MINDWAVE

London Digital Mental Wellbeing (LDMW)

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Why London Digital Mental Wellbeing?

One in four people in the UK will experience a mental health problem in any given year. (Mind.org.uk)

Mental health problems are one of the main causes of the burden of disease worldwide.

In the UK, they are responsible for the largest burden of disease - 28% of the burden, compared to 16% each for cancer and heart disease. (Mentalhealth.org.uk)

A survey by the National Centre of Social Research (2014/2015) asked 5000 adults about their experience of mental health. 26% had been diagnosed with a mental illness.

An additional 18% of adults have experienced a mental illness but have not been diagnosed; they have "met the criteria for a common mental disorder (CMD)". (Digital.nhs.uk)

NB: Other users will not identify as having a CMD - but will report "stress", "trouble sleeping", "loneliness". Initial user research should start to identify the language that we should focus on, and subsequent user research can confirm this for MVP. Continuous user testing of MVP can refine and adapt this (amongst other things) to ensure the widest reach, understanding and use of this product.

Why digital?

Mental health services in the UK are overstretched, have long waiting times and, in some regions, lack specialist services.

Mental health research receives only 5.5% of total UK health research spending, even though it is responsible for 28% of the burden of disease - there is not enough money to solve this problem offline.

37% of adults aged 16-74, with conditions such as anxiety or depression were accessing mental health treatment in 2014. This figure has increased from 24% since 2007; This means that more people are trying to access treatment and offline services which are already overstretched. There is no capacity and so people need to be empowered to help themselves. (Mentalhealth.org.uk)

'If we don't act urgently, by 2030 depression will be the leading illness globally.' (Who.int)

Considerations

Cormobidity - multiple CMD

"When two disorders or illnesses occur in the same person, simultaneously or sequentially, they are described as comorbid. Comorbidity also implies interactions between the illnesses that affect the course and prognosis of both." (Drugabuse.gov)

Psychiatric comorbidity

"...co-occurrence of two or more psychiatric diagnoses ('psychiatric comorbidity') has been reported to be very frequent. For instance, in the US National Comorbidity Survey (Kessler et al, 1994), **51% of patients with a** DSM–III–R/DSM–IV (American Psychiatric Association, 1987, 1994) **diagnosis of major depression had at least one concomitant ('comorbid') anxiety disorder and only 26% of them had no concomitant ('comorbid') mental disorder**".

In a study based on data from the Australian National Survey of Mental Health and Well-Being (Andrews et al, 2002), **21% of people fulfilling DSM–IV criteria for any mental disorder met the criteria for three or more concomitant ('comorbid') disorders**."
(British Journal of Psychiatry - http://bjp.rcpsych.org/)

Cormobidity - multiple CMD

Drug addiction

"Addiction changes the brain in fundamental ways, disturbing a person's normal hierarchy of needs and desires and substituting new priorities connected with procuring and using the drug. The resulting compulsive behaviors that weaken the ability to control impulses, despite the negative consequences, are similar to hallmarks of other mental illnesses."

"Many people who are addicted to drugs are also diagnosed with other mental disorders and vice versa. For example, **compared with the general population, people addicted to drugs are roughly twice as likely to suffer from mood and anxiety disorders**, with the reverse also true."
(Drugabuse.gov)

Physical health

Physical health conditions

The Survey of Mental Health and Wellbeing (by NHS Digital) looked into comorbidity across mental disorders, chronic physical conditions, psychological wellbeing and mental disorder.

There was an association between CMD and chronic physical conditions: 38% of people surveyed with severe CMD symptoms reported a chronic physical condition, compared with 25% of those with no or few symptoms of CMD.

There was a clear association between CMD and chronic physical conditions. For example, people with severe symptoms of CMD were twice as likely to have asthma (15%) as people with no or few symptoms (7%). (digital.nhs.uk)

NB: chronic physical conditions looked at were asthma, high blood pressure, diabetes, cancer and epilepsy

Physical health - continued

Physical health conditions

Depression has been linked to:
- a 67% increased risk of death from heart disease
- a 50% increased risk of death from cancer

Schizophrenia is associated with:
- double the risk of death from heart disease
- three times the risk of death from respiratory disease

People with mental health conditions are less likely to receive the physical healthcare they need.

Mental health service users are statistically less likely to receive the routine checks (like blood pressure, weight and cholesterol) that might detect symptoms of these physical health conditions earlier.

They are not as likely to be offered help to give up smoking, reduce alcohol consumption and make positive adjustments to their diet. (Mentalhealth.org.uk)

Sleep

Chronic sleep problems affect 50% to 80% of patients in a typical psychiatric practice, compared with 10% to 18% of adults in the general U.S. population. Sleep problems are particularly common in patients with anxiety, depression, bipolar disorder, and attention deficit hyperactivity disorder (ADHD).
(www.health.harvard.edu)

There is no evidence that sleep disorders are a cause of psychiatric disorders. (WebMD.com)

- Anxiety can cause thoughts to race through your mind, making it difficult to sleep.
- Depression and seasonal affective disorder (SAD) can lead to oversleeping – either sleeping late in the morning or sleeping a lot during the day. If you experience difficult or troubling thoughts as part of depression, this can also cause insomnia.
- Post-traumatic stress disorder (PTSD) can cause nightmares and night terrors, disturbing your sleep.
- Paranoia and psychosis may make it difficult for you to sleep. You may hear voices or see things that you find frightening, or experience disturbing thoughts, which make it hard to fall asleep.
- Mania often causes feelings of energy and elation, so you might not feel tired or want to sleep. Racing thoughts caused by mania can make it hard to fall asleep and may cause insomnia.
- **Psychiatric medication** can cause side effects including insomnia, disturbed sleep or oversleeping. You may also experience sleep problems after you stop taking psychiatric drugs.

(Mind.org.uk)

Medication

Medication

Medication was the most common form of mental health treatment for all conditions assessed within the Survey of Mental Health and Wellbeing - and was reported as being taken by 10 per cent of all people interviewed.

Medication was more common than psychological therapy both in those with current symptoms of CMD (31% with medication and 12% with therapies) and in those without current symptoms. (6% with medication and 1% with therapies). (Digital.nhs.uk)

Targeting our audience for MVP

Who are we targeting?

1. Undiagnosed CMD - our key target audience

We can target these users by pin-pointing high risk areas and demographics.

Data from the census, mental health organisations and charities, and the government will help us to identify where we can find potential users with a high risk of CMD to allow us higher rates of success.

We can also access users through the other factors already discussed - physical health conditions leading to pain management groups / cancer support groups etc.

2. Diagnosed CMD

We also can target this group by pin-pointing high risk areas and demographics, with the additional criteria that they have had a CMD diagnosis.

Data can show us where there are higher numbers of these users, but we can also access users through contacts of Kumar and Chris, eg clinical psychiatrists and clinical groups etc.

3. "Severe" cases

Those who have been through the system and had an "extreme" experience with the mental healthcare system and services.

This will allow us to identify key problem areas within the system and start to identify opportunities for earlier intervention and self-management, and potentially how we can assist users to navigate the system in a more productive and efficient way.

We can access these people in the same ways as groups 1 & 2.

Location

The most common mental health issue facing Londoners is mixed depression and anxiety (Data.london.gov.uk). Data shows that the boroughs where this is most prevalent are as follows (cases per 1000 people):

Islington - 99.95
Hackney - 99.6
Camden - 96.9
Lambeth - 96.8
Hammersmith and Fulham - 95.9
Southwark - 95.6
Wandsworth - 94.4
Haringey - 93
Tower Hamlets - 92.9
Westminster - 91.6

We could also consider Barking & Dagenham or Brent as these are also high risk areas and allow some diversity in location from the inner boroughs.

NB: This is not to disregard other users in **any** location for MVP - we will not restrict the product. This data, however, allows us to focus our efforts and be more effective in targeting users.

Gender

Women were more likely than men to have reported CMD symptoms. One in five women had reported CMD symptoms, compared with one in eight men.

 - Suicide is the leading cause of death among young people aged 20-34 years in the UK and it is considerably higher in men, with nearly four times as many men dying as a result of suicide compared to women.

One reason that men are more likely to commit suicide is because they are less likely than women to ask for help or talk about depressive or suicidal feelings. Recent statistics show that 72% of people who died by suicide between 2002 and 2012 had not been in contact with their GP or a health professional about these feelings in the year before their suicide. (mentalhealth.org.uk)

NB: Women are not necessarily more likely to suffer with CMD - they are just more likely to talk about it - and therefore they will be an easier group to access for this product, allowing us to focus our efforts more effectively.

NB1: We must not forget that men are a high risk group and we should not disregard male users or restrict the product to women only.

NB2 : Campaign Against Living Miserably - reducing stigma around mental health in men.

Other factors

Working-age adults living in bad housing are disproportionately at greater risk of poorer general health, low mental wellbeing and respiratory problems including asthma and breathlessness.

Substantially more working age adults living in bad housing report fair, bad or very bad general health (26%) than those living in good housing (17%).

Adults in bad housing are 26% more likely to report low mental health compared with those living in good housing (19% vs 14%). (Shelter.org.uk)

People living in low income households were far more likely to have been diagnosed with mental illness than those in high income households (27% of men and 42% of women in the lowest income quintile compared to 15% of men and 25% of women in the highest).

Attitudes to mental illness were also linked to demographic characteristics - participants in lower income households were less likely to be sympathetic to mental illness.

Despite the prevalence of mental illness, the study also found that considerable stigma still exists - 19% of adults agreed that 'one of the main causes of mental illness is a lack of self-discipline and willpower'. (Wired.com)

Other factors- relationships and employment

In five London boroughs, more than a quarter of households with dependent children had no adult in employment – Islington, Tower Hamlets, Hackney, Westminster and Barking & Dagenham

44% of all Londoners aged 16 or over are single. 2011 was the first time that the "singles" group has been larger than the number who are married for London. In borough terms, 13 of the 20 local authorities with the highest proportions that were single are Inner London boroughs, topped by Islington (almost 60% single).

A fifth of unemployed young people in Britain believe they have "nothing to live for" and 40% have symptoms of mental illness. (Princestrust.org.uk)

Worklessness is associated with poorer physical and mental health and well-being. Work can be therapeutic and can reverse the adverse health effects of unemployment. That is true for healthy people of working age, for many disabled people, for most people with common health problems and for social security beneficiaries. (Gov.uk)

NB: Outside of our target demographic of "working age adults" - other high risk groups to be aware of are adults over the age of 64 in care homes, and children in care homes.

Ethnicity

The project should aim to get a proportionate representation of ethnicities across London

45% White British
18% Asian / Asian British
13% Black / African / Caribbean / Black British
13% Other White
5% Mixed / multiple ethnic groups
2% White Irish

NB: From the LiveWorks research, we know that the Somali community is a high risk group, however, it is a risk to target specifically by ethnicity if we are aiming to get a representative snapshot of Londoners. The issues within the Somali community are a specific problems with specific contributing factors and specific outcomes.

Key requirements

Empower Londoners to manage their mental wellbeing

Reduce pressure on services

Reduce stigma around mental health

Next steps (January)

Set up user research sessions:

- Initial user group will inform and define methods:

Which questions gave us better / more relevant insights?

Which language do users prefer / respond better to? Does certain language alienate users?

Were workshops or depth interviews more informative? Are these methods audience specific?

How will we analyse the data that we get?

Can we ask questions in a better way in order to provide more "analysable" data?

How easy is it to reach these groups?

How technologically capable do they view themselves as?

What digital services do they currently use?

What channels do they use?

What health services do they currently use?

Can these answers help us to target more people more effectively?

Start to understand how users are accessing information

Where do they go for information?

Who do they trust to get that information from?

What do they consider appropriate in terms of support we offer and suggest

What do they consider appropriate for raising awareness of the product in the first place?

Next steps (January) continued

Further research with 75-100 users in our target demographic:

MH experience - diagnosed / undiagnosed / severity / sought info or advice - and where from?
Prevalence of physical conditions coupled with CMD symptoms OR comorbidity of CMD
Importance put on self-management AND primary care of physical vs mental health
Circumstances and life experience - impact of these on MH - and impact of MH on these (chicken and egg?)
Impact of MH on family - relationships - marriage, children, parents, siblings?
Management of MH - self management, e.g. apps, websites, clinical groups, support groups, psychiatrist / psychologist, medication

Analysis of data - qualitative and quantitive

Other things to think about

What is available in other cities? Melbourne?

What do Londoners already have? Local / London / Nationwide?

Are Londoners aware or using any of these things?