Mental Health Needs Assessment

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Executive Summary

Mental health is at an important turning point with the publication of the NHS Haringey and Haringey Adult Services strategy, the Department of Health New Horizons work and the Healthcare for London mental health polysystem development. This mental health needs assessment, part of the Joint Strategic Health Needs Assessment work programme, seeks to inform commissioning at both the Local Authority and the Primary Care Trust.

Haringey has a high burden of mental illness. There are more patients with dementia in West Haringey which as a greater proportion of older people. In the East of Haringey there are more people with common mental illnesses. It is likely that both dementia and common mental illnesses (particularly depression) are under-diagnosed both indigenous and Black and Minority Ethnic Groups (BME). This could be predicted as mental health problems are related to a variety of socio-economic conditions and within in East Haringey there are greater levels of deprivation, poorer housing and a wider variety of socioeconomic groups. Socioeconomic factors in Haringey are likely to adversely affect the mental health of the population and have a greater effect on BME groups in the area who live in more deprived conditions on the whole. Haringey has the second highest numbers of self reported illness in London.

Primary care is a vital part of a mental health services and has been shown in this study to be highly valued by patients. A mental health component comprises of 25% of all GP consultations in Caucasian patients (less in BME groups) and the literature suggests that 90% of mental health problems are picked up in primary care. Primary care works mainly to a medical model of care, with little involvement of the voluntary and statutory sector other than the Mental Health Trust. GPs said that they really only refer patients to the START or IAPT teams. This study has demonstrated the vast array of services available in the voluntary sector, some of which are targeted directly as certain ethnic groups. Better integration of services between health, social care and the voluntary sector is key to both best use of resources and improved patient care.

Mental and physical health have been traditionally treated separately as if they were unrelated medical conditions. Over the years research has repeated told us that they are intertwined, particularly in some Black and Minority Ethnic Groups. The study has again demonstrated the isolated working patterns between the Mental Health Trust and Primary Care so patients are not treat in a holistic way but treated separately for their mental and physical health.

Improving Access to Psychological Therapies (IAPT) is a key service that is used by primary care and provides an excellent service for patient with anxiety or depressive disorders. What is clear is that this service is not used by all primary care providers; it is preferred by some BME groups but not all and has very few elderly patients relative to the burden of disease. IAPT needs to be integrated into all levels of mental health service provision in Haringey.
Some black and minority ethnic groups have a higher risk of suicide, psychotic illness and hospital admissions. It is likely that there is significant under-diagnosis in this group of patients due to a variety of cultural and social factors. There are many unique problems in different groups with this broad category and particularly for refugees and asylum seekers. The role of the Third Sector is significant in Haringey and needs to be integrated into the broader mental health arena.

Spirituality is an important part of physical and mental well-being for many patients and its significance in recovery must not be overlooked.

Lastly and most importantly, the needs of carers need to be considered for their own mental and physical health as well as the patient they are caring for. Voluntary sector services often target them through particular programmes but may be difficult to identify as neither primary care or social services have a role in signposting within Haringey.
What's a Joint Strategic Health Needs Assessment?

Undertaking Joint Strategic Needs Assessment became a statutory duty for Directors of Public Health, Directors of Adults’ Services and Directors of Children’s Services on 1 April 2008 in order to ensure commissioning of services is based on population need.

A JSNA describes the current and future health, care and well-being needs of a population. It aims to be a key resource for all agencies that have a role in improving health and well-being locally. The JSNA will be critical in determining local priorities, and will contribute to the development of the community strategy and local area agreements.

The JSNA is based on a core dataset, including the National Indicator Set. Local areas are expected to supplement this with additional, locally relevant information to add depth and insight into the needs of their populations, having locally agreed standards on data quality for inclusion.

In August 2008 we published Towards Joint Strategic Needs Assessment in Haringey: The core dataset. Available at:-

http://www.haringey.gov.uk/index/social_care_and_health/joint_strategic_needs_analysis.htm

The other needs assessments that are being completed are the sexual health needs assessment, alcohol needs assessment and young people’s substance misuse needs assessment. The children and young peoples mental health needs assessment has already been completed.
Introduction

Mental health problems are common amongst the general population\(^1\) however it is estimated that one in four patients come from a black and minority ethnic group (BME)\(^2\). It is likely that the combination of ethnicity with factors associated with deprivation lead to a greater proportion of black and minority ethnic patients suffering from a variety of mental health problems\(^3\).

The majority of patients, including BME groups, suffering from mental health problems will access services via primary care. It is vital that early identification and treatment is available for all patients. There is much literature on difficulties BME communities have accessing primary care and the level of stigma attached to mental health conditions in their communities\(^4\) \(^5\) \(^6\). Services for BME groups are often not specific to their cultural needs. BME patients themselves site a ‘lack of choice and voice’ when trying to access health services\(^7\) \(^8\). It is vital that primary care services are responsive to the needs of the ethnically diverse communities.

In Haringey, it is estimated that 55% of the 228,000 residents come from a black and minority background\(^9\) \(^10\). It is known that some patients, especially those from BME groups, do not access services until they are at crisis point. This has led to recent failures of care\(^11\). Haringey needs to ensure that primary care services are available for early identification and treatment and that its services are culturally specific.

New Horizons\(^2\), published in October 2009 is a new national strategy to promote good mental health and well-being. Its key themes are prevention and public mental health, stigma, early intervention, personalised care, multi-agency commissioning/collaboration, innovation, value for money and strengthening transition.

NHS Haringey and Haringey adult services have a joint strategy which focuses on shifting the balance of care between hospital and community services, integrating mental health into the polysystem model, improving services for BME communities and implementing personalised social care budgets across mental health services.

This mental health needs assessment should act as a key part of the strategy as it has looked at the current and future needs of the population of Haringey and will inform commissioning of services.
Aim and Objectives

Aim

To identify the mental health need for patients in primary care, particularly those from black and minority ethnic groups (BME), in order to improve access to services and reduce stigma for mental health conditions.

Objectives

To determine if there is any unmet mental health need in primary care by:-

a. Identifying relevant national and local policy in relation to primary care mental health provision

b. Gathering relevant data on population mental health and existing services including identifying which BME groups are accessing primary and secondary care mental health services

c. Identifying the prevalence of common mental health conditions including recognising where there are gaps in patient identification and comparing the number of BME groups currently accessing services to the predicted number

d. Identifying the current service provision in Haringey

e. Identifying those cases who only reach services at crisis point and ascertaining reasons for lack of early intervention

f. Identifying specific services for BME communities and discovering how users may access these services

g. Understanding how Community Development Workers can work with particular ethnic groups to improve access to services and decrease stigma.

h. Understanding the cultural barriers to accessing mental health care in relation to stigma and discrimination.

i. Engaging with service users in the BME communities and recognising why patients access services late and developing ways to overcome stigma.

j. Mapping the provision of mental health services according to population need

k. Making recommendations to increase the number of patients accessing treatment in primary care
I. Making recommendations to improve the access and update of services for BME communities and reduce stigma
Methodology

A health needs assessment is a systematic and explicit process, which reviews the health issues affecting a population. Needs assessment is about change in order to bridge the gaps identified - Bradshaw’s groups of need (felt, expressed, normative and comparative) can help us understand the difference between desired state and the perceived reality. A traditional model of epidemiological, corporate and comparative healthcare needs has been developed by Stevens and Raffety and can be directly linked to Bradshaw’s model. Epidemiological need looks at the severity and size of the health problem. Corporate need looks at the perceptions of the service providers and comparative need looks at the different service providers and users managing the health issue.

Epidemiological

The epidemiological needs assessment examined:-

- A brief literature policy analysis of mild to moderate mental health provision
- A model service was developed from the literature
- Population and ethnicity breakdown in London

A brief literature review and policy analysis was identified by searching:

- Medline,
- Cochrane library
- Department of Health
- National Electronic Library for Health web-sites
- Bibliographic references of identified articles
- Asking experts and colleagues

Corporate

Individual interviews were conducted with almost all mental health organisations that are commissioned by NHS Haringey. Additional interviews were conducted with mental health GP collaborative leads and key informants in Barnet, Enfield and Haringey Mental Health Trust. A structured questionnaire was used (Appendix 1) which had a list of closed questions with open ended questions asked at the end the interview.

A group consultation was arranged to interview Haringey Association of Voluntary and Community Organisations (HAVCO). Questions were posed around key themes relevant to these organisations.

Users were interviewed as part of a group consultation and questionnaire which was organised by Haringey Users Network.
All quantitative data from the open and closed questions was analysed using thematic analysis.

Comparative

A comparative needs assessment most often looks outside the local area to compare need. Data comparisons were made with other Primary Care Trusts in London. Informal comparisons were sought during the interviews of key stakeholders and users. International examples and examples from outside London were not used for the purpose of this needs assessment.
Results

Literature review

1. Introduction
Much progress has been made nationally in specialist mental health services. The focus now seems to have shifted towards the mental health of the community as a whole with emphasis on policies to break down the traditional boundaries that exist between professional groups, between primary and secondary care, between the NHS and the independent sector, between health services and other agencies. One of the main policy priority areas is the service for ethnic minorities aimed to remove inequalities in patient experience between ethnic groups by providing services that are more responsive to their needs.

Black and Minority Ethnic groups (BME) are one of the most socially excluded people in society. They are more likely to live in deprived areas, be poor, be unemployed, experience ill-health, and live in overcrowded and unpopular housing compared with others. Studies have found out that psychiatric disorders and suicidal attempts were more likely to occur in people facing socio-economic disadvantage, and that they were also less likely to recover from common mental disorder.

A review of literature was conducted to summarise literature regarding mental health needs in primary care, and also looking at specific needs of the Black and Minority Ethnic (BME) groups. The review also looks at service models and examples good practice in primary care mental health provision as well as issues around mental health care at the adolescent-adult interface.

2. Search strategy
The following databases were searched in preparing this literature review: PsychInfo, Medline, CINAHL, NHS Evidence, HMIC, BNI and AMED using the defined search terms. In addition, print and electronic literatures and references were also hand-searched from the Department of Health website, Royal College of Psychiatrists, Royal College of General Practitioners. Universal search engine such as Google, Yahoo search were also searched and personal communications made. Relevant published papers were considered in the review.

3. Evidence summary

3.1 Prevalence
Mental illness prevalence data varies considerably for different populations and between migrants and those born in the United Kingdom. Figures published by the Office of National Statistics shows that 1 in 6 adults in Great Britain had a neurotic disorder (such as anxiety and depression), while 1 in 7 had considered suicide at some point in their lives in 2000. One in 200 had a psychotic disorder such as psychosis and schizophrenia. The most common
mental disorders were mixed anxiety and depression (7% for men, 11% for women), anxiety (4% for men, 5% for women and depression (2% for men, 3% for women).18,19.

In general, the rates of psychiatric disorders in 1993 and 2000 were similar, but the proportion of people receiving treatment increased considerably over the period.18,19 Serious mental illness such as schizophrenia has been shown to have increased in people of African-Caribbean and African origin who are resident in the United Kingdom20,21 and less consistently so in those of south Asian origin.22,23 A study in London, based on contact with psychiatric services over a 10-year period, found that the lower the proportion of non-white ethnic minorities in a local area the higher the incidence of schizophrenia in those minorities.24 Among mental health problems presenting at the general practices in the United Kingdom, depression is the third most common reason for consultation.25 Between 1 in 2 and 1 in 7 patients with depression or anxiety are estimated to go through primary care undiagnosed in primary care.32,26

Comparison of the prevalence of Common Mental Disorders (CMD) among representative samples of White, Irish, Black Caribbean, Bangladeshi, Indian and Pakistani individuals living in England shows that ethnic differences in the prevalence of CMD were modest. Compared to Caucasian counterparts, the prevalence of CMD was significantly higher among middle-aged Irish and Pakistani men. Higher rates of CMD were also observed among Indian and Pakistani women aged 55–74 years, compared to Caucasian women of similar age. A low prevalence rate of CMD was seen among Bangladeshi women compared with their Caucasian counterpart, which contrasted with high levels of socio-economic deprivation among this group. Further study is needed to explore reasons for this variation.27

### 3.2 Treatment and Access

All individuals with a common mental health problem should be able to make contact round the clock with the local services necessary to meet their needs. There are ethnic differences in access to mental health services with significant differences between the Caucasian majority and black and minority ethnic groups in experience of mental health services and the outcome of such service interventions.38 In 2000, overall 24 per cent of people received treatment for psychiatric disorders compared with 14 per cent in 1993. The proportion receiving psychological treatment, however, remained level, at 9 per cent in 2000 – 1 percent point higher than in 1993. The proportion of people receiving both medication and psychological treatment also remained level at 3 per cent in 1993 and 4 per cent in 2000. In 2000, 85 per cent of people with psychosis were receiving some kind of treatment; 83% medication and 40% psychological treatment. People with a psychotic disorder were also more likely to use mental health services on offer in the community and in hospitals than people with a neurotic disorder.18,19

The barriers to minority ethnic groups seeking and successfully accessing services are significant. These include language, the discrepancy between the patient’s and doctor’s views as to the nature of the presenting symptoms, cultural barriers to assessment produced by the reliance on a narrow biomedical approach, lack of knowledge about statutory services, and lack
of access to bilingual health professionals. Black and South Asian patients are less likely to have mental health problems recognised by their GP or the nature of their presentation wrongly attributed to mental illness. They are also much less satisfied with services when contact is made.

It has been demonstrated that cultural and racial stereotyping is a common experience in their assessment and decisions concerning treatment. This is likely influence the types of services and diagnosis individuals from minority backgrounds seek and receive. There is evidence that stereotyping of Irish people as alcoholics obstructs treatment for mental health problems. Interpreting services are often unavailable, which makes the diagnosis or assessment procedure both unreliable and highly stressful.

Relative to the majority Caucasian population, minority groups (particularly younger people and those of African Caribbean and Irish backgrounds) appear to be at increased risk of hospital admission, and coercive care within mental health services. GPs survey acknowledge that they feel less involved in the care of patients with severe mental illness from minority ethnic groups. Evidence also shows that GPs' decisions to refer patients with mental health problems to specialist services are influenced by the patient's ethnicity.

3.3 Consultations and Appropriateness of addressing mental health in primary care

Many people with mental health problems contact their GP, or another member of the primary health care team. Mental health problems account for about 25% of general practice consultations. However, this does not appear to be true for all black and minority ethnic groups.

Studies have shown that one in four people suffer from mental health problems each year, and about 90% of them present at the General Practitioner. They present in a number of ways ranging from social, psychological, medical, emotional, financial and family difficulties. Hence, the primary care setting is critical and offers a strategic location for improving and promoting mental health. Also, primary care is usually the first point of contact with the health service for most people. There is evidence that 22% of patients who go on to kill themselves will have seen their General Practitioner in the week before their death, and 30-40% will have seen their doctor in the previous month. Therefore an opportunity exists for primary care services to help in preventing suicides as well as depressive illnesses.

Research suggests that there are variations in GP registration and overall consultation rates between minority ethnic groups and the majority population. Indications are that consultation rates for mental disorders, in particular, anxiety and depression, may be reduced in some minority groups, such as amongst South Asians and the Chinese, while recent evidence shows that Irish people had particularly high rates of consulting GPs for psychological problems. Chinese groups tend to access their GP only after long delays and the GP is the first contact person for less than 40% of all individuals.
A cost-effectiveness study in Manchester using patients aged between 16 and 65 years old with new episodes of depression and anxiety found that there were no significant differences between the patients treated in the community and hospital in terms of clinical outcome, social problems, or social disabilities. Non-urgent cases were examined faster in the community service than in the hospital service (13.5 days versus 47.5 days, P <0.01). Patients treated in the community also had more continuity of care and were more satisfied with the service than patients from the hospital services.\(^{31}\)

A UK study suggests that the unmet need for mental health in primary care is high. In this two phase study of three hundred and thirty-six consecutive general practice attenders aged 17–65 years, it was found that the overall prevalence of need was 27.3%. More than half of the consulters (59.6%) had unmet needs and a further 6.2% had partially met needs. Needs were met in 28.1% and not meetable in 6.2%. The prevalence of unmet need in those with anxiety disorders was 13.9% and depressive disorders 9.5%.

### 3.4 Primary care interventions and services
Each person with mental disorder should receive the range of mental health services they need and prompt and effective help should be available as close to home as possible.\(^{38}\)
Holistic services
Patients that are presenting to the primary care with mental health problems present with problems that are a mixture of psychosocial, medical, emotional, financial and family difficulties. It would be appropriate that the primary care mental health model should use the psycho-bio-social approach rather than a purely medical approach. Using the public health tool of health needs assessment among Black and Minority Ethnic communities, it has been demonstrated that there is a strong demand for services which offer a holistic approach and recognize the impact of racism on people’s experiences of everyday life. Involving service users in the service planning process can help to develop more acceptable and culturally sensitive services.

With regard to Black and Minority Ethnic groups, it is well-known that there are cultural differences in the way in which psychological distress is presented, perceived and interpreted, and different cultures may develop different coping mechanisms.

The evidence base on risk and protective factors for mental health and mental illness is largely drawn from research on White European or North American populations. Mental health promotion interventions which emphasised individualism may not be appropriate for all cultures and belief systems.

Tackling Racism and Racial Discrimination
Black and minority ethnic (BME) groups and their communities experience widespread racial harassment and racist crime which impact on their mental health and well being. Cumulative exposure to racism and racial discrimination has been identified as one of the key risk factor for mental health problems, especially for depression and is particularly damaging for people who are already vulnerable, such as mental health service users. The overall greatest risks of CMDs from racial insults and unfair treatment were observed among Black Caribbean’s exposed to unfair treatment at work and Indian, Bangladeshi, and Irish. Ethnic inequalities evident in most aspects of public life are likely to have a bearing on the mental health of black and minority ethnic groups.

People from BME communities also experience widespread racial harassment and racist crime that also impacts on their mental health and well being.

Preventing, treating and detecting Depression and Anxiety
Depressive disorders are a major health problem in primary care, and around half of these disorders remain undetected. In a follow-up study comparing routine depression screening of patients in primary care compared with suspected cases of depression selected for depression evaluation, it was found that the sensitivity of family doctors’ unaided clinical diagnosis was 65%, which was improved to 93% when a wellbeing screening tool was used.

Clinical depression has been shown to be prevented by exercise, and is also as effective as other psychotherapeutic interventions. Exercise also been
shown to reduce anxiety, enhance mood and improve self esteem.\textsuperscript{32} Regular exercise also improves cognitive functioning, improves the mental health of older people.\textsuperscript{32}

In addition, a number of studies have suggested that patients respond positively to GP advice to take more exercise.\textsuperscript{32}
A high quality systematic review of evidence has shown that training health professional such as midwives, health visitors and practice nurses to detect mental health problems in primary care can improve early identification of peri-natal anxiety and depression.\textsuperscript{40}

Self-help/ Support network
Evidence from a systematic review of RCTs and controlled before and after studies suggests self-help as a form of intervention in primary care offer some clinical advantages over routine primary care.\textsuperscript{41} People with a small support group of three people or less have also been shown to be at greatest risk of mental health problems.\textsuperscript{42}

Alcoholism
Substance misuse is a significant risk factor for mental health problems. Surveys have shown that less than a quarter of general practitioners routinely ask patients about their drinking habits.\textsuperscript{28} Men of Indian origin are known to have more than twice the prevalence rates of alcohol related disorders than white men.\textsuperscript{43} Evidence suggests that brief interventions in primary care may be effective in reducing excessive alcohol consumption. However, screening in general practice does not seem to be an effective precursor to brief interventions targeting excessive alcohol use.\textsuperscript{44, 45}

Counselling
Counselling services now appears to be an important component of primary care setting in the United Kingdom. In a systematic review of counseling services in primary care, it was found that the group that was counseled showed greater effectiveness that the usual care group, and there were higher service satisfaction ratings from the counseling service patients in the short term. The study also suggests that counselling is more costly than usual care.\textsuperscript{32}

Personality Disorders
People from Black and Minority Ethnic group are known to present at personality disorder services at lower rates when compared with the white population. The reasons for this are probably because of long-standing patterns of misdiagnosis, over-representation in in-patient and secure services, and low access to talking therapies.\textsuperscript{46} The Department of Health advised that in developing personality disorder services for the Black and Minority Ethnic groups, commissioners and Trusts should ensure that access by BME residents is routinely monitored and reviewed to ensure racial and cultural appropriateness. The racial and ethnic profile of the service workforce should reflect that of the local population. Link workers may also be helpful in providing information about services to particular population groups and in improving access, and training for service staff to alert them to issues relating to personality disorders and minority ethnic populations.\textsuperscript{46}
3.5 Local population - primary care Interface
Certain activities and programmes have been shown to be effective in strengthening mental health at the population-primary care interface. These include exercise, arts and education referrals, 'walking for health' schemes, and increased benefit uptake as key aspects of primary care in strengthening community mental health. Other key interventions identified include use of protocols for user networks shared care, referrals to self-help and voluntary groups. These programmes also provide opportunities for service development at this interface for groups that are socially excluded such as refugees and the homeless, and to address inequalities in access to services. 

47, 32

3.6 Adolescent - Adult transition arrangements
There is a higher incidence of serious mental health problems in older adolescents than in younger children48, hence should meet their needs, and do so in an environment which service users feel is appropriate to their age and development.

Good Practice: 48
- Adult Mental Health (AMH) and CAMHS commissioners with their local authority (LA) partners, together with local agencies, act in partnership to plan joined-up, multi-agency, young people’s services. They include adult mental health and child and adolescent mental health, social care and leaving care teams, youth employment, advocacy services, housing, Connexions/youth teams and youth offending teams, young people’s health services including sexual health and substance misuse services, and the voluntary sector.

The needs of local black and minority ethnic communities should be taken into consideration for instance in:-

1) The buildings from which teams work, provide accessible and age appropriate settings.

2) The Care Programme Approach (CPA), modified to meet the needs of younger people, is used to plan transition, and transition is supported by agreed protocols.

3) Arrangements exist for alternative provision to meet the on-going need of young people who do not meet the criteria for AMH, for example, either by specific packages of care or by using other local voluntary community services.

Summary
Research shows that 1 in 6 people have a neurotic disorder, 1 in 7 considered suicide and 1 in 200 have a psychotic disorder

Serious mental illness is more common in African/Afro Caribbean ethnicities
Many patients are not diagnosed in primary care (between 1 in 2 and 1 in 7)

There are many barriers to BME groups seeking access to services

BME groups are more at risk of hospital admissions

Mental health problems comprises of 25% of all GP consultations among the Caucasian but not BME groups

90% of mental health problems are picked up in primary care

Clinical depression can be reduced by self-help treatments including exercise

Patient engagement and participation in a wide range of activities is key to the provision of cost effective services

Personality disorders are under-diagnosed in BME groups
Data analysis

Demographic trends in Haringey

According to official (ONS) estimates, Haringey had a population in 2008 of 226,200. This makes Haringey the 17th most populated borough in London. In Haringey there are approximately 600 more males than females, with 113,400 males and 112,800 females in 2008. Haringey has a similar age profile to London as a whole, with 31.2% of Haringey residents aged under 25 years (compared with 31.2% in London). 21.8% of residents are aged between 25 and 34 years. Over half the population is aged less than 35 years. The population aged 65 and over has declined slightly as a proportion of the total population, from 9.8% in 2001 to 9.3% in 2008. This is consistent with London as a whole, the population of which has declined over the same period from 12.4% to 11.6%.

According to 2001 Census, 34.4% of Haringey’s population were of Black and Ethnic Minority origin (BME). In 2007 the experimental ONS figures suggest, the largest ethnic groups in Haringey were White British (49%), White other (13.5%), Caribbean (7.9%) and African (8.7%). Between 2001-07, the largest growth in Haringey was seen in the Pakistani (61.3%), Chinese (43.2%), and mixed White and Asian (20.2%) categories. Haringey’s population is expected to comprise 36.1% Black and Ethnic Minority Groups by 2026.

It is estimated that 10% of the total population is made up of refugees and asylum seekers, although Home Office published information in June 2009 suggesting that Haringey has 140 Asylum seekers in receipt of subsistence only support and 240 supported in accommodation. About 160 languages are spoken in the borough.

Haringey’s population is projected by the ONS to expand by 9.5% (21,500 residents), between 2006 and 2029, whereas Haringey’s population is projected by the GLA to grow by 24.8% (57,312 residents) over the same period. As of July 2009 there are 9,634 people claiming Job Seekers Allowance. This is 6.1% of the working age population. This compares to a figure of 4.4% for London and 4.2% for England.

1. Prevalence of Mental Health disease in Haringey

Haringey is thought to have a high prevalence of mental health illness. Data obtained from QOF (Quality Outcome Framework, a performance management system for GPs recording the prevalence of certain illnesses) suggests Haringey has, for example, rates of depression and psychosis well above the London and national average. Furthermore, QOF data is likely to underestimate the real prevalence as it can only record patients registered with GPs, so the real burden of mental illness is likely to be higher than the figures given. Additionally, estimations of need indicate that only of proportion of patients suffering with mental illness access adequate health services.
1.1. **Prevalence of psychoses**

Haringey has the 4th highest rate of psychosis in London (Figure 1.1). The neighbouring boroughs of Islington, City and Hackney and Camden were also amongst the boroughs with the highest prevalence.

**1.1: Prevalence of psychoses in London, FY 2007/08**

*Source: Quality outcome framework (QOF) data FY 07/08*
According to 2009 QOF data, there were a total of 3230 patients registered as psychotic in Haringey. This figure is likely to be an under-estimation, but it is not possible to evaluate how underestimated it is. Additionally, there are variations within the borough. 1.31% of patients registered in the South East GP collaborative were on the Psychosis Register while the figure was only 1% in the West collaborative (figure 1.2).

**1.2: MH8: The practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses**

<table>
<thead>
<tr>
<th>Collaborative</th>
<th>Number of pts on register</th>
<th>% of register</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>842</td>
<td>1.00%</td>
</tr>
<tr>
<td>Central</td>
<td>747</td>
<td>1.26%</td>
</tr>
<tr>
<td>NE</td>
<td>867</td>
<td>1.27%</td>
</tr>
<tr>
<td>SE</td>
<td>774</td>
<td>1.31%</td>
</tr>
</tbody>
</table>

Source: QOF 2009

**1.2. Prevalence of neuroses**

The prevalence of depression is higher in Haringey than national average. The 2009 QOF data records 14067 people or 5.2% of the Haringey population suffering from depression, while the figure is 4.9% nationally. This is underestimated as it only takes into account patients registered with and does not record patients with mild depression. The real figure is likely to be substantially higher.

Additionally, there are variations within the borough. Only 3.86% of patients registered in the West collaborative were identified as suffering from depression, while this figure increased to 5.16% in the South East collaborative, 6% in the Central collaborative and 6.15% in the North East collaborative (figure 1.3).

**1.3: Number of registered patients with a diagnosis of depression in Haringey by collaborative, 2009**

<table>
<thead>
<tr>
<th>Collaborative</th>
<th>Number of registered patients with depression</th>
<th>Percentage of the register</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>3244</td>
<td>3.86</td>
</tr>
<tr>
<td>Central</td>
<td>3557</td>
<td>5.99</td>
</tr>
<tr>
<td>NE</td>
<td>4209</td>
<td>6.15</td>
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<tr>
<td>SE</td>
<td>3057</td>
<td>5.16</td>
</tr>
<tr>
<td>Haringey</td>
<td>14067</td>
<td>5.19</td>
</tr>
</tbody>
</table>

Source: QOF 2009

A household survey conducted nationally and analysed at borough level indicates a higher rate of neurosis than QOF figures indicate, suggesting a part of the burden of disease for neuroses is not known to or managed by primary care. In this self reported survey (figure 1.4), 8.8% of the population report mixed anxiety and depressive disorder, while 2.6% reported suffering from depression only. The total of 16.4% of Haringey residents are reported to suffer from a form of neurosis. Additionally, there is an unequal distribution of
disease amongst ethnic groups, with black ethnic groups less likely to report neuroses and Asian ethnic groups more likely to report.
1.4: Self reported Psychiatric morbidity among adults living in private households in Haringey, 2000

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>All adults</th>
<th>%</th>
<th>%</th>
<th>%</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
<td>Black</td>
<td>south Asian*</td>
<td>Other</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td>Mixed anxiety and depressive disorder</td>
<td>8.7</td>
<td>7.4</td>
<td>10.0</td>
<td>13.4</td>
<td>8.8</td>
<td></td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td>4.5</td>
<td>3.8</td>
<td>4.2</td>
<td>4.0</td>
<td>4.4</td>
<td></td>
</tr>
<tr>
<td>Depressive episode</td>
<td>2.5</td>
<td>2.7</td>
<td>3.7</td>
<td>3.2</td>
<td>2.6</td>
<td></td>
</tr>
<tr>
<td>All phobias</td>
<td>1.8</td>
<td>1.9</td>
<td>1.9</td>
<td>1.2</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>1.0</td>
<td>1.8</td>
<td>4.0</td>
<td>-</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Panic disorder</td>
<td>0.7</td>
<td>0.3</td>
<td>-</td>
<td>1.6</td>
<td>0.7</td>
<td></td>
</tr>
<tr>
<td>Any neurotic disorder</td>
<td>16.3</td>
<td>14.1</td>
<td>19.2</td>
<td>20.4</td>
<td>16.4</td>
<td></td>
</tr>
</tbody>
</table>


Additional evidence of underestimating the prevalence of depression can be found on the NHS Comparators website (www.nhscomparators.nhs.uk) that compares the number of patients known to be depressive with the numbers expected to be. While the database records 15010 people over 18 registered with depression, the model estimates that in reality 18180 adults in Haringey suffer from depression, or a prevalence of 8.9% in the adult population.

1.3. Prevalence of dementia

Haringey has a comparatively young population, and this is reflected in the prevalence of dementia. Haringey has the 4th lowest rate of dementia in London (figure 1.5). Within London, only City and Hackney PCT, Tower Hamlets PCT and Hammersmith and Fulham PCT had lower rates.

There are a total of 602 patients registered as having dementia in Haringey according to QOF data. This represents about 2 dementia sufferers for every 1000 people. This figure is likely to be an underestimate as it only takes GP registered patients in account. The prevalence of dementia is uneven across the borough, with most cases registered with the West GP collaborative (figure 1.6). The prevalence of dementia in the West collaborative is twice the prevalence in the South East collaborative. This reflects the population distribution in the borough, with more elderly people living in the west of the borough.

Illustrating the likelihood of underreporting of disease, when recorded prevalence is compared to expected numbers of people suffering from dementia, it is likely that, even though only 602 people are registered by GPs as having dementia, the real figure is likely to be between three and four times higher (figure 1.7). According to this model, 1911 people would be
expected to have dementia in the borough, more than three times the observed figure.
1.5: Prevalence of dementia (QOF), FY 2007/08

Source: Quality outcome framework (QOF) data FY 07/08

1.6: Number of registered patients with a diagnosis of dementia in Haringey by collaborative, 2009

<table>
<thead>
<tr>
<th>Collaborative</th>
<th>Number of registered patients with dementia</th>
<th>Percentage of the register (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>west</td>
<td>231</td>
<td>0.28</td>
</tr>
<tr>
<td>central</td>
<td>114</td>
<td>0.19</td>
</tr>
<tr>
<td>NE</td>
<td>180</td>
<td>0.26</td>
</tr>
<tr>
<td>SE</td>
<td>77</td>
<td>0.13</td>
</tr>
<tr>
<td>Haringey</td>
<td>602</td>
<td>0.22</td>
</tr>
</tbody>
</table>

Source: QOF 2009

1.7 Prevalence of dementia in Haringey, per GP collaborative, 2008

- SE Collaborative
- NE Collaborative
- Central Collaborative
- West Collaborative

prevalence (%)
Source: QOF 2008, NHS comparators
1.4. Estimation of Need

The Mini2k is a tool developed by Durham University that can estimate the relative need for mental health services for severe mental illness. It is benchmarked against the national average. Haringey is estimated to have 1.16 times the average need. However, there are wide variations within borough, with most of the need concentrated to the east of the borough, with a visible west/east gradient (figure 1.8).

Another tool developed by The Care Services Improvement Partnership (CSIP) estimates prevalence of Common Mental Illness (CMI) and estimates the numbers of people with mental illness who will present for primary care. The tool is based on data from Office of National Statistics Psychiatric Morbidity Survey and population estimates from 2006. CSIP estimates that a total of 28,757 people aged 16-74 years are currently experiencing Common Mental Illness (CMI) in Haringey. The majority of these would experience mixed anxiety and depressive disorder and generalised anxiety disorder. The model also estimates that only about a third of these patients will present for treatment, identifying a large unmet need (Figure 1.9). These figures are likely to be underestimated as the model does not take into consideration factors that impact on mental health such as deprivation, unemployment, homelessness or ethnicity.

Source: University of Durham
### 1.9: Estimated weekly prevalence and presentation of common mental problems in Haringey in people aged 16-74

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Estimated number of cases/week</th>
<th>Estimate cases/week presenting for treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed Anxiety and depressive disorder</td>
<td>15,547</td>
<td>5453</td>
</tr>
<tr>
<td>Generalised Anxiety Disorder</td>
<td>7,565</td>
<td>2653</td>
</tr>
<tr>
<td>Depressive episode</td>
<td>4,475</td>
<td>1569</td>
</tr>
<tr>
<td>All phobias</td>
<td>3,173</td>
<td>1113</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>2,022</td>
<td>709</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>1,202</td>
<td>422</td>
</tr>
<tr>
<td><strong>Any neurotic disorder</strong></td>
<td><strong>28,757</strong></td>
<td><strong>10,086</strong></td>
</tr>
</tbody>
</table>

Source: Mini 2k, University of Durham

---

2. **Proxy measurements of the burden of mental illness**

While the previous section describes the prevalence of mental illness in Haringey, the figures quoted are likely to be underestimated, as the figures tend to be calculated based on the population registered by GPs. Additionally, some factors that are known to increase the risk of mental illness are not taken into account by the models described in the previous chapter. These factors are:

1. **Deprivation:** Haringey is the 13th most deprived borough in England and the 5th most deprived borough in London. Deprivation is not evenly distributed across the borough, with areas in the east of the borough experiencing much higher levels of deprivation than the west. Psychiatric morbidity (including anxiety, depression, schizophrenia and psychotic disorders) is known to be associated with social deprivation. Social deprivation is also known to result in longer duration of illness episode, higher risk of relapse, poorer treatment response and clinical outcome.

2. **Employment:** 7.5% of economically viable residents of Haringey (excluding students) were unemployed in 2004. This was higher than the figure for both London and England and Wales (4.7% and 3.1% respectively). Unemployment affects mental health, especially anxiety and depression, and increase the risk of suicide and self-harm. Unemployment is not evenly distributed across the borough, with Northumberland Park experiencing 17.2% unemployment. Duration of unemployment is also an important predictor of psychiatric morbidity. 8.8% of unemployed people in Haringey have been unemployed for 2 years or more.

3. **Age:** The age structure of Haringey differs from that of those surveyed. The Haringey population is relatively young compared to the national picture; approximately 49% of Haringey residents are aged between 15 and 45.
years. Most people with psychosis present for the first time before they are 45 years old.

4. **Housing:** Housing and homelessness is an important determinant of mental health. Higher prevalence of mental illness has been found in homeless people or in people in insecure accommodation. Haringey has one of the highest rates of people living in temporary accommodation in the country: 36.1 households per thousand in 2007.

5. **Refugees and Asylum Seekers:** There is evidence that refugees and asylum seekers are especially vulnerable to psychiatric disorders including depression, suicide and post-traumatic stress disorder. It is estimated that between 25 and 30,000 refugees and asylum seekers live in Haringey. This group also has more complex needs and often have more difficulty accessing health services than the general population.

6. **Ethnicity:** Patterns of prevalence of mental illness vary across different ethnic communities and evidence is hampered by smaller sample sizes in minority communities. There is evidence that Black Caribbean ethnic groups are at higher risk of being admitted to psychiatric hospital than White ethnic groups. In Haringey 9.5% of residents are of Black Caribbean origin. This proportion is higher than that predicted for London and nationally.

7. **Drugs and Alcohol:** There is an established link between mental illness and substance misuse. In Haringey 1457 adults have been in contact with drug treatment agencies in 2008-2009 in Haringey. Of these 74.5% (1085 people) of clients were male, 25.5% (372 people) were female. There were 18.7% of patients who were in contact with drug treatment services had a dual diagnosis (diagnosis of another mental health illness). The majority of patients in contact with drug services were Caucasian (56%) followed by black ethnic background (23%) (Figure 2.1). The proportion of substance misusers in contact with drug treatment agencies is likely to only represent a small proportion of all substance misusers.

Service users spanned all age groups, with the majority of patients aged between 25 and 44. There only a few users over the age of 55 (figure 2.2).
2.1 Distribution of patients in contact with drug treatment services in Haringey 2008/2009, by ethnicity

![Pie chart showing distribution by ethnicity]

- White: 56%
- Mixed race: 7%
- Asian: 5%
- Black: 23%
- Chinese/other: 5%
- Not stated: 4%

2.2 Distribution of patients in contact with Drug treatment services in Haringey 08/09, by age

![Bar chart showing patient distribution by age]

- 18-24: 300
- 25-29: 250
- 30-24: 200
- 35-39: 150
- 40-44: 100
- 45-49: 50
- 50-54: 25
- 55-59: 5
- 60-64: 5
- 65-69: 5
- 70-74: 5

8. **Crime:** Under the Mental Health Act 1983, The Police force has the power to section an individual they deem to be mentally disordered, for assessment by a mental health professional. Patients sectioned under these acts are very likely to have a mental illness and represent late presentation or poor management of disease. There are two subsections of the Mental Health Act the police can use:
**Section 135** is a magistrates' order. It can be applied in the best interests of a person who is thought to be mentally disordered. Section 135 magistrates' orders gives police officers the right to enter the property and to take the person to a “place of safety”, usually either a police station or a psychiatric hospital ward.

**Section 136** is a similar order that allows a police officer to take a person whom they consider to be mentally disordered to a “place of safety”. This only applies to a person found in a public place.

A total of 256 individuals were sectioned under section 135 and 136 of the Mental Health Act in 2007 and 2008. 51% of sectioned individuals were of Black ethnic background, 28% were Caucasian (figure 2.3) (note: ethnic categories recorded by the police differ from categories used in censuses).

When looking at postcode of residence of sectioned individuals, half of all sections were concentrated in two postcodes, N15 and N17, both in the east of the borough (Figure 2.4).

**2.3: Individuals sectioned under section 135 or 136 of the MHA, by ethnicity, 2007-2008**

- White: 28%
- Mediterranean: 5%
- African/Caribbean: 13%
- South Asian: 5%
- South East Asian: 2%
- Arabic: 1%
- Other: 2%
3. **Public self-perception of mental health status**

The Health Survey for England (HSE) is a series of annual surveys about the health of people living in England covering a wide variety of topics including mental health. An additional and separate sample is collected for London, called the Health Survey for England London Boost (HSfE-LB). This sample included around 275 Haringey residents.

One question in the survey addressed mental health. This was achieved through submitting the sample to a 12 question general health questionnaire (GHQ-12), a validated measure of self assessed mental well being. The sample was drawn from the general Haringey population, not specifically from mental health patients. A lower GHQ-12 score is an indication of better mental health. A score of 4 or more indicates poorer mental health.
Overall results

- Less than half of adults (48.6%) had an overall GHQ-12 score of 0 (see Figure 3.1) indicating good mental health. This is less than the London average of 56.9%
- 23.9% of Haringey adults had a score of 4 or more, indicating poorer mental health. This figure was the second highest in London.

### 3.1: Overall GHQ-12 scores for Haringey, 2006

![Overall GHQ-12 scores for Haringey, 2006](chart)

*Source: Health for England survey, London Boost data, 2007*

### 3.2 Inequalities by Gender

- In Haringey, while more than half of males (52.9%) had an overall GHQ-12 score of 0, the figure dropped to 44.2% for females (figure 3.2). Both values were under the London averages of 59.5% for males and 54.4% for females.
- In contrast, the percentage of those who scored 4 or more was higher in females than in males (27.7% compared with 20.2%). The figure for females is the highest in London.

### 3.3 Inequalities by Age

- Only 41% of 55+ had a score of 0, compared to 60% in London as whole. There are less 55+ year old people with a GHQ-12 score of 0 in Haringey than anywhere else in London.
- In Haringey there was a much higher proportion than average of young adults with a score of 4+ (27% vs. 17% Figure 3.3). This percentage is higher in Haringey than anywhere else in London.
3.2: GHQ-12 scores by gender for Haringey, 2006


3.3 GHQ-12 scores by age for Haringey, 2006

4. **Primary care data**

Primary care data gives an indication of the burden of mental illness in the population registered with a GP. It is likely to underestimate the true extent of mental illness in Haringey, for several reasons:

1) Not everyone is registered with a GP
2) GPs are unlikely to record mild mental illness (e.g. mild depressive episode) leading to underreporting
3) A proportion of the mental health needs will be addressed by the voluntary sector rather than primary care.

Nevertheless, the data gives an estimate and helps identifying inequalities in accessing services. The data is drawn from three sources:

1) **QOF (Quality Outcome Framework)** a performance management and payment system for GPs recording a series of indicators representing the quality of service of single GP practices by measuring specific outcomes.
2) **IAPT (Improving Access to Psychological therapies)**: a nationwide initiative to improve access to psychological therapies. The aim of the project is to increase the provision of evidence based treatments for anxiety and depression by primary care organisations.
3) **Psychological Therapy Services**: a local, primary care based counselling service, able to deal with complex cases not appropriate for IAPT. The service is run at Somerset Gardens Family Health Care Centre.

### 4.1 Referral to IAPT (Improving Access to Psychological Therapies)

Over a period of 11 months (October 2008 to August 2009), 1741 referrals were made to IAPT in Haringey, leading to 1460 therapies being initiated (84% of referrals). In the same period, around 13000 prescriptions for anxiolytics and 102059 prescriptions for antidepressants were made in the borough. Over a slightly longer period of time (April 2008 to December 2009), there were 2543 referrals to IAPT.

Referrals to IAPT are not evenly distributed throughout the borough. While having the lowest burden of disease, the West collaborative refers more than other collaboratives (figure 4.1)

<table>
<thead>
<tr>
<th>4.1 Origin of referrals to IAPT, by GP collaborative, between 10/08 and 08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>West</strong></td>
</tr>
<tr>
<td><strong>South East</strong></td>
</tr>
<tr>
<td><strong>Central</strong></td>
</tr>
<tr>
<td><strong>North East</strong></td>
</tr>
</tbody>
</table>
Gender and ethnicity inequalities can also be identified: women represented 69% of referrals, while men accounted for 31%. While referral rates were similar in the White British ethnic group as in the Black Caribbean and Black African ethnic groups (9.2/1000, 9.9/1000 and 7/1000 respectively), the “Other Whites” and “Other ethnicity” groups, believed to reflect in majority the Turkish and Kurdish community, were referred much more often to IAPT (22.2/1000 and 19.6/1000). It is difficult to estimate referral to initiation and initiation to completion conversion rates as there are sometimes long delays (sometimes over a year), and patient captured in the data as having been referred may have not been treated yet by the time data was stopped being recorded, leading to artificially low figures.

When looking at the nationality of patients referred to IAPT (figure 4.2), the overrepresentation of people of Turkish origin is confirmed, with Turkish people making over 14% of all referrals to IAPT, far above any non UK country.

Looking at trends in referrals to IAPT, no obvious trend can be identified over 2009 with number of referrals similar (or perhaps slightly lower) at the end of the year than at the beginning.
There are relatively few elderly patients referred to IAPT as it can be seen from graph 4.4. The majority of patients are between 26-45 years old.
4.3 Trends in IAPT referrals, Feb 09/Dec 09

Source: IAPT data, 08/09

4.4 Number of patients referred to IAPT 01/04/2008 to 31/12/2009 by age

4.2 Psychological Therapy Services data

Since 2001, PTS has seen a relatively stable number of patients, between 80 and 100 a year. However, this number has started to decline since the introduction of IAPT. Between 2001 and 2009, 70.5% of patients have been women, while 20.5% have been men. Figure 4.4 presents the trends in attendance, by sex.
Looking at attendance by ethnicity between 2001 and 2009, just under half of all attendants were White British (48.5%). The most represented ethnic groups were patients of Caribbean ethnicity (14%), and of Turkish ethnicity (10%). Broadly speaking, attendance reflected the ethnic make up of the borough. Figure 4.5 summarises the attendance to PTS by ethnicity between 2001 and 2009.

Source: Psychological Therapy Services Profile – January 2010
4.3 QOF DATA (2009)

The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of General Practitioners (GPs) in the National Health Service (NHS). There are six routinely recorded QOF outcomes, described in this section, related to mental health. These outcomes are:

**MH8:** The practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses

There were a total of 3230 registered as psychotic in Haringey. There are variations within the borough. 1.31% of patients registered in the South East GP collaborative were on the psychosis register while the figure was only 1% in the West collaborative (figure 4.6).

<table>
<thead>
<tr>
<th>Collaborative</th>
<th>Number of pts on register</th>
<th>% of register</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>842</td>
<td>1.00%</td>
</tr>
<tr>
<td>Central</td>
<td>747</td>
<td>1.26%</td>
</tr>
<tr>
<td>NE</td>
<td>867</td>
<td>1.27%</td>
</tr>
<tr>
<td>SE</td>
<td>774</td>
<td>1.31%</td>
</tr>
</tbody>
</table>

Source: QOF 2009

**MH9:** the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the preceding 15 months. In the review there should be evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status

This outcome is a proxy measure of adequate long term monitoring of patients with psychotic illness. It seems the monitoring rates are the lowest in the South East collaborative, where prevalence is highest. However, in the North East collaborative, where rates of schizophrenia a proportionally high (figure 4.3), the follow up rates are the highest in the borough (figure 4.7)

<table>
<thead>
<tr>
<th>Collaborative</th>
<th>% psychotics with r/v in previous 15 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>92.38%</td>
</tr>
<tr>
<td>Central</td>
<td>90.57%</td>
</tr>
<tr>
<td>NE</td>
<td>94.75%</td>
</tr>
<tr>
<td>SE</td>
<td>87.03%</td>
</tr>
</tbody>
</table>
MH4: The percentage of patients on lithium therapy with a recording of serum creatinine and TSH (thyroxine stimulating hormone) in the preceding 15 months

MH5: The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous 6 months

These two indicators measure adequate medication monitoring. The South East collaborative, covering an area of high prevalence of psychosis, has a lower monitoring rate than the rest of the borough (figures 4.8, 4.9). The North East collaborative, the other area with high psychosis rates, has a high rate for the MH5 indicator (figure 4.9). Overall, the West collaborative, covering the area with the lowest prevalence of psychosis, has the best medication monitoring rates (figures 4.8, 4.9).

4.8: MH4: The percentage of patients on lithium therapy with a recording of serum creatinine and TSH in the preceding 15 months

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>98.38%</td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>88.13%</td>
<td></td>
</tr>
<tr>
<td>NE</td>
<td>100.00%</td>
<td></td>
</tr>
<tr>
<td>SE</td>
<td>88.69%</td>
<td></td>
</tr>
</tbody>
</table>

Source: QOF 2009

4.9: MH5: The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous 6 months

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>93.95%</td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>88.75%</td>
<td></td>
</tr>
<tr>
<td>NE</td>
<td>84.72%</td>
<td></td>
</tr>
<tr>
<td>SE</td>
<td>73.08%</td>
<td></td>
</tr>
</tbody>
</table>

Source: QOF 2009

MH6: The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and / or carers as appropriate

Another measure of adequate patient care is the presence of a comprehensive documented care plan. The South East collaborative (along with the west collaborative), has a low rate compared to average (figure 4.10).

4.10: MH6: The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and / or carers as appropriate
<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>86.47%</td>
</tr>
<tr>
<td>Central</td>
<td>87.73%</td>
</tr>
<tr>
<td>NE</td>
<td>92.94%</td>
</tr>
<tr>
<td>SE</td>
<td>86.88%</td>
</tr>
</tbody>
</table>

Source: QOF 2009
MH7: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by the practice team within 14 days of non-attendance

By measuring the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by the practice team within 14 days of non-attendance, it is possible to evaluate the ability of practices to identify missed appointments and act upon it. This is important in a population likely not to fully engage with health services. It seems that the South East collaborative, the area with the highest prevalence of psychosis, also has the lowest pick up rate in the borough (figure 4.11). The North East collaborative has the best rate.

4.11: MH7: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by the practice team within 14 days of non-attendance

<table>
<thead>
<tr>
<th></th>
<th>West</th>
<th>Central</th>
<th>NE</th>
<th>SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>83.33%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>80.95%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NE</td>
<td>89.68%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SE</td>
<td>69.76%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: QOF 2009

5. Secondary care data
(2006-2009 data from Secondary Uses Services, SUS)

Secondary care data allows estimation of the number of Haringey residents admitted to an Acute Trust or a Mental Health Trust primarily for a mental health reason. While a proportion of admissions are unavoidable, part of these admissions could be avoided with better management in primary care and as such secondary care data is a proxy measurement for late presentation of disease.

Haringey admits more people to hospital for mental health than anywhere in London (Figure 5.1), with 457 admissions per 100000 population per year, 1.62 times the national average of 281/100000. This equates to roughly 1000 admissions per year with a primary mental health diagnosis.
5.1: All mental health admissions, FY 2006/07

Between March 2006 and March 2009, there were a total of 3197 admissions with a primary mental health diagnosis, or a rate of 1066 admissions per year. The most common causes for admissions (Figure 5.2), in decreasing order were: alcohol (681 over three years), schizophrenia (563 admissions) and depression (336 admissions).

- 20% of patients admitted for mental health reasons are readmitted within 28 days of discharge.
- 43% of patients admitted are not registered with a GP.
- The vast majority of admissions (85%) are acute, non elective admissions, with little variation across the borough.
The majority of patients with an admission for a primary mental health diagnosis are admitted at the Mental Health Trust. In 2008/09, there were 607 adults and 85 older people admitted at Barnet, Enfield and Haringey Mental Health Trust (BEHMHT). Schizophrenia was the most common cause of admission with over half of the admissions. Figure 5.3 details causes for admission at BEHMHT.

5.3 Admission diagnosis at BEHMHT, 2008/2009

- Dementia: 3%
- Psychoactive Substances: 4%
- Schizophrenia: 59%
- Mood Affective: 18%
- Personality Disorders: 15%
- Other: 1%
5.2 Admissions by ward of residence

There is huge variation in admission rates within the borough, from 150/100000 in Alexandra (less than national average) to over 550/100000 in Bruce Grove or Harringay (figure 5.4). In the registered population there are still large variations, from 221/100000 in the West to 293/100000 in the North East (Figure 3.3).

5.4: Rate of admission for mental health reasons in Haringey, per 1000 pop, per ward:

[Map of Haringey showing rate of admission per ward]

Source: Secondary User Services, 2009

When the admission map is compared with a map of population distribution by ethnicity (figure 5.5) it appears that a large proportion of admissions originate from areas with a large proportion of BME residents.
5.3 Admissions by ethnicity:

While the overall rates of admissions are high, there are differences between ethnic groups, and different groups are admitted for different reasons. Patients from Black Ethnic groups account for 20% of the population, but represent 43% of all admission for schizophrenia (figure 5.6). Patients from Caribbean ethnic groups particularly account for 23% of admissions for schizophrenia but represent only 9.5% of the population.

Black ethnic groups also represent 36% of all admission for bipolar disorder/mania (Figure 5.7). Caribbean ethnic groups particularly account for 18% of admissions for bipolar disorder/mania.

White ethnic groups make up 70% of alcohol related admissions (figure 5.8) and 90% of opioid related admissions (Figure 5.9).

Admissions for depression, dementia and anxiety do not seem to vary by ethnicity. Asian ethnic groups are admitted less than would be expected in all categories (except personality disorder where they are over represented).
5.4 Admissions by age and sex

While there are disparities amongst ethnic groups, the rates of admissions also vary according to age and sex. Men are more likely to be admitted for mental health, making up 58% of the admitted population. The bulk of admissions were in young and middle aged men between ages 20 and 44 (figure 5.10). In younger patients (15-19), women were more likely to be admitted than men (figure 5.10). The average age of admission was 44 years old for men and 46 years old for women.
5.5 Trends in admission

The number of admissions for mental health in Haringey is decreasing over time. While 586 patients were admitted with a primary diagnosis of mental health between April 2006 and October 2006, that figure dropped to 414 patients between October 2008 and March 2009, or a drop of 29.5% (figure 5.11). Rates of admissions in Black and Minority Ethnic groups, the minority groups with the highest rates of mental admissions, had also decreased, albeit at a slower pace, from 269 admissions in the April 2006-October 2006 period to 214 between October 2008 and March 2009, or a drop of 20.5%.
Source: Secondary User Services, 2009
6 Secondary care data in the unregistered population
(2006-2009 data from Secondary Uses Services, SUS)

When looking at admissions in patients who are not registered with a GP, intra-borough inequalities have a very pronounced East/West divide (figure 6.1). There were a total of 706 unregistered patients admitted with a primary mental health diagnosis between April 2006 and March 2009. Only 20% of these patients originated from the West of the borough.

6.1: Admissions for mental health reasons in the unregistered population in Haringey between 04/06 and 03/09

Source: Secondary User Services, 2009

6.1 Admissions by age and sex in the unregistered population

Compared to the total admissions, admitted patients who are unregistered are more likely to be male (61%, vs58%), and are younger on average (figure 6.2)
6.2 Mental health admissions by age and sex in the unregistered population, between 04/06 and 03/09

Source: Secondary User Services, 2009

6.2 Admissions by ethnicity in the unregistered population

While there are wide ethnic variations in admission rates, the differences are even more striking in the unregistered population (figure 6.3). While the Black and Ethnic minority groups make up 18% of all mental health admissions in the general population, they represent 31% of admissions for unregistered patients. The percentage of admissions from the White British ethnic group drops to 29% (vs. 41% for all mental health admissions), while other groups are roughly stable.

6.3 Ethnic distribution of admissions for all causes in the unregistered population, between 04/06 and 03/09

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>49.22%</td>
</tr>
<tr>
<td>White British</td>
<td>28.94%</td>
</tr>
<tr>
<td>Irish</td>
<td>4.68%</td>
</tr>
<tr>
<td>Other White</td>
<td>15.60%</td>
</tr>
<tr>
<td>Mixed</td>
<td>2.27%</td>
</tr>
<tr>
<td>White and Asian</td>
<td>0.28%</td>
</tr>
<tr>
<td>White and Black African</td>
<td>0.28%</td>
</tr>
</tbody>
</table>
### Demographic Data

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White and Black Caribbean</td>
<td>0.99%</td>
</tr>
<tr>
<td>Other mixed</td>
<td>0.71%</td>
</tr>
<tr>
<td><strong>Asian</strong></td>
<td><strong>3.97%</strong></td>
</tr>
<tr>
<td>Indian</td>
<td>0.99%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>0.43%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>0.71%</td>
</tr>
<tr>
<td>Other Asian</td>
<td>1.84%</td>
</tr>
<tr>
<td>Black</td>
<td><strong>31.06%</strong></td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>15.60%</td>
</tr>
<tr>
<td>Black African</td>
<td>11.91%</td>
</tr>
<tr>
<td>Other Black</td>
<td>3.55%</td>
</tr>
<tr>
<td><strong>Chinese or other</strong></td>
<td><strong>8.37%</strong></td>
</tr>
<tr>
<td>Chinese</td>
<td>0.43%</td>
</tr>
<tr>
<td>Other</td>
<td>7.94%</td>
</tr>
</tbody>
</table>

*Source: Secondary User Services, 2009*

### Prescription Data

Haringey has high prescription expenditure for mental health (£1.2m/100 000 population in primary care only, Figure 7.1). Only Brent and Islington PCT, both neighbouring PCTs, spent more on mental health medication in primary care.

#### 7.1 Prescription Expenditure for Mental Health (£thousands/100 000 Pop), FY 2007/08

[Map of prescription expenditure]

*Source: http://www.nchod.nhs.uk/

Overall, between April 2006 and August 2009 a total of 594149 prescriptions for mental health medication were made (figure 7.2), or an average of 14 000 per month. The cost of prescriptions for the same period has amounted to
£9,150,148, or an average of £223,000 per month (Figure 7.3). The patterns of prescribing are not the same throughout the borough: while having the lowest prevalence of depression and anxiety, the West GP collaborative prescribes more anti-manic medication than the rest of the borough, more than twice the amount of any other collaborative. The prescription of dementia medication, while being low in volume, is expensive due to high costs of the drug. While there are strict guidelines in place for prescription of dementia drugs, it is not clear how closely they are followed. The North East collaborative prescribes the most antidepressants. They also have the highest prevalence of depression.

### 7.2 Mental health prescriptions in Haringey, in volume, 04/06-08/09

<table>
<thead>
<tr>
<th>Drugs for Dementia</th>
<th>West</th>
<th>Central</th>
<th>NE</th>
<th>SE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-manic Drugs</td>
<td>5429</td>
<td>3797</td>
<td>3034</td>
<td>2843</td>
<td>15103</td>
</tr>
<tr>
<td>Antipsychotic Drugs</td>
<td>25308</td>
<td>26073</td>
<td>33277</td>
<td>30835</td>
<td>115493</td>
</tr>
<tr>
<td>Anxiolytics</td>
<td>21023</td>
<td>8998</td>
<td>9755</td>
<td>9295</td>
<td>49071</td>
</tr>
<tr>
<td>Drugs for Dementia</td>
<td>4773</td>
<td>1408</td>
<td>1462</td>
<td>1499</td>
<td>9142</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>104295</td>
<td>76583</td>
<td>93755</td>
<td>13070</td>
<td>405340</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>160828</td>
<td>116859</td>
<td>141283</td>
<td>17517</td>
<td>594149</td>
</tr>
</tbody>
</table>

Source: Haringey PCT

### 7.3 Mental health prescriptions in Haringey, in price, 04/06-08/09

<table>
<thead>
<tr>
<th>Drugs for Dementia</th>
<th>West (Cost)</th>
<th>Central (Cost)</th>
<th>NE (Cost)</th>
<th>SE (Cost)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-manic Drugs</td>
<td>£23,971.39</td>
<td>£15,918.16</td>
<td>£18,228.18</td>
<td>£15,510.48</td>
<td>£73,628.21</td>
</tr>
<tr>
<td>Antipsychotic Drugs</td>
<td>£1,107,650.50</td>
<td>£1,348,999.56</td>
<td>£1,451,271.20</td>
<td>£1,389,003.69</td>
<td>£5,296,924.95</td>
</tr>
<tr>
<td>Anxiolytics</td>
<td>£63,928.05</td>
<td>£36,514.72</td>
<td>£47,203.19</td>
<td>£45,316.22</td>
<td>£192,962.18</td>
</tr>
<tr>
<td>Drugs for Dementia</td>
<td>£287,534.83</td>
<td>£88,773.51</td>
<td>£91,481.27</td>
<td>£89,871.05</td>
<td>£557,660.66</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>£856,702.24</td>
<td>£585,592.19</td>
<td>£658,643.90</td>
<td>£928,034.42</td>
<td>£3,028,972.75</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£2,339,787.01</td>
<td>£2,075,798.14</td>
<td>£2,266,827.74</td>
<td>£2,467,735.86</td>
<td>£9,150,148.75</td>
</tr>
</tbody>
</table>

Source: Haringey PCT

The volume of prescription is increasing year on year in Haringey. Volume of prescription increases constantly. The period between April 2006 and August 2009 has seen increases of:

1. 40% in antipsychotic prescription volume
2. 28% in anxiolytics prescription volume
3. 150% in dementia drugs prescription volume (figure 9.4)
4. 42% in antidepressants prescription volume
8. Estimate of children’s mental health problems in Haringey (adapted from CAHMS needs assessment)

Prevalence amongst all Haringey Children

Much of the information below is estimated based on national information or surveys (Census) but is supplemented by local data wherever possible. The needs analysis data is compared against services currently provided to help identify gaps in services and areas where services are under resourced.

The 2004 Haringey Health Report highlighted that a significant number of children and young people may be experiencing mental health problems in Haringey, but that their needs may not be identified. Early identification and intervention for children with mental health problems is crucial in preventing a cycle of ill health and social exclusion for these children.

A large-scale national survey of child mental health in the UK showed that more than one in ten 5-16 year olds had emotional or behavioural problems. Boys were more likely to have a mental health problem than girls in both the 5-10 age group (10.5% of boys compared to 5.5% of girls) and the 11-16 age group (13.4% of boys and 10.8% of girls).

Figures for inner London, which are more likely to reflect the situation in Haringey, suggest that the prevalence of children with mental health problems was a percentage point lower at 8.6%. Rates were lower than the national average for boys and girls aged 5-10 and for girls aged 5-16. Rates
were higher for boys aged 11-16 (13.6% compared to 13.4% nationally) (see figure 8.1).

8.1: Prevalence of mental disorders, by region, age and sex, 2004

<table>
<thead>
<tr>
<th></th>
<th>Inner London</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Boys</td>
<td>Girls</td>
</tr>
<tr>
<td>5-10</td>
<td>8.1</td>
<td>4.6</td>
</tr>
<tr>
<td>11-16</td>
<td>13.6</td>
<td>7.1</td>
</tr>
<tr>
<td>5-16</td>
<td>11.0</td>
<td>5.7</td>
</tr>
</tbody>
</table>

Source: ONS 2004

When the Inner London figures in Figure 8.15 are applied to the 2008 Haringey population it is predicted that there are a total of 2452 children aged 5-16 with mental health problems living in the borough. This is broken down by boys and girls as follows:

643 boys age 5-10
940 boys aged 11-16
365 girls aged 5-10
504 girls aged 11-16

Furthermore population estimates from the GLA suggest that the overall number of children and young people will grow over the next 5 years.

An increase of 2.4% is expected between 2008 and 2013 such that it is predicted that there will be 55,118 people under 20 living in Haringey. Numbers of children aged 0-9 are set to increase by 1,801 a rise of around 6%, whereas the numbers in the 10-19 age group are set to decrease by -2.1%. Between 2013 and 18 the number of under 20’s is currently set to remain stable (see figure 8.2).

8.2: Population estimates 2008-2018

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>16,764</td>
<td>17,629</td>
<td>17,810</td>
<td>+5.16%</td>
<td>+1.03%</td>
</tr>
<tr>
<td>5-9</td>
<td>13,360</td>
<td>14,296</td>
<td>14,060</td>
<td>+7.01%</td>
<td>-1.65%</td>
</tr>
<tr>
<td>0-9</td>
<td>30,124</td>
<td>31,925</td>
<td>31,870</td>
<td>+5.98%</td>
<td>-0.17%</td>
</tr>
<tr>
<td>10-14</td>
<td>11,899</td>
<td>11,980</td>
<td>12,215</td>
<td>+0.68%</td>
<td>1.96%</td>
</tr>
<tr>
<td>15-19</td>
<td>11,790</td>
<td>11,213</td>
<td>10,995</td>
<td>-4.89%</td>
<td>-1.94%</td>
</tr>
<tr>
<td>10-19</td>
<td>23,689</td>
<td>23,193</td>
<td>23,210</td>
<td>-2.09%</td>
<td>+0.07%</td>
</tr>
<tr>
<td>All</td>
<td>53,813</td>
<td>55,118</td>
<td>55,080</td>
<td>+2.43%</td>
<td>-0.06%</td>
</tr>
</tbody>
</table>

Source: GLA 2007

When the prevalence figures from Figure 8.1 are applied to the 2013 population estimates the number of children with mental health problems is predicted to be 2650 (198 more children than in 2008; an increase of 8.1%) The breakdown by age and gender is as follows:

684 boys aged 5-10
1,142 boys aged 11-16
319 girls aged 5-10
505 girls aged 11-16
There is evidence to suggest that many forms of mental health problems in young people are becoming more frequent. For an example there has been an increase in emotional problems and conduct disorders amongst adolescents over the last 20-25 years. The association between these problems and poor outcomes in later life suggest that these are the result of real changes in problem levels.

A number of possible explanations have been put forward to explain these increases including education and future expectations, changes in the family context and parenting and changes in the social situation. Certain factors such as parental separation have increased. Divorce rates increased steadily from the 1960’s until the 1990’s, reaching a peak of 180,000 in 1993. In 2003, the number of divorces granted in the UK increased from 160,760 in 2002 to 166,700, an increase of 3.7%. Figure 8.3 estimates the prevalence of a range of conditions in Haringey based on the Inner London figures.

**Trends in prevalence**

The survey that has been used to estimate numbers of children in Haringey with mental health needs was carried out in both 1999 and 2004. The survey of approximately 12,000 children aged 5-16 suggests that the prevalence of mental health need in England increased over 5 years between surveys from 9.5% to 10.2%. However, responses from residents in Inner London suggested that the rate fell from 10.9% to 8.6%. The prevalence of emotional disorders and conduct disorders in Inner London both fell (Figure 8.3).

The rate of Hyperkinetic disorders increase amongst 11 to 16 year olds increased from 1.6% to 2.3%. The rate of less common disorders (including psychosis) increased from 0.2% to 0.7%, which suggests, an increase from 55 to 209 children aged 5-16.

### 8.3: Prevalence estimates of mental health conditions in children and young people.

<table>
<thead>
<tr>
<th>Age group</th>
<th>Condition</th>
<th>Inner London Prevalence (%)</th>
<th>Haringey Estimate (number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-10 years</td>
<td>Emotional disorders</td>
<td>2.1</td>
<td>333</td>
</tr>
<tr>
<td></td>
<td>Conduct disorders</td>
<td>3.1</td>
<td>492</td>
</tr>
<tr>
<td></td>
<td>Hyperkinetic disorders</td>
<td>1.4</td>
<td>222</td>
</tr>
<tr>
<td></td>
<td>Less common disorders</td>
<td>0.7</td>
<td>111</td>
</tr>
<tr>
<td></td>
<td>Any disorder</td>
<td>6.4</td>
<td>1015</td>
</tr>
<tr>
<td>11-16 years</td>
<td>Emotional disorders</td>
<td>4.3</td>
<td>602</td>
</tr>
<tr>
<td></td>
<td>Conduct disorders</td>
<td>6.2</td>
<td>868</td>
</tr>
<tr>
<td></td>
<td>Hyperkinetic disorders</td>
<td>2.3</td>
<td>322</td>
</tr>
<tr>
<td></td>
<td>Less common disorders</td>
<td>0.7</td>
<td>98</td>
</tr>
<tr>
<td></td>
<td>Any disorder</td>
<td>11.0</td>
<td>1540</td>
</tr>
<tr>
<td>All Children*</td>
<td>Emotional disorders</td>
<td>3.1</td>
<td>926</td>
</tr>
<tr>
<td></td>
<td>Conduct disorders</td>
<td>4.5</td>
<td>1344</td>
</tr>
<tr>
<td></td>
<td>Hyperkinetic disorders</td>
<td>1.8</td>
<td>538</td>
</tr>
<tr>
<td></td>
<td>Less common disorders</td>
<td>0.7</td>
<td>209</td>
</tr>
</tbody>
</table>
Prevalence amongst Looked After Children

Looked-after-children (LAC) are five times more likely to experience mental health problems than other children. As at September 2008 Haringey council looked after 447 children and young people. This equates to 91 looked after children and young people per 10,000 children and young people in the general population – higher than the London average of 75. Of these, 41 were unaccompanied minors in care. Over 70% of children looked after have Black and minority ethnic origin – an overrepresentation compared to the population of the borough.

Source: ONS/GLA Population
*NB: Figures do not add up due to rounding up
A recent needs assessment carried out in Haringey comments that research evidence identifies the following as exacerbating factors:

- Placement type - so that LAC in residential care had significantly higher levels of assessed mental health difficulties.
- Placement instability - increased the risk of mental health problems.
- Whilst none of the cited studies demonstrated a statistical link between ethnicity and mental health disorders amongst LAC, the ethnically diverse character of Haringey LAC would seem likely to further exacerbate the risk of mental health difficulties.
- The research evidence suggests an increased level of mental health need amongst Haringey’s refugee and asylum seeking children and young people (including unaccompanied minors).

This evidence is used to project possible levels of mental health difficulties within Haringey’s LAC population based on numbers of looked after children in Haringey at 31 March 2008 (see figure 8.4).

### 8.4: Estimated prevalence of mental health disorders amongst looked after children in Haringey.

<table>
<thead>
<tr>
<th>Type of disorder</th>
<th>Estimated prevalence rates of mental health need</th>
<th>Projected need for Haringey LAC (numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall level of need</td>
<td>45 - 67%</td>
<td>201 – 300</td>
</tr>
<tr>
<td>Anxiety</td>
<td>11 - 26%</td>
<td>49 – 116</td>
</tr>
<tr>
<td>Depression</td>
<td>12 - 37%</td>
<td>54 - 165</td>
</tr>
<tr>
<td>Conduct Disorders</td>
<td>28 - 37%</td>
<td>125 – 165</td>
</tr>
<tr>
<td>Hyperkinetic disorders</td>
<td>7 - 30%</td>
<td>31 – 134</td>
</tr>
<tr>
<td>Developmental disorders</td>
<td>4%</td>
<td>18</td>
</tr>
<tr>
<td>Post traumatic syndromes</td>
<td>26%</td>
<td>116</td>
</tr>
<tr>
<td>Psychotic disorders</td>
<td>8%</td>
<td>36</td>
</tr>
</tbody>
</table>

Source: ONS

### 9. Suicide Data

Analysis of suicides in Haringey between 2001 and 2004 shows that an average of 35 Haringey residents commit suicide each year - approximately 50% higher than the national average. Around three-quarters of people who committed suicide in Haringey had no contact with mental health services in the previous 12 months."
Suicides figures for six years in residents of Haringey are shown in figure 9.1. The number of reported suicides was down from 38 in 2001-02 to 23 in 2005-06. This was followed a surge in the year 2006-07; a 56% rise from the previous year. Since then, Barnet, Enfield and Haringey Mental health trust reports a sharp decrease in number of suicides by users of mental health services. It is not known if the recent drop is reflected in the whole population. It is estimated that in Haringey about 40% of people committing suicide in Haringey have been in touch with health services in the 12 months preceding their death.

9.1: Suicide deaths in Haringey, 2001-2007

![Graph showing Suicide deaths in Haringey, 2001-2007](source: Coroner court reports, ONS)

Figure 9.2 presents the number of suicide by age group. There have been 41 deaths due to suicide or undetermined injury from April 2006 to March 2007. There were more cases reported in 2006 than in 2007. The majority of suicides were below the age of 44 years. Nine of the cases were females (22%) and 32 were males (78%); a ratio of 3.6 males to 1 females; this is higher than national ratio at 3 to 1.

9.2: Suicides in Haringey, by age group, 2006-07

<table>
<thead>
<tr>
<th>Age band</th>
<th>2006</th>
<th>2007</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 - 24</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>25 - 34</td>
<td>8</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>35 - 44</td>
<td>7</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>45 - 54</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>55 - 64</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>65 - 74</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>75 - 84</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>11</td>
<td>41</td>
</tr>
</tbody>
</table>

Source: Coroner court reports, ONS

Data from the Department of health budgeting atlas illustrate the fact that the suicide rate in Haringey is not amongst the highest in London (figure 9.3). By contrast, two neighbouring PCTs Islington and Camden PCTs, had amongst the highest suicide rates in London.
6.3 Ethnicity

When looking at rates of suicides by ethnicity, 42% percent of data on ethnicity were missing. For those with recorded ethnicity “White British” were the highest ethnicity group at 19.5% followed by “Black Caribbean” at 15% followed by “Other White” at 12.0%. Excluding the missing data, 58% (14) of cases were from ethnic minority groups.

9.4: Ethnicity of Individuals Committed Suicides, Haringey 2006-2007
**Place of Birth**

Data from one fifth of patients stating the place of birth was missing. 39% of people committing suicide in Haringey were born outside the UK (Figure 9.5). For comparison purposes, 37% of Haringey residents were born outside of the UK according to the 2001 census.

![Place of Birth Chart](chart.png)

**Employment Status**

Almost half of data on employment status were missing. The majority of suicide cases were on paid employment at 29% (fig 8.6); however, about 10% were unemployed and 12% were retired.

![Employment Status Chart](chart.png)
6.5 Marital Status

In total 17% of data on marital status was missing. Overall, 56% of the people who committed suicide were single (fig 9.7). Divorced and married/cohabitating were at 12% each.

9.7: Marital Status of Suicide Cases, Haringey 2006-2007

6.6 Living Arrangements

Over half of data on living arrangements were missing. The majority of suicides were among people who lived alone (19.5%) followed by people living with a spouse (15%) (Fig 9.8).

9.8: Living Arrangements of Suicide Cases, Haringey 2006-2007
6.7 Contact with Health Services in the last 12 months

A total of 17 (41%) of suicide cases were in contact with mental health services in the last 12 months of whom 17% were in-patients and 7% were discharged in the past year. Only 29% of the suicide cases have been on prescription. 29% only are registered with a GP of those only 34% of were in contact with their GP prior to death.

6.8 Diagnosis

Figure 9.9 shows the distribution of the diagnosis found in all cases. Above 77% of data is missing. Schizophrenia was the most frequent diagnosis at (10%) followed by bipolar disorder at 7%. Depression and generalised anxiety came third.

9.9 Psychiatric Diagnoses of Suicide Cases, Haringey 2006-2007

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>10%</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>7%</td>
</tr>
<tr>
<td>Depression</td>
<td>2%</td>
</tr>
<tr>
<td>Generalised anxiety</td>
<td>2%</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>2%</td>
</tr>
<tr>
<td>Missing</td>
<td>77%</td>
</tr>
</tbody>
</table>

Although it is not possible to identify the registered address or postcode for all suicide cases, this data is available for the 40% of suicide cases that were in touch with health services before their death (fig 9.10). Although there is no obvious geographical pattern, the three wards with the highest suicide rates are in the east of the Borough, and two wards (Noel Park and Tottenham Hale) have much higher rates than the rest of the borough. Unfortunately no data on ethnicity is available for individual patients.

9.10: Number of suicides in patients in touch with health services, Haringey, 2004-2008

<table>
<thead>
<tr>
<th>Ward</th>
<th>Suicides 04-08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexandra</td>
<td>5</td>
</tr>
<tr>
<td>Bounds Green</td>
<td>5</td>
</tr>
</tbody>
</table>
Summary:

Prevalence

- Haringey has a high burden of mental health illness, with the fourth highest rate of patients with psychosis.
- There are wide variations of prevalence of disease within the borough, with prevalence of most mental health illness higher in the east (apart from dementia).
- The numbers of patients with mental health identified by GPs is likely to be underestimated.
- The number of missing dementia patients, according to prevalence data is significant.

Proxy measurements of the burden of mental illness

- Socio-economic factors suggest Haringey has a higher than recorded prevalence of mental illness.
- These factors will not affect everyone equally, with BME groups more likely to be affected.
- It is likely that the prevalence of mental illness in Haringey is much higher than that predicted by the model although we currently do not have methods to estimate how much higher.

Public self-perception of mental health status

- Haringey has the second highest rate of self reported mental illness in London.
- Haringey has more women and young people aged 16-34 with a GHQ-12 score above 4 than anywhere else in London.

Primary care data
- IAPT represents a small proportion of treatment when compared with prescriptions for anxiety and depression
- There are disparities in how patients are referred to IAPT with patients belonging to the West collaborative more likely to be referred
- Women are much more likely to be referred to IAPT than men and are more likely to attend
- There is a high referral rate for IAPT in the Turkish community
- Elderly patients are likely to be underrepresented
- The referral rates to IAPT are not increasing over time
- PTS represents a small proportion of treatment when compared to IAPT
- Attendance is decreasing since the introduction of IAPT
- Usage of the service reflects the ethnic make up of Haringey

QOF data
- Globally the highest prevalence of psychoses are concentrated in the South East collaborative
- The South East collaborative also has the lowest rates of adequate patient monitoring and follow up.
- The North East collaborative, covering an area of high disease prevalence, scores well on patient monitoring and follow up

Secondary care admissions
- The rate of admission for mental health in Haringey is very high.
- There are wide variations within the borough: the bulk of admissions come from the East of the borough, particularly the North East which has a high proportion of BME population.
- A large proportion of patients admitted are not registered with GPs

Admissions by ethnicity
- Admissions for dementia, depression and anxiety are not ethnically determined.
- White ethnic groups are overrepresented in admissions for alcohol and substance abuse.
- Black ethnic groups, particularly Caribbean groups, are overrepresented for psychoses.
- Asian ethnic groups are underrepresented in all categories.
- Young and middle age males represent the bulk of admissions.
- The number of admissions is overall decreasing over time, but not at the same rate for all ethnic groups

Trends in admission
- A large proportion of patients admitted for mental health are not registered with GPs.
- Inequalities are even more pronounced in unregistered patients than in the general population.
- Unregistered patients admitted for mental health are younger, more likely to be male and more likely to belong to a black ethnic minority

Prescriptions
- Haringey's expenses in mental health drugs are amongst the highest in London.
- The west collaborative prescribes disproportionately considering their burden of disease.
- The volumes of prescriptions constantly and rapidly increase for almost every drug category, but dementia drugs are seeing the biggest increase

**CAMHS**
- Based on inner London prevalence estimates there are currently 2,452 children aged 5-16 with mental health problems. (1,008 aged 5-10 and 1,444 aged 11-16) in Haringey.
- Boys are experiencing mental health problems more than girls (1,583 boys and 869 girls).
- Numbers of children in Haringey population age 0-9 are set to increase by 6% between 2008 and 2013, whereas the numbers of children aged 10-19 are set to decrease by 2%.
- By 2013, based on population estimates there will be 2,650 children aged 5-16 with mental health problems in Haringey, an increase of 8.1%.
- The number of children within care of the Local Authority in Haringey is greater than the London average, and with looked after children, five times more likely to develop mental health problems; there are potentially significant mental health needs amongst these children in this borough.
- An increased level of mental health needs among Haringey's refugee and asylum seeking children and young people (unaccompanied minors) has been identified.
- Overall, there is evidence to suggest that many forms of mental health problems in young people are becoming more frequent. Further work is needed to develop Haringey specific information sources that can be used as a basis for service planning

**Suicide**
- Haringey has an average to below average suicide rate when compares to London.
- It seems that certain ethnic groups (i.e. Caribbean's) are more likely to be victims of suicide (although data is incomplete and should be interpreted with caution).
- Country of origin does not alter the likelihood of suicide.
- Mental health, single households, unemployment all appear to be risk factors (but data is incomplete): these are well established associations.
- It seems that some wards East of the boroughs have much higher number of patients committing suicide
**Service users**

**Mental Health Service Users and Carers Consultation 1 December 2009**

The event was held at on the 1st December 2009, at the Cypriot Community Centre. Information about the event was widely circulated to the voluntary sector, community mental health teams and in acute services. Forty four people, including service users and carers signed the attendance register. However, the day was also attended by representatives from PCT Commissioning, the BEH Mental Health Trust and Public Health.

**Methodology**

**User Satisfaction Questionnaire**

A self completion questionnaire was designed:

i. To establish minimum data on service users and carers attending

ii. To monitor knowledge of health, social care, voluntary sector services available and how to access them

iii. To monitor rates of satisfaction with services people were currently accessing including: Health care, Social Services, Voluntary Sector, Leisure Services and services that promote independent living.

**Joint Strategic Needs Assessment**

This session divided the group into 3 workshops which considered:-

i. Access to mental health and other NHS service

ii. Quality of services

iii. Mental health and stigma

**Analysis and findings**

**User Satisfaction Questionnaire**

Thirty five questionnaires were completed and successfully collected afterwards.

Some were comprehensively completed, others had significant gaps.

An analysis of the 35 returned self-completion questionnaires indicates that those who attended were representative of the range of adult mental health service users in Haringey, from those with mild conditions to those with significant and enduring mental illness.
1. Age Range of Service Users and Carers Attending

There was a broad range of ages from 25 to 84 years though the majority were between 45 and 54 years old. There were more people with enduring and established conditions, i.e. people over the age of 35 than those who were newly diagnosed (people aged 18-34).

2. Attendance from Across the Borough

A significant number of people attending came from N17 post code, followed by N22 and N4. This might have been coincidental, to do with where people receive services (Canning Crescent Community Mental Health Centre was round the corner in N22), or indeed where they live. The highest service use of Haringey mental health services is in Bruce Grove ward, which is in N17.
3. **Range of Mental Health conditions represented**

A significant number of those present were affected by depression, including carers. Two people said they had an eating disorder, although it was unclear whether this had been medically diagnosed. There were people with a wide range of mental health problems including two patients receiving NHS continuing healthcare. There were also three people who had dual diagnosis of mental illness and learning disability.

4. **Religious Diversity of Attendees**
Christians represented the largest religious group, followed by the category ‘other’, Muslim being the third largest group.

According to the 2001 census, Haringey is very religiously diverse with half the borough residents recorded as Christian, 11.3% Muslim, and 2.1% Hindu. A fifth of Haringey residents stated they did not have a religion – and this may be reflected in the results of the consultation day.

5. Satisfaction with Haringey mental health services
a) Voluntary Sector Provision
The service users and carers attending are not always clear what provision is voluntary sector or statutory sector so the projects below include 684 Project and the Clarendon Centre – which are in fact Haringey Council provisions. Voluntary sector agencies that were not represented at all were the Turkish Carers Support and the Eating Disorders organisations BEAT. The most popular facility is Project 684, followed by the Citizens Advice (not funded from the mental health budget), Bureau with the Clarendon Centre and Mental Health Carers’ Association taking joint third place. Mind in Haringey runs several projects which in this exercise would benefit from being consolidated into one. Many people were surprised at the range of voluntary sector services, they had never heard of many of them, and a few people were sceptical they were all delivering adequately and meeting identified needs.

b) Satisfaction with healthcare services
Primary care and GP service provision in particular were the unsung heroes of the day. The GP service was the most highly valued with twenty one people ranking it most highly valued or moderately highly valued. There were seventeen service users who had a GP check up in the previous 12 months, three recorded that they had not. Several mentioned a desire for less waiting time to see the GP. The hospital consultant was the next most highly regarded health service, with ten ranking them as moderately and five highly. Community Mental Health teams ranked third in the health category. Several people were frustrated by the long wait for cognitive behaviour therapy.

![Satisfaction with Health Services](chart.png)

**c) Satisfaction with social care services**

Although fourteen service users and carers were moderately or highly satisfied with access to social care services, many people did not answer these questions. This could indicate a lack of knowledge of what services are available. Fourteen people were moderately or highly satisfied with their care package and twelve people were moderately to highly satisfied with their social worker.

**6. Independent living**

This category was least understood, with eleven people saying they had considered direct payments (five had not), only ten had heard of individualised budgets, (nine categorically had not). Three people said they would like to hear more about independent living. The assumption is that those who ignored the category altogether did not understand what it was about. However, twenty people confirmed they were able to access the Council’s leisure services including swimming pools and libraries. There was a wish that leisure services were free of charge (for people with learning difficulties and mental health problems). Nine people did not use leisure services at all and a few wanted specific women’s sessions in leisure facilities.

**7. Carer information**

Ten people had carers, and fifteen did not. Seven carers had received a carers’ assessment and one had not. Four carers were the parents of a patient, and another four were children of a patient. The recognition of carers might be under reported, simply because people are not clear what
constitutes a carer. A woman who was the main carer of her husband (who had died 3 months ago) felt she had little choice about the quality of carers who provided care in her home, and in the end had to move him to a residential home. She wished there was financial support to help main carers meet the cost of bills. Another female carer (aged over seventy years old) asked for possibility of family therapy at a time and place convenient for family members. Yet another female carer felt she was not listened to when she asked for choices of care. She also complained about the lack of dignity afforded to those suffering from early onset of Alzheimer’s. She would rather have been supported with caring for her loved one twenty four hours a day, rather than statutory sector staff talking about putting him in a residential or nursing care home, which she found extremely upsetting.

8. Information
People would highly value receiving information through leaflets and electronically via websites. The telephone is the third most popular method, followed by individualised letters. Other methods mentioned were via DVD and newspapers. The lack of effective translation services makes it very difficult for people whose first language is not English to access any service at all or to know of what might be available for them.

Workshop
The workshop addressed three areas with specific theme related questions

A. Access
How did you first access mental health services in Haringey? Was this easy? Do you still access services? Has it been easy to continue to use services?

Most people accessed services first via GP, but access to GPs was reported as difficult. Access to other services was variable.

There were many other groups with good services, but not often sufficient advertising of services. E.g. free leaflets (attendees felt the council should produce more). Lots of people reported using the voluntary sector and local authority services such as MIND, Clarendon House etc. Clarendon centre was considered very useful –

“Meet people and get nice meals. Not enough staff though, looks grotty on the surface, but treat you well”

“No complaints, well looked after – always get private space”

People were happy to use the voluntary sector, but felt there should be better co-ordination of various bodies, that many of the leaflets were out-of-date and needed updating and that on-line resources needed to be improved/developed. There is a gap in the provision of Alzheimer’s care for younger people, as services are targeted at older individuals.
Some people need continuous support rather than support only when they are in crisis. There was particular concern about triage for access to services as people reported that they needed to be in crisis to access a service, but often they could tell that they were going into a crisis and needed to access the service to prevent them getting worse, but were unable to do so until they could show that they were truly in crisis. People were generally satisfied with the Alexandra Crisis Centre. Access to childcare was mentioned as some users would need childcare to allow them to access care/support groups. Access to respite breaks for carers was raised.

Do you find it easy to get to your services? Are there any problems with physical access, e.g. stairs that you find difficult? How easy is it to get to services? Are there good transport links? Do you have to travel far to go to services?

There were problems were reported on access with wheelchairs or prams/buggies. Attendees reported problems with the cost of transport and concerns were raised about changes to the Freedom Pass (but Clarendon Centre has been looking into this and can offer advice).

B Quality

- How important to you is it that you are treated in a professional way?
- How important to you is it that the staff you are in contact with are polite?
- How important is the knowledge of the person you see?

Safety and governance was particularly important to the users. They reported that GPs are variable in knowledge of mental health issues, but voluntary services are better. They thought that GPs should have lists of voluntary services that people can access. Some thought that GPs should help with isolation

Haringey Mind and the Clarendon Centre are considered good services. A key issue was respect for users and good facilities are important

3. Stigma

- Do you believe mental illness is an illness like any other?
- Do you hide the fact that you have a mental illness? Why?
- Do you think that people discriminate against you because you have a mental illness?
- Have you ever had problems getting or keeping a job because of mental illness?

They believed that attitudes are important but vary among professionals and in different settings, there are various levels of stigma. Some users felt they were discriminated against because of stigma and did not get the help they needed. Others blamed TV and the media for their portrayal of mental health issues.
Others thought that dual diagnosis means double stigma. Some patients believed that there was more stigma associated with bipolar disorder or schizophrenia. Users reported that people didn’t talk about Alzheimer’s because of stigma. Sometimes users reported that they are treated ok because they are eloquent, but people don’t realise that they need extra support.

Somali groups thought that they suffered most stigma from their own community. Women from some ethnic groups were more prone to isolation

4. Miscellaneous
The role of care-giver in the community was raised as an issue

Issues around benefits and poverty were raised, including the loss of the benefits advisor at the CAB, and problems when people are considered long-term ill, but their circumstances are not considered to have changed, so their benefits are not re-assessed.

Staff changes were reported as a problem, especially in HUN

People were concerned about individualised budgets – cost per person – allocated on personal need etc. and how that might affect their treatment

Summary

- The users were most commonly between 45-54 years from East Haringey
- Depression was the commonest mental health condition though a variety of conditions were represented
- There was confusion between the role of the voluntary and statutory sector
- GPs were amongst the most highly rated services
- Few patients had much idea about personalised budgets
- Accessing services both in terms of physically getting to premises and continuing mental health care were problematic
- The role of stigma whether real or perceived should not be underestimated both by condition and cultural group
Mental health organisations in Haringey

What kind of Mental Health organisations exist and operate in Haringey?

The range and scope of mental health organisations in Haringey is very wide: from large national charities, to private residential facilities, small local initiatives, or social support/social reinsertion organisations. While some organisations focus on treatment of mental health, others have a more social agenda, mixing social reinsertion and patient advocacy. Figure 1 presents the organisations operating in Haringey. There are additional mental health organisations in Haringey that could not be interviewed as part as this needs assessment. These were:

- Haringey Somali Community and Cultural Organisation
- Ethiopian Refugee & Outturn Project
- Catch 22 (National charity that works with 10-19 who find themselves in difficult situations)
- Rethink (National charity helping people severe mental illness recover a better quality of life.)
- Six&four centre (social environment for people with severe and enduring mental health problems)

Figure 1 - Some of mental health organisations commissioned by NHS Haringey

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Target population</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age concern</td>
<td>Provides information and support for elderly population: identifies a lot of social isolation and depression</td>
<td>Elderly population, not mental health specific</td>
<td>2000+ patients per year</td>
</tr>
<tr>
<td>MIND/Patient council</td>
<td>National charity offering information/counselling/social activities for patients with MH</td>
<td>Adults with MH illness</td>
<td>200 patients per year</td>
</tr>
<tr>
<td>Mental Health Carers’ Support Association</td>
<td>Provide services and support for carers of patients with MH</td>
<td>Carers of patients with MH illness</td>
<td>?</td>
</tr>
<tr>
<td>Arbourys Advocacy</td>
<td>To provide a platform empowering service users to have a voice within Mental Health Networks</td>
<td>Anyone with MH illness</td>
<td>?</td>
</tr>
<tr>
<td>Arbourys psychotherapy service</td>
<td>Long term Residential therapeutic community</td>
<td>Clients across the mental health illness spectrum</td>
<td>15 beds in Haringey</td>
</tr>
<tr>
<td>Arbourys Residential Crisis Centre</td>
<td>medium term “crisis” residential facility, alternative to hospital</td>
<td>Clients across the mental health illness spectrum but mainly personality disorder</td>
<td>6 beds</td>
</tr>
<tr>
<td><strong>Clarendon Centre</strong></td>
<td>Mental health aftercare centre/social reinsertion</td>
<td>Mental health aftercare centre/social reinsertion</td>
<td>Any adults who have suffered from severe mental health illness</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td><strong>MIND/Patient council</strong></td>
<td>National charity offering information/counselling/social activities for patients with MH</td>
<td>National charity offering information/counselling/social activities for patients with MH</td>
<td>Adults with MH illness</td>
</tr>
<tr>
<td><strong>Psychiatric rehabilitation services</strong></td>
<td>Employment activities/social activities to people with mental health problems</td>
<td>Employment activities/social activities to people with mental health problems</td>
<td>Adults with mental health illness</td>
</tr>
<tr>
<td><strong>Patient Council</strong></td>
<td>Volunteer run, social hub and advocacy for St Ann's patients</td>
<td>Patient Council</td>
<td>St Ann's patients and ex-patients</td>
</tr>
<tr>
<td><strong>Age concern</strong></td>
<td>Provides information and support for elderly population: identifies a lot of social isolation and depression</td>
<td>Provides information and support for elderly population: identifies a lot of social isolation and depression</td>
<td>Elderly population, not mental health specific</td>
</tr>
<tr>
<td><strong>Highgate Counselling Centre</strong></td>
<td>Provide affordable counselling to individuals, couples and families</td>
<td>Provide affordable counselling to individuals, couples and families</td>
<td>Anyone who needs counselling</td>
</tr>
<tr>
<td><strong>Open door</strong></td>
<td>Counselling and psychotherapy to young people aged 11-24 and their families, tier 3 service with tier 2 access</td>
<td>Counselling and psychotherapy to young people aged 11-24 and their families, tier 3 service with tier 2 access</td>
<td>11-24 year old and their families with personal issues (bullying, violence etc) or MH illness</td>
</tr>
<tr>
<td><strong>Pyramid</strong></td>
<td>Counselling and family mediation for BMEs primarily</td>
<td>Counselling and family mediation for BMEs primarily</td>
<td>Mainly BME patients but anyone welcome</td>
</tr>
<tr>
<td><strong>MIND/Patient Council</strong></td>
<td>National charity offering information/counselling/social activities for patients with MH</td>
<td>National charity offering information/counselling/social activities for patients with MH</td>
<td>Adults with MH illness</td>
</tr>
<tr>
<td><strong>NAFSIYAT</strong></td>
<td>Intercultural therapy providing culture specific IAPT</td>
<td>Intercultural therapy providing culture specific IAPT</td>
<td>11 yo+ from any ethnic minorities</td>
</tr>
</tbody>
</table>

“We cover a broad spectrum of young people, from people dealing with bullying, violence as well mental health issues such as early onset psychosis, self harm or eating disorders”

“We help parents parent”

“We provide help to people who cannot cope with life in society anymore”

“Our purpose is to help people re-integrate in society after a severe mental health episode”

“We provide employment activities as well as social activities to people with mental health problems in order to empower them, give them employment and stimulate initiative and social awareness”
Nafsiyat started on the basis that BMEs do not access oral therapies.

`We are helping people think things through`.

**How do patients come in contact with organisations?**

Some organisations have formal referral systems from other organisations and have established links with NHS institutions as part of a mental health pathway. The majority of clients come to these organisations by self-referral or enquiries from concerned relatives. They hear about them by word of mouth, through their GPs, or are referred by NHS services. Sometimes these organisations are the only point of contact for people with mental health illness, and people present in a time of crisis. Often organisations, especially smaller ones, are not sure how to advertise their services to the NHS. There is a belief health professionals simply do not know they exist. Organisations dealing with patients with more severe illness tend to receive more referrals from NHS services, generally from care coordinators as the patients are already known to psychiatric services. Organisations that offer counselling and support tend to rely more on informal referrals.

Informal referral represented more than half of all referrals to the organisations (figure 2, figure 3). While referrals from the GP and the Mental Health Trust were the second and third most common source of referral.

**Figure 2: What is your primary source of referral?**

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self/family</td>
<td>67%</td>
</tr>
<tr>
<td>GP</td>
<td>17%</td>
</tr>
<tr>
<td>Care coordinator</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
</tr>
</tbody>
</table>

**Figure 3: Where do you get referrals from?**
“Carers are sometimes referred by professionals, but more commonly they find out about the organisation by word of mouth.”

“There is no referral system- patients drop in whenever they want”

“We are well integrated with other services”

“We try our best to make ourselves known to local GPs”

“People ring up – sometimes they are desperate”

How organisations are integrated in borough-wide mental health pathways

There is a wide range of organisations providing mental health services in Haringey, from large, well established organisations to small scale, volunteer run organisations. While some are well aware of the range of services available to clients and know where to point them to for specific needs, others work in a more isolated way, with little awareness of how to direct their clients to adequate organisations catering for specific needs. Overall, few organisations had a global understanding of the organisation of mental health services in the borough. Lack of adequate pathways was evident, with each organisation holding the responsibility for finding out where to refer clients or how to do it should the need arise.

When asked specifically whether they were aware of any patient pathway, only one third of organisations said they were (figure 3).
“We will call St Ann’s if there is a crisis situation”.

“We do not make formal referrals; we make recommendations to the funding authority upon discharge”

“We are aware of how patients come to us and move on from us but there are no formal pathways in place”.

“I am not aware of patient pathways. I would refer the patient to his GP if I had concerns”

“We refer patients to other charities if we feel patients are outside of our remit”

“We do not refer directly and would send patients back to their GP first”

“We can refer to places such as Citizen’s advice bureau for practical advice, culture specific groups, and other therapeutic services”

“For patients who are known to psychiatric services, we liaise closely with their key worker”

“We have a strict policy that for any patient who is suicidal we call 999”

“We have links with a variety of services”

“We don’t like the concept of referring as we try to move away from the medical model. We prefer to approach clients as equals and present them with choices.”

**Who are the target group of patients?**

While a few organisations cater to specific groups, such as young people or particular ethnic groups, most organisations can accommodate the majority of patients. No organisations accept or decline referrals on the basis of
diagnosis, but they tend to undertake a holistic assessment of each case. For organisations that manage clients both with mental illness and a wider range of emotional distress, mental health management is always integrated as part of the service. Organisations directed at ethnic minorities do not discriminate on the basis of ethnicity and would not reject a client if he did not belong to a minority group. There were however a few reservations expressed throughout the spectrum of organisations:

1) Most organisations cannot cater for patients in acute crises (acute psychotic episodes, manic episodes or aggressive episodes). This holds true even for the “crisis” organisations
2) Most organisations would not accept people with an alcohol addiction or other addictive behaviours. This may discriminate against clients with dual diagnoses.
3) Some organisations could not cater for patients with physical problems because of unadapted facilities.

“We are covering the array of ethnicities living in Haringey”

“We accept patients across the whole spectrum of mental illness.”

“Patients have to be psychologically minded and have willingness to change for the admission to be useful”

“Our target group is 18-65 though we take older residents providing they don’t have any physical disabilities”

“We will take anyone who we feel is likely to benefit from a psychological therapy rather than select on the basis of diagnosis”.

“We do not accept people whose primary diagnosis is substance abuse, learning disability or organic disease.”

“We do not accept people who represent a danger to others or self, and can put conditions on patients with a forensic history.”

“We do not target particular ethnic or religious groups.”

“Our target group is young people 11-24 from any background. Recently we received funding to specifically deal with violence issues in BME groups.”

“Our centre is open to everyone.”

“We do not accept people who have aggressive behaviours or are substance users/alcohol dependent”

“We are a BME service but we don’t disadvantage against any clients”

What areas of work are covered?
As previously described, the range of services offered across the borough is wide. Some organisations focus on treatment (generally focused on different types of psychotherapies, counselling, cognitive behavioural therapies or solution focused therapies), both for mental health and other emotional distress not necessarily categorised as mental health. These organisations are generally able to provide psychotherapy/counselling for almost any type of problem providing the client is not in an acute crisis. A small proportion of these provide residential facilities as a complement to NHS inpatient facilities. Figure 4 summarises the range of issues that can be dealt with. Other organisations focus on social issues and concentrate on helping people suffering from mental illness gaining back their place in society by facilitating socialising, employment or training. Figure 5 summarises the range of social activities/services offered. Another theme is advocacy, with some organisations helping clients with housing or benefits. There is also an emphasis on empowering people suffering from mental illness, by equipping them with skills allowing them to be at the centre of decision making and making mental health services as user led as possible.

<table>
<thead>
<tr>
<th>Mental health</th>
<th>Emotional distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Individual counselling</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Couples counselling</td>
</tr>
<tr>
<td>Phobias</td>
<td>Family mediation</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>Violence and aggressive behaviour</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Intergenerational problems</td>
</tr>
<tr>
<td>Personality disorders</td>
<td>Torture victims</td>
</tr>
<tr>
<td>OCD</td>
<td>Bereavement</td>
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<tr>
<td>Deliberate Self Harm</td>
<td>Interfaith and interracial difficulties,</td>
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<tr>
<td>Suicidal behaviour</td>
<td>School failure</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>Adolescent disorders</td>
</tr>
<tr>
<td>Post traumatic stress disorder</td>
<td>Emotional breakdowns</td>
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<tr>
<td></td>
<td>Bullying</td>
</tr>
<tr>
<td></td>
<td>Social Isolation</td>
</tr>
</tbody>
</table>

Other organisations focus on social issues and concentrate on helping people suffering from mental illness gaining back their place in society by facilitating socialising, employment or training.
Another theme is advocacy, with some organisations helping clients with housing or benefits. There is also an emphasis on empowering people suffering from mental illness, by equipping them with skills allowing them to be at the centre of decision making and making mental health services as user led as possible. One organisation specifically defends the interest of carers of people with mental illness.

**Who provides the services, and what are their qualifications?**

Across the wide range of organisations, service providers come from a large array of backgrounds. While most providers delivering psychotherapy/counselling have professional qualifications from accredited bodies, not all do. While some organisations ensure adequate senior supervision is in place, other centres rely heavily on “trainees”, sometimes training in house without accreditation from counselling or psychotherapy bodies. Organisations aiming at social activities/social reinsertion tend to rely on a mix of volunteers and professional from social services, housing, or employment backgrounds. Lastly, there is an emphasis on some advocacy services to encourage service user’s engagement and make their service user-led.

“Clinical services are provided by a team of qualified child and adolescent psychotherapists with ACP accredited qualifications, and adult psychotherapists who are also accredited.”
“Staff is trained in house, to become psychotherapists. I am not sure if our course is accredited”

“There are weekly clinical meetings with a senior psychotherapist.”

“We have eight qualified tutors for the training. We also have support from OTs and psychologists”

“We have a team of counsellors, all volunteers.”

“We have academics on our board that we can get help from for complex cases and we occasionally seek external opinions”

“I am the Joint Coordinator as well as a service user”

How are patients followed up?

While a minority (28%) of organisations follow up their patients to try and assess the impact of their intervention, a majority do not have such performance measures in place. The ones that do mention it is very difficult to obtain quality feedback from their users. Only a few organisations have robust systems in place with regular interviews after interventions.

“We have started to do research to evaluate the impact of our interventions”

“There is evaluation and feedback at the end of treatment”

“Currently there isn’t (feedback) but we would like to implement it”

“There is an evaluation questionnaire upon discharge and three monthly follow up meetings for 1 year”

“People tend to vanish once they have decided they don’t need to come anymore.”

Corporate issues

Of the organisations interviewed, there are a range of arrangements. Some organisations are entirely PCT funded, some have a mix of PCT/Local authority funded, some have the PCT buying a certain number of sessions/care for a certain number of sessions per year. Other organisations are not funded by the public sector and rely on donations/other sources of income, and some organisations, although physically in Haringey, do not have any Haringey patients, but are privately run or contracted by other PCTs/LAs. It is not clear whether organisations providing services to non Haringey residents were receiving funds from Haringey PCT/LA. Budgets do vary widely as well, from £10k a year to £1m a year.

Equity
Haringey has an extremely diverse population, reflected by a vast number of ethnicities, languages and cultures being represented in the borough. Most organisations are aware of this, and additionally to some organisations specifically targeting particular ethnic or cultural groups, most try to accommodate and welcome everyone equally. However, due to the number of different groups, it is not possible for every language or culture to be equally catered for. Most psychotherapy/counselling groups were reluctant to provide services throughout the services of an interpreter and as such, the extent of services can only be as wide as the number of languages spoken by their staff, which is extensive in some cases. There other equity issues around physical disabilities, as some organisations are housed in buildings unfit for disabled people, and as such these clients cannot always be accommodated for.

“Our group is open to all, although People from Black and Turkish minorities are underrepresented.”

“ We currently have therapists who speak Bengali, Turkish, Tigrinia, Amharic, Arabic, Korean, Japanese, Greek and Ga.”

“We have never had patients who do not speak English, and we have clients from a variety of backgrounds.”

“Patients have to be able to understand and express themselves in English to benefit from our services”

“There is the black women’s group, the Asian group... There are plans for self managed BME groups.”

“We are aware that Turkish/Kurdish/Somali groups are underrepresented. “

“We are not able to offer services in different languages”

“We made the decision not to work with interpreters for now, so there are some patients that we cannot treat.”

“We are very aware of cultural issues and have specific funding to train our staff in cultural issues”

“We have had non English speaking clients and have relied on personal contacts for translation”

“We cannot accept people with physical problems or personal care issues as we don’t have the facilities to cater for them.”

Summary:
• Mental Health organisations in Haringey offer a very diverse range of services

• Some organisations provided dedicated services to specific ethnic groups, however these groups are on the whole still underrepresented

• Communication between the voluntary and statutory sector needs improving

• Not all service providers in voluntary agencies have relevant qualifications or accreditations
Primary Care Service Providers

IAPT

‘IAPT does a fantastic job’

‘We need to find ways to advertise IAPT’

The IAPT service was appreciated by GPs as helping a large number of patients with milder mental health conditions. It was also particularly important for the Turkish and Kurdish population, although there seems to be a limited number of Turkish speakers. These patients often come with physical aches and want psychotherapy. Other communities are more resistant to using IAPT. Patients not speaking English and requiring interpreters also limited the usefulness of the IAPT service for some patients.

There is an ongoing problem of the large numbers of patients requiring psychological support. Most practices refer to the IAPT service, though some will use alternative counselling services including in-house counselling. Most GPs thought that eight weeks was too long for the majority of patients to start IAPT. There was also a need for the more severely ill patients to be fast-tracked to reduce wait times.

‘Who does the signposting of IAPT patients back into the community?’

Other GPs felt that IAPT wasn’t the most appropriate solution for all patients, interpersonal therapy was available and used by some GPs both as an in-house service and through the Halliwick Centre.

Some GPs do not refer to IAPT and there were no clear solutions on how to change professional’s attitudes. GPs thought the self-referral pathway was fundamental in helping patients get some control over their lives.

Mental health problems in primary care

• Domestic violence was a big problem in some areas among the Turkish community. Patients present frequently with bruising and minor physical problems before they will admit, often many years later, that they have been victims of domestic violence

• Some practices are seeing 10-15% of their practice population with panic attacks, again this was more common amongst the Turkish population

• Many patients are presenting with physical problems which are masking psychological issues.
• There are many patients with post traumatic stress disorder, those with the more severe end of the spectrum are seen at St Ann’s. The other are inadequately treated with drugs, this group of patients is reluctant to use IAPT

• The chronically mentally ill are the most difficult group of patients for GPs to look after. The patients need a lot of social support which GP are not able to assist with, though they are often expected to do so. They also run the risk of harming themselves or others and most of the GPs would like much better integration with the Acute Trust with respect to discharge planning and ongoing treatment

• Many chronically ill patients have on-going medical conditions such as diabetes or cardiovascular disease. These conditions are not being adequately managed by the psychiatrists, as often they are the only doctors seeing these patients

GP referrals

GPs have little awareness of the vast array of services available in Haringey. Most GPs ‘are giving START or IAPT as the referral point’. GPs did not have access to any Haringey directory of commissioned mental health services or any directory of voluntary services.

Patients in turn are ‘shopping’ for different agencies and different services as they are aware there is no consistent approach.

Depot injections were mentioned as an area of considerable frustration. There has been an ongoing discussion about training practice nurses to undertake depots. Issues around payments for depots and training have made this issue considerably more complicated and as a result no training has yet been delivered.

‘It is demoralising to promise depot training to practices and then not give it’

Secondary care

There is an ongoing problem with the primary/secondary care interface with very little written or verbal communication between the two services. Patients are discharged back into the community, often without the GPs being aware of their ongoing needs.

‘We need someone you can pick up the phone to’

There are also concerns that they are unable to discuss complicated patients with psychiatric colleagues. A few practices get considerable support from a Consultant Psychiatrist and greatly appreciate this.

‘A lot of patients have no follow-up or are lost to follow-up’
A holistic approach

Many GPs wanted a more holistic approach to mental health bringing together mental and physical health. They also wanted a more multidisciplinary approach to involve the wider remit of social care.
**Missing patients**

GPs were unsure how to identify missing dementia or depressed patients that did not directly present during a consultation. Although every attempt was made to correctly diagnose patients, it was recognised that using the PHQ9 to identify new dementia patients was particularly time-consuming in primary care.

**Dementia**

GPs have very little control over the starting and stopping of dementia drugs as once a referral is made to the memory clinic, their dementia management is taken over. There needs to be a decision made about whether those patients with mild dementia are entitled to dementia drugs. Likewise there needs to be a discussion on how to stop dementia drugs as bills for this medication are soaring in the West.

**Summary**

- **IAPT provides a good service for many patients but waiting lists are still too long**
- **Physical health needs to be considered together with mental health**
- **The primary and secondary care interface is not working and needs rethinking**
- **There are many mental health providers outside the NHS that are not known to GPs**
Improving Access to Psychological Therapies (IAPT)

IAPT is a Department of Health programme aimed to improve and increase access to evidence-based psychological therapies for depression and anxiety. It is part-funded by the government with £170 million new money being invested from 2008. The budget for 2009 is shown in figure 1. The service delivers treatments as defined within NICE guidance using the stepped care model.

Figure 1 Budget for IAPT 2009

The Haringey IAPT service is part of a national initiative to improve access to psychological therapy for people with Common Mental Illness (CMI). The service aims to provide easy access to evidence-based psychological treatment for people with mild to moderate/severe depressive and anxiety-based emotional disorders.

The Haringey IAPT workforce consists of:

Step 2 workers - Low intensity trainees and psychological well-being practitioners
Employment Advisors
Step 3 workers - Hi-intensity CBT trainees, counsellors, CBT therapists

Haringey IAPT service sees patients who are over the age of 16 years with a GP based in Haringey who have a depressive or anxiety disorder. Clinical exclusions are primary drug and alcohol problems, acute psychotic
symptoms, significant risk of acting on suicidal thoughts and personality disorders. Figure 2 show the activity from 2008-2009.
IAPT has three administrative bases in Crouch End, St Ann’s and Langdon Road. Therapy is carried out from 35 GP surgeries, 10 children’s centres, 4 libraries and Turkish/Kurdish community centres. Referrals are made by professionals (3/4 of all referrals are from GPs), carers and patients (1/4 are self-referrals). The team aims to respond within a week of receipt of the referral. The initial contact is a 30-40 minute telephone call whereby the patients’ suitability for IAPT is assessed through discussion and use of assessment tools. The patient, step 2 worker, in collaboration with a step 3 duty supervisor, agree the treatment plan.

The groups are as follows:-

Step 2
- Depression and anxiety group
- Stress groups
- Turkish stress group

Step 3
- Mindfulness group
- Social anxiety group
- Worry group
- Turkish somatisation group

In addition there is guided self-help available and ‘working for health’, an IAPT integrated employment support service. The outcomes and average waiting times are shown in figures 3 and 4 respectively.
In year 1, 3000 patients were seen and 6000 are expected in year 2. Treatments can last from a month to up to a year. There is differing referral rates by practices and by collaboratives. In summary, self-referrals are mainly from the East of Haringey where there has been significant marketing of the
service through word-of-mouth (Turkish community) and poster campaigns. Only 10% of all self-referrers are from West collaborative whereas 70% of all self-referrals are from North East collaborative.

The recovery rate is roughly 45%. Roughly 80% receive treatments though they may not have recovered sufficiently to meet the treatment criteria. Often patients are happy that they have recovered sufficiently and wish to discontinue treatment. There is a drop-out rate of 10%. Roughly one quarter of all patients are Turkish and there are six Turkish speaking staff.

A barrier to the success of IAPT is in patients who are refugees or failed asylum seekers. It is very difficult to focus on a person’s mental health when they have difficulty working out where they will be living.

Men make up only a quarter of all referrals and the team believe that there has been reluctance for men to enter the service. This is probably evident from comparisons with suicide rates in Haringey where there is a male predominance. Some ethnicities e.g. Turkish/Kurdish, are overrepresented as IAPT is an acceptable treatment within this community. Other groups that are underrepresented are the Polish, orthodox Jewish and black African/black Caribbean male groups.

IAPT have ideas how to reach out to these groups such as linking with Tottenham Hotspur, via Turkish cafes and bars and using computer aided therapies for men.

Summary

- IAPT is delivering a spectrum of counselling and behavioural therapies to a diverse patient population in Haringey.
- The majority of patients enter the service via GP referral yet there is unequal referral across Haringey.
- There are missing groups of patients particularly men and various ethnicities.
- Some strategies are in place to try to increase the diversity of patients yet no specific work is being undertaken with individual GP practices.
Older people

Older people make up a significant percentage of Haringey’s population. In 2008, it was estimated there were 20,800 people aged 65+, making up approximately 9.2% of the total population (2006 Mid-Year Population Estimates, POPPI). Of this number, 43.27% (9000) were male and 56.25% (11,700) were female.

The population of Haringey is expected to increase in age over the next 25 years, to 24,200 people aged 65 and over. According to population projections, the 85+ age group will increase as a percentage of the population of older people in Haringey between 2008 and 2025 rising to 13% of all older people (3,146). Over 50% of older residents in wards on the eastern perimeter of Haringey are classified as non-British. The Greater London Authority projections estimate the proportion of people aged 50 and over from BME groups in Haringey will grow from 25% in 2001 to approximately 32.2% by 2011. This represents an increase of 19% in the proportion of older people from BME groups. Conversely, the proportion of older people who are of White Ethnic origin is expected to fall from 75% in 2001 to 68.8% in 2011. This represents a fall of 7% in the proportion of older people who are of White Ethnic origin.

Many common mental illnesses are more prevalent in deprived areas and this holds true for the older population as well as the younger population.

Dementia

According to The Audit Commission’s ‘Forget me Not’ report, one quarter of people aged 85 and over will develop dementia. Projected dementia figures are set out in Table 1 below. 6.29% of Haringey’s 65+ population was estimated to suffer from dementia in 2008; of these, 35% are men and 65% women. This compares with an overall male population in 2008 of 43.27%, and, of women aged 65+, 56.25%. According to the new National Dementia Strategy, it is vital that dementia is diagnosed early so that optimum support and treatment can be provided.

Table 1 - Projected populations with dementia

<table>
<thead>
<tr>
<th>People aged 65 and over predicted to have a dementia projected to 2025</th>
<th>2008</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total males aged 65 and over predicted to have dementia</td>
<td>459</td>
<td>490</td>
<td>520</td>
<td>587</td>
<td>637</td>
</tr>
<tr>
<td>Total females aged 65 and over predicted to have dementia</td>
<td>849</td>
<td>852</td>
<td>864</td>
<td>905</td>
<td>986</td>
</tr>
</tbody>
</table>
Using the prevalence figures above the table below gives the likely breakdown of people with mild, moderate and severe dementia.

**Table 2 - Severity of dementia in older people**\(^53\)

<table>
<thead>
<tr>
<th>Dementia severity</th>
<th>2008</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild (55.4%)</td>
<td>725</td>
<td>899</td>
</tr>
<tr>
<td>Moderate (32.1%)</td>
<td>420</td>
<td>521</td>
</tr>
<tr>
<td>Severe (12.5%)</td>
<td>164</td>
<td>203</td>
</tr>
</tbody>
</table>

Prevalence projections of levels of dementia in people under 65 in Haringey

Alzheimer’s Disease (30%) is the commonest cause of early onset dementia in the under 65 age group followed by vascular dementia (15%), frontal temporal lobe degeneration (13%) and alcohol related dementia (12%)\(^54\).

It is estimated that between 67\(^55\) and 81\(^56\) people per 100,000 in the 35 to 64 age group will have young onset dementia. This suggests that there will be about 74 people in Haringey with young onset dementia in 2008. This is likely to be an underestimation of the numbers as the figures are not adjusted for demographic data such as the increased prevalence of vascular dementia in this age group in Haring in comparison to the total population of England.

Healthcare for London Needs Assessment Data

The Healthcare for London Dementia Services Guide included a London wide needs assessment; the following are extracts of this work relating to Haringey:

**Numbers of places in homes registered in Haringey to take older people with dementia per 100 people aged 65 and over in 2005-06** (Source: Commission for Social Care Inspection data quoted in Dementia UK 2007).
- Number of places in Haringey per 100 aged 65+ = 1.5

**Numbers of people with dementia recorded on GP registers compared to estimated prevalence in Haringey, 2007/08** (Source: QoF 2007/08 and prevalence derived from ‘Dementia UK’ rates.)
- Number of people with dementia recorded on QoF 2007-08 = 552
Estimated total number of people with dementia 2007 = 1330
QoF recorded dementia as a % of estimated prevalence = 39%

Numbers of people in Haringey with dementia reviewed in primary care in relation to those eligible to be reviewed: (Source: QoF 2007/08)
- Number of people with dementia whose care has been reviewed in the previous 15 months = 404
- Number of people eligible to be reviewed on GP register = 482
- % of people with dementia reviewed against those eligible to be reviewed = 84%
- % of people with dementia reviewed (with exceptions not excluded) = 77%

Numbers of older people (65+) receiving social care for mental health problems compared to estimated prevalence of late onset dementia in Haringey: (2007 Source: DH return RAP P1.1c 2007/08)
- Number of people aged 65+ receiving social care for mental health problems = 410
- Estimated prevalence of late onset dementia = 1289
- Social care users as a % of estimated late onset dementia prevalence = 32%

Depression

Key facts about depression in older people

- Depression is three times more common in older people than dementia
- It increases in prevalence in people over 65 especially for those living alone with poor material circumstances
- Co-morbid depression incrementally worsens health status more than depression alone or any combination of chronic diseases without depression in older people
- The World Health Organisation predicts that depression will be the second highest cause of health burden by 2020
- Depression in later life is a major risk factor in increased suicide, increased levels of natural mortality and impairment of independent function which necessitates need for long term care
- Treatment of depression in older people has a similar level of efficacy as for younger people\textsuperscript{60}.

- Only 1 in 6 older people with depression get treatment vs. 50% of younger people with depression are referred to mental health services\textsuperscript{60}.

- Up to 50% of older people in care homes have clinically severe depression and only 10-15% gets treatment\textsuperscript{61}.

- Up to 70% of acute general inpatients beds are occupied by people over 65 and around 30% of these patients have depression\textsuperscript{61}.

- Older people are at greater risk of sudden onset of depressive symptoms after recovery from a manic episode\textsuperscript{62}.

**Prevalence projections of levels depression in Haringey in over the 65’s age group**

Depression in elderly people is most often related to social isolation, lower levels of deprivation and chronic medical problems. Table 3 and 4 show the predicted numbers of older people likely to be depressed.

**Table 3 - Predicted depression in the elderly**

| People aged 65 and over predicted to have depression, projected to 2025 |
|--------------------------------------------------|---|---|---|---|---|
| People aged 65 and over predicted to have depression: LOWEST estimated level of prediction |
| 2008 | 2010 | 2015 | 2020 | 2025 |
| 2,080 | 2,070 | 2,150 | 2,230 | 2,420 |
| People aged 65 and over predicted to have depression: HIGHEST estimated level of prediction |
| 2008 | 2010 | 2015 | 2020 | 2025 |
| 3,120 | 3,105 | 3,225 | 3,345 | 3,630 |

**Table 4 - Predicted severe depression in the elderly**

| People aged 65 and over predicted to have severe depression, projected to 2025 |
|--------------------------------------------------|---|---|---|---|---|
| People aged 65 and over predicted to have severe depression: LOWEST estimated level of prediction |
| 2008 | 2010 | 2015 | 2020 | 2025 |
| 624 | 621 | 645 | 669 | 726 |
People aged 65 and over predicted to have severe depression: HIGHEST estimated level of prediction

<table>
<thead>
<tr>
<th></th>
<th>1,040</th>
<th>1,035</th>
<th>1,075</th>
<th>1,115</th>
<th>1,210</th>
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</table>

**Suicide**

Key facts about suicide and self harm in older people

- Whilst suicide rates are declining for all age groups the rate for people over 65 is double that in younger people under 25\(^{63}\)

- 80% of people over 75 who commit suicide have depression\(^{64}\)

- The risk of completed suicide after self harm is much higher in older people \(^{65}\)

- In 2006 the national prevalence of suicide in over 65’s was 8.14 per 100,000 population\(^{66}\) which is double that of people under 25.

**Psychosis**

Key facts about psychosis in older people

- Psychosis is more common in older than younger people: 20% of over 65’s develop psychotic symptoms by the age of 85, most of which are not precursors to dementia\(^{67}\)

- Whist schizophrenia beginning in earlier life is more common, the annual incidence of late onset schizophrenic-like psychosis increases by 11% with each 5 year increase from age 60 and up\(^{68}\)

- A study of people aged 95 and above without dementia revealed that 2.4% met the criteria for the diagnosis of schizophrenia, prevalence higher than that in younger people\(^{69}\)

**Age Concern in Haringey**

Age Concern in Haringey is one of the largest voluntary organisations dealing with the mental health problems of the elderly population. They are in contact with 2000 people per year and have noticed an increase in referrals from relatives and carers. They currently provide an information advice service (including advocacy), a well-being service (including mental and physical health), befriending, home help and safely and help after hospital service.

Age Concern aims to keep people longer in social networks e.g. stroke, dementia clubs and Haringey Forum for older people, to reduce social isolation and subsequent depression. They remain very concerned about the missing dementia patients. According their statistics, they estimate that there are 700 people in Haringey with dementia that have not been formally
identified. They also recognise that certain BME communities in Haringey do not see dementia as an illness so are less like to present to health and social services.

Carers play a vital role in the both the mental and physical health of older people. Some of their needs are met with support groups run by Age Concern however these are probably the tip of the iceberg as there are many people in the community who may not ever recognise themselves as formal carers.

Summary

- The mental health needs of older people in Haringey are significant
- Not only is the number of people suffering from dementia due to rise substantially in Haringey, but there is significant under diagnosis of current sufferers
- Depression in the elderly is also a significant problem
- Voluntary groups are undertaking vital work in reducing social isolation and integrating older people into the community
- The needs of carers are often forgotten or ignored
Mental Health Trust

An in-depth analysis of the mental health trust is beyond the remit and scope of this health needs assessment, however several key themes have emerged in discussion with key informant that impact upon the local population. Current data collection systems in the mental health trust make it difficult to identify actual numbers of patients, ethnicities, diagnoses and ages in different services within the mental health trust. Complex care pathways add to the difficulties identifying the patients’ journey through the system.

START team

The service is the link between primary and secondary care, and the community and acute services. Patients can self-refer but are more often referred by recognised health services. This interface has communication difficulties between primary and secondary care and problems are yet to be completely resolved. The ERC is incorporated into the START team.

Home treatment teams

Home treatment teams are divided into East and West Haringey and have appointments in a variety of locations from individual’s homes, parks and cafes and St Ann’s. Patients are managed in the community via two crisis beds in Alexander Road (part of an 8 bed unit which is managed by social care). There is little communication between primary and secondary care while patients are being treatment and no ongoing joint reviews (these were discontinued in 2008).

Summary

- Primary care and the mental health trust currently work as isolated service rather than functioning as a united mental health team

- Communication difficulties and frustrations that both sides are unavailable for discussions are detrimental to patient care.
HAVCO

A consultation with HAVCO was undertaken in January 2010. The list of organisations with their involvement in mental health is listed in Appendix 3.

Do your mental health patients have specific needs/does your organisation have specific needs around mental health?

- **BME groups**
  - Many mental health services have not been adapted for BME groups

- **Elderly**
  - Elderly people cannot access services adequately - automated telephones, confusion about access
  - Elderly Iranian people, because they are shy, embarrassed, don’t speak good English. As a result they present late, and in a crisis state.

- **Information/signposting**
  - There is a lack of user friendly simple information on how to access services when you need them

- **GPs**
  - GPs are key to the issue. Almost everyone has a contact. That is where people would expect to have a contact
  - Charges for individual reports
  - GPs don’t talk to the voluntary sector
  - Patients not having individual GPs

- **Data protection**
  - Some GPs/organisations will not share information

- **Support for carers**

- **Young adults**
  - There is a lack of dedicated services for people between 18-21: they don’t fit anywhere: not with adult services, not with children services

Are you aware of the mental health referral care pathways?

- **GPs**
  - Often not aware of care pathways and organisations

- **Communication**
- Lack of communication with the NHS and Third Sector regarding pathways

  - Care pathways
    - No written list
    - No descriptions of criteria for referral or about the service
    - Exploring different models of care e.g. Swedish model of community care for people with Schizophrenia. (Allocation of weekly care hours which the service users control uptake and use)

**Are there any unmet needs/gaps in service provision that you are aware of?**

- Communication
  - About physical conditions
  - With GPs
  - With other voluntary and statutory sector groups

- Continuity of care
  - There is a lack of consistency and continuity of care which can lead to a lack of trust in the system.

- Location of services
  - There are accessibility issues. There is a lack of local, community services.
  - Services are not where people live.

- Awareness of mental health
  - Patients are concerned about lack of Mental Health awareness of public services such as the police force.

- Family issues
  - There is not enough focus on the child’s family. Often there are family problems that are not tackled.

- Waiting lists
  - There are serious issues with waiting lists. Some people have been referred for IAPT more than 6 months ago and not yet seen. As a result, there are in a permanent crisis state and keep attending A&E. This causes great anxiety.

- Funding
  - There is a lack of funding for community services/third sector

- Health promotion
  - The balance between prevention and treatment is not right. All the money goes to hospital and not community services. When people have mental health issues, there is no «buffer zone » service to go to.

- Training
- Community workers that are not trained in Mental Health end up dealing with Mental Health issues that they are not equipped to deal with. There is no specific training for mental health awareness for community workers.

- **Coordination**
  - A lot of care coordination relies on the GP, but a lot of people are not registered
  - Lack of knowledge about the Community Link Workers
  - Integration between social services and health services to prevent Mental health issues from arising

- **Prison/Police**
  - There is a lack of support for people who come out of prison, lack of psychological support. The current interventions provided are short term and there is gaps in the service for people who need longer term work.
  - Better involvement and involvement with the police.

- **Psychological therapies**
  - Providing innovative ways of delivering CBT and psychological services

- **Employment**
  - PCTs and LA should lead by example and employ people with mental health problems

- **Training**
  - Mental health first aid
  - Crisis training

**Summary**

- **There was a lack of communication with the statutory sector due to different working practices and data protection**

- **There is a lack of knowledge about roles and responsibilities of different organisations**
Finance

Overview

NHS Haringey and the Haringey Council spend approximately £51 million in mental health care. The vast majority of this amount is spent on commissioning local providers to deliver inpatient and community services to meet the population's needs.

Providers

The largest provider of mental health services in Haringey is BEH-MHT. At least 84 percent of mental health spend is with BEH-MHT.

Although Haringey Council mostly commissions services in mental health they do provide some mental health services which account for 3 percent of local provision. The non-statutory providers deliver 13 percent of mental health provision in the borough.

Figure 1 – A chart of total spend in Haringey 2008-2009

![Pie chart showing spend distribution: BEH-MHT 84%, Haringey Council 3%, Non-Statutory Providers 13%]

Services Commissioned

At least 42 percent of mental health spending is on inpatient hospital beds at St Ann's hospital and North London Forensic Service. The remaining 58 percent is spent on community health services delivered by statutory and non-statutory organisations.
Current budget split shows a high dependency on a secondary care-led model. Part of our strategy is to take a robust approach to provider management to reduce over-reliance on secondary care-led provision and to enable a redistribution of this spend to secure a greater investment in commissioning primary and community services.

The services we currently fund and amount of investment allocated to these services are illustrated in the diagram below.

**Graph 1 - Allocation of funds within mental health in Haringey**

**Projections**
The NHS operating framework 2010/11 outlines that there will not be any uplift in NHS funding for the next financial year.

**Summary**

- Approximately £51 million is spent on mental health in Haringey, of which 84% is spent with Barnet, Enfield and Haringey Mental Health Trust
- There is a reliance on secondary care provision
- Changes to financial allocation of budgets will give greater investment to primary care and community services
Refugees and asylum seekers

Introduction

There are significant mental health needs of refugees, asylum seekers and irregular migrants living in the London borough of Haringey. Evidence has been gathered from relevant literature and case studies taken from both local and national organisations providing specific services to these groups of people in Haringey. The case studies illustrate well documented barriers in accessing and mental health services, and highlight the gaps in service provision. The overall aim is to ensure that people from ethnic minorities, including refugees and asylum seekers with mental health problems will get the treatment they need, in a way that suits them. (DOH 2009, New Horizons)

According to the International Organisation for Migration70:-

"Refugee" is a person who, pursuant to the 1951 Convention relating to the Status of Refugees, owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his or her nationality and is unable, or owing to such fear, unwilling to avail himself or herself of the protection of that country.

An "asylum-seeker" is a person who has crossed an international border and has not yet received a decision on his or her claim for refugee status. This term could refer to someone who has not yet submitted an application for refugee status, or someone who is waiting for an answer to their claim. Until the claim is examined fairly, the asylum-seeker is entitled not to be returned. Not every asylum seeker will ultimately be recognized as a refugee.

An "irregular migrant" is a commonly used term describing a migrant in an irregular situation in a transit or host country due to illegal entry, or to the expiry of his or her visa. The term is applied to non-nationals who have infringed the transit or host country's rules of admission; persons attempting to obtain asylum without due cause; and any other person not authorized to remain in the host country. Such persons may also be defined as an "undocumented migrant," "clandestine migrant," or "illegal migrant."

Demographics of refugees and asylum seekers Haringey

Since the introduction of the Asylum and Immigration Act 1999, dispersal out of London and the South-East is compulsory for asylum seekers claiming support form the UK Borders Authority (UKBA). Asylum seekers are sent to various locations such as Glasgow and the North-West of the UK. The government states that dispersal is necessary as it eases the pressure on services in the South-East. A significant number however choose to remain in, or migrate back to London. Information on the numbers of refugees and asylum seekers resident in Haringey is not routinely collected. Data obtained
form Researching Asylum in London (RAL) reveals that Haringey is one of the top five boroughs in London with the largest number of supported asylum seekers (See Figure 1 and Figure 2). Although the figures for supported asylum seekers in Haringey provide some estimate of the number of asylum seekers in the area, they do not give a clear picture of the numbers of refugees and asylum seekers not supported by UK Border Authority (UKBA), or the number of irregular migrants. Based on the 2001 census, an estimate for the numbers in Haringey is about 25-30,000, which represents 10% of the population.

**Supported Asylum Seekers: Top five boroughs in London**

**Figure 1 - The number of Asylum Seekers in North London Boroughs**

<table>
<thead>
<tr>
<th>Year</th>
<th>Waltham Forest</th>
<th>Redbridge</th>
<th>Haringey</th>
<th>Enfield</th>
<th>Newham</th>
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<td>1000</td>
<td>1100</td>
<td>1200</td>
<td>1300</td>
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</tbody>
</table>

**Figure 2 - The estimated numbers of Asylum Seekers in Haringey**

<table>
<thead>
<tr>
<th>Year</th>
<th>Haringey</th>
</tr>
</thead>
<tbody>
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<td>2007 Q2</td>
<td>900</td>
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<tr>
<td>2007 Q1</td>
<td>1000</td>
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</tbody>
</table>

**Irregular Migrants**
The 2001 census is also unlikely to have included people who may have overstayed on their visas and women/men trafficked into the country. There are estimated to be 430,000 irregular or undocumented migrants in the UK who may have significant health needs but have very limited entitlement to health care within the National Health Service due to their irregular status and for most, no financial resources to fund alternative treatment. According to the Health Protection Agency (HPA), NHS services must include, and reflect the needs of those most affected and in need of healthcare.

**Mental Health needs of Refugees, Asylum Seekers and Irregular migrants**

Refugees and asylum seekers are more likely to experience poor mental health in comparison to host populations. Although refugee and indigenous populations share similar common risk factors for mental health problems, the needs refugees and asylum seekers remain distinct. This is due to pre-migratory and additional post-migratory factors including experiences of war, persecution, and multiple losses including family, friends, home and income. Difficulties with integration, language barriers and low socio-economic status are identified as additional post-migratory factors that add to the increased vulnerability of refugees and asylum seekers.

There is a lack of recognition within mainstream social and health care services that refugees and asylum seekers have distinct multiple and complex needs. This is compounded by the category “BME” defined by the Department of Health (2005) as “Black and Minority Ethnic including those of Irish, Mediterranean origin and Eastern European migrants. According to the Social Care Institute for Excellence (2007), the lack of information about numbers, characteristics, and needs of local refugees and asylum seekers is also a direct result of their treatment as part of the larger generic “Black and Minority Ethnic” and has led to a disregard of their specific needs, evident in service provision that is often informed by data referring to existing ethnic minority categories.

**The voluntary sector**

Refugee Community Organisations (RCO’s) are often the first port of call for many refugees and asylum seekers. These organisations are deemed to have knowledge about the cultural, social and political context of people in the community and have a better understanding of the difficulties surrounding access and entitlements to health care. RCO’s play an important role in the provision of emotional support, help with social and practical needs including increasing social networks, sign posting to other community and voluntary sector services and language and interpreting support. The stigma surrounding mental health may act as a preventative factor in accessing support from these community organisations, as well as obtaining help from statutory services. Refugee Community Organisations are in a good position to provide support outside of mainstream services, however it is important not
make generalisations and assumptions that RCO’s should be the only available choice. Most RCO’s suffer from a lack of resources to specifically focus on mental health and have a limited amount of specifically trained professionals.

The Selby Centre in Tottenham has been used by over 100 community groups and local enterprises for over 20 years, many from historically marginalised BME and refugee communities in Haringey. Examples of some RCO’s currently based at the Selby centre include; Angolan Community Association, Cabinda Community Association, Ethiopian Community Centre, Eritrean Community, Kurdish Housing Association, Somali Cultural Association.

There are similar organisations based away from Selby centre such as the African Women’s Welfare Group, Casa De La Salud Hispano Americana, JAN Trust, and Kurdish Community Centre who also provide services reflecting the needs of the multi-ethnic migrant population in the borough. These organisations do not have regular funding streams and operated separately from mainstream services sometimes forcing them into a peripheral existence. Additionally, in most cases funding streams do not come from mainstream health providers therefore committing these organisations into peripheral existence in relation to mainstream health services.

**Christian Action and Response in Society (CARIS) Haringey**

CARIS is the only organization in Haringey that works with and for homeless families. Advice, advocacy and outreach are provided in the areas of healthcare, education, housing benefit claims, and immigration issues. Additional services include English classes and a summer play scheme. Service-users include a high proportion of refugees, asylum-seekers, victims of domestic violence, and those with mental health issues. CARIS also supports families with no recourse to public funds, those in temporary accommodation and families having financial difficulties through the provision of weekly food parcels and toiletries.

**Nafisyat**

Nafisyat is a registered charity providing community based ‘intercultural’ psychodynamic psychotherapy in Finsbury Park, north London. It provides psychotherapy for patients from diverse cultural backgrounds. Therapists come from a wide range of ethnic and cultural backgrounds and also work with patients from cultures and ethnicities different from their own. Nafsiat receives funding from NHS Haringey and has a short term Healthy Communities grant to enable it to perform short-term mental health work with BME groups. The focus is on capacity building and working with community groups in areas such as mental health promotion, training for staff from the statutory and voluntary sector and group work for Turkish Kurdish women, men and carers.
The statutory sector

Through the No Recourse to Public Funds team, Haringey Local Authority provides support to asylum seekers awaiting a decision on their asylum application, only if they have an assessed community care need under Section 4 of the Immigration and Asylum Act 1999. Section 4 allows for the provision of support consisting of accommodation and vouchers only with no cash support. Community care needs are identified as those requiring support due to physical and mental health disabilities and older persons (65+). The team no longer supports asylum seekers diagnosed with HIV. UK Borders Authority (UKBA) supports asylum seekers not entitled to community care. Figure 1 shows the current numbers of supported asylum seekers in Haringey. The NRPF team report that out of a current live caseload of 57, 41 people (72%) have identified mental health needs. Haringey NRPF team refer patients to the Mental Health Trust but have identified problems around communication and continuity of care for this hard to reach group.

The service is supported by organisation from the Third Sector struggling to provide the additional support and advocacy. People who are granted leave to remain by the Home Office are discharged from the NRPF team within two weeks and need to find their way into mainstream services. Accommodation and financial support are withdrawn simultaneously. Many rejected asylum seekers have significant health problems and are not able to access services to meet their basic medical needs not only in Haringey but throughout London and beyond.

Primary care

GP’s are often the first point of contact for people seeking health care. However, there are well-documented difficulties for people from BME communities accessing and receiving appropriate GP care. A major barrier in attempting to access primary care services for some refugees, asylum seekers and migrants remains difficulty with communication, compounded by a lack of interpretation services. Lack of information regarding access to institutional services and the therapies available remains an issue.

Asylum seekers including those granted leave to remain and refugees have the same rights to access the National Health Service as nationals. However, access to health care is more complex for undocumented migrants including failed asylum seekers. According to Medecins du Monde (MDM) since the amendment of the 1977 law on medical services in 2004, the definition of “ordinarily resident” has been restricted to “lawfully resident”. This means that undocumented migrants are no longer entitled to free hospital treatment. Registration with a general practitioner is still possible, at the discretion of the doctor. Access to GP care and subsequent primary and secondary mental health care therefore poses a significant challenge for these groups of people. MDM observe that Haringey is amongst one of the most difficult boroughs in London for allowing GP registrations, despite having a high population of migrants. GP practice managers in Haringey maintain that they
are following guidelines from the PCT, and most practices (with some exceptions), insist in asking for photo ID and documentation, refusing registration if they are not provided. The outcome is that large numbers of irregular migrants in Haringey are left without access to healthcare, in particular those at risk including people with enduring mental health problems and those at high risk of suicide. Similarly populated boroughs to Haringey, with a high number of undocumented migrants, such as Newham, have fewer barriers to accessing medical care for these groups of patients.

Although IAPT is available to patients through self-referral, it is not always the most appropriate psychological therapy. Although IAPT has been used for a variety of ethnicities, it is clear how many of those patients are refugees and asylum seekers and whether it is able to address the multiplicity of complex problems that they often present with.

Secondary care

Barnet Enfield and Haringey Mental Health National Health Service Trust provide services to an ethnically diverse population in North London. Entry into acute services is through the single point of entry for all adult mental health services. All referrals therefore pass through Short Term Assessment and Recovery Team (START). Support and Recovery Mental Health Teams located in the North and East of the borough provide assessments and treatment to people who have complex and enduring mental health needs. Statistics for current services users from refugee and asylum seeking backgrounds, using the Trust's mental health services are difficult to obtain. According to the information officer for the Trust, registration in the system is based on categories of ethnic origin therefore records of refugee or asylum status are not collated trust wide. Individual services including psychology and support and recovery mental health teams may hold their own statistics. Ethnicity statistics for inpatients also provide imprecise figures for refugees and asylum seekers. These are now recorded through the Count me in Census. As part of Delivering Race Equality (DRE) in mental health care, the Count Me in Census was created to provide local ethnicity information about in-patients, and to assess any difference in care provided for minority ethnic groups.

Figure 3: Clinical Audit and Effectiveness Report BEHMHT
According to the Count me in Census for Haringey, on 31st March 2008 there were 246 inpatients. A total of 58% service users were from an Asian, Black African or Caribbean, and mixed background. 15% were from a white other background that includes Irish, Eastern European and people from the Mediterranean regions. Significantly people from a Turkish/Kurdish, background are not given a ‘box’ that describes their ethnicity; therefore they are assimilated into “white other”. Haringey had the highest proportion of other languages spoken at 19% including; Somali, Greek, other and Turkish. The Count me in Census offers a snap shot of inpatients on one particular day in March, but illustrates the general inefficiencies in establishing information about the numbers of refugees and asylum seekers accessing mental health services. However, it is evident that the numbers of service users from a BME background, of which this group fall into, formed the majority of in-patients in Haringey in 2008.
Gaps in service provision

The following case studies provide empirical evidence of the distinct needs of refugees and asylum seekers and highlight the fundamental need to work across health and social care boundaries to address the complexity of their needs.

Case study 1

M is a 36-year-old Eritrean male, married with five children. He arrived in the UK from Eritrea in 2007, where he claimed asylum. He was granted indefinite leave to remain in the UK. M was initially dispersed to Newcastle, and whilst there he was diagnosed with depression and prescribed anti-depressants. He then informed his GP that he wished to travel to London as he was finding it lonely, he did not speak English and had no friends or family in the North East. By travelling to London he felt that at least he would be surrounded by friends and his social contacts would increase. M travelled to London in 2008, and he was homeless for a few months before being housed in Haringey. His wife and family joined him in 2009 and they were re-housed in temporary accommodation in the borough. Through links with a migrant drop in centre in Hackney, M was brought to the attention of the Community Development Workers (CDW) as the centre that he was attending was having difficulty ensuring M was accessing appropriate services in Haringey. M had managed to register some of his children with schools, but two remained at home and he was unsure why this had happened. He was supporting his family on his benefit allowance alone, causing great financial stress, and the house provided by the council was in disrepair with an infestation of rats. He did not know where else to get any help. CDW attempted to locate a service that would assist M with orientation, advocacy and language support in Haringey. There was no such service identified within the statutory sector. The advice given from the local authority was that M should access mainstream services and go to his Citizens advice Bureau. This is despite explaining that M was unable to speak or read English and did not have any knowledge of the way institutional services operate, themselves confusing and disjointed for ‘ordinary citizens’ at the best of times. M’s priorities were to get his children in school, ease the financial burden as he was having difficulty feeding his family and sort out the poor accommodation he was placed in. Still taking anti depressants, M’s depression was of secondary concern despite mitigating circumstances to worsen it. Attempting to sign post him to appropriate services was time consuming and difficult. The Eritrean community centre in Haringey was contacted but did not respond; they are under resourced and staffed part time. The only other voluntary agency identified in the borough was CARIS, and a referral was made for family and welfare support. The British Red Cross based in Islington, were also able to accept urgent referrals for further advocacy and sustenance assistance.

Case Study 2

D is a 38-year-old married woman. She came to the UK from Turkey in 2005 to join her husband after he was granted refugee status. D was first admitted to St Ann’s in 2007 receiving a diagnosis clinical depression. She was then discharged with medication and was briefly followed up by community
mental health team, as she appeared to recover well. However D was re-admitted to St Ann’s in 2009, and was discharged with follow up from the Day Therapy Unit. Her husband reported that she was isolated and did not have many friends locally. A member of the OT Day Therapy Unit approached CDW as D did not speak any English and was having difficulty participating in the ward activities. She was also still very tearful and anxious. Her husband had therefore asked for extra support in helping his wife access a therapeutic service that spoke her language (Turkish Kurdish). Initially the most appropriate and suitable service was quickly identified as Derman, a voluntary sector agency that provides a range of health-related services to Kurdish, Turkish, and Turkish Cypriot people, mainly refugees and asylum seekers. The services include health advocacy, mental health outreach and support, counselling, family support and welfare rights advice. However once contacted, a representative from Derman advised CDW that they were no longer providing such services to Haringey, as they did not receive any funding from the borough. The service was therefore only open to Hackney residents. The only other local option was the Kurdish community centre, but D’s husband did not want her to attend the centre as he felt the community would talk about him and his family in a negative way, and there were no specific mental health services provided. D was therefore referred to mainstream psychology and out of borough Nafisyat, where she was placed on a waiting list.

It remains vitally important that all service providers and health professionals have an understanding of the problems that vulnerable populations such as refugees, asylum seekers, and irregular migrants face. These problems may not be just physical or psychological illness but also include political and social barriers to healthcare, such as entitlement to health care and barriers to accessing primary care, particularly for irregular migrants. Equally important is an understanding of interconnected difficulties with integration, socio-economic status and language barriers as contributory factors to poor mental health within these communities.

The needs of travelers and gypsies have not been considered separately in this study. Clearly their needs are not the same as BME or refugee groups. Their mental health needs are significant and their temporary location in the borough makes them a particularly vulnerable and difficult to treat group. Further work needs to be done to identify separate issues for this group of patients to identify their specific mental health needs.

Summary

- Refugees and asylum seekers experience many barriers to registration and uptake of medical services in the UK
- There is a lack of culturally appropriate services for refugees, asylum seekers and irregular migrants
- There is an huge contribution by the Third Sector in providing services to these groups of patients
There is little accurate information regarding the numbers and movements of this group of patients.
**Spirituality and Religion in black and minority ethnic groups**

**Introduction**

This section aims to highlight the challenges involved in ensuring that statutory and voluntary mental health service providers meet the religious and spiritual needs of people from black and minority ethnic communities (BME). In recognition of the importance of spirituality on recovery, NHS services will need to give greater consideration to the whole issue of spirituality and religion and their role, in supporting those using mental health services. Research suggests that attention to the religious and cultural needs of service users can contribute to their well-being and for instance, reduce their length of stay in hospital.

**Figure 1 - Multi faiths in Haringey**

![Pie chart showing religious affiliations in Haringey](image)

Office of National Statistics 2004

In 1997, The Mental Health Foundation found that over half of service users had some form of spiritual belief and that these beliefs were positive and important to them in terms of their mental health. Following this, service users were asked to describe the role spirituality and religious beliefs and activity had in their lives and themes that emerged included the importance of guidance, a sense of purpose, comfort, and grounding. Additionally the Mental Health Foundation state that in order to provide culturally appropriate mental health services for minority ethnic groups it is imperative that all aspects of spirituality including religion are understood in context of cultural norms and practices. Furthermore they acknowledge the complex relationship between spirituality and culture, and note that in some cultures religion is seen as being central to an individual and the community's sense of self, with collective religious ceremonies playing an important role as they reinforce cultural values, community cohesiveness, belonging, moral
standards and self-esteem. The treatment of psychiatric illness based on the
medical model is one that is free from religious and spiritual aspects of culture.
Traditional cultures of Africa, Native American and Asia, mind and body are
integrated together, in sharp contrast to the distinct division between mind
and body that dominates western paradigms of health78.

Christianity is the most practiced religion in Haringey, followed by a proportion
that do not practice any religion and then those who identified themselves as
Muslims. The smallest numbers are practicing Sikhs.

Interfaith service provision for inpatients

At present, there is a Muslim prayer group that includes both staff and service
users. The space is used each week, on average by 22 people. The space is
not suitable long term and there are challenges to the group continuing in
this venue. The layout of the room and lack of suitable partitions also means
restricted access for Muslim women to worship. St Ann’s Hospital is supported
by St Ann’s church and a part time Chaplain providing regular visits, events
and supporting individuals. The local Bishop from Broad Water Farm estate
also provides Sunday services in the upper Link corridor. Both groups have
been involved for several years in caring for service user’s spiritual needs.
Downhill’s Ward in St Ann’s hospital receives visits from a Community Church
group; this is solely managed by the ward and is a long-standing
arrangement.

Multi-faith space

The Royal College of Psychiatrists79 (2008) state, “Spiritual health care should
include the provision of space and privacy in which to pray and worship, and
an opportunity to explore spiritual or sometimes religious matters”. There is a
small soft-seated area called the ‘Peace room’ in the upper link corridor,
located within St Ann’s hospital. However despite being designed as a space
for all, this room is not suitable for all faiths to use. It excludes Muslims due to
the décor. Islam bans images that may distract or detract from worship. Other
issues are the room’s capacity, accessibility and placement of the room as
the room forms part of a walk through between inpatient wards, so privacy
and quietness may be difficult, as many faiths may need to perform washing
rituals, worship, or to read from their religious books without fear of outside
disturbance or interruption. Many patients choose to wait for leave and
access faith institutions in their local communities.

It is also important to recognize that some service users may choose to forgo
their faith whilst in hospital, preferring to avoid their community due to the
stigma surrounding perceptions of mental illness. The influence of cultural and
religious traditions on mental illness should also include awareness that some
cultures may also have stigmatising views against people who are mentally
unwell. Although the stigma associated with mental illness maybe cushioned
by religious principles of tolerance and acceptance, for some individuals
certain religious beliefs and practices may exacerbate mental illness. Cultural
beliefs could determine that individuals are viewed as being evil, in need of
punishment and consequently face rejection by the community. This may also put other factors such as isolation, low self-esteem and dissociation with family, social networks and religion into context.

Summary

- Spirituality is important for many residents of Haringey and may be particularly important to those with mental health problems.
- There is inadequate provision of prayer space for some patients.
- There is significant stigma attached to mental illness that may affect the individuals' access to prayer facilities.
Conclusion

The needs identified in this report related to primary care, the needs of BME groups, the voluntary and statutory sector, carers and asylum seekers and the collection of data. The needs may not be completely identified within the confines of this report and further work as part of the JSNA cycle may pick up additional needs within these defined areas.

This needs assessment has identified several areas of unmet need in Haringey. Although the needs assessment particularly focussed on the Black and Minority Ethnic Groups, it became clear that there were other groups that were not receiving adequate services or whose illnesses were probably not being picked up through standard mechanisms. The two groups that most significantly stood out were the needs of older people and the 16-25 year olds who transition from the child and adolescent mental health teams to the adult services. Both these groups require further work to provide further evidence to inform commissioning.

The recommendations are listed separately in the next chapter and have been divided according to population, health or Agency lead. Many of the recommendations could be fitted in across several categories and should not be read in isolation.

This needs assessment must influence the commissioning and provision of mental health services across Haringey both in the statutory and voluntary sectors and across health and social care. The Darzi report is providing the blueprint for creating services closer to home. This needs assessment is produced at an important time for services commissioning allowing for the redesign of services to better meet the needs of the population of Haringey and to also allow for the integration of mental health into mainstream health services.
Recommendations

Primary care
1. Consider how primary care can best link with secondary care so that complicated patients care given optimal treatment at an early stage to prevent further deterioration and possible readmissions
2. Ensure discharged patients receive adequate follow-up and support by providing ongoing secondary care support real or virtual
3. Treat patients in a more holistic way encompassing both their mental and physical health
4. Consider developing GPs with an interest in mental health to become GPs with a Special Interest (GPwSI)
5. Consider how the Mental Health Trust can provide ongoing support and education to primary care
6. Understand at both a practice and collaborative level which patients have not been diagnosed e.g. elderly patients with depression and dementia, black and minority ethnic groups with milder mental health problems and target these patients in primary care led interventions.

Older people
1. Improve the awareness, diagnosis and treatment of dementia
2. Improve the recognition and treatment of depression in older people
3. Consider how services can best meet the needs of older people within a polysystem model e.g. memory clinics
4. Improve ways to signpost older people into voluntary sector and local authority services
5. Ensure that sufficient care is taken in drug prescribing for the elderly, particularly in relation to polypharmacy and antipsychotic prescribing
6. Improve access to psychological therapies for older people and their carers
7. Ensure that older people can access services both logistically and financially
8. Ensure that mental and physical health needs are considered together and a more holistic approach is taken to the older persons health

Carers
1. Signposting of carers to statutory and voluntary services that are available to treat them
2. Consider the carers needs with all mental health patients

Voluntary sector/Commissioned organisations
1. There is a need for a regularly updated voluntary/commissioned services directory to help signpost patients and educate care providers of the range of services available and direct patients to the most appropriate services for them.
2. Signposting/education of these organisations what is available within the statutory sector and what service are provided by the NHS
3. Quality assurance mechanisms within contracts to ensure that services commissioned are of a high standard and continue to deliver services to this standard.
4. Develop mechanisms to ensure that hard to reach groups are particularly targeted
5. Assist groups to work according to population need and provide training and support to these groups when undertaking population needs assessment.

**Statutory sector/local authority**
1. Identify the number and flow of refugees, asylum seekers and irregular migrants
2. There was also a need to understand how to access other NHS and local authority Services that are not mental health specific
3. Resolve issues of transport and difficult accessing services

**Social Care**
1. Patients, voluntary and commissioned groups need information on how to access a range of social care issues from information on housing and respite to direct payments and individualised budgets
2. Resolve issues of transport and difficult accessing services

**Refugees and asylum seekers**
1. Identify the number and flow of refugees, asylum seekers and irregular migrants
2. Acknowledge and support, financially or otherwise, the contribution made by the Third Sector.
3. Provide care in an integrated and holistic way throughout Haringey and throughout the many care providers
4. Ensure that all service providers are aware of the cultural needs of this group of patients by providing awareness training of where these patients have come from and what difficulties they may have faced
5. Address the difficulty patients have in getting GP registration
6. Work in a more coordinated way with the statutory and voluntary sector
7. Encourage greater participation from local communities which may aid issues of capacity and also help get more appropriate services

**Spirituality**
1. Develop BEH Spirituality/religious operational policy
2. Develop training for all staff on spirituality/Religion, the relationship with mental health and recovery.
3. Develop training on mental health issues for faith groups wishing to work with hospital or community services
4. Encourage the employment of local faith leaders to support wards, communities and staff.
5. Provide multi-faith space giving service users privacy and permanent place for worship.
6. Research into the spiritual/Religious need of mental health service users in Haringey.
7. Give greater consideration of by mental health services/practitioners of spiritual/religious needs of service users.
8. Health service documentation could be expanded to ask and explore in greater depth the spiritual and religious needs of service users.
9. Consider providing spiritual resources e.g. prayer books, leaflets etc.
10. Give greater support to staff and service users wishing to access faith activities.

Data
1. Improve data quality and collection for Primary Care and within the Mental Health Trust
2. Ensure that all commissioned groups and organisations provide regular data and mechanisms exist to monitor both quality and outcome.
3. Encourage data collection by the voluntary sector and provide technical assistance where necessary to set up simple data collection systems
4. Ensure that data is compared within the sector, London and wider to ensure that outlying services are picked up early
5. Ensure that data feeds into the commissioning of services, programme budgeting and the polysystem as a whole

Joint working/commissioning
1. Ensure a more integrated way of commissioning mental health service across different agencies
2. Ensure best practice according to evidence based guidelines
Appendix 1

Stakeholder Interviews – Primary Care Mental Health Needs Assessment

Name

Organization

Tell the subject: What the interview is for/ Where their names were obtained from

General

What do you do/ What is the role of your organisation?

How are patients referred?

Do you refer patients on? Yes ☐ No ☐

To where? How?

Who are the target group of patients?

What areas of work do you cover?
Is mental health part of this?
Is mental health recognised as a separate area or is it integrated with other areas?

Are you aware of any patient pathways? Yes ☐ No ☐
What does the treatment/counselling consist of? who does this, what is their experience/qualification?

Is there patient follow-up? Yes ☐ No ☐

Corporate

Do you just work for Haringey? Yes ☐ No ☐

If not, what proportion of your patients/users are based in Haringey?

Do you have any agreements with the PCT? Any agreements with LB Haringey? Yes ☐ No ☐

What type of agreement? SLA? Other?

How is the organisation funded?

Facilities

What are your facilities like?
Do you think that patients/users would want to use them?

Do you maintain the facilities? If not, who does?

Data
Do you have any data? Any data on ethnicity?

Equity
Language and cultural issues

Would it be possible to have copies of any agreements or data?
Appendix 2

The improving Access to Therapies (IAPT)

The improving Access to Therapies (IAPT) programme was launched in May 2007 in order to improve the availability of psychological therapies, especially relating to people with depression or anxiety disorders. It also aims to promote a more person-centred approach to therapy. IAPT aims to prove that by developing different models of service delivery, the whole community will benefit. The opening up of self-referral routes enables the services to be more accessible to different community groups, especially Black and minority ethnic communities.

The Haringey IAPT services are part of a national initiative to improve access to psychological therapy for people with Common Mental Illness (CMI). CMI is a collective term used to refer to anxiety, depression, phobias, obsessive-compulsive and panic disorders. These disorders are different to the severe mental illness e.g. psychosis that require access to specialist mental health services.

The inclusion criteria for IAPT are that the patients must be over 16 years old with a Haringey based GP. They must also have a depressive or anxiety disorder. Exclusions include primary drug and alcohol problems, acute psychotic symptoms, significant risk of acting on suicidal thoughts, and personality disorders.

Referrals can be made by professionals, carers and patients. They can be made by phone, fax, post and by email. The service aims to respond to referral with a week of receipt and the initial contact is a 30-40 minute telephone call. This assesses the patients suitability to treatment with discussion and the use of assessment tools.

Both step 2 and step 3 groups are run. Step 2 groups consist of depression and anxiety, stress and Turkish group. Within step 3 are mindfulness, social anxiety, worry and Turkish somatisation groups. There are also step 2 CBT based interventions including computer aided CBT (Beating the Blues and Fearfighter).
Appendix 3

Which organisation do you come from and what is its role in Mental Health?

Pyramid (PY):
- organisation based in Chestnut community Centre
- providing counseling to individual and their families as well a range of social activities

Polar Bear Community (PB):
- established for 9 years and provide support for people with emotional difficulties.
- provide a befriending service.
- reach out to people who otherwise do not engage with services

Embrace UK (E):
- organisation specifically working with BMEs, trying to identify patient with MH issues before they reach crisis point, directing people to the appropriate services

Haringey Forum for older people (HF):
- represent the interest of the older people of Haringey, highlighting the needs and wants of the older community

Iranian Welfare organisation (IWO):
- represent the interest of the Iranian community.
- often the only point of contact for Iranians living in Haringey

Involve Haringey (IH):
- provide support for 13-21 year old with drugs and alcohol problems

Haringey African Cultural Voluntary Organisation
- work with people with mental health problems in day centres.
- The project engages people and provides services like story telling, drumming, arts and crafts

CARIS Haringey
- provides advocacy and support with tribunals for benefits and similar tribunals.
- They work directly with patients and focus on early intervention and prevention.

PRA
- is charity that works with people with mental health problems.
- They provide residential rehab accommodation and supporting people accommodation.
- They provide sheltered workshops to help people back into employment and currently host the Haringey User Network.

Freemind
- is a social enterprise.
• They make products like recordings which can be used in conjunction with therapy.
• The products facilitate psychodynamic work whilst people are waiting on a waiting list.

Ilse Amnot Centre
• provides childcare support and drop in centres.
• They work indirectly with people with mental health problems.

Tuilip
• is a voluntary sector provider.
• They sit on the mental health partnership board and provide strategic input.

Haringey Forum for Older People
• represents the church community and Alzheimer’s society.
• They provide networking links to information.
• They liaise with other voluntary sector providers and signpost people to relevant services.

Hail
• provides residential and supporting people accommodation.
• They mostly work with people with learning disabilities and have been working in Haringey since 1986.

Home Start
• is a family support organisation however they are receiving an increasing number of referrals from health.
• They provide advocacy and sign posting, train volunteers and provide emotional support.

Haringey Disability First Consortium
• rights of disabled people (including mental health)
• On average, they have 150 attenders (including services users and many people with mental health problems).
• Although mobility issues many be the primary needs, there may be other mental health and emotional needs.
• Personalisation issues - around depression and wheelchair use.

Homeless Family Project
• 5000 families in temporary accommodation
• environmental and housing issues add to the problems of an already isolated environment
• difficulty accessing services.

PACE (Project Advocacy Counselling and Education)
• London wide organisations for Lesbian and gay community
• Specific funding by Haringey council
• Focus on youth and mental health and mental health advocacy]

Muswell Hill Methodist Church
• young families, older people
- 2 Methodist houses
- overcome isolation

Age Concern Haringey
- National organisation
- Preventative role
- Transition action project – using volunteers in schools to support individual children
- Befriending service to fight the issue of isolation
- Exercise groups
- Signposting
- Concern about the increase in dementia – particularly in relation to the new strategy

Haringey Forum for Older People
- 900 members
- targeting people who are not accessing services
- Campaigning role
- Their focus is mental health this year – especially around preventative services

Haringey Women’s Aid
- women and children suffering domestic violence.
- Housing
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