HARINGEY JSNA: FOCUS ON

ADULT MENTAL HEALTH

APRIL 2019

Mental health conditions are very common, affecting one in four people at some point in their life and one in six adults at any one time. Mental health conditions include depression, anxiety, psychosis, schizophrenia and dementia. Together, they account for the single largest source of disability and ill health in the UK. Although suicide is relatively rare, it is an important cause of preventable deaths with lasting, devastating impacts on those bereaved. People with mental health conditions experience more physical ill health and earlier mortality than the rest of the population. Mental ill health, and the stigma and discrimination associated with it, can have negative impacts on every aspect of life, including social inclusion, employment and education, with economic hardship and physical ill-health leading to a significant risk of earlier death.
Good mental health is also characterized by wellbeing, self-esteem and social inclusion.

Facts and figures

- There were 22,752 adults diagnosed with depression, anxiety or both registered with Haringey GP practices in 2018.[1]
- Sixty-one per cent of people aged 18 and over diagnosed with depression and/or anxiety were women in 2013.[1]
- 4,103 adults with a serious mental illness were registered with a Haringey GP practice in 2018.[2]
- 64 suicide deaths were reported in Haringey between 2015-2017.[3]

Measures for reducing inequalities

- Reducing structural barriers to mental health - Promoting access to education, meaningful employment, housing, services and support for those who are vulnerable.
- Strengthening communities - Increasing social support, inclusion and participation.
- Strengthening individuals - Increasing emotional resilience through interventions designed to promote self-esteem.

Population groups

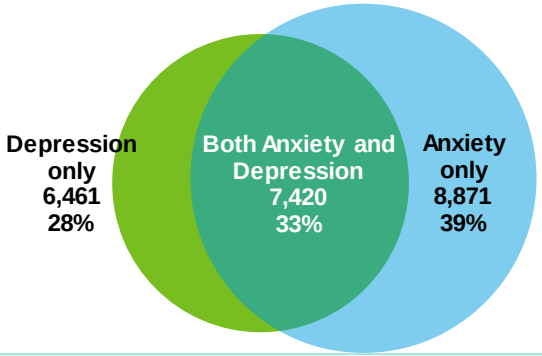
- In Haringey, 3% of people of Black or Black British ethnicity have a diagnosis of serious mental illness, higher than other ethnic groups.[1]
- In Haringey, BME groups and LGBT people are more likely to be diagnosed with a psychotic disorder.[1]
- In Haringey, people living in deprived areas are more likely to be affected by depression.[1]

National & local strategies

- The Five Year Forward View For Mental Health- NHS England
- Haringey's Borough Plan 2019-2023
- Haringey's Health and Wellbeing Strategy
- NHS Long Term Plan
- Haringey Joint Mental Health and Wellbeing Framework

Mental health: Who is at risk?

Prevalence of common mental illness, 2018



Almost one in ten (22,752) adults in Haringey have a common mental illness (CMI).

Women account for about **61 per cent** of all CMI diagnoses.

Common mental illness (CMI) includes depression, anxiety or both

Prevalence of serious mental illness (SMI), 2018

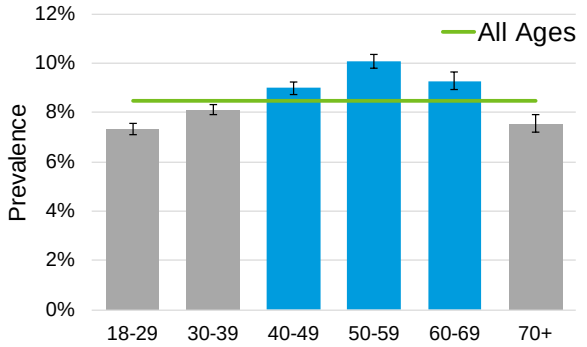
Haringey has a higher prevalence of SMI (1.3%) than London (1.1%) and England (0.9%).

Prevalence of dementia (65+), 2018

1,266 people were diagnosed with dementia in Haringey.

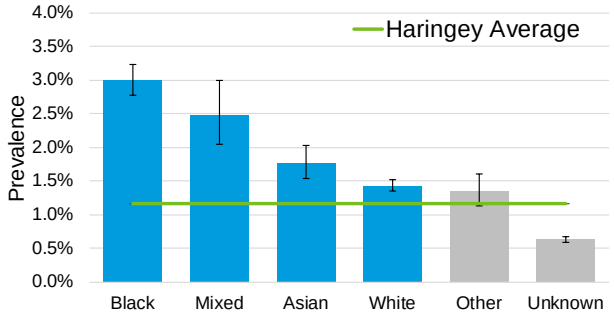
Locally, women aged 65+ were more likely to be diagnosed with dementia (3.1%) than men (2.4%) reflecting the national pattern.

Prevalence of common mental illness by age, 2018



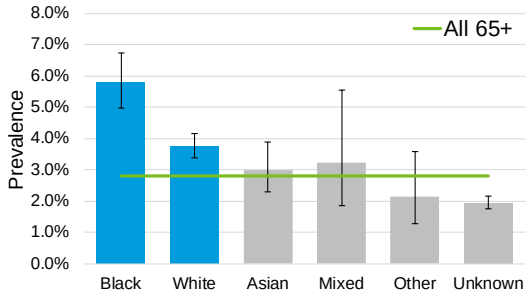
Middle age adults aged 40-69 are more likely to have a common mental illness in Haringey, particularly among those aged 50-59 (10%) compared to the Haringey average (8.5%).

Prevalence of serious mental illness (SMI) by ethnicity, 2018



Black and Black British and Mixed ethnic groups have the highest prevalence of SMI (3.0% and 2.0%, respectively), higher than the Haringey average (1.2%).

Prevalence of dementia (65+) by ethnicity, 2015



Black and White ethnic groups have higher prevalence of dementia than the Haringey average (5.8% and 3.8% vs 2.8%)

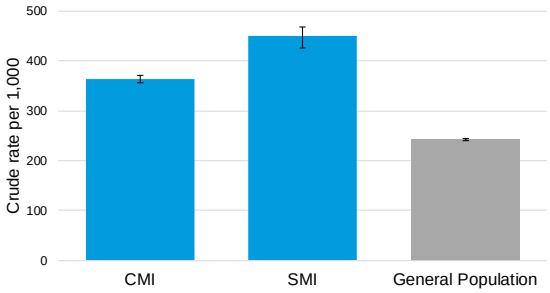
Mental health and its impact

Death by suicide and undetermined intent in Haringey, all ages, Haringey, London and England [4]

Source: ONS 2017

In Haringey, there were 64 deaths from suicide and injuries of undetermined intent between 2015 and 2017, or 9.4 per 100,000 residents. This is similar to London and England, but shows no significant change in recent years.

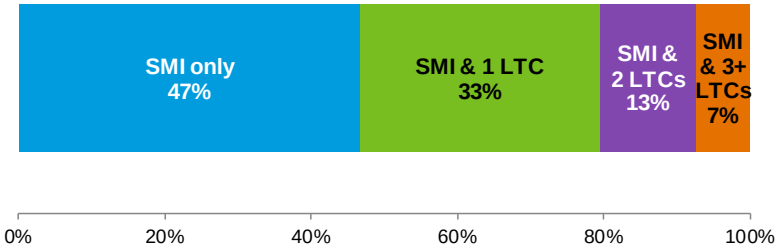
Mental Health and Hospital admissions Haringey, 2018[1]



In Haringey, the crude rate of hospital admissions per 1,000 patients was higher among people with CMI (364) and SMI (449) than the general population (242).

Associated health risks

Prevalence of comorbidity with other long term conditions (LTCs) among people with serious mental illness, Haringey [1]



Over 50% of people with a serious mental illness have one or more other long term condition.

More than one third of people with SMI and around a quarter of people with CMI are smokers (37% and 26% respectively) compared to the general population in Haringey (15%).

People diagnosed with a SMI are more than twice as likely to be obese (29%) than the general population (12%).[1]

Wider determinants

In Haringey, 5,510 people are on Employment Support Allowance or Incapacity Benefit due to mental illness, 50% of all claimants. [5]

Diagnoses of Serious Mental Illness are 170% higher in the most deprived areas of Haringey, and diagnoses of Depression are 10% higher.

- Over the past few years there has been a growing recognition of the need to make dramatic improvements to mental health services for CYP. 50% of mental health problems are established by age 14 and 75% by age 24. A child with good mental health is much more likely to have good mental health as an adult, to be able to take on adult responsibilities and fulfil their potential.
- It is anticipated that the levels of mental ill-health will increase over the coming years as the current economic climate of long term austerity causes more financial hardship and unemployment and fears of destitution.
- Unfortunately, no models exist which can account for these changes. However, assuming no change in underlying prevalence of mental health conditions, then we estimate that due to population structure changes alone:

The number of adults with **depression and/or anxiety** will increase from 22,752 in 2018 to 30,900 by 2028. A part of this increase will come from the 5,500 16-24 year olds who are currently estimated to have depression or anxiety.

Haringey also currently has an estimated 5,000 5-16 year olds with an emotional or behavioural disorder. This indicates that hundreds of children will be transitioning to adult services in the coming years.

Approximately 300 additional cases of **serious mental illnesses**, rising to around 4,400 diagnosed cases overall.

378 new cases of **dementia** by 2028, as the population aged 65+ increases by 30%.

WHAT WORKS?

The mental health and wellbeing of adults is influenced by individual, family, community and society level factors. It is influenced throughout the life-course, from birth to older age. Examples of these factors are shown in Table 1.

- **Individual:** Lifestyle factors such as diet, physical activity and sleep affect mental health. Living in debt increases the risk of mental health problems. Physical health problems increase the risk of mental health problems, and those with mental health conditions have worse physical health. An individual's response to relationships and events also affects mental health.

- **Family:** Adverse conditions in childhood are associated with poor mental health. Poor childhood attachment, neglect and conflict increase the risk of future poor mental health. Protective parenting activities can promote good mental health. Low household socioeconomic status is associated with mental health problems.

- **Community:** Unstable housing, no access to open space and homelessness all increase the risk of poor mental health. Social isolation and loneliness increase the risk of mental health problems and older adults are particularly vulnerable.

- **Society:** There is an association between socio-economic disadvantage, such as low education and unemployment, and poor mental health. Difficult work environments can worsen mental health. Experiencing discrimination and a lack of support from society also increases the risk of mental health problems.

Individual	Family	Community	Society
Lifestyle factors	Family structure	Personal safety	Equality vs discrimination
Attributional style (how events are understood)	Family dynamics (high/low expressed emotion)	Housing and access to open space	Unemployment levels
Debt or financial security	Genetic makeup	Economic status of community	Social coherence
Physical health	Intergenerational contact	Isolation	Education
Individual relationships and responses to those	Parenting	Neighbourliness	Healthcare provision

Table 1 - Examples of determinants of mental health (adapted from McCulloch and Goldie 2010 table, from Health Foundation Report (1))

1. Fundamental Facts About Mental Health. [internet] Mental Health Foundation. 2015 [cited 2018 Nov 14]. Available from: https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-15.pdf

- Mental wellbeing is described as ‘feeling good’ and ‘functioning well’ (1). The term mental health covers the spectrum from mental wellbeing, through to mental illnesses and disorders.
- Interventions to promote mental wellbeing and prevent mental illness either target everyone, populations with a high risk of developing mental illness, or those with early signs of mental illness (2). Treating severe, enduring mental illness and suicide prevention are also significant concerns.
- Please refer to the appendix for the methods and full report of this brief evidence review.
- The evidence-based ‘five ways to mental wellbeing’ are connect, be active, take notice, keep learning and give (3). Mindfulness is ‘taking notice of the present, in mind, body and the environment with curiosity and kindness’ (9).

Promoting Mental Health

CONNECT

It is well known that social interactions and good relationships contribute to overall well being and act as a buffer against mental illness (1).

This is true of all ages and an intergenerational study found that older adults had an increased sense of meaningfulness after reading picture books to school children (4).

BE ACTIVE

There was moderate evidence that exercise reduced depression, but the higher quality studies found a smaller benefit of exercise in a review by Cooney et al. (5).

Yoga and muscle relaxation were found to reduce anxiety and depression in older adults, in a review by Klainin-Yobas et al. (6)

Exercise can improve symptoms of schizophrenia, as well as verbal short term memory. (7)

MINDFULNESS

A review by Carlson et al. (9) found evidence that mindfulness interventions for adults with long-term physical health conditions such as cancer, cardiovascular disease and diabetes, improved mental wellbeing and reduced anxiety and depression.

Mindfulness was shown to protect from future mental ill health in a review by Piet et al. (10) Adults with three or more episodes of depression in the past, had a significantly reduced risk of further episodes of depression when they had received mindfulness interventions.

WORK ENVIRONMENT

Employment can promote mental wellbeing and unemployment increases the risk of depression and anxiety (1). However, jobs with high effort, low reward, high demand and low control increase the risk of poor mental health (11).

A NICE review of interventions to promote employee mental wellbeing (12), found that building team relationships and stress management training were particularly effective.

Supported Employment schemes are also found to be effective in those with Serious Mental Illness at reducing hospital admissions and increasing longer term employment (13)

- **Indoor and outdoor environment -** A review by Lidell et al. (14) demonstrated that cold, damp housing was associated with sub-optimal mental wellbeing. Mental Health and aspects of physical health have been shown to improve with improvement in housing quality (15).

- **Targeting vulnerable population groups -** Improving mental health literacy increases the likelihood of a person seeking help early, accessing appropriate treatment and being involved in their treatment decisions (1). Improving mental health literacy can be targeted at population groups with low economic and social resources. Specific interventions can target for vulnerable population groups at high risk of developing mental health disorders. For example, a review by Dennis et al. (16) assessed interventions to prevent postpartum depression in new mothers. Interventions including home visits from professionals and peer-based telephone support were beneficial in preventing postpartum depression.

- **Social Care e.g. Strength Based Practices and Personalisation -** Strength based practice is a type of practice that allows for focus on strength and resources of those with mental health disorders assisting with recovery and improving life satisfaction (17). Personalisation refers to the process in which people with long term illnesses receive support specifically for their needs, including the use of personal health budgets which have been shown to improve well-being whilst being cost effective in those with mental health conditions (18).

Reducing mental ill health

- **Early interventions -** Intervening early can reduce distress and prevent progression of mental health problems (19). Healthcare professionals in primary and secondary care can be trained to recognise, manage and refer people with early stages of mental health disorders.

- **Self-help therapies -** Self-help therapies for adults with anxiety, delivered via computers, text audio and video were found to be associated with a reduction in symptoms of anxiety, compared with no therapy in a review by Mayo-Wilson et al (20). The review by van't Hof et al (21) found moderate evidence that self-help therapies reduced depression and anxiety and these results were comparable to face-to-face interventions.

- **Medication and therapy -** Medication can be used to treat an acute episode of poor mental health or as a long-term intervention. Psychological therapies are also used to treat mental illnesses and NICE recommend cognitive behavioural therapy, couples therapy, counselling for depression and brief dynamic therapy (22).
    - For adults with mild and moderate anxiety and depression, ten sessions of cognitive behavioural therapy (CBT) can result in recovery in about half of patients, within four months. This is similar to the effect of medication (23).
    - For adults with schizophrenia and psychosis, the NICE guidelines (24) advise offering a choice of anti-psychotic medication, cognitive behavioural therapy and family interventions. During an episode of psychosis, depending upon the person's preference and need, treatment from the following services is advised: early intervention in psychosis services or other community teams, crises resolution and home treatment teams, acute community treatment or inpatient services.
    - For adults with PTSD, psychological therapies of Trauma-focused-CBT or eye movement desensitisation and reprocessing (EMDR) are advised. For people with chronic PTSD and who have not adequately responded to one of TF-CBT or EMDR, the alternative form of psychological therapy or pharmacological treatment is advised (25).

Additional considerations

Physical Health Needs

- Physical activity has clear physical health benefits and it has also been shown to improve mental health by reducing symptoms of depression and schizophrenia in a large meta-analysis (26).

Supported Community Living

- In a systematic review, mental health supported accommodation had the most benefit in those who were homeless, with improved housing stability and use of clinical services improving. It concluded that overall there was some evidence that supported accommodation had psychosocial benefits for all those with a mental illness (27). .
- A Cochrane review also suggested that more research needed to be done regarding the benefits of supporting accommodation, but acknowledged that it has potential for great benefit (28).

Individual Placements & Support

- Supported employment programs have evidence of improving vocational outcomes, for adults with severe mental illness, Kinoshita et al (29).
- Individual Placement & Support (IPS) schemes are establishes as a mean for people with a mental health problem to gain employment. (30).
- NICE recommends this model for people with a mental health problem looking for employment. (31).

Suicide prevention

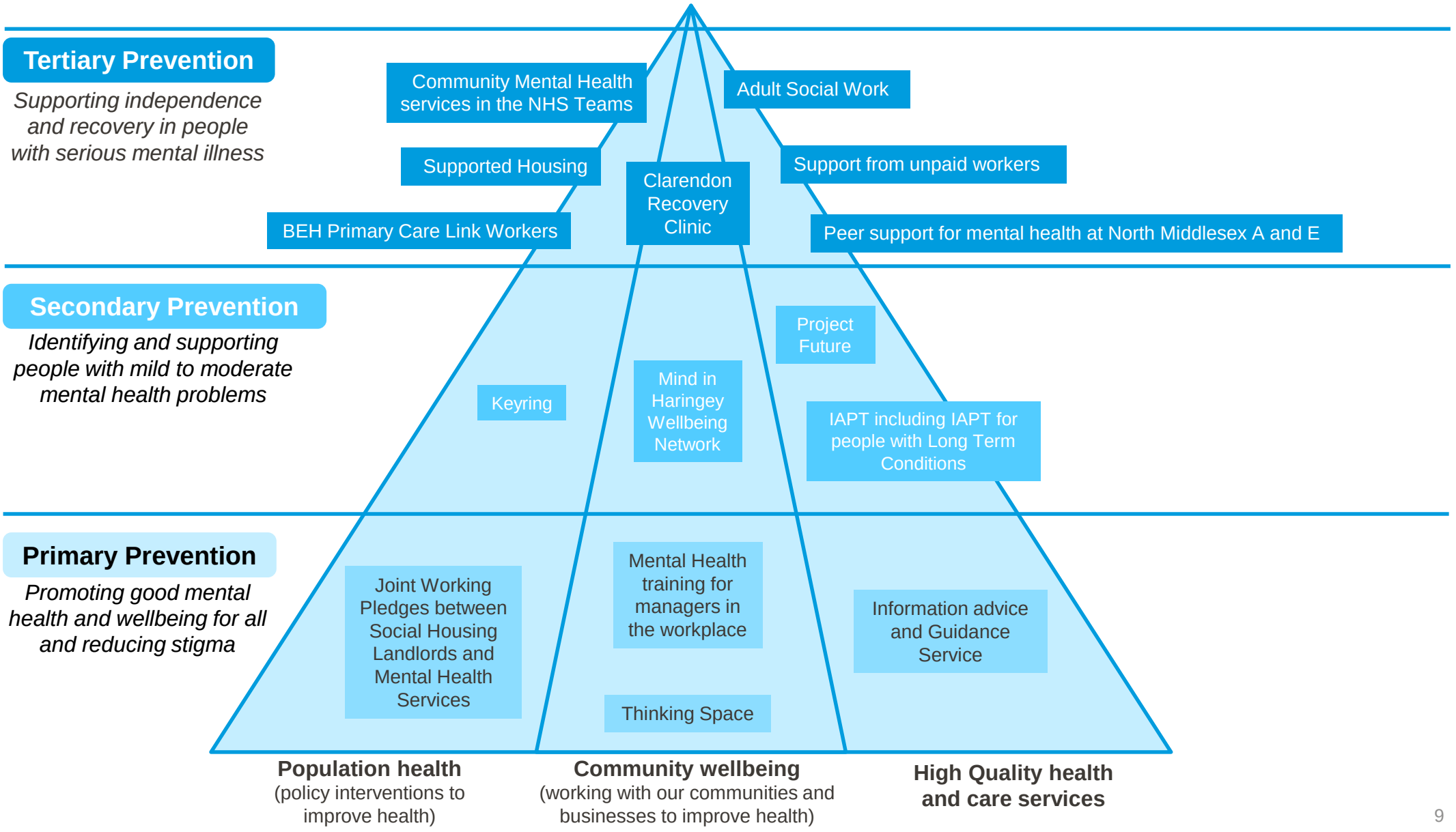
- The NICE guidelines for suicide prevention aim to 'help local services work together more effectively to prevent suicide, identify and help people who are at risk, and prevent suicide in places where it is currently more likely' (32).

- **Multi-agency working groups for suicide prevention** include the Clinical Commissioning Group, local public health, health and social care services, criminal justice services, voluntary and third sector organisations and people with personal experience of suicide attempt (32). Additional community partners include transport companies and designers of bridges that pose suicide risk, and the media to ensure best practice for reporting suicides when they occur. The NICE review and expert consultation, found evidence that multi-agency component interventions reduced suicides and suicide attempts (33).

- **Local and national suicide data** should be collected and analysed to identify suspected suicides, emerging methods and suicide clusters.

- **Reducing access to methods of suicide** can reduce the number of suicides. A review by Zalsman et al. (34) found evidence for restricting access to painkillers and hot-spots for jumping. The NICE guidelines also advise safer prison cells, restricting access to painkillers, introducing physical barriers and providing information about how to access help in high risk geographical locations (32).

- **Supporting people bereaved or affected by a suspected suicide** involves offering practical information in a sensitive manner, signposting to additional services and considering tailored support (32).


Tertiary Prevention
Supporting independence and recovery in people with serious mental illness
Community Mental Health services in the NHS Teams
Adult Social Work
Supported Housing
Clarendon Recovery Clinic
Support from unpaid workers
BEH Primary Care Link Workers
Peer support for mental health at North Middlesex A and E
Secondary Prevention
Identifying and supporting people with mild to moderate mental health problems
Project Future
Keyring
Mind in Haringey Wellbeing Network
IAPT including IAPT for people with Long Term Conditions
Primary Prevention
Promoting good mental health and wellbeing for all and reducing stigma
Joint Working Pledges between Social Housing Landlords and Mental Health Services
Mental Health training for managers in the workplace
Information advice and Guidance Service
Thinking Space
Population health
(policy interventions to improve health)
Community wellbeing
(working with our communities and businesses to improve health)
High Quality health and care services

SERVICES AND SUPPORT AVAILABLE LOCALLY

General Practices provide the majority of mental health support and treatment services in the NHS. GP's also work alongside specialist clinical input as and when required. **Barnet, Enfield and Haringey Mental Health Trust's** (**BEHMHT**) specialist community and acute mental health services supports people with severe and/or complex needs.

"Lets Talk Haringey" is the main service of psychological therapies or **Improving Access to Psychological Therapies (IAPT)** locally. The service provides an evidence based psychological therapy service for people aged 16 years and over offering support for over 5,500 Haringey residents with common mental health disorders. In Haringey, the IAPT service also supports people who are living with long term conditions and who are also experiencing low mood, stress or anxiety.

Mind in Haringey is the lead provider for Haringey's well-being network. A partnership was established between Mind and a range of other organisations to provide non-clinical support and opportunities to improve well-being, resilience and recovery from mental health conditions.

Perinatal specialist treatment has been commissioned across North Central London to tackle mental health issues arising immediately before and after the birth of the child.

Local Area Co-Ordination, which is an innovative approach to support people to be part of, and contribute to their community and to strengthen the capacity of local communities has been embedded across Haringey. In parts of the borough, local area co-ordination has been shown to reduce the use of services and increase social connectivity.

Alexandra Palace Park Run on a Saturday morning provides an opportunity for local residents to participate in physical activity whilst also having the additional benefits around improved mental well-being and social connectivity.

The Clarendon Recovery College – A community centre focused on life long learning for people experiencing mental health issues. Courses range from understanding mental health to creative writing classes. Free for those living in Haringey who live with or are supporting those living with mental illness.

Social Care and Housing – Wide range of social care including care assessments and access to a personal budget. Support with housing is available from Homes for Haringey, including help finding independent and supported housing

RESIDENTS FEEDBACK

Haringey CCGs latest feedback gathered via The Bridge Renewal Trust's annual public engagement is as follows:

Mental health treatment for adults is too short-term and not on-going. Some residents say that this does not suit everyone.

Women from the vulnerable adults team said that they didn't feel safe when admitted to the mental health wards by the Crisis Team. Some spoke of being attacked by other patients whilst security wardens on site are not around or being treated unkindly by some of the health professionals on the ward.

Some vulnerable adults said that they didn't consider accessing therapy until their GP encouraged them to accept a referral to mental health services.

People felt that they must become desperately worse before they are given any help regarding mental health.

Case studies:

A vulnerable adult who was also a carer of a dependent with a disability said that their doctor had referred them to access CAMHS but no response from this referral was received. They explained the difficulties they experienced in not being able to access specific support and health services for their child, due to individuals not being able to be diagnosed until 18 years of age.

Vulnerable adults would like to have access to a walk-in clinic just for them so that they would feel less discrimination and in turn would not put off seeing a health profession out of fear and anxiety of being discriminated against due to their addictions, or mental health or sometimes poor appearance.

Vulnerable adults feel that the therapy offered by the NHS in Haringey under IAPT is not long enough and is too general. Many were unable to access therapy for Post-Traumatic- Stress Disorder due to their symptoms not being extreme enough. This has in some cases led such vulnerable adults to continue with the same mental health issues they had before they entered the Cognitive Behaviour therapy sessions. Out of the 6-8 therapy sessions offered, at around 5 weeks into the sessions these vulnerable adults start to open up to their therapist and feel as though the therapy comes to an end before they are able to make any breakthroughs in the progress of their mental health.

One independent vulnerable adult who has Autism explained that her experience of accessing mental health services was bleak and frustrating due to therapy and support not being consistent enough. She explained that due to being left to cope on her own with her condition, she has previously ended up in prison for violence as her Autism went untreated. After this she thought she would receive the support she needed whilst in prison but explained she only received one therapy session every 6 weeks, with some weeks being missed. She found some solace in accessing the Chaplaincy but pointed out that this wouldn't be satisfactory for all, due to religious beliefs. This young lady pointed out that she hasn't received any therapy or support since being released from prison and is only accessing some support services at St. Mungo's HAGA, after self -referral. She felt strongly that no persons with disabilities should be left waiting for mental health services or for housing. She stated she has been admitted to A&E due to several incidents with her condition flaring up and that she received no after care after being released from A&E. Due to these circumstances, she has suffered further from isolation which has taken a further toll on her wellbeing.

WHAT ARE THE PRIORITIES FOR IMPROVEMENT

Recommendations	
Promote positive mental health and wellbeing and prevent mental ill-health	Take a life-course approach, which encompasses taking a whole community approach to recovery, addressing factors that influence mental wellbeing for everyone, whether or not they have a diagnosis; and creating environments and cultures that support wellbeing from schools and colleges, to work places and on the streets.
	Create supportive environments that support the five ways to wellbeing.
	Ensure that people are able to access appropriate support at the earliest opportunity to help to avoid escalation, personal distress and crisis management. Every commissioner or provider should do more to help people access mental health support earlier, throughout the life course and in a range of settings including school, housing, work and communities.
Ensure needs are met	Ensure that we meet the physical health needs of people with mental health problems and Illness and that we meet the mental health needs of people with long term conditions or acute physical health issues
	Develop a clear point of entry to the range of mental health services and share information on how people can access different services. Ensure that local care pathways exist to promote access to mental health services by wider communities including socially excluded groups such as black and minority ethnic groups, LGBT people, older people, those in prison or in contact with the criminal justice system and ex-service personnel.
Suicide and self harm	Continue to develop action to prevent self-harm and suicide for children, young people, men and women
Dementia	Ensure that we meet the needs associated with the projected increasing number of people living with Dementia. Awareness must be raised of evidence-based measures to prevent dementia (the six pillars of a brain-healthy lifestyle: regular exercise, healthy diet, mental stimulation, quality sleep, stress management and an active social life) to relevant services, professionals and the public. Community-based projects or pilots to prevent dementia and promote dementia awareness should be considered.
Develop services suited for the needs of our population	Ensure that people are able to transition between services well including child to adults services and acute to community and recovery/aftercare services
	Improve integrated and joint service models to address the needs of residents at the point of a mental health crisis in and out of usual working hours
	Ensure joint commissioning of mental health and drug or alcohol services where appropriate in the areas of general health, mental health, substance misuse (including alcohol), social care, education, community safety, crime (including domestic violence) and safeguarding in both children and adults, linking promotion and prevention much more closely with treatment and care for substance use and mental health. To support this contracts with providers need to stipulate effective joint working and clear pathways, to meet the needs of people with co-existing mental health needs and substance misuse problems.

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About Haringey's JSNA

Haringey.gov.uk brings together information held across the organisations into one accessible place. It provides access to evidence, intelligence and data on the current and anticipated needs of Islington's population and is designed to be used by a broad range of audiences including practitioners, researchers, commissioners, policy makers, Councillors, students and the general public.

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