-esteem; unemployment can be both a consequence and cause of mental health problems.
Incapacity benefit	The North East has the highest rate of adults aged 16 to 59 years claiming incapacity benefit or severe disablement allowance with a diagnosis in the mental and behavioural disorders.
Limiting Long Term Illness	The North East has the highest proportion of adults with limiting long term illness. Poor quality of life through physical illness is known to be closely related to mental health problems. People with mental health problems are up to twice as likely to report experiencing a long-term illness or disability; over two-thirds of people with a persistent mental health problem also have a long term physical complaint. Limiting long term illnesses impact upon an individual's ability to work and be economically active, which increases the risk to one's mental health.
Alcohol	Evidence suggests an association between increased alcohol consumption and mental ill health. Alcohol consumption can be a cause of mental ill health, or a resulting factor. Middlesbrough has the third highest rate for alcohol related hospital admission in the country.
Drugs	Addiction is seen as a mental health problem in its own right. Drug misuse is linked to mental health through a number of different mechanisms.
Physical Activity	There is strong evidence for the impact of physical activity on mental health: as a treatment or therapy for existing mental health problems; to improve the quality of life of people with mental health problems; to prevent the onset of mental health problems; and to improve the mental wellbeing of the general population.
Healthy Eating	There is reasonable evidence to suggest that nutrition may have an important role in maintaining good mental health.
Participation in Society	Participation and involvement in the community appears to have an important effect on mental health and acts as a buffer against conditions such as depression.
Religion	There is some evidence which suggests that involvement in religion or spirituality may be an important factor for mental wellbeing. For example, religious involvement has been shown to be associated with positive mental health outcomes such as a lower incidence and prevalence of depression.

Social Support	There is a clear relationship between social support and risk of morbidity and mortality. A lack of social support has been shown to be associated with depression and other mental health problems.
Social Networks	There is a well described relationship between social networks and mental health. Those with few social contacts are known to be at a greater risk from mental health problems. Social networks can also protect against stress and also an important factor in the recovery from depression in women.
Neighbourliness	Neighbourliness is seen as an important component of social capital and understood as people's willingness to 'co-operate for mutual benefit'.
Education	Education has significant bearing upon employment and social inclusion, both of which impact upon mental health. Certain groups of people are at higher risk of common mental health problems; these groups include those with no, or low level, qualifications and the unemployed. Psychiatric disorders and suicidal attempts are most likely to occur in people facing socioeconomic disadvantage, such as those in unskilled occupations or unemployed, and who lack formal qualifications. Individuals with a psychotic disorder are most likely to have left school before reaching sixteen years of age, and hold no qualifications.
Learning and Development	People who flourish at school enjoy better health and wellbeing than those who do not, though the effect may not be causal. Adults who participate in adult education in their 30s tend to enjoy positive transformations in their health and wellbeing more than their peers who do not. Adult learning is also associated with positive outcomes in health and wellbeing of adults who did not flourish at school.
Violence and Safety	Crime, particularly violent crime, is linked to mental health in a number of ways. Firstly, it may have similar determinants such as drugs, alcohol and deprivation. Secondly, victims of crime are more likely to suffer mental health problems such as depression. Those who suffer from mental illness are more likely to be victims of crime than to commit crime, although violent crimes committed by people with mental illnesses are more frequently reported. One would therefore expect areas with higher levels of violent crime to have higher levels of mental health problems.
Gambling	The UK is the largest gambling nation in Europe, accounting for just over 22% of the total European market. Over three quarters of the UK population are estimated to gamble; when excluding the National Lottery this falls to just below half (46%). Online gambling already allows for 24 hour access and is a rapidly growing market. Addiction to gambling is both a problem in its own right and may result in debt, which, in turn, can give rise to other mental health problems.

4. Mental Health and Wellbeing

4.1. Whilst much of the national policy has focused on mental illness per se, there has been a noticeable shift in recent years away from mental health illness and towards mental wellbeing.

4.2. The Wanless reports (2002 & 2004) were commissioned by the Treasury, acknowledging both the economic and public health case for a greater focus on promotion and prevention within the NHS. Wanless emphasises that health promotion policy must address 'individual behaviour and lifestyle risk factors, as well as wider determinants of health such as poverty and education'. The report also stated that population health cannot be assessed solely in terms of

morbidity and mortality data, but also requires measures of positive physical and mental health.[2]

4.3. As such there is now an increasing focus on promoting mental health well being within the community. This is being reflected in the increasing amount of literature (including published academic papers) on mental health, happiness and wellbeing.

4.4. Locally, these priorities are reflected within the Local Area Agreement which has prioritised the following targets with a direct association to positive mental health:

- Percentage of people who feel they can influence decisions locally
- Percentage of people how believe people from different background get on well together in their local area
- Participation in regular volunteering
- Engagement in the Arts

4.5. Similarly, the Children and Young People's Plan for Middlesbrough has prioritised the mental health and wellbeing of children within the plan with the following target:

- Percentage of secondary pupils stating that they are happy most of the time

5. Other issues to consider

5.1. The Health Scrutiny Committee may also wish to consider the following issues in relation to mental health wellbeing:

- Mental health promotion and support work for specific vulnerable groups within the population such as carers, homeless, specific ethnic groups and people with disabilities
- Local approaches to supporting parents and families
- Approaches to helping people with debt problems
- Local approaches to tackling stigma, social exclusion and discrimination
- The role of the Local Strategic Partnership in promoting mental health wellbeing across the population and through the broader partnership work
- Implementation (by PCTs) of *Improving access to psychological therapies (IAPT) programme: Computerised cognitive behavioural therapy (cCBT) implementation guidance (April 2007*)
- Local trends in prescribing of anti-depressant treatment and provision of other psychological therapies (as described in IAPT guidance)

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[2] Choosing Mental Health: A policy agenda for mental health and public health. *The Mental Health Foundation 2005*

6. Summary

6.1. Mental health and wellbeing is central to the human, social and economic capital of Middlesbrough and as a them, cuts across many if not all major policy areas such as housing, regeneration, social care, employment, education, environment and leisure as well as health.

6.2. This report has attempted to summarise the shift in policy over recent years towards mental health wellbeing and has briefly described the local challenges to improving the mental health of the population, the local mental health needs of the population and important contribution of the wider determinants influencing mental health wellbeing.

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