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JSNA– Mental Health Chapter

Table of Contents

Executive Summary.....	4
1.1.1 Prevention.....	4
1.1.2 Service improvements	5
1.1.3 Effectiveness	5
1.1.4 Parity of esteem	5
What do we mean when we talk about mental health?.....	6
Why is it an issue ⁱⁱ ?	6
Risk Factors.....	7
1.1.5 Other contributory factors include	7
1.1.6 Group at risk of poor mental health.....	7
Risk and Related Factors	8
Prevalence of mental ill health in Havering	8
Adult Psychiatric Morbidity Survey.....	10
Mental Illness Needs Index.....	11
Quality Outcomes Framework	12
Specific Mental Health Problems	12
Depression	12
Psychoses	15
Suicide and Death from Undetermined Injury.....	17
1.1.7 Suicides.....	17
1.1.8 Self-harm.....	18
Mental Health Need of Offenders	20
Mental and Physical Health	21
Mental Wellbeing.....	23
Alcohol Abuse	24
Smoking.....	25
Overweight and obesity	26
Impact.....	27
Local Burden of Disease Analysis.....	27
Demand for services.....	27
1.1.9 Utilisation of police and ambulance services	27
1.1.10 Social Care Support – accommodation and independence	29
1.1.11 Health Service Use.....	31
1.1.12 Spend.....	33
Current Mental Health Provision in Havering.....	38
Stakeholder Views.....	38
Strengths	38
Challenges	39
Barriers to people seeking help and support.....	39
Themed issues	39
1.1.13 Provision	39
1.1.14 Re-integrating into the community.....	40
1.1.15 Primary care practitioners	40
1.1.16 IAPT	40
1.1.17 Community services.....	41
1.1.18 Community understanding of mental health	41
1.1.19 Vision for community mental health services.....	41

1.1.20	Accessing mental health services.....	42
1.1.21	Clients with complex needs.....	42
1.1.22	Adult Multi-Agency Safeguarding Hub (MASH).....	42
1.1.23	Voluntary sector provision.....	42
1.1.24	Young People.....	43
1.1.25	Older people and mental health.....	43
1.1.26	People with a Learning Disability.....	43
1.1.27	Wellbeing in the community.....	44
Best Practice.....		44
No health without mental health.....		44
Long term mental health conditions (London Model).....		45
Suicide prevention strategy ^{ix}		46
Crisis care concordat.....		46
Local Strategic Context in Havering.....		46
What are the gaps?.....		47
Recommendations for Commissioners.....		48
Prevention.....		49
Service improvements.....		49
Effectiveness.....		49
Parity of esteem.....		49

Executive Summary

Overall the burden of mental health problems in Havering is comparatively low but it remains an issue for our local population particularly as there are significant inequalities in the distribution of risk factors and the prevalence of mental illness across the borough.

The evidence shows that people who live in the most deprived wards such as Gooshays and Heaton are much more likely to suffer from a mental illness than those who live in the least deprived parts of the borough such as Upminster and Cranham.

The needs assessment also shows that:

- Offenders have significant mental health need but we do not fully understand the extent of this need or whether the current provision meets these needs.
- People with mental health problems are less likely to lead a healthy lifestyle and to take up screening and health improvement opportunities that may be available to them.
- People with long term conditions (LTCs) such as diabetes and chronic obstructive pulmonary disease (COPD) are more likely to suffer from mental illness e.g. depression and anxiety; and that these can exacerbate their physical ill health.
- People with mental illness are more likely to use secondary health care services with consequent increase in accident and emergency attendances, inpatient admissions and lengths -of -stay in hospital.

However we do not yet understand why the attendance of people with mental health problems at Accident and Emergency (A&E) is higher than expected, or what the true level of mental health need is in people who have a learning disability, and why the level of antidepressant prescribing in primary care is higher than expected.

Stakeholders (service users, carers and professionals) have said that some actions work very well within the borough to support people with mental health problems e.g. Multi-Agency Safeguarding Hub (MASH), Family Mosaic and Access to Care. We can however do better to increase awareness of mental health and in reducing the stigma of mental illness; provide better access to people who do not need high level specialist support and improve people's knowledge of local services.

Residents in Havering should have access to services which reflect the six objectives of the national mental health strategy; *No health without mental health*, in addition to NICE-approved interventions such as talking therapies.

Commissioners must take action to reduce the level of unmet need in Havering and to reduce the associated health inequalities. These include the following:

1.1.1 Prevention

- Commissioners need to work with partners to explore and develop interventions that will improve mental wellbeing, mental health awareness and reduction in the stigma associated with mental illness. This could be taken forward through the expansion of the 'Havering Health Network'. The latter is a network of health champions, health trainers and voluntary sector organisations.
- Commission prevention services targeted at people with mental health problems particularly those with severe mental illness, such as specialist smoking cessation services.
- For the wider community, working with partners to ensure that there is sufficient capacity in prevention services such as smoking cessation, weight management and

physical activity to reduce the risk of developing long term conditions such as COPD, diabetes and heart disease.

- Commission additional capacity in 'talking therapies'. This may require a new model of service delivery including a range from self-help, brief interventions to specialist IAPT services.
- Development of multiagency response to suicide prevention as per the national Suicide Prevention Strategy.

1.1.2 Service improvements

- Develop capacity in primary care to support early identification of people at risk of developing mental health problems. This could be initially targeted in practices with higher levels of Quality Outcomes Framework (QOF) registered patients with LTCs and in areas with the highest levels of deprivation.
- Improve the understanding of the mental health needs of people with learning disability, those who access accident and emergency services, and those of offenders.
- Commissioners should map current services and describe the wider support available to Havering residents e.g. service directory or prospectus. This could be made available electronically and through other formats as appropriate.
- The pathway of care for older people with mental health problems needs to be clarified and effectively communicated to them and their carers and must also address their physical health care needs.
- Commissioners need to ensure that mental health services are commissioned to meet the future needs of the local population taking into account population growth; changing age and ethnicity profiles; and new models of service delivery. This should also address the rebalancing of spend which should focus more on community based and less specialist provision.

1.1.3 Effectiveness

- Commissioners will need to work with partners to assess whether the current service is able to support the delivery of the national Crisis Care Concordat.
- Commissioners need to support the required organisational culture change by working with partners to deliver real change for people with mental health problems so that irrespective of where they are seen, both their mental and physical health needs are addressed.

1.1.4 Parity of esteem

- Commissioners need to support the required organisational culture change by working with partners to delivery real change for people with mental health problems so that irrespective of where they are seen, both their mental and physical health needs are addressed.

What do we mean when we talk about mental health?

Mental health problems range from common disorders like anxiety and depression to far more severe but less common conditions, such as schizophrenia. Mental health problems can be divided as follows:

Common mental health disorders (CMDs) also known as neurotic disorders are conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They include problems such as depression and anxiety disorders such as panic disorder, obsessive compulsive disorder, phobias and post-traumatic stress disorders. CMDs can be effectively treated with medication and/or psychological therapies.

Severe mental health disorders also known as psychoses are disorder that produces disturbances in thinking severe enough to distort perceptions of reality. These include conditions such as schizophrenia and bipolar affective disorders (manic depression).

Personality disorder is defined as ‘an enduring pattern of inner experience and behaviours that deviate markedly from the expectation of the individuals’ culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment’.

Organic brain disorders are due to structural abnormalities of the brain and include conditions such as dementia.

Why is it an issue? ¹

- At least one in four people will experience a mental health problem at some point in their life and one in six adults have 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 life-time.
- 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 diagnosable mental health problem (including personality disorder) and/or a substance misuse problem.

The cost of mental health problems to the economy in England has recently been estimated at £105 billion, and treatment costs are expected to double in the next 20 years.

Good mental health is a key factor in successful psychological and social functioning, and poor mental health is associated with poor socio-economic status, poor education, poor opportunities for employment, and a host of inequalities, come of which fall under the umbrella term ‘social

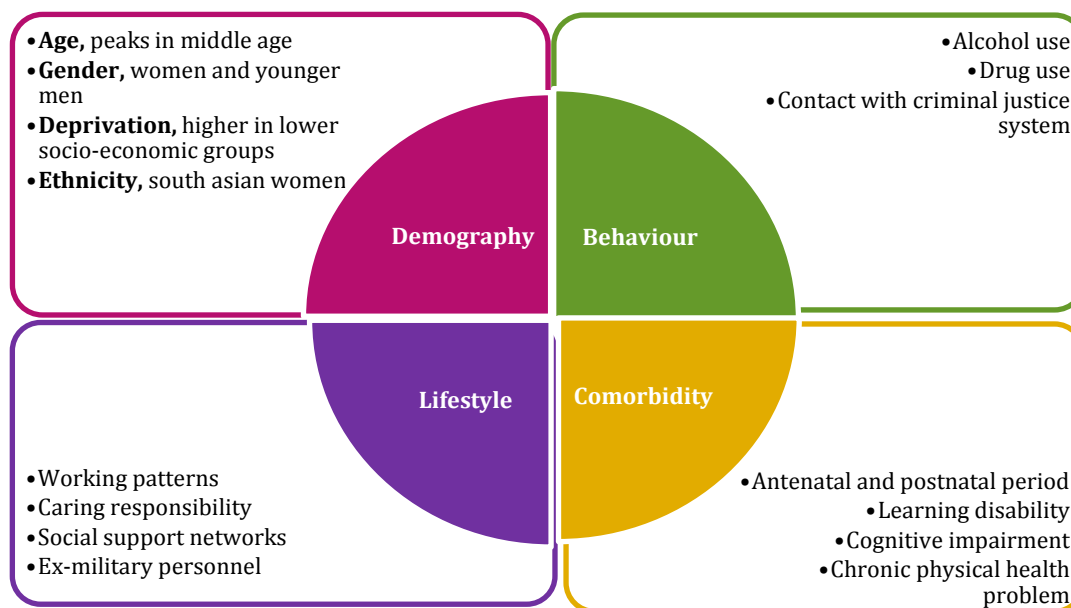
¹ No health without mental health. A cross-government mental health outcomes strategy for people of all ages.

exclusion². Physical and mental health are closely linked; poor physical health may increase the likelihood of developing poor mental health, and poor mental health may increase risks of developing or not recovering from serious physical health problems.

Risk Factors

The key risk factors for mental ill health include those identified in Figure 1.

Figure 1 NICE Determinants of Mental Health



1.1.5 Other contributory factors include

- Poor housing
- Serious trauma, death of a parent, hospitalisation, tragic accidents and other devastating events, particularly during early childhood.
- Side effects of medication, particularly in the elderly who generally take multiple medications, creating the potential for problematic drug interactions affecting mental health.

1.1.6 Groups at risk of poor mental health

People at particular life stages including

- Antenatal and postnatal women
- Older people are at risk of poor mental health, and
- Young people (teenagers)

Other groups are at risk of suffering poor mental health regardless of their life stage:

- People with long term conditions and chronic disease
- People with learning disabilities
- Carers
- Black and Minority Ethnic groups
- Offenders and ex-prisoners
- People dependent on drugs and alcohol
- Lesbian, Gay, Bisexual and Transgender people

² Martin Knapp, David McDaid et al. Mental Health Policy and Practice Across Europe. Open University, 2007.

There is a strong evidence to suggest that work is generally good for physical and mental health and wellbeing, taking into account the nature and quality of the work and its social context, and that unemployment is associated with poorer physical and mental health³.

Different ethnic groups have different rates and experiences of mental health problems. These differences are not well understood and may be explained by a number of factors, possibly including poverty, racism and cultural differences. They may also be due to the fact that mainstream mental health services often fail to understand or provide services that are acceptable and accessible to some non-white British communities, or that some groups are reluctant to engage with mainstream services.

The Severe Mental Illness Profiling (SMIP) tool developed by Public Health England (PHE) provides commissioners, service providers, clinicians, service users and their families with the means to benchmark their area against the national, regional and similar populations.

Table 1 provides a comparison of key risk and related factors for Havering in comparison to London and England. Overall Havering has significantly lower prevalence of risk factors for the development of severe mental illness compared to London and England.

Table 1: Key SMIP risk and related factors for Havering compared to London and England

	Indicator	Period	London	England
Risk and Related Factors	Socioeconomic deprivation: % of people living in 20% most deprived areas	2010	Havering has a significantly lower percentage	Havering has a significantly lower percentage
	Long-term unemployment: % of working age population	Mar-14	Havering has a significantly lower percentage	Havering has a significantly lower percentage
	Statutory homelessness: rate per 1000 households	2012/13	Havering has a significantly lower rate	Havering has a significantly lower rate
	Children in poverty: % living in low income households	2011	Havering has a significantly lower percentage	Havering has a significantly lower percentage
	Looked after children: Rate per 10,000 <18 population	2012/13	Havering has a significantly lower rate	Havering has a significantly lower rate
	Domestic abuse incidents recorded by the police: Rate per 1,000 population	2012/13	Havering has a similar rate	Havering has a significantly lower rate
	Violent crime: rate per 1,000 population	2012/13	Havering has a significantly lower percentage	Havering has a significantly higher rate
	English Language skills: % of people who cannot speak English / speak it well	2011	Havering has a significantly lower percentage	Havering has a significantly lower percentage
	Black and Minority Ethnic Groups	2011	Havering has a significantly lower percentage	Havering has a significantly higher percentage

Source: Public Health England SMIP 2014

Prevalence of mental ill health in Havering

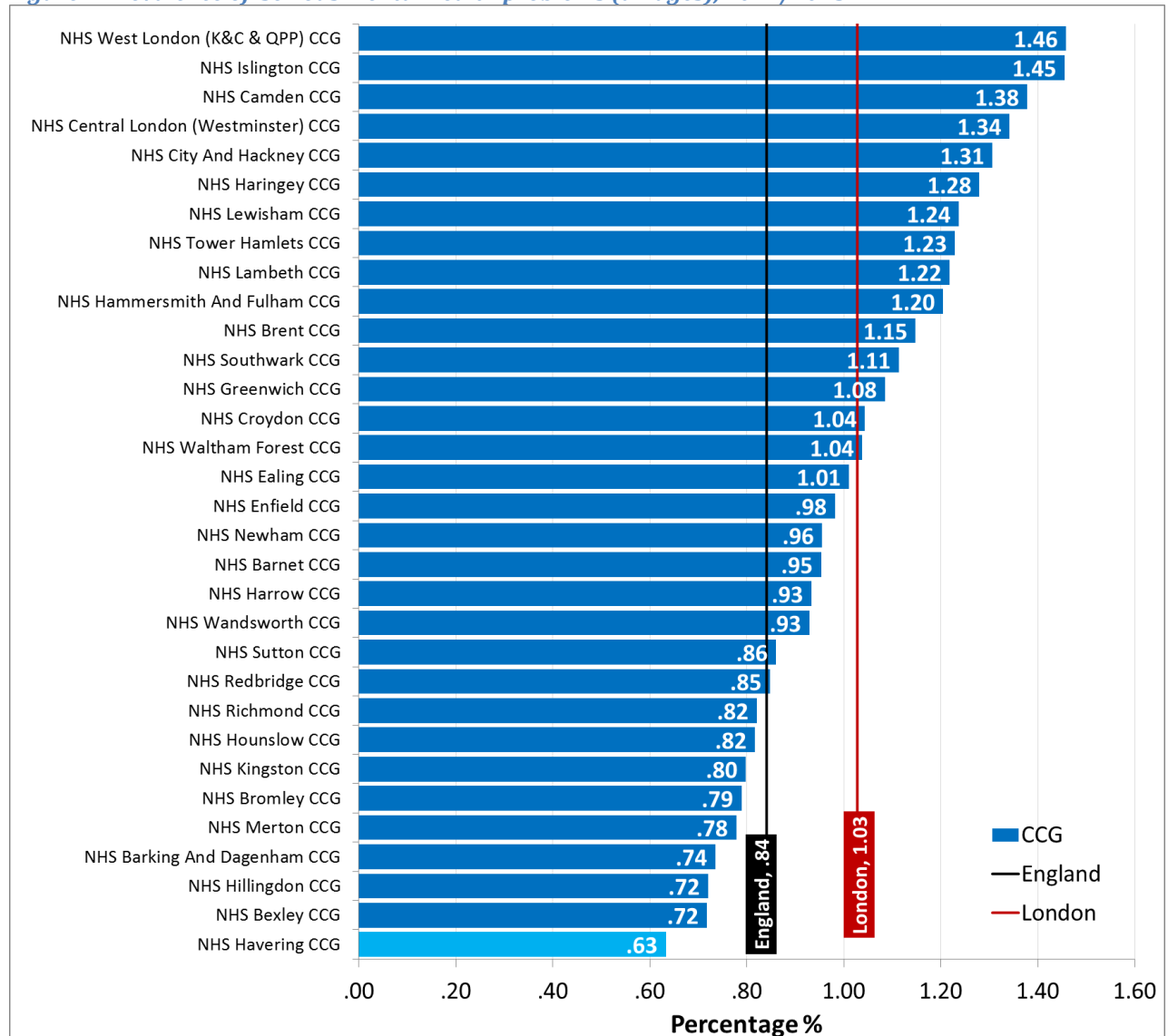
Determining the prevalence of mental health problems remains a challenge. Information on the use of mental health services especially for common mental health problems cannot be relied

³ Mental Health Foundation.2013. Starting Today – Background Paper 3: Mental Health and Inequalities.

upon entirely as many people with a mental health problem do not consult a health professional. However, the following are recognised tools which can be used to estimate the local burden of mental health problems in Havering.

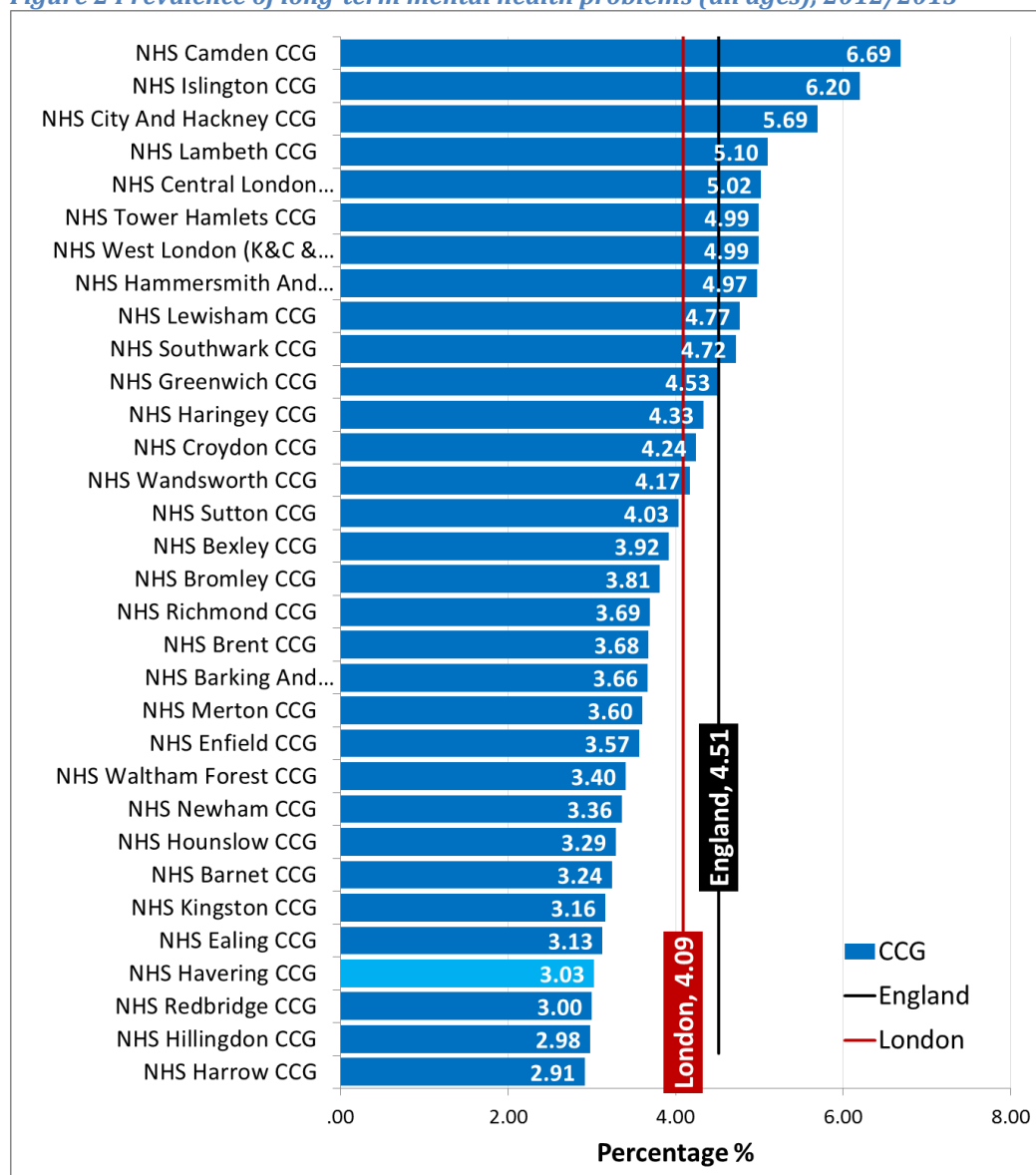
Figure 1, shows that compared to other London boroughs Havering has the lowest prevalence of serious mental health problems (0.63) and low levels of long-term mental health problems (see Figure 2).

Figure 1 Prevalence of serious mental health problems (all ages), 2012/2013



Source: QOF, HSCIC

Figure 2 Prevalence of long-term mental health problems (all ages), 2012/2013



Source: GP patient survey, NHS England

Adult Psychiatric Morbidity Survey

The Adult Psychiatric Morbidity Survey⁴ (APMS) for 2007 provides data on the prevalence of treated and untreated psychiatric disorders in the adult population aged 16 and over. Table 2 presents the national rates and estimated number of adults in Havering with various mental health disorder based on this survey.

Table 2: Estimated numbers of adults in Havering with various mental health disorders, based on the Adult Psychiatric Morbidity Survey (APMS) for 2007

Mental Disorder	National rate from 2007 study (Proportion (%) of adults 16+)	Estimated numbers in Havering (Adults in Havering aged 16 and over 2014 =200,900)
At Least one Psychiatric disorder	23.0%	46,207
Neurotic disorder	15.1%	30,336
Psychotic disorder	0.5%	1,005

⁴ McManus S., Meltzer H. et al. Adult Psychiatric Morbidity in England, 2007: Results of a Household Survey. The Health and Social care Information Centre, Social Care Statistics, 2009.

Mental Disorder	National rate from 2007 study (Proportion (%) of adults 16+)	Estimated numbers in Havering (Adults in Havering aged 16 and over 2014 =200,900)
Personality disorder	0.9%	1,808
Have considered suicide	16.7%	33,550

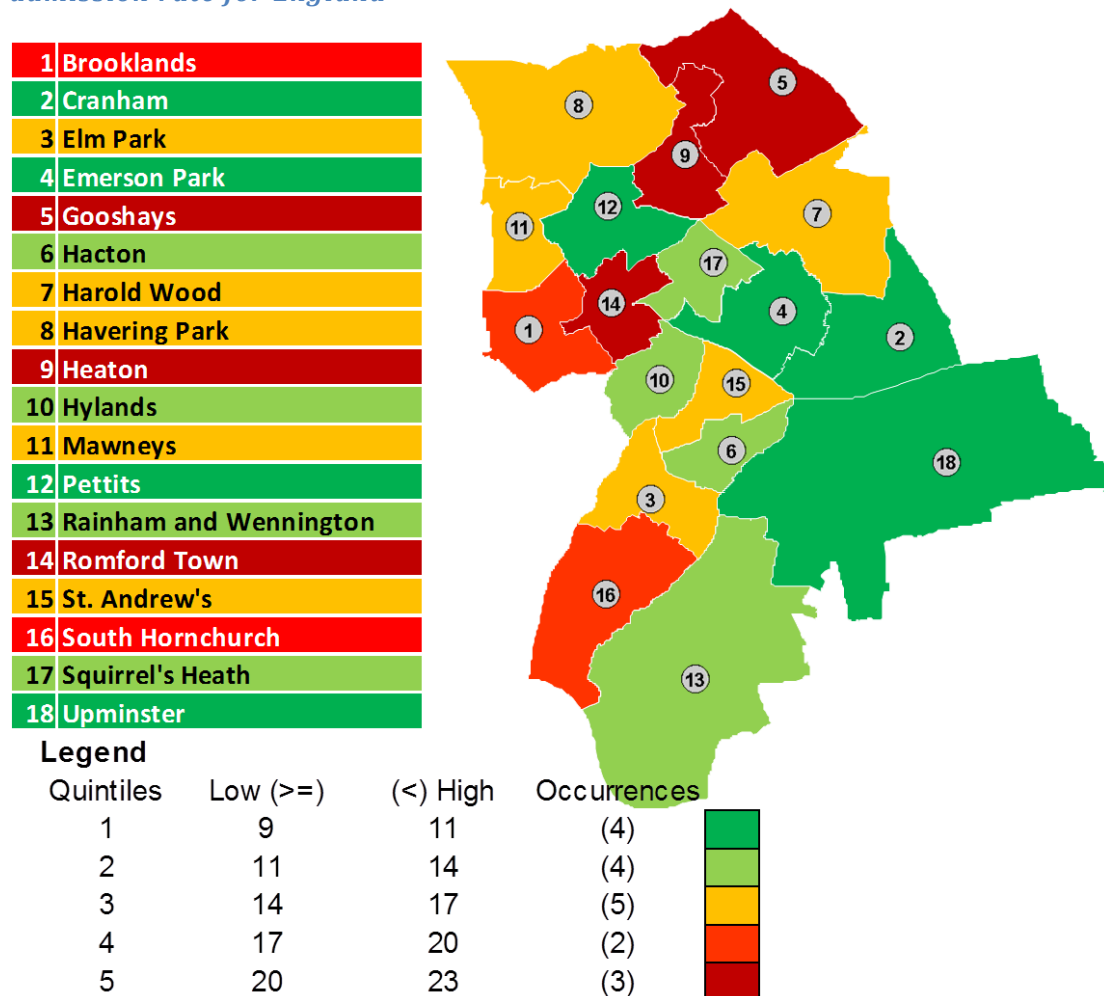
Data Source: Psychiatric morbidity among adults living in private households, 2007, The Stationery Office

Mental Illness Needs Index

Another tool which estimates mental health need is the Mental Illness Needs Index (MINI). It estimates levels of mental health need relative to England; and includes admissions related to mental health conditions. A needs index of 0.8 indicating there will be about 20% lower illness in an area than in the country as a whole, an index of 1.2 suggests 20% more.

The MINI score for Havering is 0.8 indicating there will be about 20% lower mental illness in Havering than England. The MINI score across the borough (Table 3 and Figure 3) ranges from 0.5 in Cranham to 1.2 in Heaton; the former indicating 50% less mental illness and the latter 20% more mental illness in Heaton than England. Only 3 wards out of 18 in Havering have a higher score than England indicating more mental illness.

Figure 3: MINI 2000, Predicted admission rate for the area divided by the predicted admission rate for England



Source: PHE <http://www.nepho.org.uk/mho/mini>

Table 3: Index of need by wards in Havering

Havering Wards	MINI Score
Brooklands	1.04
Cranham	0.47
Elm Park	0.81
Emerson Park	0.46
Gooshays	1.17
Hacton	0.72
Harold Wood	0.84
Havering Park	0.79
Heaton	1.21
Hylands	0.77
Mawneys	0.76
Pettits	0.56
Rainham and Wennington	0.68
Romford Town	0.91
St Andrew's	0.72
South Hornchurch	0.86
Squirrel's Heath	0.70
Upminster	0.55

Source: PHE <http://www.nepho.org.uk/mho/mini>

Quality Outcomes Framework

The Quality Outcomes Framework (QOF) register, held in primary care, includes three major forms of mental illness, namely depression, psychosis (schizophrenia, bipolar affective disorder and other psychoses) and dementia. The availability of data from QOF enables a profile to be obtained of mental ill health according to detailed demographic status, neighbourhood characteristics, GP practices responsible for care and co-morbid health conditions. It should be noted that QOF only captures diagnosed mental illness and so is likely to underestimate the true prevalence of mental illness.

Based on QOF, Havering has a significantly lower prevalence of mental health problems (0.63% or 40% less) when compared to London and our statistical neighbours such as Bexley and Milton Keynes.

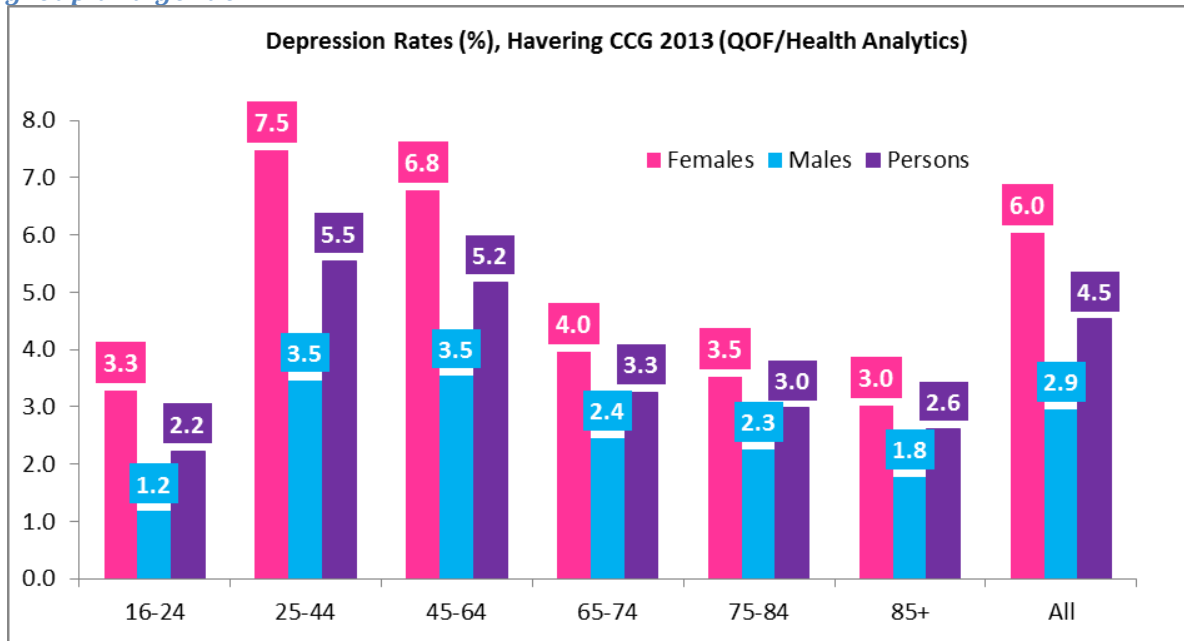
Specific Mental Health Problems

Depression

In Havering there are approximately 9,300 adults with a diagnosis of depression (5% of the registered adult population). In women the diagnosis of depression is twice that of men, 6% compared to 3% respectively. The highest age-specific rate of depression (7.5%) is among women aged 25-44 (Figure 4). Rates for men are highest (3.5%) for ages 25-44 and 45-64.

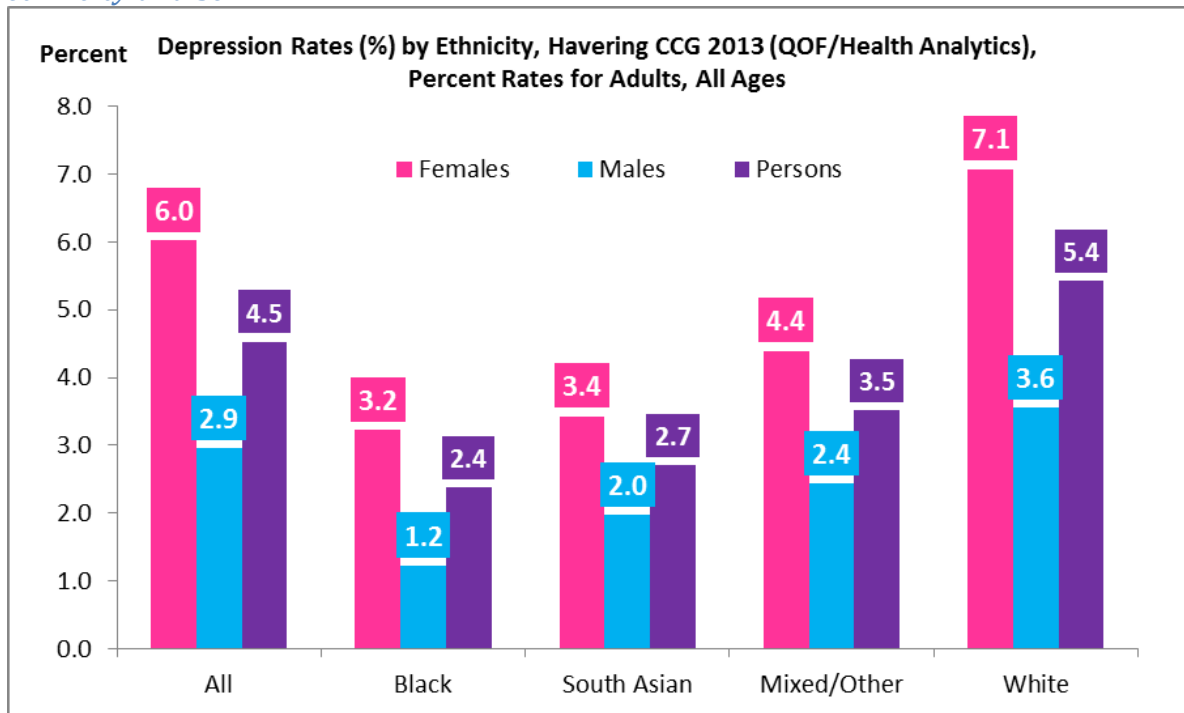
In Havering people of white ethnicity are more likely to have depression when compared to the other broad ethnic groups black, south Asian, and other/mixed with the highest rate in white females, 7.1%; (see Figure 5).

Figure 4: Proportion of registered population 16+ with diagnosis of depression by age group and gender.



Source: Havering CCG, 2013

Figure 5: Proportion of registered population 18+ with diagnosis of depression by ethnicity and sex



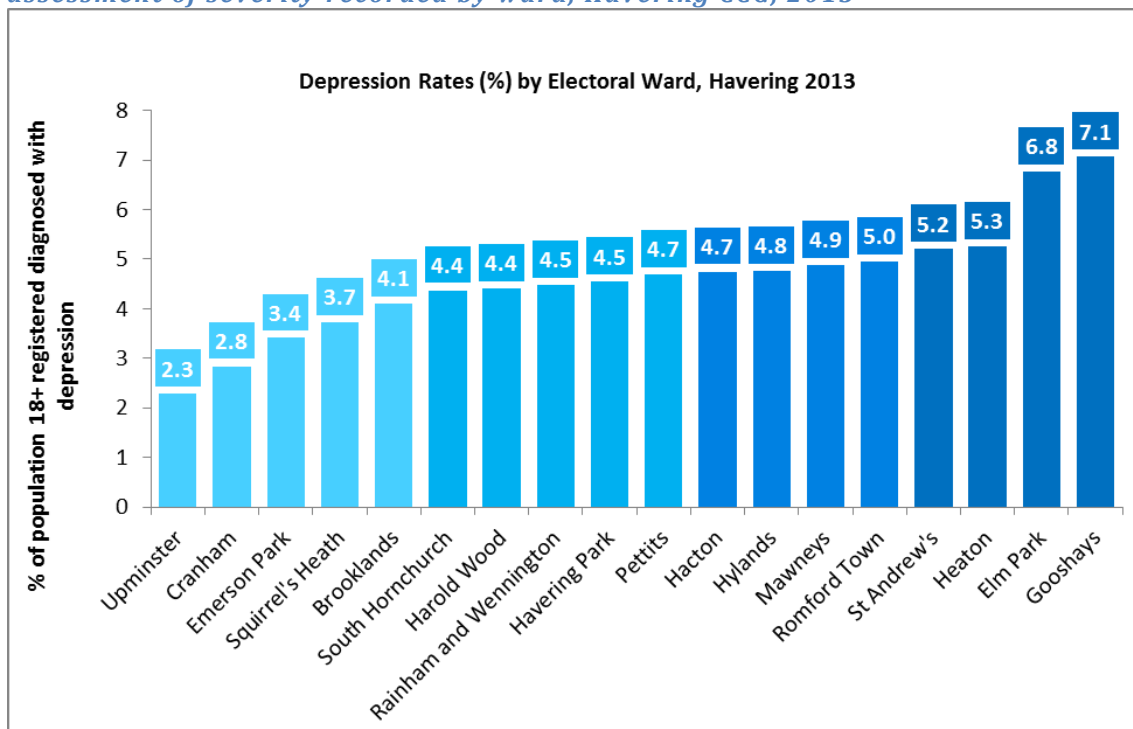
Data Source: Health Analytics

The prevalence of depression also shows a clear link with levels of deprivation (Figure 6) with depression being more common in Gooshays (7.1%) and less in Upminster (2.3%).

Increasing age is an important risk factor for increased mental health needs. There are a number of conditions that older people are more likely to experience, particularly as this group are prone to social isolation, financial difficulty, chronic physical health problems and loss.

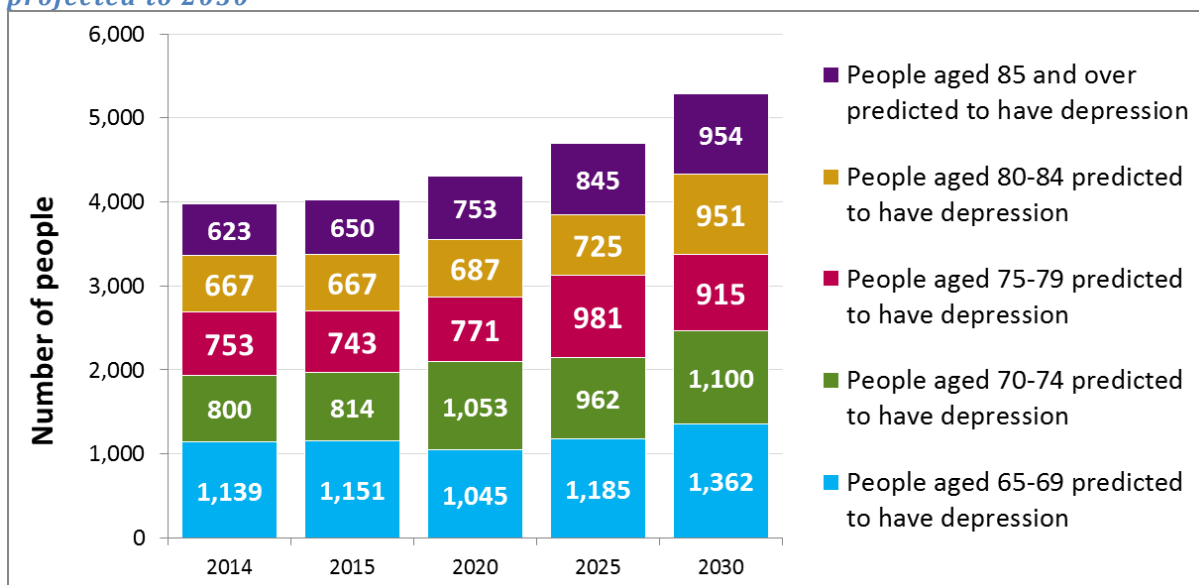
The population of people aged over 65 in Havering is likely to increase by 19% in the next 10 years (from 2014 to 2025). The likelihood of developing depression increased with age, therefore the number of people aged 65 and over predicted to have depression in Havering is expected to rise from 3,983 in 2014 to 4,698 by 2025 according to Projecting Older People Population Information System (POPPI), (Figure 7).

Figure 6: Proportion of registered population 18+ with diagnosis of depression and assessment of severity recorded by ward, Havering CCG, 2013



Data Source: Health Analytics

Figure 7: People aged 65 and over predicted to have depression, by age and gender, projected to 2030



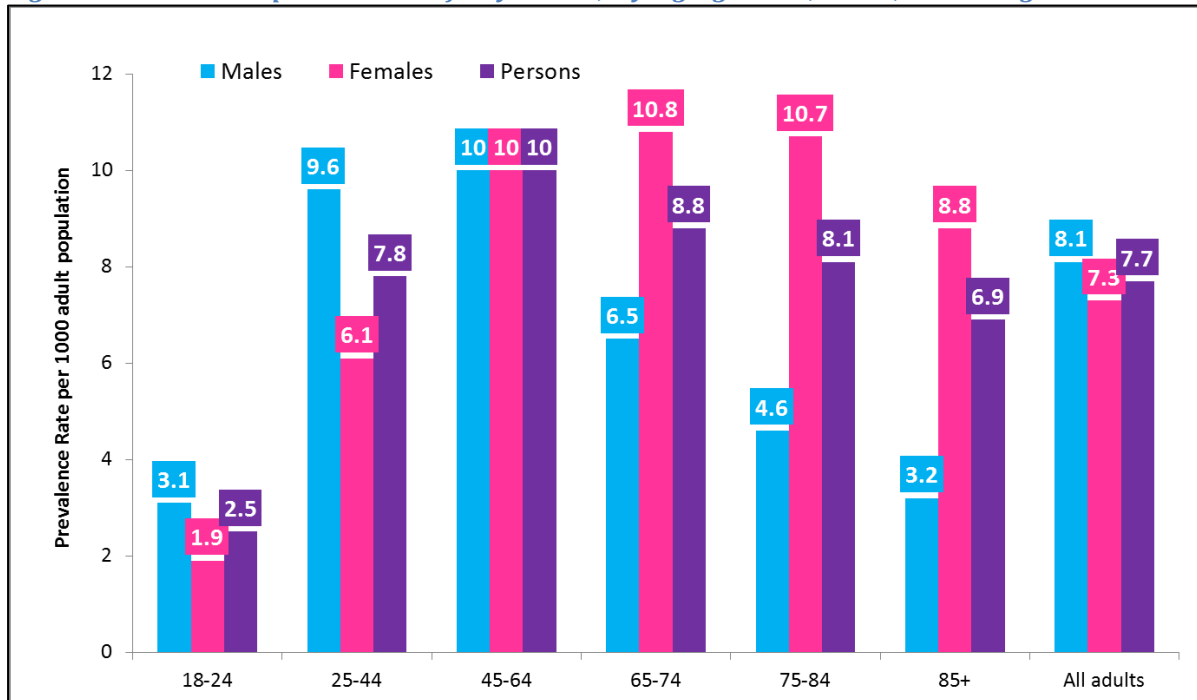
Data Source: POPPI

Psychoses

Psychoses include conditions such as schizophrenia and bipolar disorders. In contrast to depression, psychotic conditions may be more enduring, and are more likely to require hospitalisation.

Figure 8 shows the recorded prevalence of psychosis in Havering in 2013. According to GP records, around 1,595 patients have a diagnosis of a psychotic disorder. For all adults the prevalence for males is 8.1 and females 7.3 per 1,000 with predominance in men under 44 (9.6 per 1,000) and women 65 and over (10.8 per 1,000)

Figure 8: Recorded prevalence of Psychosis, by age gender, 2013, Havering CCG

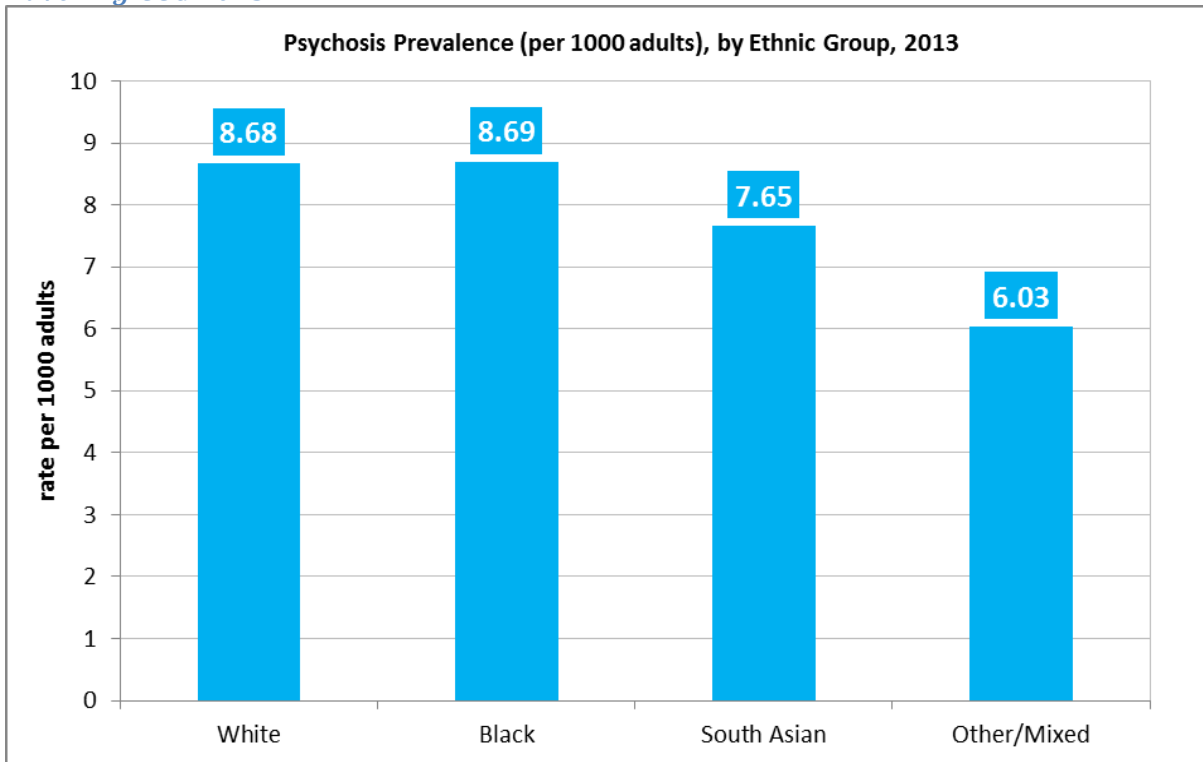


Data Source: Health Analytics

Some studies report higher levels of psychotic illness among non-white ethnic or immigrant groups. Figure 9 presents the age standardised psychosis prevalence by ethnicity for Havering. It shows a similar prevalence between the white ethnic category and black ethnic category and lower prevalence in South Asian and mixed/other ethnic categories.

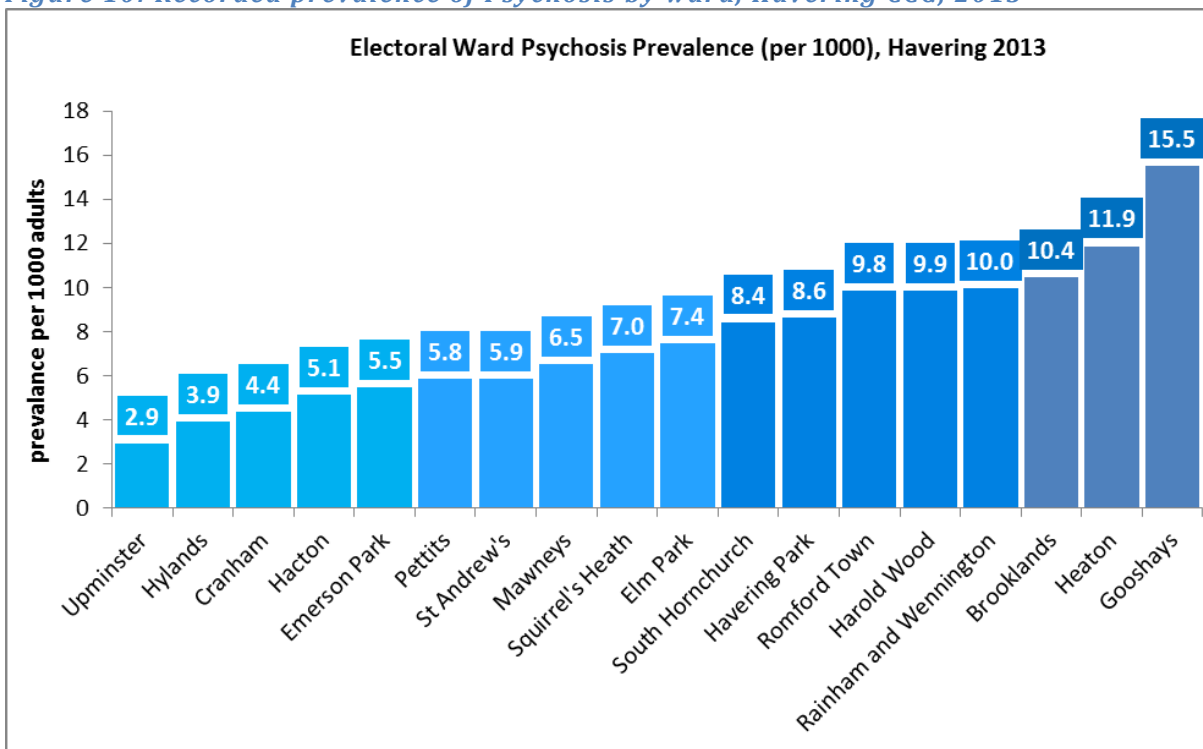
As with depression, there is a similar link between the prevalence of psychosis and deprivation (Figure 10). The prevalence of a recorded diagnosis of psychosis increases with increasing deprivations 2.9 per 1,000 adults in Upminster and 15.5 per 1,000 in Gooshays.

Figure 9: Age standardised psychosis prevalence rate by broad ethnicity group, Havering CCG 2013



Data Source: Health Analytics

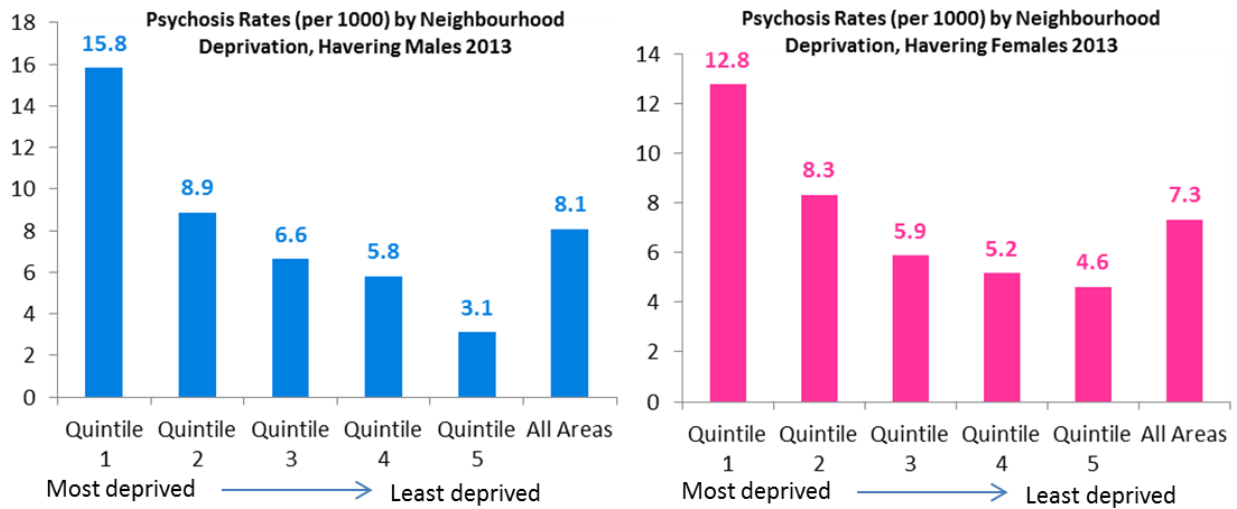
Figure 10: Recorded prevalence of Psychosis by ward, Havering CCG, 2013



Data Source: Health Analytics

Among men, the prevalence is five times higher in the most deprived neighbourhoods, quintile 1, compared to the least deprived, quintile 5 and similarly in women the prevalence is 2.7 times higher (Figure 11).

Figure 11: Psychosis prevalence rates per 1,000 adult population by deprivation quintile and gender, Havering CCG, 2013.



Data Source: Health Analytics

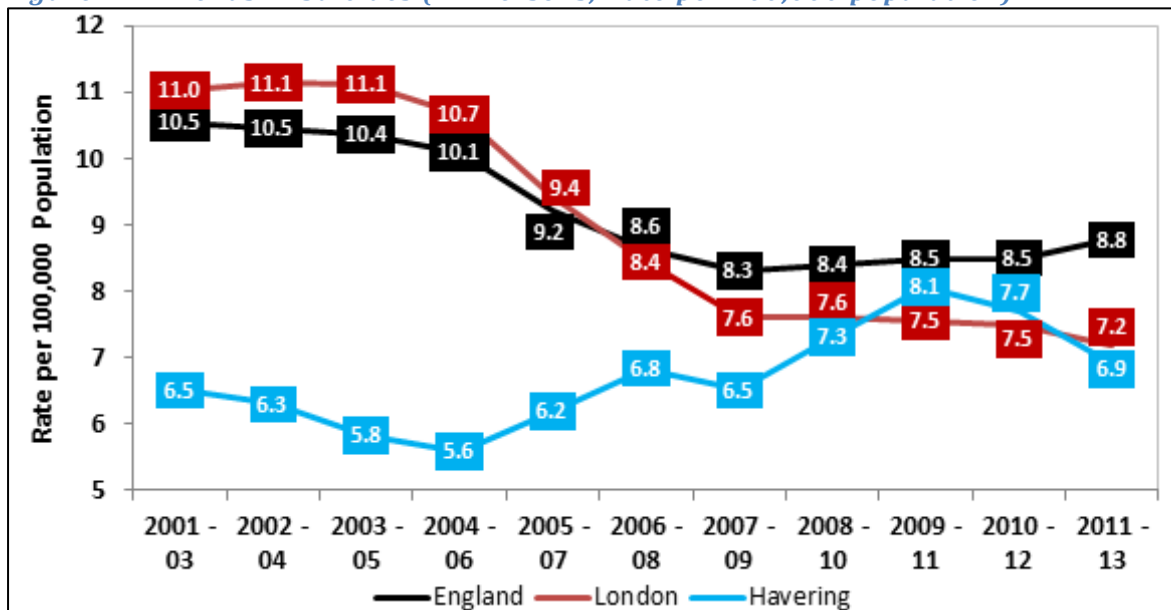
Suicide and Death from Undetermined Injury

1.1.7 Suicides

Suicides remain an important cause of premature mortality in England and Wales although the incidence has been decreasing since 2001-03, from 10.5 per 100,000 to 8.8 per 100,000 in 2011-13.

Historically the rates in Havering have been low in comparison to our statistical neighbours such as Bexley, London and in England. However, there has been a marginal increase from 6.5 per 100,000 in 2001-03 to 6.9 per 100,000 in 2011-13, which is consistent with London (Figure 12). This equates to about 16 suicides per year.

Figure 12: Trends in Suicides (All Persons, Rate per 100,000 population)



NOTE: Suicide rates are calculated over three year periods due to the small number of suicides each year.

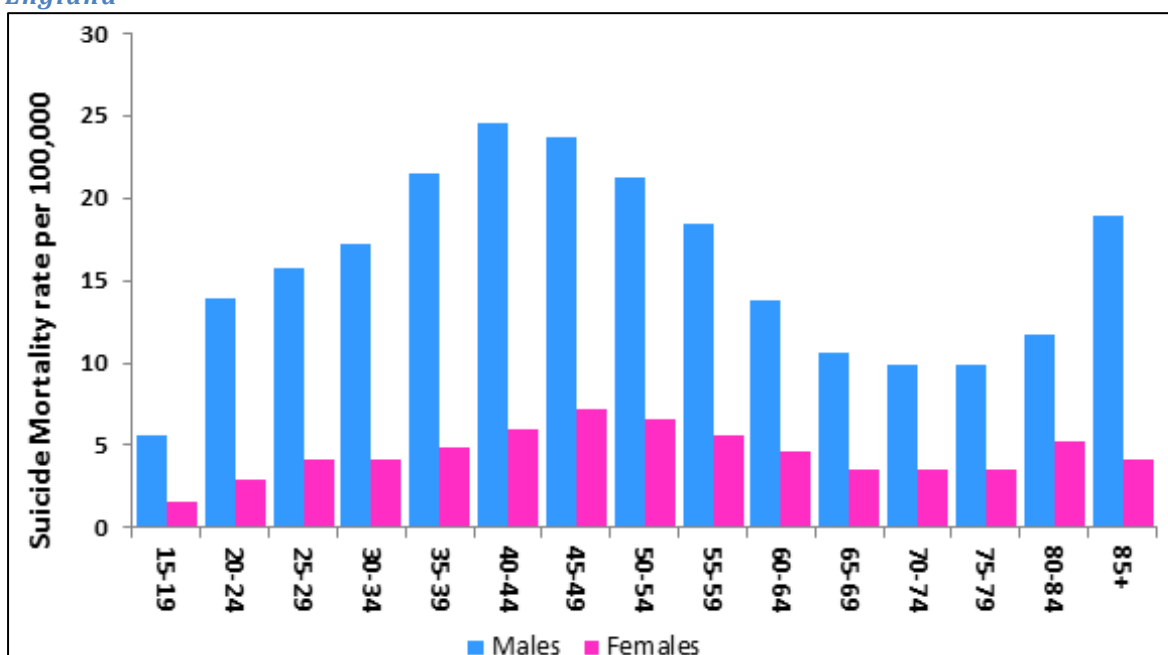
Data Source: HSCIC

The majority of suicides in Havering are seen in men. While the rate of male suicides is higher, a diagnosis of mental health problems is more likely to have been recorded for females. This may be due to (in line with the national picture) men being far less likely to present to a health practitioner with such problems.

Nationally suicide rates are three to four times higher in men (13.8 per 100,000) than in women (3.9 per 100,000) and this pattern is reflected locally. The age specific suicide rates for Havering (Figure 13) show that the risk of suicide is greater in men and peaks between 40-44 years of age.

Havering is ranked at 21 (out of 32 London boroughs) with Westminster having the highest suicide rate and a rank of 1.

Figure 13: Age Specific Suicide Mortality by age and gender, rates per 100,000, 2012, England



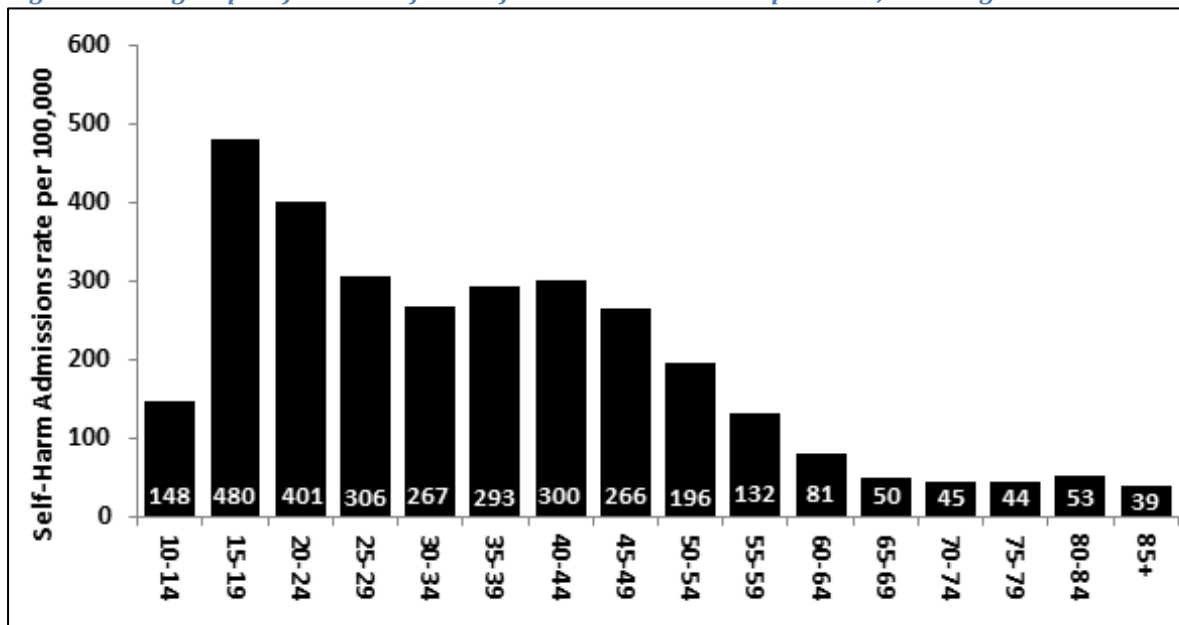
Data Source: HSCIC

1.1.8 Self-harm

The gender pattern observed for self-harm contrasts to that for suicides. Nationally, the rate of self-harm is higher in women than in men and peaks at 15-19 years of age (Figure 14). This is reflected in Havering with about 60% of admissions in females or 5 per 1,000 compared to a rate of 3 per 1,000 all persons; with rates highest at ages 15-19 (Figure 15).

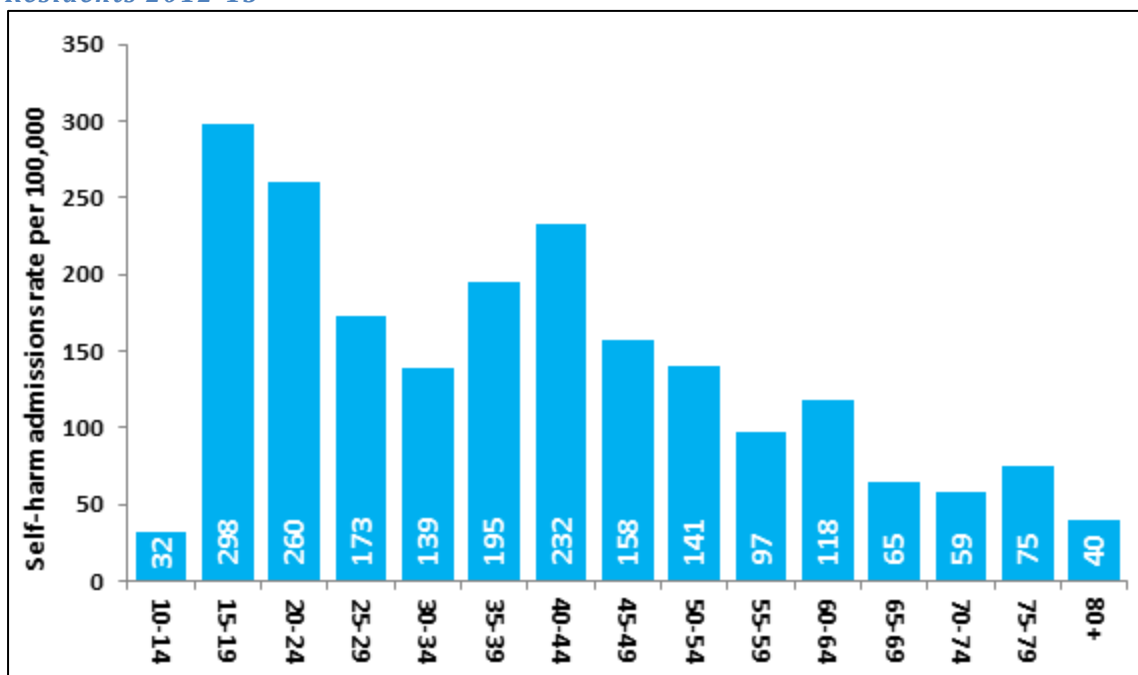
Havering is ranked at 7 (out of 32 London boroughs) where a rank of 1 means the highest rate across London.

Figure 14: Age Specific Rates for Self-Harm Admissions per 100,000 England 2012-13



Data Source: HSCIC

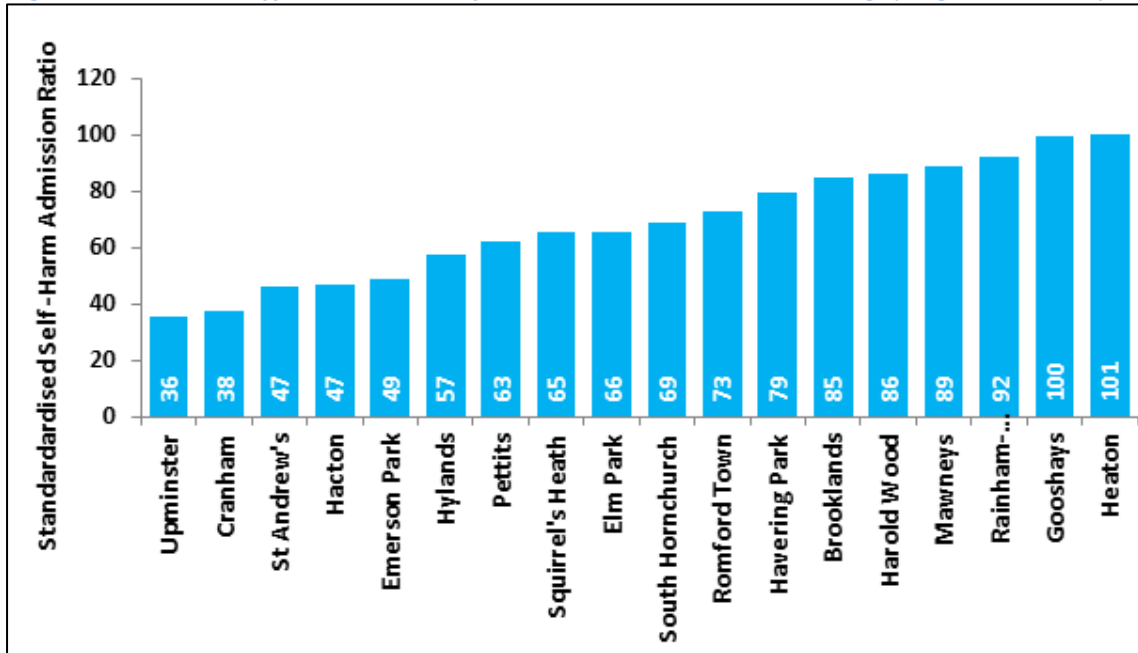
Figure 15: Age Specific Rates for Self-Harm Admissions per 100,000, Havering Residents 2012-13



Data Source: HSCIC

The risk of admission for self-harm correlates positively, with increasing deprivation (Figure 16). Residents of Heaton ward are twice as likely to be admitted for self-harm as compared to residents from Upminster.

Figure 16: Ward Differences in Self-Harm Admissions, Havering (England = 100)

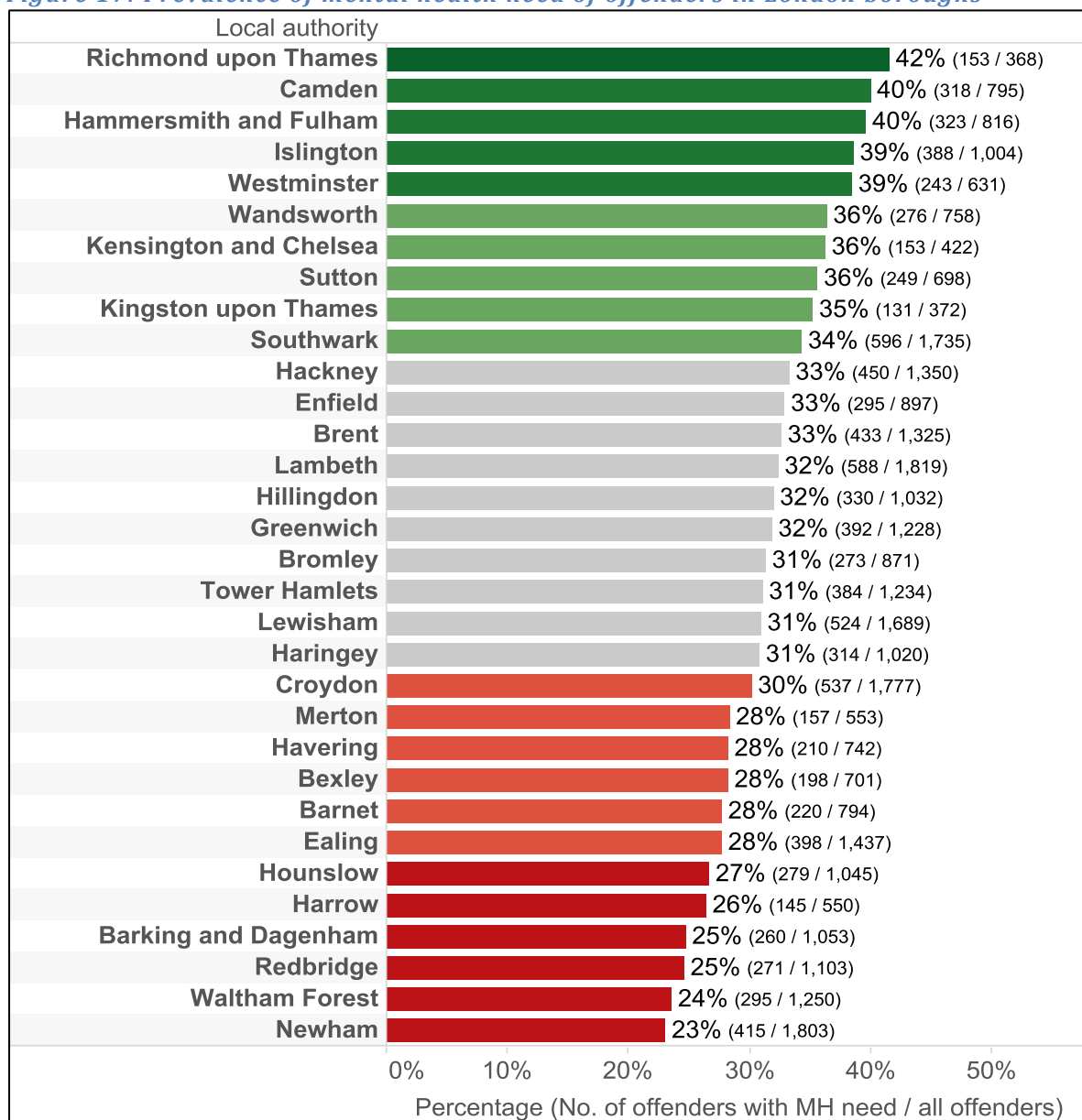


Data Source: HSCIC

Mental Health Need of Offenders

The prevalence of mental health need in offenders (Fig 17) in Havering is 28% compared to 23% in Newham (lowest) and 42% in Richmond upon Thames (highest). This appears counterintuitive as one would expect more deprived boroughs to have greater levels mental health need. It is possible that there is either a systematic failure to identify and record the mental health needs of offenders or this an example of Tudor Hart's 'inverse care law' which states that the availability of good medical or social care tends to vary inversely with the need of the population served.

Figure 17: Prevalence of mental health need of offenders in London boroughs



Data source: LAS

Mental and Physical Health

There is a strong relationship between mental health and physical health, and that this influence works in both directions. Poor mental health is associated with greater risk of physical health problems and poor physical health is associated with a greater risk of mental health problems.⁵ Mental health affects physical health and vice versa.

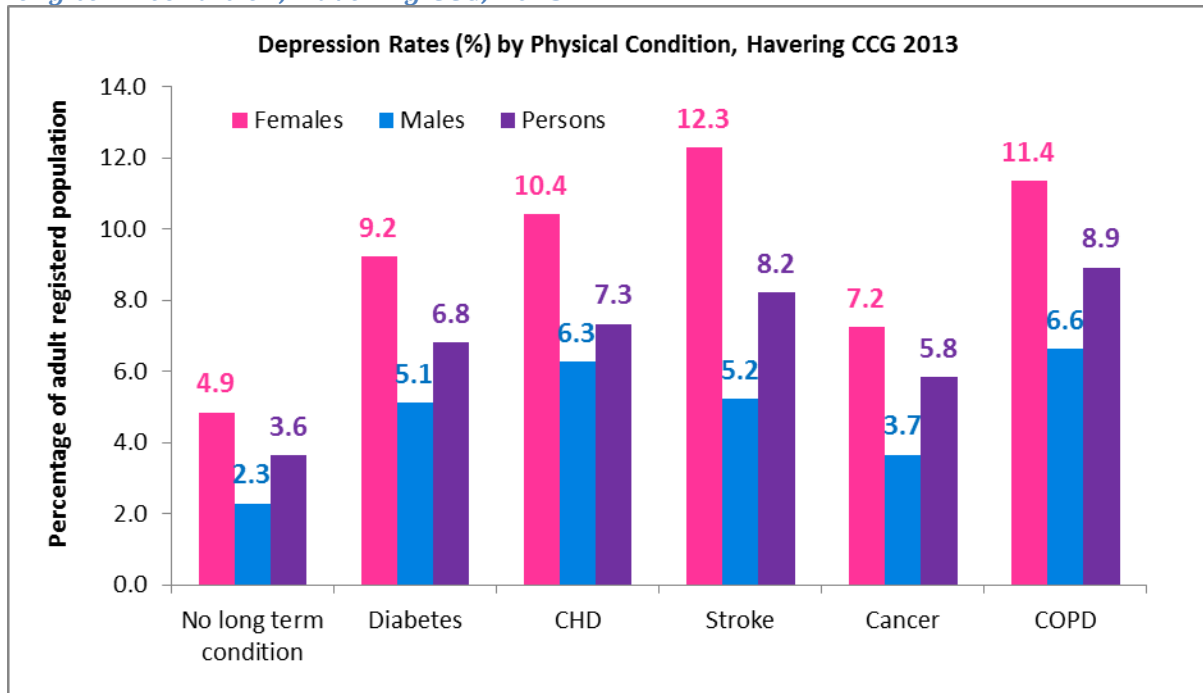
People with long term conditions such as diabetes, hypertension and coronary artery disease have double the rate of depression compared with the general population. Depression increases the overall risk of mortality by 50% and doubles the risk of coronary heart disease in adults. People with schizophrenia and bipolar disorder die on average 16 – 25 years younger than the general population. People with mental health problems are less likely to access health prevention interventions such as screening, but are also less likely to receive appropriate

⁵ RCPSYCH. Occasional paper: OP88. Whole-person care: from rhetoric to reality-Achieving parity between mental and physical health. March 2013.

interventions when they do present to health professionals (ibid). This could be due to real or perceived barriers such as stigmatisation which prevents people from taking up health improvement opportunities; or due to professionals assuming that such services are not relevant to or a priority for people with mental health problems.

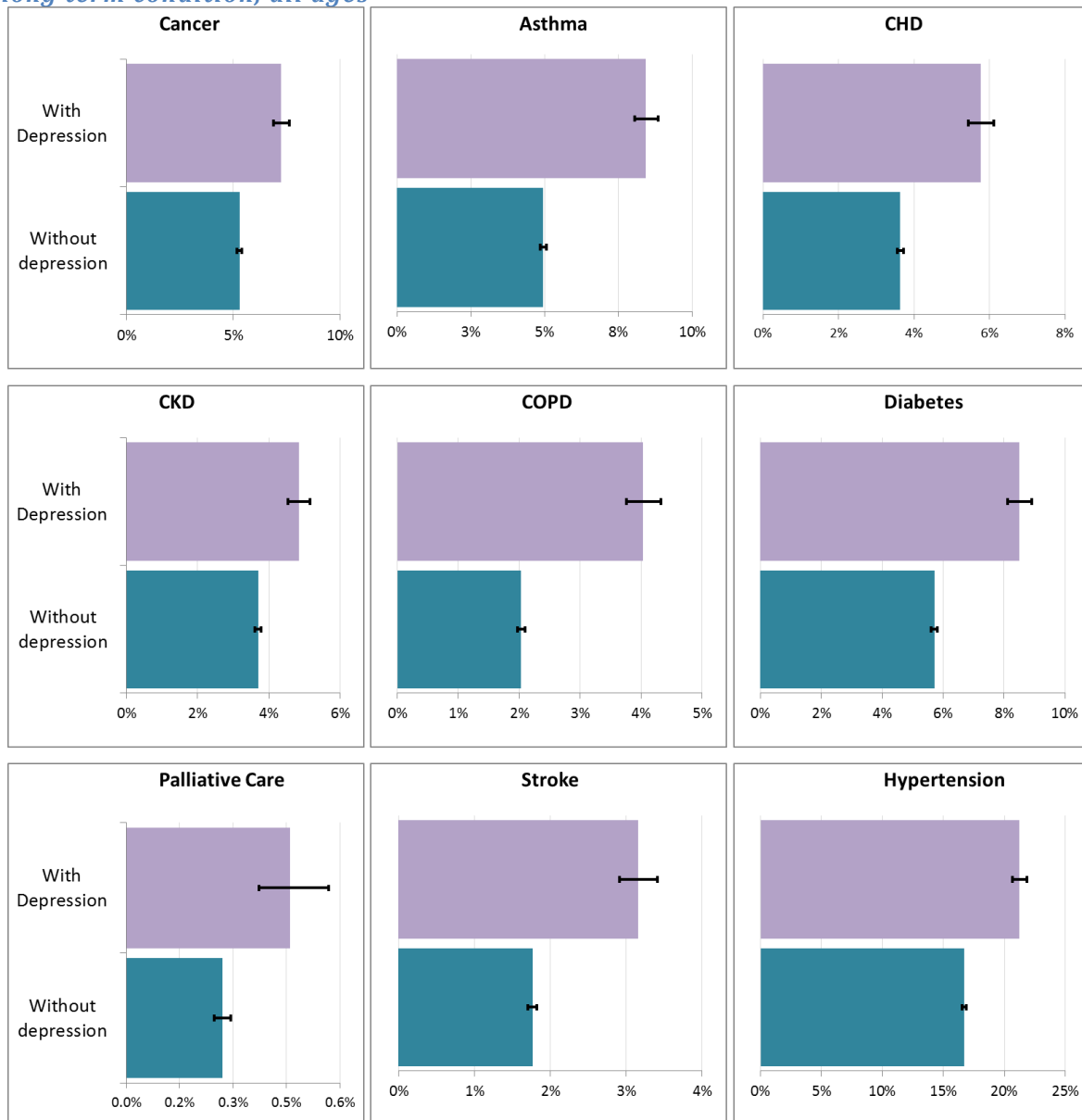
Figure 18 presents the age standardised prevalence of depression by long term conditions in patients aged 45 and over. The recorded prevalence of depression is higher in patients with a diagnosed LTC compared to those without. Figure 19 shows that with a recorded diagnosis of depression, there is a greater likelihood to have an LTC, cancer or stroke.

Figure 18: Proportion of registered population 18+ with diagnosis of depression and long term condition, Havering CCG, 2013



Data Source: Health Analytics

Figure 19: Proportion of registered population 18+ with diagnosis of depression and long term condition, all ages



Data Source: Health Analytics

Mental Wellbeing

There is a clear association between well-being, good mental health and improved outcomes for people of all ages and social classes⁶.

Poor mental health and well-being can have an impact on every area of a person’s life; physical health, education, employment, family, relationships, and the effects can last a lifetime. It plays an important part in contributing to and maintaining health and social inequalities.

Good mental health and well-being is associated with improved outcomes for individuals including longevity, physical health, social connectedness, educational achievement, criminality, maintaining a home, employment status and productivity.

⁶ Royal College of Psychiatrists. Position statement: PS4/2010. No health without public mental health – the case for action.

Mental health is not simply the absence of mental illness. People recovering from mental health conditions can have a positive state of well-being, and while those who do not have a mental health condition may experience low levels of well-being.

Although future costs of mental illness will double in real terms over the next 20 years, some of this cost could be reduced by greater focus on whole-population mental health promotion and prevention, alongside early diagnosis and intervention.

Build strength, safety and resilience: address inequalities and ensure safety and security at individual, relationship and environmental levels.

Develop sustainable, connected communities: create socially inclusive communities that promote social networks and environmental engagement.

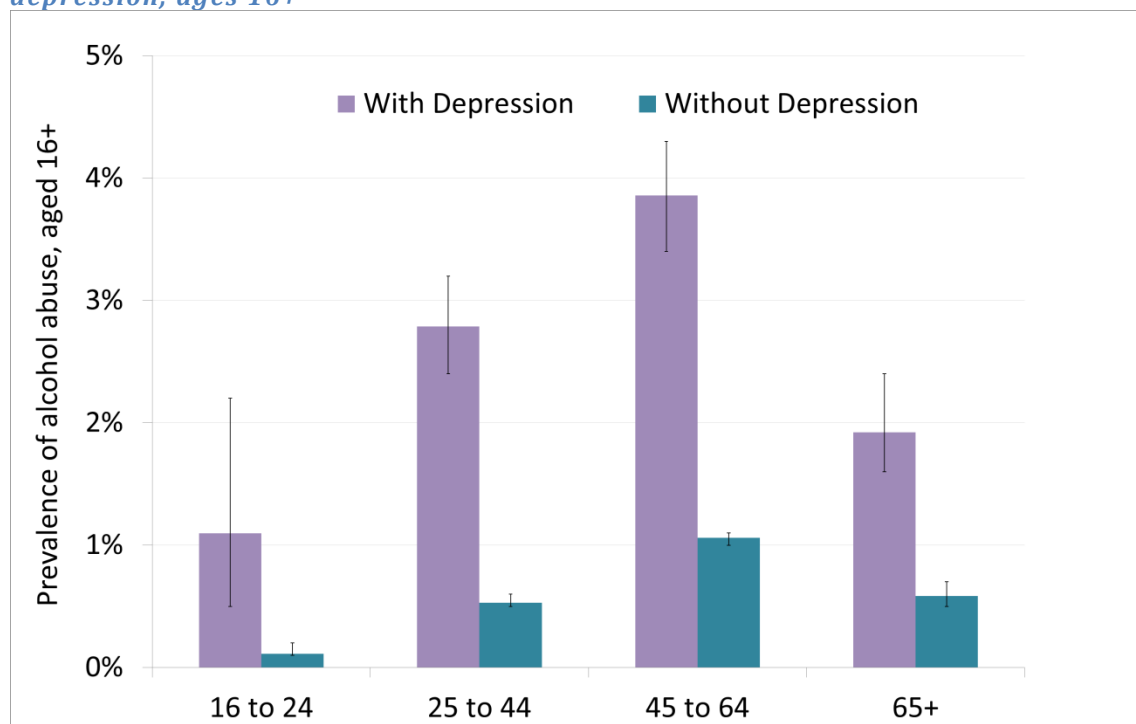
Integrate physical and mental health, reduce health-risk behaviour and promote physical activity.

Promote purpose and participation to enhance positive well-being through a balance of physical and mental activity, relaxation, generating a positive outlook, creativity and purposeful community.

Alcohol Abuse

Evidence suggests that people with mental health problems are at increased risk of alcohol misuse. Figure 20 shows that the prevalence of alcohol abuse is significantly higher in patients with a diagnosis of depression than in those without.

Figure 20: Prevalence of alcohol abuse in registered patients by presence of depression, ages 16+



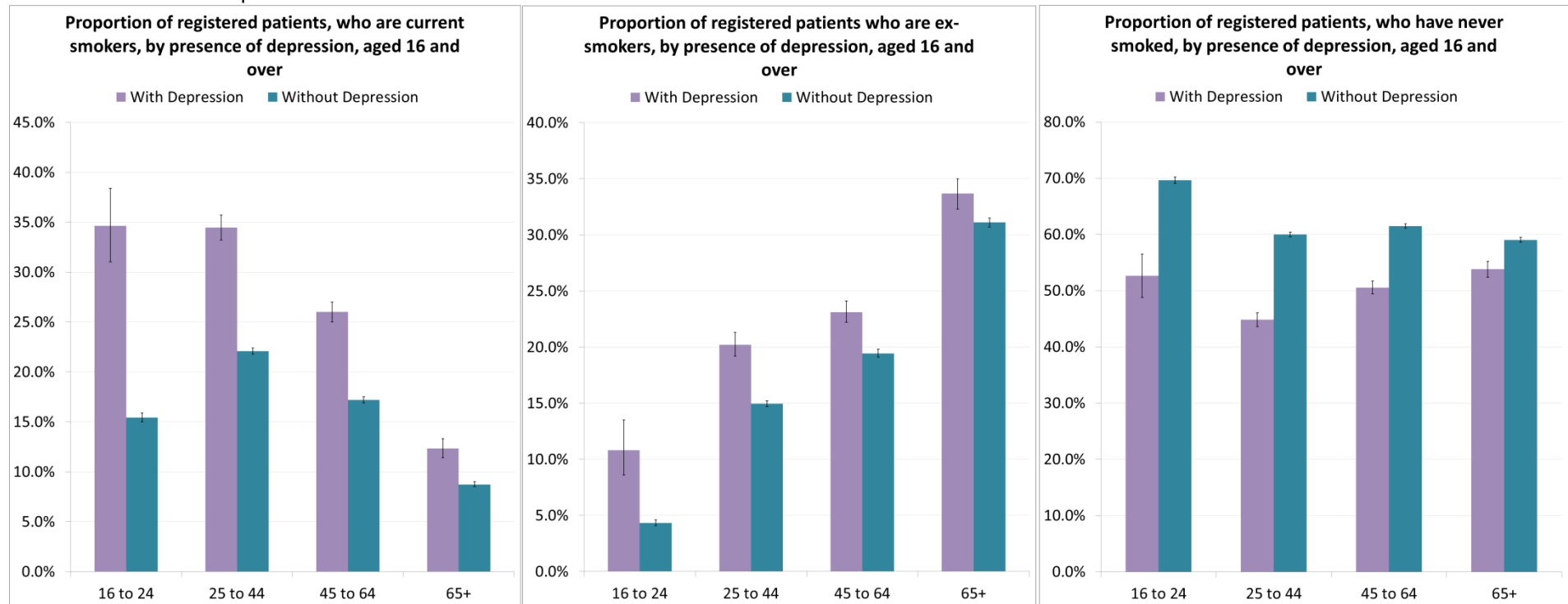
Data Source: Health Analytics

Smoking

People with mental health problems are more likely to smoke and this is reflected in the Havering population. Figure 21 presents the proportion of registered patients with a recorded diagnosis of depression who are current smokers, ex-smokers and non-smoker compared to patients without a diagnosis of depression. Across all age groups, the proportion of current smokers and ex-smokers was significantly higher in patients with a diagnosis of depression.

Figure 21: Proportion of registered patients, who are current smokers, by presence of depression aged 16+

NOTE: Y Axes are not equivalent



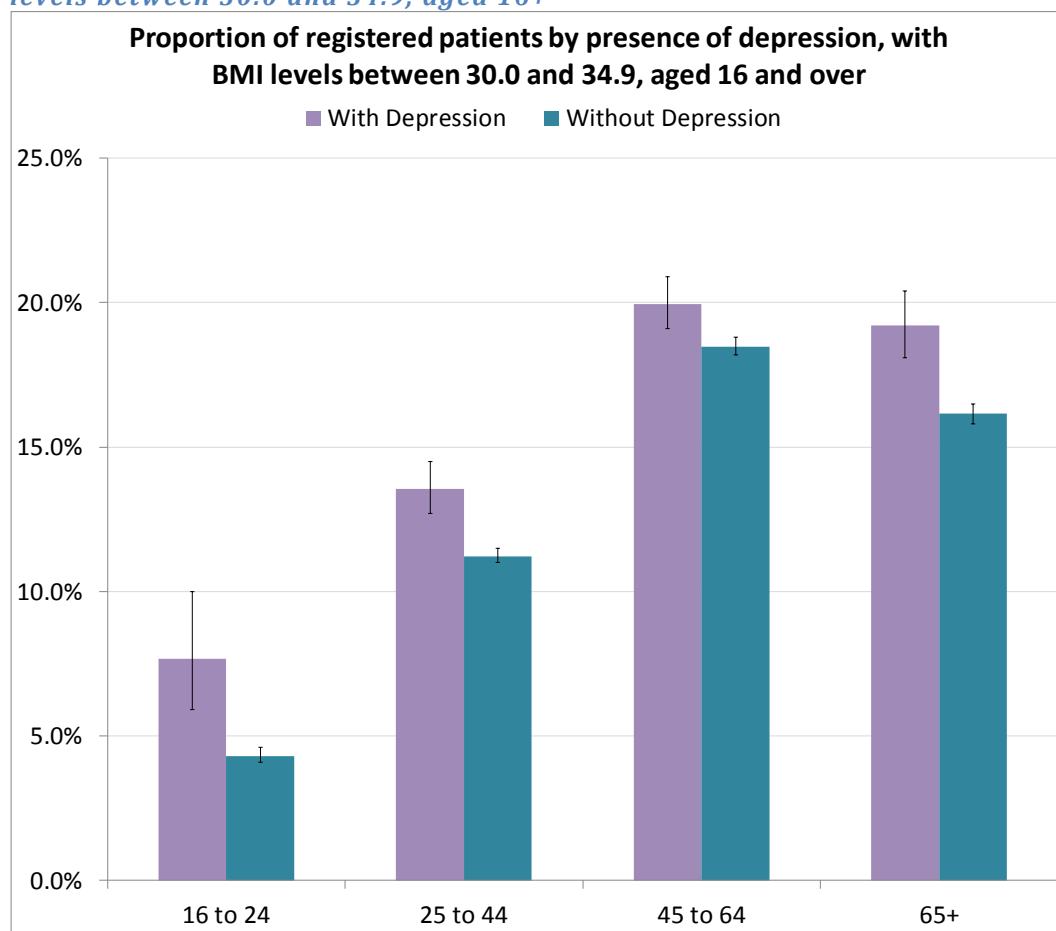
Data Source: Health Analytics

Overweight and obesity

People with a mental health problem are also more likely to be overweight or obese. As stated before this is likely to be due to a combination of individual health seeking behaviour, professional practice and the accessibility of health improvement services.

For example in Havering, the proportion of patients who are obese (BMI 30-34.9) is significantly greater in patients with a diagnosis of depression than in those without (Figure 22). This association is also seen in those patients whose BMI falls within the overweight and morbidly obese categories.

Figure 22: Proportion of registered patients by presence of depression, with BMI levels between 30.0 and 34.9, aged 16+



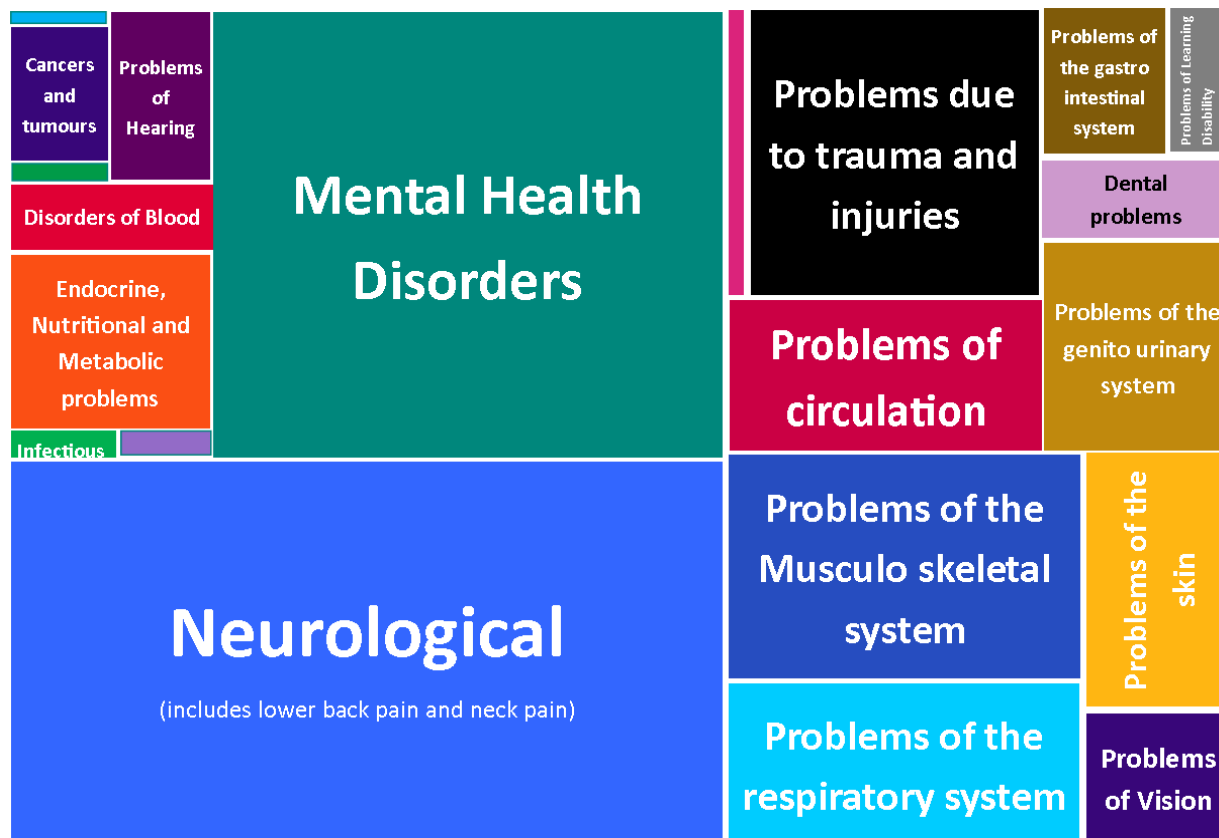
Data Source: Health Analytics

Impact

Local Burden of Disease Analysis

Application of the Global Burden of Disease (GBD) methodology to the 21 NHS programme budget categories show that in Havering mental health problems account for 23% of years of life lost due to disability (YLD), second only to neurological problems (Figure 23).

Figure 23: Years of life lost due to Disability (YLD) by Programme Budget Category in Havering



Data Source: GBD 2010 IHME Washington- 2010 Global Burden of Disease data adapted to Havering

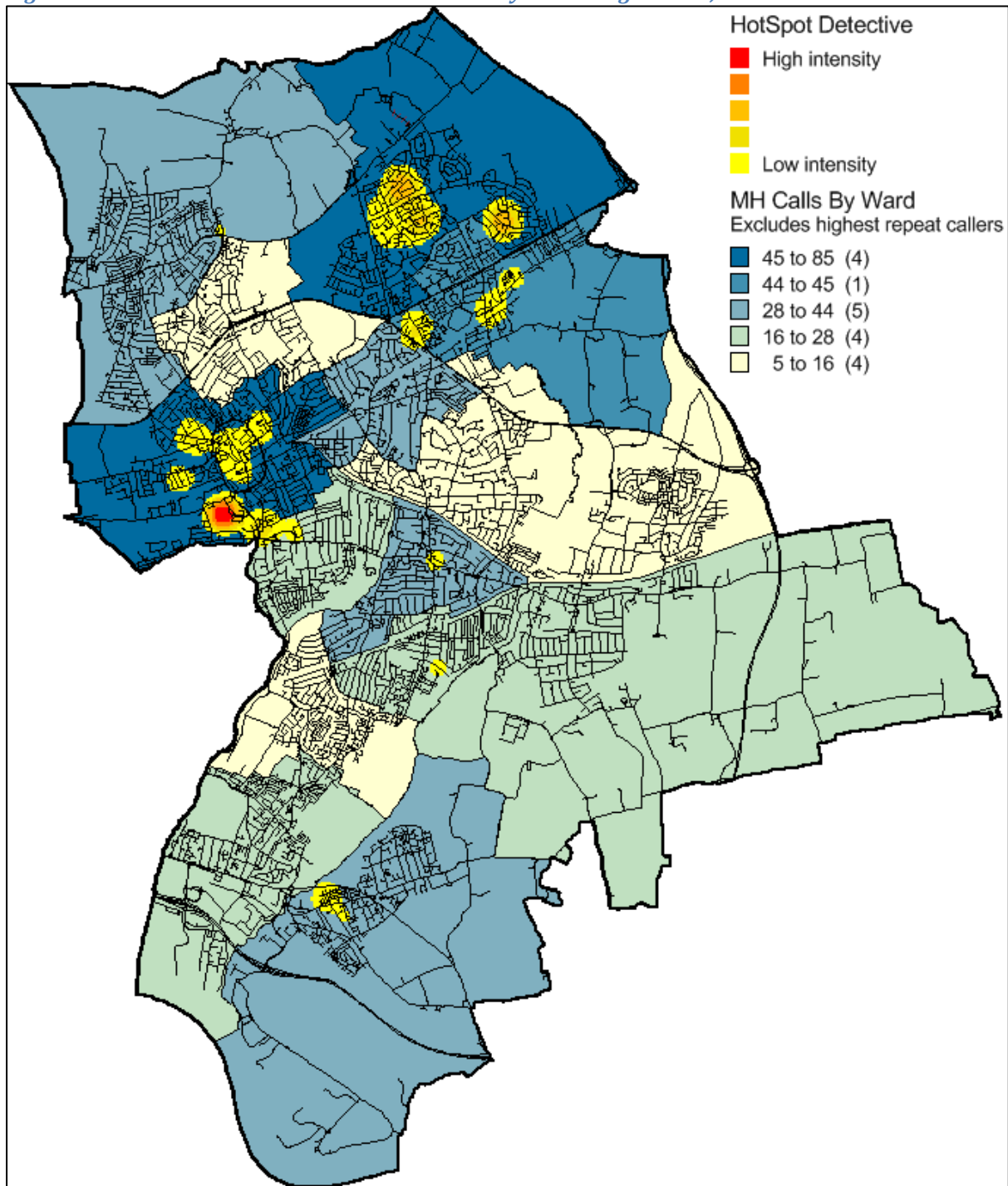
Demand for services

This section provides information on how people in Havering have used local services including emergency service, health and social care.

1.1.9 Utilisation of police and ambulance services

The impact of mental ill health is far reaching and affects other services in addition to health. Police and ambulance call outs associated with mental health problems varies across the borough (Figure 24). In general demand is greatest in wards such as Gooshays, Heaton and Brooklands.

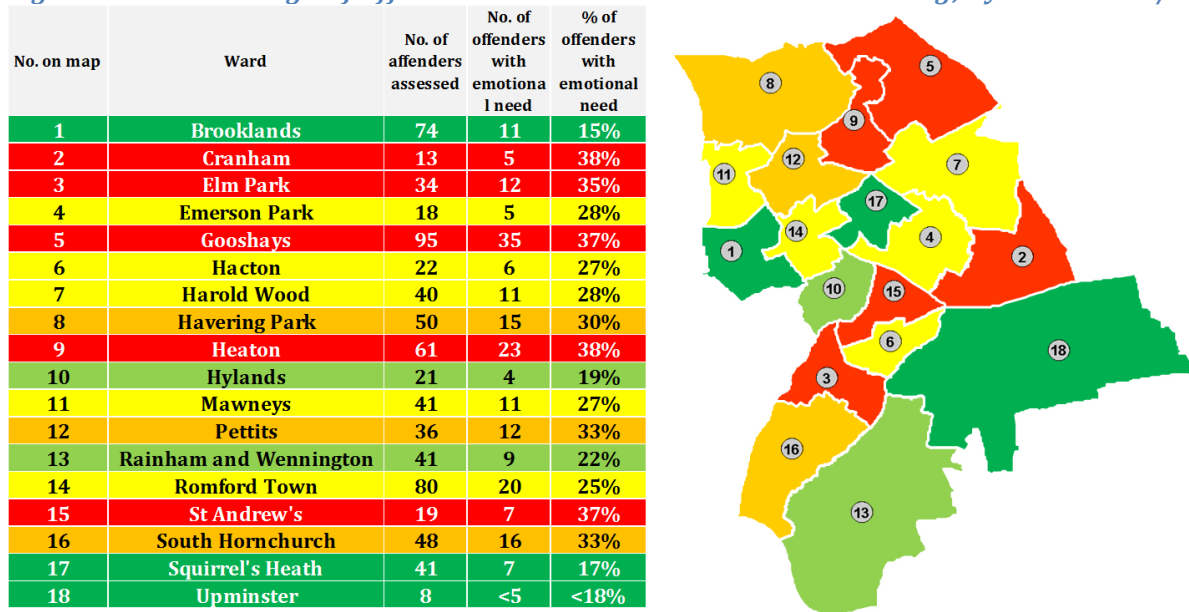
Figure 24: Police and ambulance call outs by havering wards, 2013



Data Source: Police Data

Information from the probation service shows variation in the number of offenders with emotional need (Figure 25). The prevalence is higher in wards such as Gooshays and Heaton and lower in Upminster. There is no clear association with deprivation as the prevalence of offenders with emotional need is similar in Brooklands, one of the more deprived wards, to that in Upminster, the least deprived ward in Havering.

Figure 25: Percentage of offenders with emotional need in Havering, by ward 2013/14



Legend				
Quantiles	Low (>=)	(<) High	No. of wards	
1	12%	18%	(3)	Green
2	18%	25%	(2)	Light Green
3	25%	30%	(5)	Yellow
4	30%	35%	(3)	Orange
5	35%	39%	(5)	Red

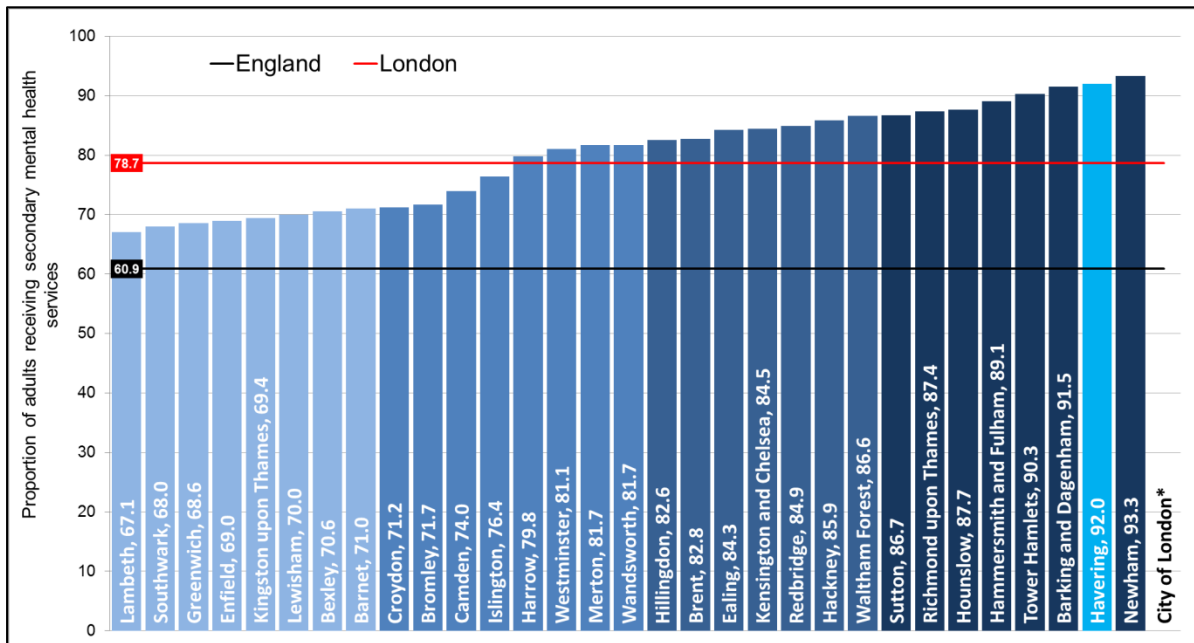
Data Source: London Probation Service

1.1.10 Social Care Support – accommodation and independence

Stable accommodation can improve outcomes for adults with mental health problems by improving their safety and reducing their risk of social exclusion. Providing social care support in this environment promotes personalisation and quality of life, prevents the need to readmit people into hospital or more costly residential care and ensures a positive experience of social care.

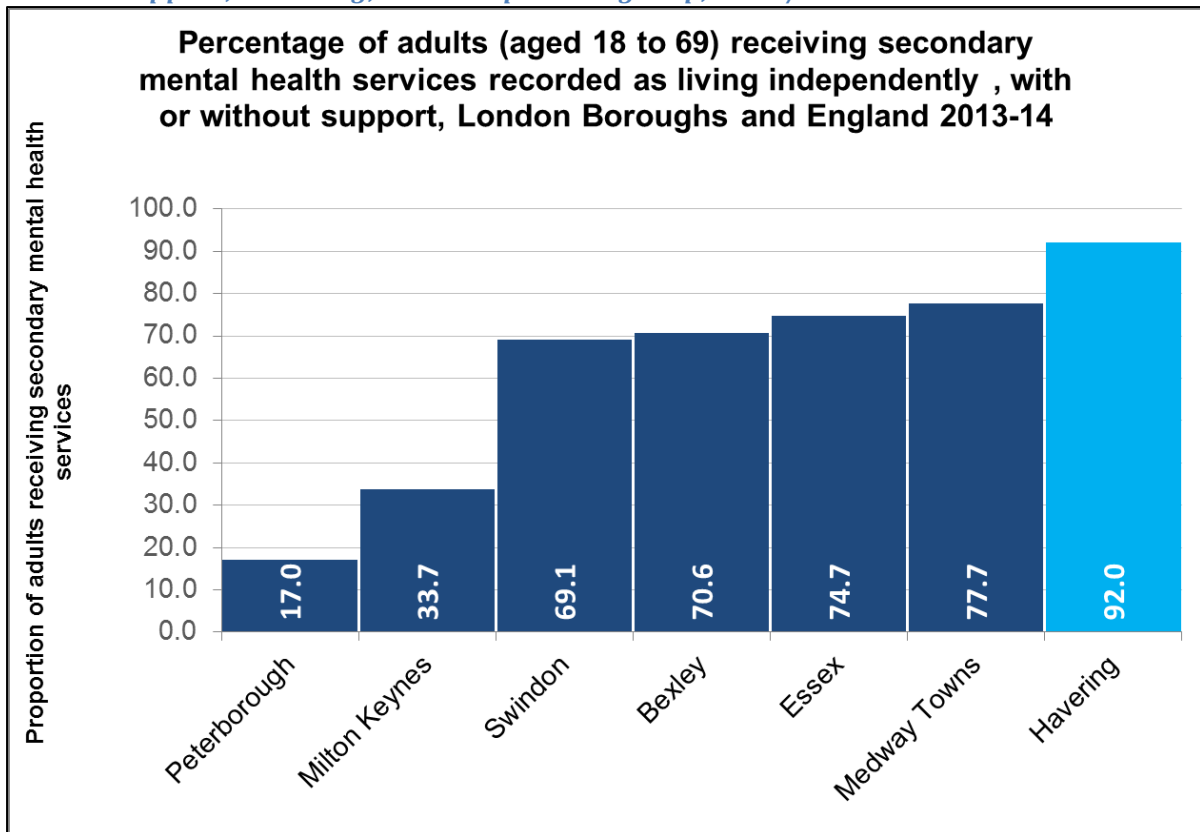
In 2013/14, 92.0% of adults (aged 18-69) in Havering receiving secondary mental health services were recorded as living independently, with or without support. This ranks amongst the highest across all London boroughs (Figure 26) and Havering's statistical neighbours (Figure 27). This support has been relatively consistent since 2010-11 (Figure 28).

Figure 26: Percentage of adults (age 18-69) who are receiving secondary mental health services on the Care Programme Approach recorded as living independently, with or without support, London boroughs, London and England, 2013/14



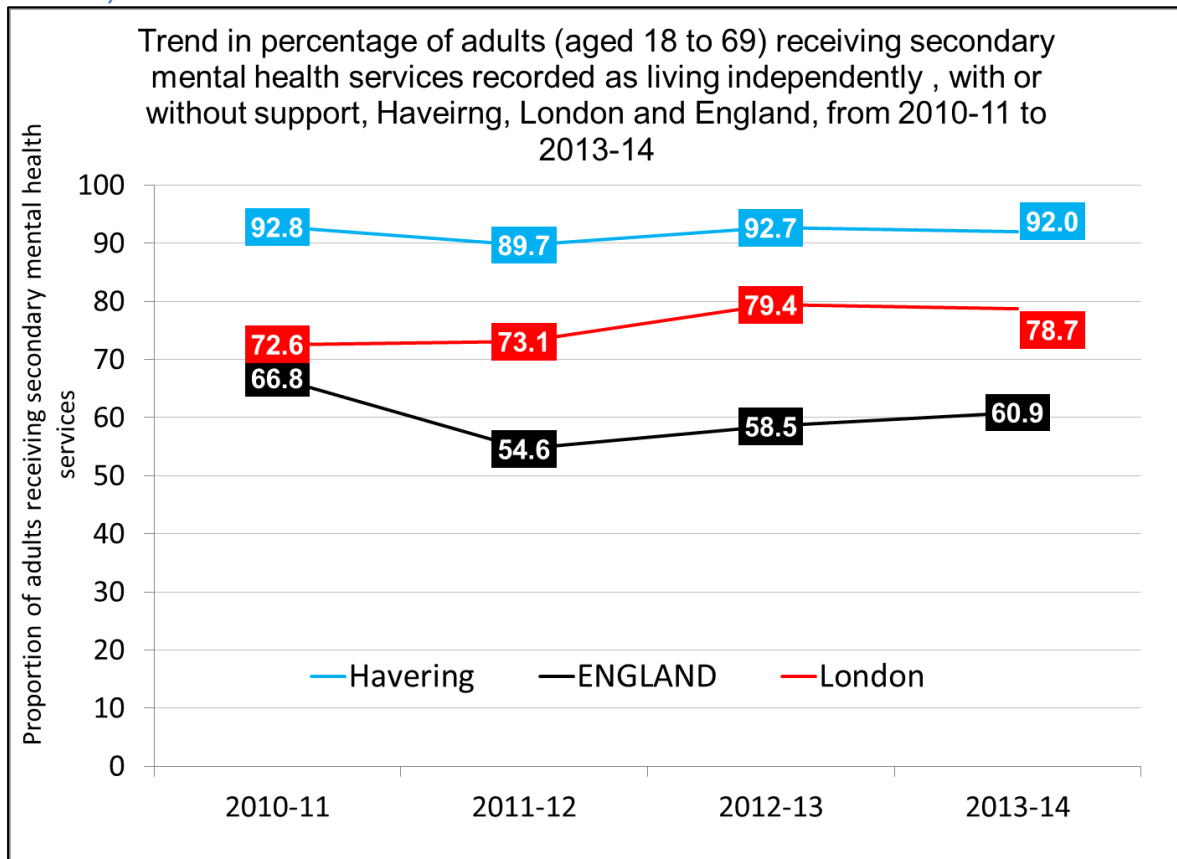
Data Source: ASCOF

Figure 27: Percentage of adults (18-69) who are receiving secondary mental health services on the Care Programme Approach recorded as living independently, with or without support, Havering, ONS comparator group, 2013/14.



Data Source: ASCOF

Figure 28: Trend in percentage of adults (age 18-69) who are receiving secondary mental health services on the Care Programme Approach recorded as living independently, with or without support, Havering, London and England, from 2010/11 to 2013/14.



Data Source: ASCOF

1.1.11 Health Service Use

The demand for health services varies depending on the local prevalence of mental health problems, the health seeking behaviour of the local population and how accessible are the different types of services.

1.1.11.1 Community Mental Health Profile (CMHP) indicators

Treatment and early intervention can help to minimise the impact of mental illness and improve overall wellbeing.

CMHP indicators for treatment of people with mental health problems provide useful comparisons with respect to service access and quality (Table 4). These also suggest areas where further analysis and understanding of the variation may be useful in order to improve mental health outcomes for our service users.

Havering has a significantly lower prevalence of patients recorded with a diagnosis of mental illness. This could be real or it may reflect under diagnosis and recording within general practice.

For patients in Havering who are in receipt of mental health care, the appropriateness of the interventions they receive is likely to be better than for England as a whole, as indicated by the significantly higher proportion of patients assigned to a mental health care cluster and who have a comprehensive care plan. A mental health care cluster is part of a currency developed to support the National Tariff Payment System for Mental Health Services. Mental Health Care

Clusters are 21 groupings of mental health patients based on their characteristics, and are a way of classifying individuals utilising mental health services from that forms the basis for payment.

The proportion of service users who were in inpatients is significantly lower than England, London and Havering ONS cluster (or statistical neighbours). This is consistent with the national shift from hospital-based care to care closer to home or in the community.

However, the proportion of Havering residents that seek help in A&E is significantly higher than England, nationally. This could indicate that people with mental health problems are inadequately supported in the community particularly in times of crisis.

Many patients with mental health problems are enabled to live independently only with the assistance of carers. For such clients the wellbeing of their carers is of utmost importance. Havering has a significantly lower proportion of carers who have had an assessment when compared to England, London and its statistical neighbours.

Table 4: Community Mental Health Profile (CMHP) Indicators 2012/13 – Treatment, Havering compared to England, London and ONS cluster.

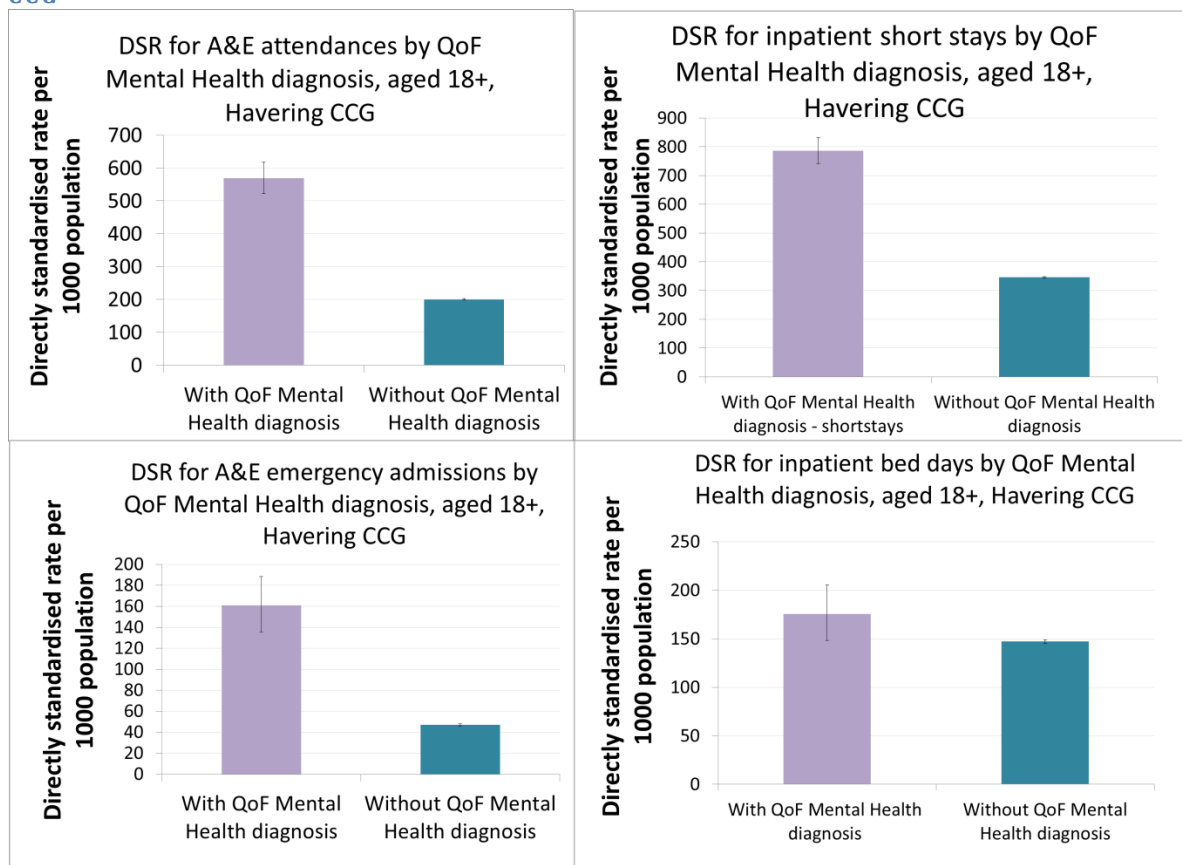
	Indicator	Compared to:		
		England	London	ONS cluster
Treatment	Patients with a diagnosis recorded, 2013/14 (Q1)	Havering has a significantly lower percentage	Havering has a significantly lower percentage	Havering has a significantly lower percentage
	Patients assigned to a mental health cluster, 2013/14 (Q1)	Havering has a significantly higher percentage	Havering has a significantly higher percentage	Havering has a significantly higher percentage
	Patients with a comprehensive care plan, 2012/13	Havering has a significantly higher percentage	Not compared	Not compared
	Patients with severity of depression assessed, 2012/13	Havering has a similar percentage	Havering has a significantly higher percentage	Havering has a similar percentage
	People with a mental illness in residential or nursing care per 100,000 population, 2012/13	Havering has a significantly lower rate	Havering has a significantly lower rate	Havering has a similar rate
	Service users in hospital: % mental health service users who were inpatients in a psychiatric hospital, 2013/14 (Q3)	Havering has a significantly lower percentage	Havering has a significantly lower percentage	Havering has a significantly lower percentage
	Detentions under the Mental Health Act per 100,000 population, 2013/14 (Q1)	Havering has a significantly lower rate	Havering has a significantly lower rate	Havering has a significantly lower rate
	Attendances at A&E for a psychiatric disorder per 100,000 population, 2012/13	Havering has a significantly higher rate	Not compared	Not compared
	Number of bed days per 100,000 population, 2013/14 (Q1)	Havering has a significantly lower rate	Havering has a significantly lower rate	Havering has a significantly lower rate
	People in contact with mental health services per 100,000 population, 2013/14 (Q1)	Havering has a significantly lower rate	Havering has a significantly lower rate	Havering has a significantly lower rate
	Carers of mental health clients receiving of assessments, 2012/13	Havering has a significantly lower rate	Havering has a significantly lower rate	Havering has a significantly lower rate

Data Source: <http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp>

1.1.11.2 Hospital utilisation

An analysis of GP-linked hospitals for all patients aged 18 and over (Figure 29) shows that patients with a QoF diagnosis of a mental health problem are twice as likely to attend A&E, four times as likely to be admitted, twice as likely to be an inpatient, and more likely to stay longer as an inpatient than patients without a QoF diagnosis of mental health problems.

Figure 29: Directly standardised ratios for hospital utilisation, 2010/13, Havering CCG

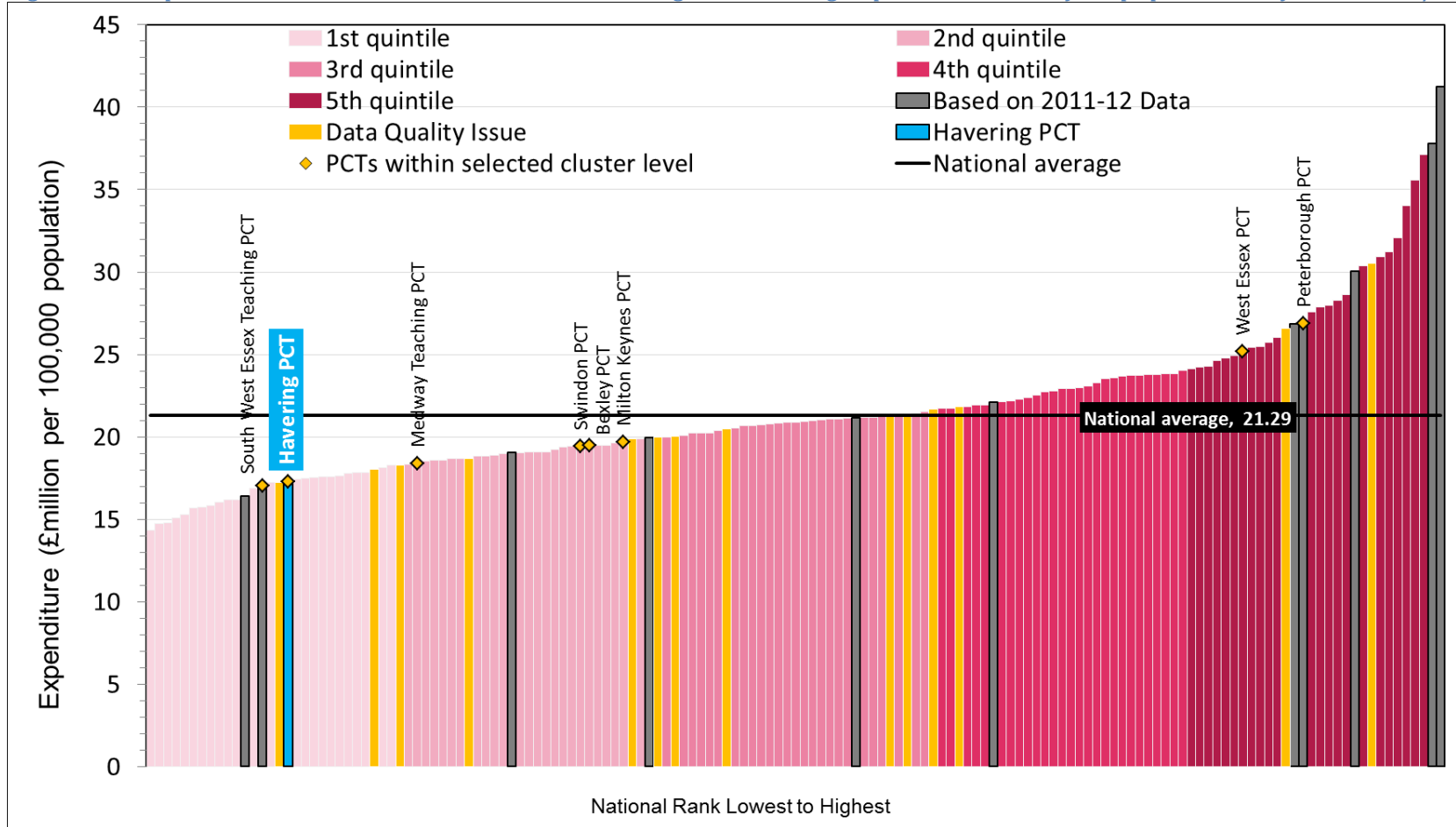


Data Source: Health Analytics

1.1.12 Spend

The most recent data available suggests that, in 2012/13 Havering PCT, now CCG, spent £44 million on mental health conditions (Figure 30), the equivalent of £17 million per 100,000 weighted populations. This was less than the London (£25 million per 100,000) ONS cluster (£20 million per 100,000) and national spend (£21 million per 100,000).

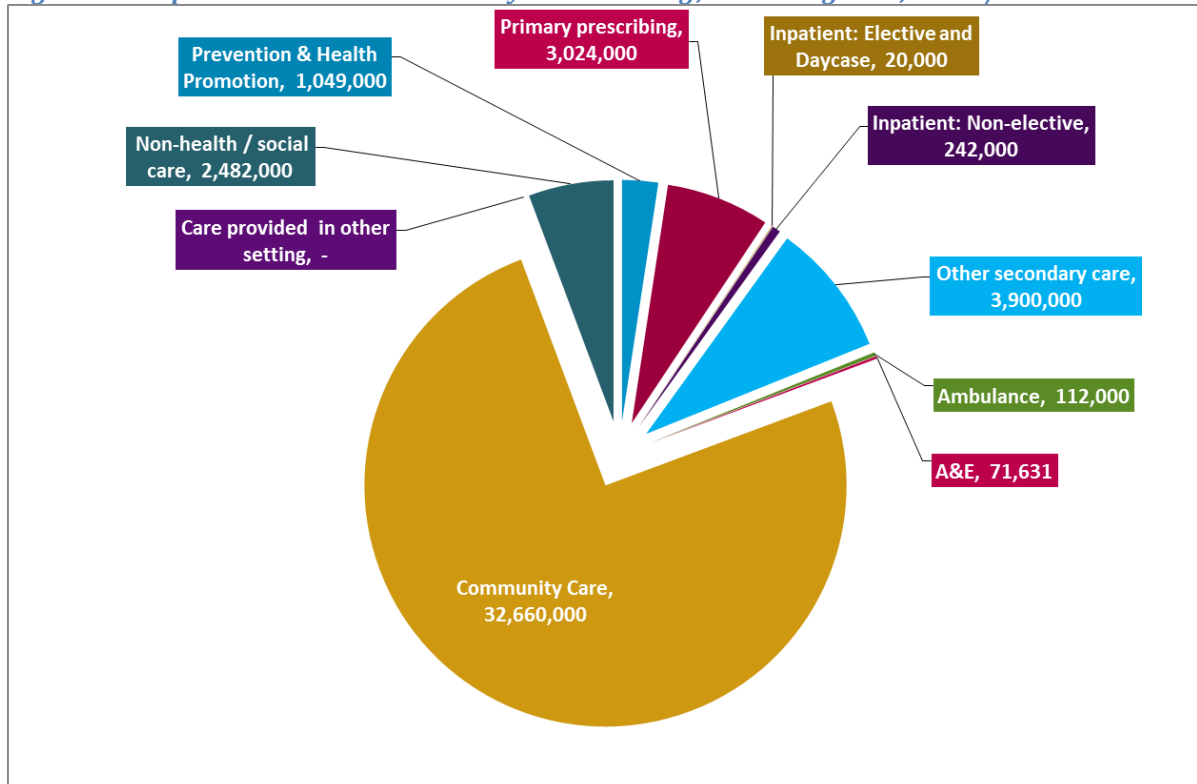
Figure 30: Expenditure on Mental Health Disorders Programme Budget per 100,000 unified population, by PCT, 2012/13



Data Source: PBC Benchmarking tool, Department of Health

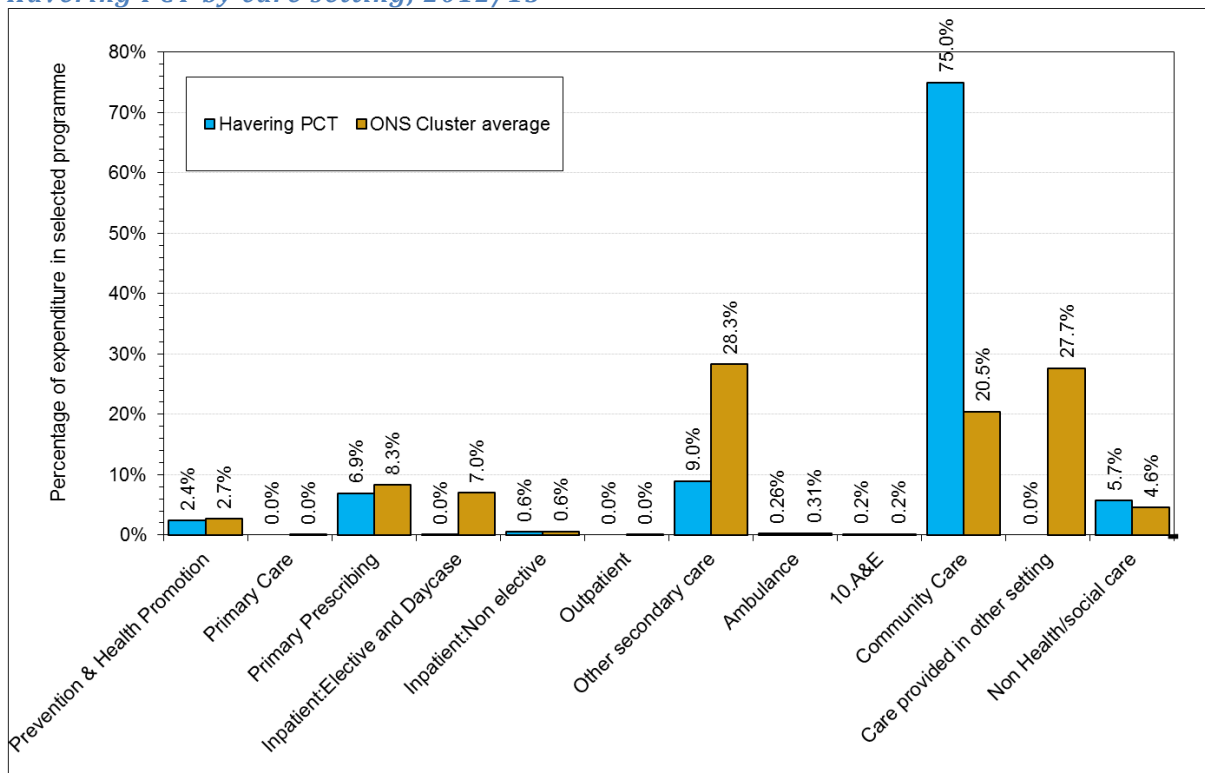
A breakdown of spend by care setting show Havering spend 75% of its mental health budget on community care (Figure 31). This was more than the national (19%), regional (14%) and ONS averages (25%) (Figure 32). This pattern of spend is in keeping with the national drive to provide mental health care closer to home with service users being supported and maintained in community based services.

Figure 31: Spend on Mental Health by care setting, Havering PCT, 2012/13



Data Source: PBC Benchmarking tool, Department of Health

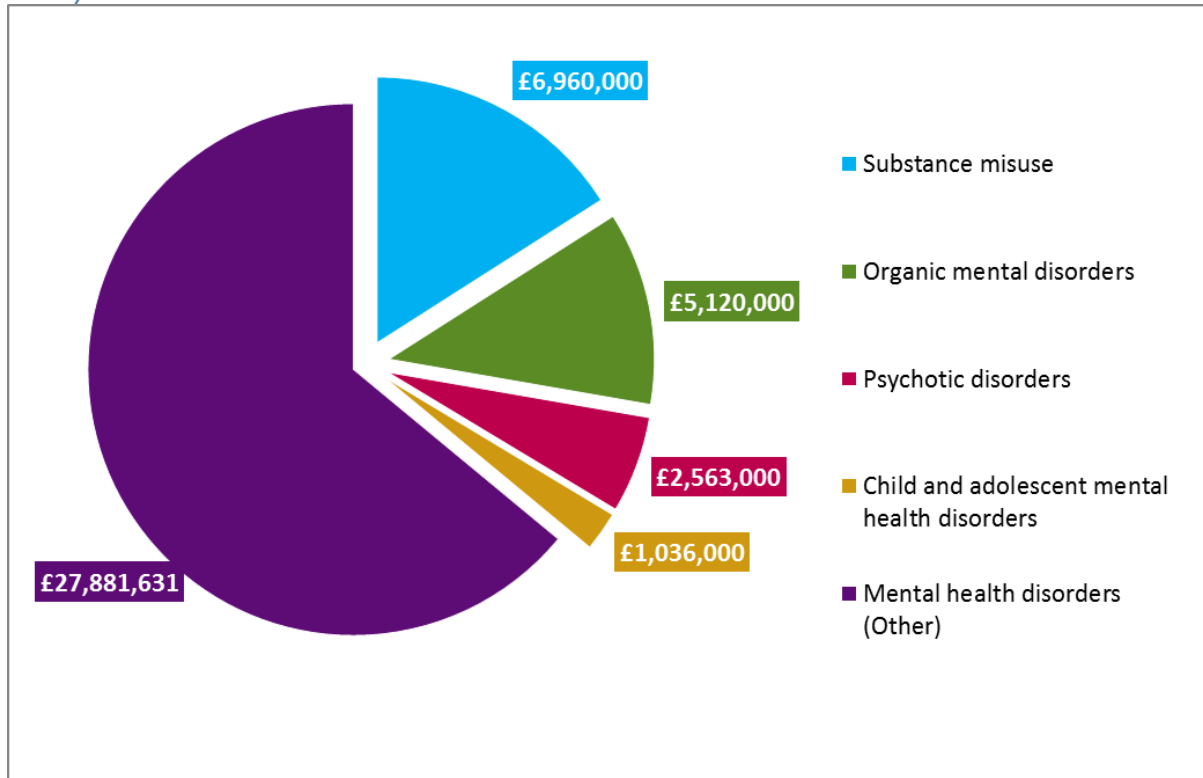
Figure 32: Proportion of mental health expenditure in ONS Cluster average and Havering PCT by care setting, 2012/13



Data Source: PBC Benchmarking tool, Department of Health

Figure 33 shows that 65% of the budget was spent on 'other' mental health disorders which would include common mental health disorders, namely: depression and anxiety.

Figure 33: Spend by mental health programme budget sub-categories, Havering PCT, 2012/13



Data Source: PBC Benchmarking tool, Department of Health

Table 5 shows the distribution of spend by mental health problem and care setting. This shows that for psychotic disorders, the majority of the expenditure is in a secondary care setting but a significant proportion is also spent on primary care prescribing. The most significant finding is that only 2% of the total budget was spent on prevention and health promotion, and only within the substance misuse service. The reliability of these findings is dependent on the accuracy and completeness of the returns made by PCTs to the Department of Health. It is possible that more was spent on prevention and health promotion but was not identified as such.

Table 5: Spend on Mental Health Programme Budge by programme care setting and programme budge care-setting, Havering PCT, 2012/13

Programme Budgeting category	Prevention & Health Promotion	Primary prescribing	Inpatient: Elective and Daycase	Inpatient: Non-elective	Other secondary care	Ambulance	A&E	Community Care	Non-health / social care	Total expenditure
05a Substance misuse	£1,049,000	£229,000	£0	£21,000	£59,000	£0	£0	£5,226,000	£376,000	£6,960,000
05b Organic mental disorders	£0	£643,000	£5,000	£212,000	£13,000	£0	£0	£3,919,000	£328,000	£5,120,000
05c Psychotic disorders	£0	£705,000	£0	£9,000	£1,801,000	£0	£0	£0	£48,000	£2,563,000
05d Child and adolescent mental	£0	£315,000	£0	£0	£2,000	£0	£0	£653,000	£66,000	£1,036,000
05x Mental health disorders (Other)	£0	£1,132,000	£15,000	£0	£2,025,000	£112,000	£71,631	£22,862,000	£1,664,000	£27,881,631

Data Source: PBC Benchmarking tool, Department of Health

Current Mental Health Provision in Havering

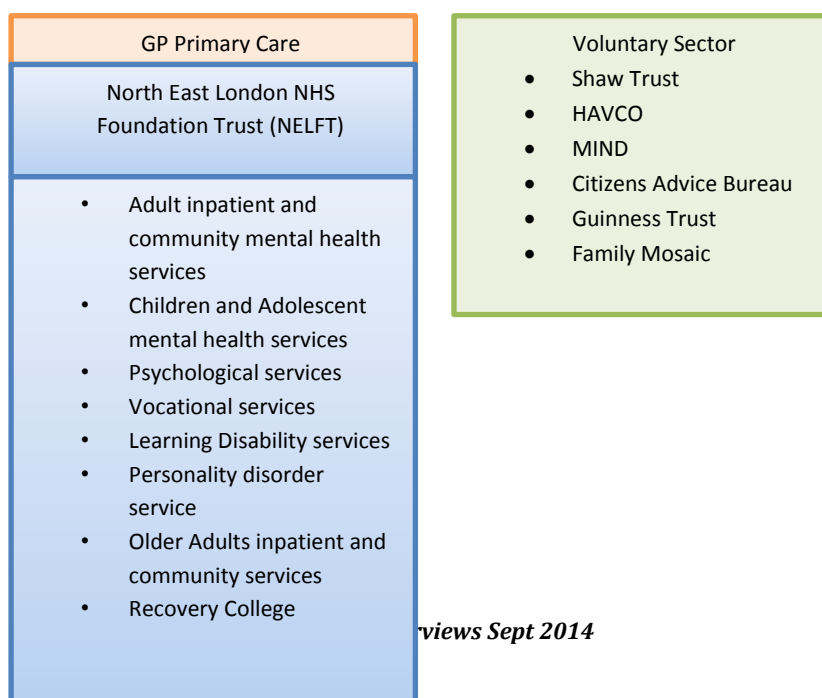
In Havering (Figure 34), people with mental health problems have access to primary care services and GPs are funded to maintain QoF registers of patients with mental health problems. In so doing this enables identified patients to be supported in primary care with appropriate interventions such as medications and talking therapies.

A comprehensive range of specialist mental health services are largely provided by North East London Foundation Trust (NELFT) in both community and inpatient settings.

Social care support is provided to service users and carers by the council's adult social care, children and young people, and housing teams.

There are also a range of non-statutory organisations which support service users with mental health problems and their carers

Figure 34: Mental Health Services available to Havering residents



Stakeholder Views

The next two points in this section provide a summary of the views and the third themes that arose during stakeholder consultation.

Strengths

- Links between mental health and substance misuse services were good (New Directions)
- Excellent working relationships with partner agencies (Family Mosaic) such as
- Positive and Effective partnerships between the Havering Access and Assessment Team (HAAT) and other agencies including MIND, the Shaw Trust and Family Mosaic; work being done currently with the Multi Agency Safeguarding Hub which should improve working together from a safeguarding perspective (HAAT).
- The Havering Community Recovery Team having become an integrative trust, meaning that professionals are able to meet and network with other clinicians in different

practice areas of health/social care, in order to promote and improve communication between both physical and mental health services and promote clearer referral pathways (Havering Community Recovery Team)

- IAPT recovery rates are good
- Range of recovery services including Mental Health Employment Services
- MASH – Multi-Agency Safeguarding Hub has improved working relationships across the system

Challenges

- People with mental illness have a significantly higher risk of emergency presentation and admission than those without a mental health diagnosis
- Under-diagnosis and under-treatment of mental illness across the population
- Spend on mental Health in Havering is comparatively low
- Performance of our services in achieving recovery associated outcomes is mixed
- Positive and effective partnerships exist but not consistent between all agencies
- The interface between mental and physical health needs to be improved
- Crisis and contingency planning needs to be improved
- Transitions need to be seamless – CAHMS to adult; step-up and step-down services; thresholds between services and teams
- Carer support needs to be consistent – a more strategic approach is required
- People with learning disability have significant unmet needs
- Value for money-skewed towards inpatient services
- Information – sharing and inter-agency working practices
- High expectations from referrers (such as being able to see clients immediately, not always possible due to planned work and staffing constraints), and service users; needs exceeding the services capabilities resulting in repeated referrals

Barriers to people seeking help and support

- Limited knowledge and awareness of what services are available
- Capability and professional language / labels
- Waiting times for services such as IAPT
- Fear of the unknown and stigmas associated with mental health services
- Chaotic behaviour, lack of motivation and difficulty in planning and keeping appointments
- Service location, cost and timing
- Sometimes the system makes things slow and difficult to respond to the needs of individuals
- Languages, other than English

“Making an appointment is really difficult and it can take people two months to even pick up the phone; people will move appointments endlessly and that alienates the service”

“Services aren’t available when I want them” (service user)

“There are significant language barriers – something that changes as the diversity of the area changes”

Themed issues

1.1.13 Provision

A recurrent theme expressed by interviewees was that local mental health services were primarily set up / oriented towards those with a severe or enduring mental health issue and that, furthermore, these services tended to have high and strict thresholds – in many cases, interviewees stating that thresholds were too high and strict. A number of respondents noted that work is being carried out with GP Practices to redirect clients to the right service, to

improve the quality of referrals but the overall impression was of a service landscape “skewed” towards higher end treatment.

The predominant provider of specialist services for Havering is NELFT and the extent of their position was characterised by one interviewee as being that of a “*monopoly provider*”. Some interviewees with commissioning responsibilities felt that contracts with NELFT had not historically been robustly performance managed and so it was not always clear what a given service was achieving with the investment made. As such, one commented that:

“We need a systematic review of contracts and a commissioning process to get the best out of what we are commissioning.”

1.1.14 Re-integrating into the community

A number of interviewees felt that better consideration was needed for individuals who are discharged from specialist services back into a family home and were particularly concerned about the impact upon the family. It was felt that crisis / contingency plans needed to be carefully developed with carers (with patient consent) so that there is an acknowledgment that, if a carer rings to say their family member is starting to deteriorate, this is acted upon. One interviewee pointed out that carers are often ‘experts’ as they have been looking after a family member and are therefore familiar with their mental health and know when they are deteriorating. It was noted that support to the carer, and recognising their role, increases the recovery environment for the client and maximises the opportunity to stay in the community and the situation to not reach crisis.

1.1.15 Primary care practitioners

It was suggested by some of those interviewed that more work needs to be done to up-skill GPs so that they are able to provide low level interventions themselves, with some interviewees of the opinion that GPs do not all “*understand*” mental health.

Interviewees saw an opportunity for more screening in the surgery environment which was commonly recognised as a key location where residents in Havering will first present with a concern about their mental health, or with a health issue that may have an underlying mental health component. One stakeholder noted that the CCG are developing a screening tool for dementia and would like something similar to be in place for mental health.

It was also noted that GPs can initiate medication and that they don’t always have to refer to the Access and Assessment Team (which then means an individual has to wait to be seen). As one stakeholder observed:

“GPs need to be trained to feel confident to be able to manage patients’ mental health within primary care where appropriate.”

1.1.16 IAPT

The local IAPT service was generally highly regarded among those consulted who felt that it offered a valuable resource in the community, enabling those with mental health issues to gain support and help before needing specialist interventions. Some interviewees were unsure as to whether there was sufficient capacity within IAPT in Havering for the level of mental ill-health in the community, and therefore whether all those who could benefit from the service were able to access it. Where clients do access however, the consensus was that it achieves positive outcomes and is a useful and successful intervention.

1.1.17 Community services

Interviewees noted that there is an increased emphasis on recovery and supporting individuals to become 'well', encouraging access into local community support offerings and thereby ameliorating the need for higher end, more specialist interventions.

Stakeholders were aware of a range of recovery services offering a range of different interventions including psycho-education groups, mindfulness and goal setting techniques. Stakeholders were aware that the focus is for individuals to have a better understanding of their mental health in order to sustain their wellbeing when back in the community.

Recently the CCG has commissioned an employment service for individuals with mental health needs. The contracts will be to provide Mental Health Employment services to help unemployed people with mental health problems to enter into employment and to help employed people with mental health problems to sustain their employment.

1.1.18 Community understanding of mental health

Respondents reported a comprehensive range of mental health conditions existing within the community. Conditions commonly mentioned were psychosis, eating disorders, substance misuse, self-harm and the problematic use of alcohol.

Stakeholders with strategic responsibility noted that mental health conditions and prevalence were largely what they would anticipate given that Havering is largely a white, elderly and affluent area. This was however caveated by one interviewee who noted that the demographic profile of the borough is changing and that Havering is becoming more diverse as new communities settle in the area. As such, the stakeholder expressed a concern that the mental health service should look ahead and "future proof" themselves, rather than continuing to be predicated on serving the historic population.

Stakeholders tended to feel that levels of mental health "literacy" in Havering were not good. As one interviewee noted, Havering has a white working class culture that does not naturally lend itself to seeking support from statutory services for health conditions – including mental health. As such, there was a sense that there is much undiagnosed mental ill-health in Havering, driven in part by the fact that many people suffering from mental ill-health are not aware of what they may be suffering with. Given this, a number of stakeholders felt that there was a role to promote the mental health awareness of the residents of Havering, in particular looking to de-stigmatise mental health and promoting help-seeking behaviour.

1.1.19 Vision for community mental health services

A number of stakeholders expressed an enthusiasm and desire for more mental health work to be located in the community – for spending and much of the focus of provision to be shifted from specialist treatment to more work around prevention and support.

One interviewee noted that work in the community could take the form of provision through non-mental health and non-health services – that is capacity building and training organisations such as BME groups, faith groups and community groups to deliver very basic screening and interventions as well as enabling them to direct people to lower level mental health services (such as IAPT). The vision expressed was one of the local voluntary sector drawing on its assets and being enabled to provide elementary support in the community, particularly given that local voluntary groups will often come into contact with residents who have yet to appear on the "radar" of formal mental health services. In this was, in addition to support being provided in the community, pathways into specialist services could be extended deep into the community.

Another stakeholder talked about building "*mental health resilience in the community*", shifting to a strong focus on prevention.

1.1.20 Accessing mental health services

In describing the presentation of clients, it was commonly noted that a number presented with social issues which have had a significant impact upon their mental health. Such wider social factors include people who are not able to maintain or who are at risk of losing a tenancy, those who are homeless and jobless. Professionals stated that, for many, these wider social factors have had a direct and casual effect on the deterioration in their mental health.

It was noted that working with external services has proven to be more difficult than internal networks – that is where the individual requires support from another part of the mental health service where pathways work relatively well. Some of the mental health teams operate without formal pathways and agreements with the external support services and as a result the response can vary and not necessarily be the response which the team are looking for. Issues can be further exacerbated when individuals have more social concerns which need addressing but can take time to organise in which time their mental health may continue to deteriorate and then they cannot engage with the expected process to try and practically sort out the social problem.

1.1.21 Clients with complex needs

The Access and Assessment service report seeing an increase incidence with complex issues due to changes in criteria for the Community Recovery Teams (CRT) who work with individuals with recognised severe and enduring problem and who need community care assessment. Even with a formal mental health diagnosis, clients will not automatically be seen by the team who have fairly strict thresholds and are clear who they will and won't see (this following national guidance). As a result the Assessment team end up working with patients longer than the intended six months due to the criteria changes in CRT who works with a different cohort of patients. Some interviewees therefore noted that further exploration is needed about those individuals who fall between the remit of the Access and Assessment Service and the Community Recovery Team and map out what their needs are.

1.1.22 Adult Multi-Agency Safeguarding Hub (MASH)

Havering have recently set up an integrated Multi-Agency Safeguarding Hub (MASH) building on the success of the children's MASH. Whilst only in operation since June 2014, there is evidence that the MASH is proving to be an effective mechanism for engaging with adults with a significant enough mental health condition for this to have come to the notice of a statutory service, but where the condition is not serious enough to warrant access to specialist treatment. This has improved partnership working and provided key agencies with a more in-depth picture of the wider needs of clients.

1.1.23 Voluntary sector provision

Interviewees spoke of having good links with a number of local agencies from the voluntary sector; in particular those which can provide practical support such as Family Mosaic who, although a housing provider, offer support such as accompanying appointments, benefits advice and so forth.

MIND was also quoted by several of the stakeholders as offering excellent services, and some of the statutory services are co-located with MIND. MIND is used in particular when individuals are being discharged from the system and require support to sustain recovery in the community.

Stakeholders also flagged up the work of Family Mosaic, a floating support service commissioned by Havering. This service carries out assessments and designed for packages for tenants who are in council accommodation and who are showing signs of being in crisis – flags include self-neglect, anti-social behaviour, alcohol and drug use and chaotic behaviour. Housing officers can make a referral to the service which can then offer a package of support to help

people support their tenancy. On occasion, this can lead to an onward referral to mental health services but often manifests as support by the service within the community.

1.1.24 Young People

Recognising that mental health services for young people are out of scope, a number of issues were raised by interviewees that warrant some attention due to the “upstream” effect that they will have on mental health provision for adults.

Those with a knowledge of children’s and adults services noted that there is a marked difference between ways of working between CAMHS and adult services and this needs to be acknowledged and managed so that young people are adequately for the change in focus and approach between children’s and adults service.

Transition meetings have been set up to support young people coming from children services but it was noted that there are not many referrals tend to be from Special Education Needs (SEN) rather than Child and Adolescent Mental Health Service (CAHMS).

1.1.25 Older people and mental health

The Primary Health Workers who support GP Practices and are involved in Integrated Care Management (ICM) reported that the main issues that they face are individuals over 65 and into their 90's, where deterioration of physical health is impacting upon their mental health. As a result individuals present with anxiety, depression and problematic alcohol use.

The older people pathway (for mental health) was reported as difficult to access. Referrals only tend to get picked up if urgent it's and so it some stated that it is not unusual for an older person to have to wait for a mental health assessment whilst in A&E/hospital. Once in the community it becomes even more difficult. Thresholds into the service were reported to be high and so older people can end up staying with the Community Recovery Team or being treated in community clinics.

Some stakeholders noted that older people's mental health can adversely impact upon their rehabilitation when trying to discharge patients back into the community from hospital. Some interviewees expressed a concern that lower level mental health issues such as depression and anxiety may not necessarily be picked up and supported by older people’s mental health services and therefore, in turn, the rehabilitation team. The lack of this diagnosis can therefore impede the effectiveness of their rehabilitation.

At the moment it was noted that services tend to tap into local services for older people such as Help the Aged, British Cross. In particular, Help not Hospital were reported to be an excellent service as they are able to support with practical support.

1.1.26 People with a Learning Disability

Interviewees with a professional Learning Disability (LD) background consistently reported poor relationships with mental health services. Mental health services were reported to not take referrals from people with an IQ score below 70, automatically thinking the person should be dealt with via LD services. As one commented:

“The LD tag fogs everything else.”

Those working in the LD field noted that mental health problems among their clients are “extremely high” and that they commonly deal with clients who are struggling with issues around depression, anxiety and other mental disorders – in particular it was noted that clients with a LD can particularly struggle with grief following a bereavement (often of a parent).

LD professionals noted that individuals with mild difficulties would benefit from receiving support in a generic mental health team as they focus more so with individuals with high end learning disability. At the moment, the mental health needs of their clients are met by the LD team in-house but it was felt that access to specialist provision would be of significant advantage.

One senior stakeholder working in the LD field noted the caveat that, whilst there is a common perception among LD workers that their clients suffer from a variety of mental health conditions, there is as yet not yet an evidence base that describes exact levels of prevalence. As such, it is not yet possible to commission specific LD mental health services given the absence of evidence that would be used to inform the type and nature of provision.

1.1.27 Wellbeing in the community

Some of the “common” factors reported by both stakeholders and services users affecting mental health in the community include physical isolation, financial difficulties and long term physical illness. In addition loss of confidence and self-esteem, and the changed behaviours can lead to deterioration in relationships within the family as well as a loss of friends. This loss of social support can compound the individual’s ability to cope with day-to-day living.

Best Practice

There has been a sea-change in terms of delivery of mental health services over the last 30 years with the deinstitutionalisation of mental health care in favour of community based mental health services as the norm.

No health without mental health

The new mental health strategy ‘No health without mental health’ outlines six objectives in order to improve the health and wellbeing of the population, the outcome of which should transform mental health care and change the way persons with mental health problems are supported as a whole in society. It is also expected that new ways of working will result in a parity of esteem between mental and physical health services.

The Government expects to see tangible changes in the following areas:

- Increasing access to mental health services
- Integrating physical and mental health care
- Starting early to promote mental wellbeing and prevent mental health problems
- Improving the quality of life of people with mental health problems

Table 6: No Health Without Mental Health- The 6 shared objectives

	Six shared objectives	Actions
1	More people will have good mental health	Prioritise mental health in the Health and Wellbeing Board
2	More people with mental health problems will recover	Recovery needs to be embedded throughout the patient pathway
3	More people with mental health problems will have good physical health	Reduce lifestyle risk factors by improved access to the following services: smoking cessation, healthy weight, alcohol and substance misuse services, physical activities
4	More people will have a positive experience of care and support	Develop patient centred services and strong user involvement in developing and redesigning services
5	Fewer people will suffer avoidable harm	Manage risk through the use of effective evidence based interventions; appropriate information sharing; and dissemination of learning from serious incidents
6	Fewer people will experience stigma and discrimination	Improve the wider community's understanding of mental health and wellbeing

Long term mental health conditions (London Model)

The London model of care for long term mental health conditions aims to support and promote wellbeing and recovery through improvements in the quality and delivery of services and improved access to mental health interventions when required. This is due to the distinct challenges with regard to mental health faced by London compared to the rest of the country.

These include:

- High levels of deprivation
- Higher prevalence of psychosis and a higher proportion of mental health admissions.
- Higher than average numbers of people with complex needs including refugees, asylum seekers and people with dual diagnosis of mental illness and drug or alcohol problems.
- Higher spend per head on mental health services with wide variation between different localities.

The principles of the proposed London model of care for long term mental health conditions⁷ include:

Recovery: to promote and support recovery and to enable those who no longer need specialist services to control the planning and delivery of their own care.

Appropriate care setting: to increase the numbers of people whose support is appropriately managed within primary care through the introduction of 'shared care'. This would free up capacity in specialist secondary mental health services to enable quicker access for those who need it.

Shared care: describes a transfer of clinical responsibility to primary care with the support and collaboration of secondary care. By improving the competence and capacity of primary care services, the model is designed to ensure that other health problems, such as physical health, are not neglected.

⁷ NHS London Health Programmes 2011. Mental Health Model of Care for London.

Moreover, a 'navigator' role is proposed to facilitate access to services available to support people with a range of other issues such as employment and housing, which may well be integral to their recovery.

Partnership working: Improved and effective communication and partnership working underpins the model. By working in partnership, it is envisaged that the expertise of the individual, their family members, friends and carers, and a range of relevant professionals, can be harnessed to develop the most appropriate plan for their care.

Suicide prevention strategy

This strategy⁸ recognises the need for action and has as its objectives and areas for action the following;

Objectives:

- A reduction in suicide rate in the general population in England; and
- Better support for those bereaved or affected by suicide

Six key areas for action to support delivery of these objectives:

- Reduce the risk of suicide in key high-risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivery sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

Crisis care concordat

The purpose of declaration is to ensure that partnerships between the NHS, local authorities and criminal justice system work to embed the following principle into service planning and delivery: *Right and appropriate response at the right time without service users and carers facing obstacles that in effect leads to harm and distress.*

The areas for action are as follows:

- Commissioning to allow earlier intervention and responsive crisis services
- Access to support before crisis point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovery and staying well / preventing future crises

Local Strategic Context in Havering

The vision in Havering is for the people of Havering to live long and healthy lives, and have access to the best possible health and care services as highlighted in its draft Health and Wellbeing Strategy (2015 - 2016). The strategy prioritises the actions needed to deliver improved outcomes for local people whilst working on the most pressing health and social care issues in the borough.

By focusing on prevention and early intervention, the Strategic Partnership hopes to relieve some of the pressure on services and enable more people to live independently and safely in their own homes for longer and with a better quality of life. One of the most effective prevention methods identified relating to positive mental health is to reduce the isolation and social exclusion experienced by many older and vulnerable people, which can contribute to mental health conditions such as depression. Tackling isolation is a focus of local preventative work

⁸ DH. 2012. Preventing suicide in England – A cross-government outcomes strategy to save lives.

with a view to do more within the community to better support these individuals and families. In this context it is therefore worth noting that the current emphasis on treatment in Havering runs counter to the expressed focus of the Health and Wellbeing Strategy.

The local Community and Voluntary Sector is recognised in providing much of the “glue” that makes Havering such a strong and cohesive community. Havering is fortunate in having a diverse range of community and voluntary sector organisations covering culture and arts, sports and leisure, health and mental health issues, cohesion and diversity issues, children and young people, technology, carers and support groups, religion and belief. There is a strong commitment to encourage community activity and ensure that the level of partnership working between Community and voluntary sector organisations is further enhanced as well as between the third sector and public sector bodies.

Havering Culture Strategy (2012-2014) highlights the role which culture services can play and the impact upon people’s lives: ranging from one-off enjoyment in an activity, to a complete transformation in a person’s life and behaviour. Participation in Culture is viewed as a powerful contribution to all three main areas of health and wellbeing; recovery from periods of illness, prevention in the development of ill health and helping to maximise a sense of wellness.

The Strategy actively seeks to promote health and wellbeing by encouraging participation and incentivising certain behaviours, such as exercise and intellectual stimulation through engagement in culture.

Given this, it is reasonable to suggest that any serious attempt to promote mental wellbeing and an assets approach in Havering needs to integrate the work of stakeholders involved in delivering the Havering Culture Strategy and reflect the role that culture can play in helping to build mental capital.

Havering Sport and Physical Activity Strategy (2013-2015) recognises that engagement in physical activity can have an impact on a range of cross-cutting issues beyond physical health, from reducing anti-social behaviour, to promoting mental wellbeing and a helping to encourage a sense of community. Again, following from this, it is possible to deduce that any work to promote mental wellbeing should seek to align and work with stakeholders engaged in the physical activity strategy given the purported benefits that activity can have on wellbeing as well as reducing social isolation.

What are the gaps?

Examination of the epidemiological, comparative and corporate information used to build this needs assessment provides a reasonable picture of the current situation in Havering. Important gaps in our local knowledge and areas of unmet need have been identified through this process and consequently a number of key recommendations for commissioners will be made.

Table 7: Key Gaps and Unmet Need in Havering

Key Gap	What is lacking
Profile of people attending A&E due to mental illness	A&E attendance for mental health problems is higher than expected however the profile and reasons for attendance is not understood. A sample of these patients needs to be reviewed in order to identify the underlying service gaps.
Prevalence of mental illness in people with learning disability	No local estimates of the prevalence of mental health problems in people with LD are available. Stakeholders have identified that the mental health need in this particular group of the population is not being adequately met
Offender mental health needs	We know that offenders have significant mental health need but we do not fully understand the

	extent of this need and whether the current provision meets these needs.
Spend on mental health services by contract – cost effectiveness of each element of the service	The data reviewed in this needs assessment is at a fairly high level. The actual spend by service lines would help to understand which elements of local services give ‘value for money’ and would inform commissioning/decommissioning decisions.
Interventions that increase the uptake of ‘ healthy lifestyle ‘services specifically in people with mental health problems particularly those with severe and enduring illness	Both stakeholders and the spend data show the lack of investment in lifestyle support for mental health service users. This is also reflected in the earlier mortality experienced by people with mental health problems particularly SMIs. Evidence suggests that professionals need to signpost and encourage people into effective services and those delivering HP services need to be trained and be confident to deliver these interventions to people with MH problems.
Effectiveness of the current service provision	There are a number of high level indicators that offer some benchmarking on the quality of MH provision in Havering but a more detailed understanding of how services particularly community services perform against NICE quality standards would be useful .
Health improvement that supports mental wellbeing and reduces lifestyle risk factors in people with mental health problems	The data shows that comparatively very little (less than 1% of MH budget) is spent on prevention. People with MH problems are more likely to die prematurely. The burden of disease increases with deprivation. This unmet need must be addressed through the commissioning of appropriate support and interventions.
Primary care capability and capacity to provide low level interventions	Stakeholders were of the view that GPs need to be up skilled to provide early identification and support within primary care.
Access to ‘talking therapies’ for people at risk of developing mental illness in particular those with LTCs	Stakeholders raised their concerns about capacity and accessibility to talking therapies. Evidence suggests that people with LTCs especially inn older age group would greatly benefit from early access to IAPT
Alcohol and substance misuse services that can provide early interventions for people at risk of developing mental health problems i.e. not patients with a dual diagnosis	There is a gap in provision for people who fall below the threshold for specialist services but who are at risk for deteriorating to the level where they then do meet the access criteria for more expensive interventions.
Carers	The needs of carers who look after people with MH problems are unknown. Carers are an essential part of the support network for people with MH problems and their needs are not consistently met despite the presence of a Havering Carer’s strategy
Suicide prevention	No strategic multiagency approach to suicide prevention in Havering

Recommendations for Commissioners

The following are recommendations which will enable Havering to address the objectives set out in the national mental health strategy.

Prevention

- Commissioners need to work with partners to explore and develop interventions that will improve mental wellbeing, mental health awareness and reduction in the stigma associated with mental illness. This could be taken forward through the expansion of the 'Havering Health Network'. The latter is a network of health champions, health trainers and voluntary sector organisations.
- Commission prevention services targeted at people with mental health problems particularly those with severe mental illness e.g. specialist smoking cessation services.
- For the wider community work with partners to ensure there is sufficient capacity in prevention services such as smoking cessation, weight management and physical activity to reduce the risk of developing long term conditions such as COPD, diabetes and heart disease.
- Commission additional capacity in 'talking therapies'. This may require a new model of service delivery including a range from self-help, brief interventions to specialist IAPT services.
- Develop a multiagency response to suicide prevention as per the national Suicide Prevention Strategy.

Service improvements

- Develop capacity in primary care to support early identification of people at risk of developing mental health problems. This could be initially targeted in practices with higher levels of QoF registered patients with LTCs and in areas with the highest levels of deprivation.
- Improve the understanding of the mental health needs of people with learning disability, those who access accident and emergency services, and those of offenders.
- Review the appropriateness of antidepressant prescribing in primary care and understand whether these patients are accessing the full range of interventions and support that should be available to them.
- Commissioners should map current services and describe the wider support available to Havering residents e.g. service directory or prospectus. This could be made available electronically and through other formats as appropriate.
- The pathway of care for older people with mental health problems needs to be clarified and effectively communicated to them and their carers and must also address their physical health care needs. Commissioners need to ensure that mental health services are commissioned to meet the future needs of the local population taking into account population growth; changing age and ethnicity profiles; and new models of service delivery. This should also address the rebalancing of spend which should focus more on community based and less specialist provision.

Effectiveness

- Commissioners will need to work with partners to assess whether the current service is able to support the delivery of the national Crisis Care Concordat.
- Commissioners should ensure that mental health service providers are compliant with NICE guidance and quality standards through a process of systematic audits and service line evaluations guided by the service user / carer feedback and serious incidents.

Parity of esteem

- Commissioners need to support the change in organisational culture working with partners to deliver real change for people with mental health problems so that irrespective of where they are seen both their mental and physical health needs are addressed.