Unite in Health Thinking Thursday #UiHTT

Austerity is bad for your mental health: findings from an exploration of the literature’ Thursday 19th December 2013

Steve Hemingway & George Coxon

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Austerity is bad for your mental health: findings from an exploration of the literature'

University of Huddersfield

Steve Hemingway

Senior Lecturer in Mental Health

School of Human and Health Sciences

University of Huddersfield

George Coxon

MHNA Chair – Regional lead for South West England

Commissioning and Healthcare Consultant / Advisor

Specialist Mental Health Advisor, Nursing in Practice

Objectives

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- Present results of a literature review evaluating the impact of austerity cuts in health and social care provision on mortality and morbidity in mental health.
- Suggest what mental health nurse clinicians and academics need to consider toward managing and prevent the worsening of health status for service user's and loss of life.
- Facilitate the sharing of experience, knowledge and problem solving ideas from session participants.

Austerity

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- Recent figures show that throughout Europe individual states debt is near to all of or equal to their respective gross domestic product status.
- Economists have estimated it may take until 2030 to get the overall debt we owe to manageable proportions.
- Commentators have also stated that one way of putting things is that we are the generation who sold the family jewels and also left grandkids with a debt legacy (Newbold and Hyrksas 2010).

Austerity is needed but…

- The relationship between economic recession and mental health conditions is well recognised by practitioners (McDaid and Knapp 2010).
- Decreased well-being will put greater burden on people and will in many cases increase mental health problems, alcohol abuse, increase suicide rates, increased social isolation and deteriorating physical health (Knapp 2010).
- An increase in suicidal ideation and attempts across Europe –UK (Barr et al 2012), -Greece (Economou et al 2013)

Physical Health

- In times of recession people tend to spend more on cheaper or convenience foods, their lifestyle can deteriorate and this leads to increased mortality and morbidity for the general population (Stuckler et al 2009).
- Some commentators have stated that in times of recession people may lead more healthy lifestyles in some ways related to less extravagant diets and excesses (Stuckley and Banu 2013).
- Stuckler and Banu (2013) in their findings have found countries such as Sweden, Iceland and Japan whose population grew healthier in a time of recession but the significant factor was investment in welfare and targeted support such as work programmes.

Severe mental illness

- Research has shown they can die 25 years on average sooner than the general population or those without a history of a long term SMI (Parks 2011).
- People with an SMI also have increased risks of chronic cardiovascular diseases such as diabetes due to hereditary, lifestyle and iatrogenic side effects of psychotropic medication (Hemingway et al 2013).
- Hardy and White (2013) showed how the health needs of people with an SMI can be missed by both the mental health and primary care services despite being regularly seen at the GPs for consultation.
- Clitfon et al (2013) highlighted how the welfare *reforms* introduced in 2012 by the coalition government have introduced a whole set of anxiety about the cycle of claims assessment they now have to endure-thus the economic uncertainties have been passed onto to a vulnerable group with a negative affect on mental health and well being.
- These effects are also present with ageing population whose mental health needs are often overlooked in primary care

Is there another way?

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- Increasing evidence that the austerity measures have failed.
- If there are targeted interventions to stimulate employment and provide a financial security net this will in turn boost economic recovery, increase taxes, increase positive health and well being .
- Examples can be seen in Iceland, Japan & Sweden.
- In essence public spending can save limit the impact of economic recession and save lives

(Stuckley and Banu 2013)

Consequences for MHNs

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- A changed working environment-Payment by results? Impact on SU
- (Wilford 2013)
- Increased incidence of self harm and suicide (Santos 2013)
- MHNs may feel ethically compromised in delivering sub-standard care (no direct causal evidence found) (Holley 2012; McKeown et al 2013)
- Blurred boundaries between MH professionals (Hannigan et al 2011).
- Peer support (Simpson 2013)
- A generic MH worker? (Hemingway 2013; MHF 2013)
- The end of MH nursing as we know it? (Hannigan et al 2011; Wilford 2013)
- Time for MHNs to prove itself (Hemingway 2013)

The Challenge

- MHNs need to show how their interventions can improve mental health outcomes
- Be at the centre of any targeted interventions e.g. vulnerable populations and geographical areas.
- Become more visible rather than bow to medical dominance,
- Increase their political literacy (awareness, advocacy & support)
- Many service users, even those within mainstream mental health services, do not have the positional power or acumen to overcome many of the economic, organisational and social structures which can impact on their recovery

(Hemingway et al 2013b).

Further data on incidence and prevalence

- 1m deaths per year worldwide
- Rising to 1.5m by 2020
- 5% of suicides occur in hospital
- 410 people per day in Europe
- 90% suffer from a treatable psychiatric condition – many not diagnosed
- Take account of societal and predictive factors eg health inequalities, cultural issues as well as past and family histories

Deliberate Self Harm

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- There were 53,273 individual service users, who were also admitted to hospital at least once in the year as a consequence of self-harm in 2012/13
- Nearly half (25,009) were already known to mental health services prior to 2012/13
- There were a total of 76,232 episodes of care that related to self-harm for these service users (an average of 1.4 per individual)
- Nearly a third (25,152) of these inpatient episodes of care are related to intentional self-poisoning using over the counter drugs such as Paracetamol, Aspirin and Ibuprofen.
- There were 225,672 A&E attendances for these service users (those who had been admitted for self-harm within the year), averaging 4.3 A&E attendances (per individual).

Further data on incidence and prevalence

- Know your own local data
- Work with partners in information sharing – taking due care on data protection and confidentiality
- Modelling and projections on need – eg UK have JSNA and strategic priority documents reviewed and refreshed annually
- ‘on the ground’ front line service specifications and design

Impact and implications for MHNs

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- A call to action
- Contracting and KPIs
- Added value in models of care
- Protecting capacity and resources
- Access to quality care, evidenced approach, choice and outcome based therapies
- Understanding your population profiles and reaching the most vulnerable and hardest to reach

Conclusions and action steps

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- Add the issue of austerity and suicide to you list of topics and themes to take away and share with colleagues
- Consider a service review
- Consider a business case to provide a more proactive service in your area - high risk groups and behaviours, ED / A&E services, addiction substance misuse services, young people / CAMHS services and focus on the SMI service users

Key themes for action

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- Reflection on our skills, knowledge, attitudes and confidence
- Not being complacent or defensive
- CQI – what training in new models of care is there?
- Are we research friendly enough in terms of austerity links to suicidal ideation and incidence?
- Do we show purchasers and policy makers enough persuasive detail related to austerity and suicide?
- Getting political !

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#CPHVACPD

At last weeks Unite/CPHVA conference we launched #CPHVACPD and are currently in beta testing on the Community Practitioner Journal website.

CPHVA members will be able to undertake a #CPHVACPD module as part of todays training session which they will be able to access next week at http://www.communitypractitioner.com.

This will include some multi-choice questions and an area for reflection. Once completed, members will be able to store or download their certificate.

We plan to launch this #CPD resource to the wider health sector in the coming months.

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