Healthy Minds, Healthy Lives:

Widening The Focus On Mental Health

Annual Public Health Report 2015

Camden and Islington

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Foreword

Welcome to this year's Annual Public Health Report for Camden and Islington, for which I have chosen mental health and wellbeing as the focus. Camden and Islington have arguably the highest level of mental health needs in the country, and improving mental health is a key priority for Camden and Islington Councils and our partners on the Health and Wellbeing Boards.

There is ever greater recognition locally of the fundamental role that mental health conditions play in the health, economic and social inequalities experienced within the two boroughs. Mental health conditions are common in almost all groups and communities in Camden and Islington, but consistently the highest rates of mental health conditions are among people and communities experiencing deprivation, disadvantage and discrimination. The inequalities associated with mental health conditions are complex. In part, these inequalities reflect the direct impact that mental health conditions have on people's health, but there are many other factors. These include social isolation and exclusion, the historic division of services between mental and physical health, poverty, and the stigma and discrimination that can accompany mental health conditions.

Given this fundamental role that mental health conditions play in inequalities locally, my report this year seeks to provide an in-depth look at how mental health and wellbeing affects the two boroughs from multiple perspectives, ranging from how needs change through our lives, how local environments shape and influence our mental health, how mental and physical health affect each other, through to new models of service provision which are promoting access to early help and support and new approaches that promote recovery.

Whilst we often focus on mental health as being about illness, it is also about emotional wellbeing and resilience. Particularly in early life and adolescence, but throughout people's lives, there are opportunities to build better mental health in the same way as we do for physical health, which can help people to flourish, weather the ups and downs of life with greater resilience, and help protect against the risk of mental ill-health. The social determinants of health – such as housing, poverty, education, employment and the environment – are just as important in promoting and protecting mental health as they are in physical health.

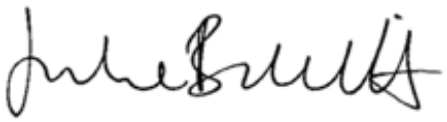
Some of the challenges identified in the report are very significant since they relate to long-term, sometimes generational inequalities associated with mental health. They include: the inter-generational impacts of parental mental ill health; inequalities in long-term worklessness and in life expectancy between people with severe and enduring mental health conditions and the rest of the community; and the stigma and discrimination associated with mental health. Action to address these longstanding issues is made even more challenging against a backdrop of the biggest cuts to local government in recent history and

of welfare and other economic changes that are likely to impact disproportionately people with mental health conditions or groups where there are particular vulnerabilities.

This report will inform the work of our department and our work with other departments and teams across the two councils, CCGs and wider NHS, and with the voluntary and community sector. Actions to improve mental health and to reduce inequalities means promoting better mental health, preventing mental illness and promoting early access to effective help and support. We have taken the opportunity in this report to highlight the many ways in which this is being done in both boroughs across a range of settings and services, demonstrating the many strengths we already have locally.

In addition to these local strengths, the priority given to mental health in both boroughs through the Camden and Islington Health and Wellbeing Boards gives increased opportunities to tackle some of the most important 'cross-cutting' inequalities associated with mental health. This builds on the commitments to improve mental health and reduce inequalities that exist across both councils and the NHS, and the enthusiasm and high level of commitment among councillors, GPs, council and NHS officers, the voluntary and community sector and other partners in Camden and Islington.

Finally, I would like to thank the team that produced the report for all of their hard work, and in particular Jonathan O'Sullivan who led the production of the report, Alice Ehrlich who provided excellent support and project management throughout, and Dalina Vekinis who led the in-depth analysis which informed much of the work. I would also like to thank the officers from other council departments and colleagues from the NHS and voluntary and community sector who gave their time and input or made contributions to the report. Our work on mental health has always been strongly formed through partnership working, and I look forward to continuing this collaborative working as we find new ways to address some of the most important inequalities in the two boroughs.



Julie Billett
Director of Public Health, Camden & Islington

Executive summary

1. Public mental health is about improving the psychological health and wellbeing of the population and helping to prevent mental ill-health. To achieve this, we must see it as a population issue and as everybody's business, and we must acknowledge its broad determinants and consequences. The stigma still attached to mental health disorders and the discrimination that accompanies this, make mental health a complex and challenging public health problem. The determinants of population mental health are, to a large extent, social and economic, and align closely with the strategic plans and priorities of both Camden and Islington Councils. The consequences of poor mental health for individuals and communities make a strong economic case for action. Mental wellbeing has an important role to play in both mental and physical health, and in a number of other social outcomes.

2. The prevalence of diagnosed mental health conditions is high in both Camden and Islington. Depression and psychotic conditions, in particular, are greater here than in most parts of London or England. However, we know that many mental health conditions go undiagnosed. Over the coming years, it is likely that the prevalence of mental health conditions–especially dementia–will rise, due to a growing and ageing population. The impact of mental health conditions can be enormous, at both an individual and a societal level. To improve the health and wellbeing of residents with mental health conditions, it is essential we have an accurate understanding of disease patterns, their demographic distribution and comorbidities.

3. Mental health conditions are an important source of inequalities between different groups in both Camden and Islington. There are significant differences by age, sex, ethnicity and socioeconomic status. Depression and anxiety are more commonly diagnosed in middle aged and older people, women, white people and those living in more deprived areas. Psychotic disorders are more commonly diagnosed in black men and women and those living in the most deprived areas. Additionally, mental health conditions are both cause and consequence of important social inequalities, such as poverty, worklessness and employment problems, isolation, deprivation and homelessness. There is also an important intergenerational element in mental health which reinforces these inequalities; parental psychological health and wellbeing has a profound effect on the protective and risk factors for a child's mental health and wellbeing throughout their entire life; mental health conditions in childhood are an important risk factor for mental health conditions in adulthood.

4. The life course approach to mental health emphasises the wider determinants of health, the influences of life events and physical health, as well as social and economic inequalities on mental health and wellbeing. Mental health needs can fluctuate throughout life, due to situational changes and life events. Understanding the cumulative risks and impact of these is essential to improving mental health from both preventative and treatment perspectives, and this is true throughout life. Protecting mental health and building resilience from an early age can improve mental health later in life. Living well at a working age is important, and employment plays a huge role during this period, in a person having a good quality job, or being supported into training, volunteering and employment as part of mental health recovery. Ageing well is also important in life course mental health. In all of these periods, building resilient communities, as

well as supporting individual resilience, is an important part of a public mental health approach.

5. Physical health and mental health are inextricably linked. Life expectancy is lower among people with some mental health conditions, and this is largely attributed to long term physical conditions. The relationship between physical and mental health is complex and two-directional; people living with a long term physical condition are more likely to experience common mental health disorders as a result, and some lifestyle risk factors are more common among people with mental health conditions, increasing their risk of developing physical health problems, such as heart or respiratory disease. These associations are becoming more recognised, and there are more interventions available to meet the mental health needs of those with physical health conditions, and vice versa. Locally, this is reflected in care planning and self-management programmes for people with physical health conditions. Additionally, developing pathways of care for people with all mental health conditions, which include prevention and management of long term conditions, will contribute to better overall health outcomes.

6. The physical environment can have a significant impact on the mental wellbeing of residents and communities. Access to quality housing, healthy high streets, green spaces and workplaces where mental wellbeing is promoted, all play a role in ensuring that the boroughs are healthy places to live, work and visit. There are opportunities to develop our 'places' to better promote mental health.

7. Timely access to effective help is essential for improving population mental health. Demand for mental health and care services in Camden and Islington is high. Services are under increasing pressure to improve population mental health outcomes, at a time when resources are becoming tighter and tighter. Responding to this is an ongoing challenge, and requires new ways of thinking across the whole health and care system. Services must focus on early intervention, taking a holistic, recovery-based approach to meeting service users' needs. They must also play a part in addressing inequalities in mental health conditions, acknowledging that some groups are under-represented in primary care and other preventive or early intervention services, and some groups, notably men and women from some BME communities, are significantly over-represented in secondary care mental health services. A targeted approach is therefore needed. These approaches can achieve better outcomes which are aligned to service users' aspirations, and can deliver economic savings in the long term.

8. Suicide is a complex public health issue. It disproportionately affects younger and middle-aged adults, as well as those bereaved by the suicide of someone else. Whilst most suicides are among those diagnosed with a mental health condition, suicide is often the end-point of a series of ongoing risk factors, distressing events and adversity. Primary care, mental health services and urgent and emergency services are central to addressing this, by providing timely access to treatment and support, as well as risk-management. There has been an overall decline in suicides over the previous decade, but many preventable suicides still occur.

9. To improve public mental health in an effective and equitable way, we must acknowledge the social and economic context in which it exists. The approach to improving mental health and wellbeing in Camden and Islington set out in this report focuses on four key areas: i) giving every child the best start in life, ii) addressing economic conditions, iii) improving mental health in the community, and iv) addressing physical and mental health conditions more holistically to improve life expectancy and quality of life.

1

Population mental health: risk and resilience

Introduction

This chapter outlines the importance of looking at mental health at a population level. That is, considering 'public mental health', rather than the mental health of an individual. This way, evidence of what influences mental health can be used to identify and address risk and resilience (protective) factors at both individual and community levels. Rooted in a holistic view of mental health and wellbeing, the benefits of public mental health extend to physical health, as well as wider social and economic outcomes.

Public mental health

The World Health Organisation (WHO) defines health as: "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity." Specifically, mental health is described by WHO as: "….a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". [1]

These two definitions capture four key concepts:

- Mental health is an integral part of health
- Mental health is more than the absence of illness
- Mental health is intimately connected with physical health and behaviour
- Mental health is related to economic and social wellbeing.

Mental health is often measured in terms of illness or illness prevention, but a wider notion of mental health which includes an individual's subjective 'wellbeing' has emerged over recent years. This conceptual framework is described later in this chapter. Mental health and wellbeing are determined by a combination of genetic, environmental and behavioural factors. Understanding of these factors has increased in recent years, as the evidence base has grown. Two significant points have emerged:

- some of the factors which determine mental health are resilience factors, while others are risk factors for mental health
- whilst some of these factors are fixed, others can be influenced in order to promote better mental health or reduce the risk of mental ill health.

Our understanding of these relationships form the basis of effective interventions to improve public mental health, through boosting protective factors and minimising exposure to risk factors.

The WHO's framework for public mental health (Figure 1.1) argues that to improve individual and public mental health, a combination of three broad approaches are needed:

- mental illness prevention
- mental health promotion
- access to effective services for treatment and recovery.

Responsibilities for, and interests in, these approaches fall to a wide range of stakeholders, including individuals, communities, voluntary sector organisations, local government, NHS commissioners and providers of mental and other health services.

The determinants of mental health

Risk and resilience factors exist at many levels from the individual to community and wider environmental, familial and social levels. Some of the major mental health risk factors are

explored below, and throughout this report.

Some individuals and communities demonstrate greater resilience to mental health conditions, and the ability to 'bounce back' from adversity more than others. This observation has informed an extensive body of research which identifies individual characteristics such as optimism, self-esteem, self-efficacy and interest in others that protect mental health. [3]

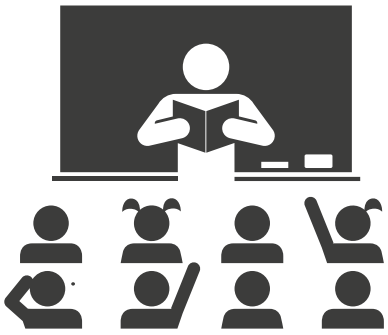
Figure 1.1 A conceptual model of approaches to protecting and improving mental health

Source: Annual Report of the Chief Medical Officer 2013, [2] adapted from the WHO framework

At a community level, resilience is characterised by similar features, such as trust, tolerance, support and participation. Additionally, social capital and social networks have a protective effect on health, including mental health. Helping individuals to develop resilience and building resilient features into our communities may provide some protection from mental health conditions. Table 1.1 outlines some of the major risk and resilience factors. [4]

Camden

Self - Esteem of Children



51% of Year 8 boys and **55%** of Year 10 boys reported high self - esteem scores.

39% of Year 8 girls and **44%** of Year 10 girls reported high self - esteem scores.

Source: Camden HRBQ survey, 2013

Table 1.1 Risk and resilience factors in mental health

Level	Risk factors		Resilience factors
Individual Attributes	Low self-esteem	⟷	Self-esteem, confidence
	Cognitive/emotional immaturity	⟷	Ability to solve problems and manage stress or adversity
	Poor communication skills	⟷	Good communication skills
	Physical illness, alcohol and substance abuse	⟷	Physical health, fitness
Families and Social Circumstances	Use of alcohol/tobacco/drugs during pregnancy	⟷	Good antenatal maternal health
	Early neglect, family conflict looked after child	⟷	Good parenting/secure attachment
	Difficulties or failure at school	⟷	Educational achievement
	Exposure to violence/abuse	⟷	Physical security and safety
	Loneliness, bereavement	⟷	Relationships, social support, family and friends, social connectedness
	Low income and poverty	⟷	Economic security
	Work stress, unemployment	⟷	Satisfaction and success at work
Community Factors	Isolation	⟷	Connected communities, social cohesion, strong voluntary sector
	Lack of influence/control	⟷	Local community influence and participation
	Crime, fear of crime and anti-social behaviour	⟷	Physical security and safety
	Poor quality, poorly maintained local environment	⟷	Pleasant physical surroundings that support community integration
Environmental Factors	Poor access to basic facilities (housing, jobs, open space)	⟷	Equality of access to basic facilities
	Poor access to health/mental health services	⟷	Easy, equitable access to health services
	Injustice and discrimination	⟷	Social justice, tolerance, integration
	Social and gender inequalities	⟷	Social and gender equality

A spotlight on... mental health and resilience in schools in Islington

Mental Health and Resilience in Islington Schools

Islington Mental Health and Resilience in Schools (I-MHARS) helps school staff to understand the risk and protective factors involved in mental health and how school systems can contribute to improving mental health and developing the emotional resilience of pupils. The project is an example of direct action to develop understanding of mental health and early access to local services as well as to build resilience into school communities. It has already delivered a new scheme of work which is being used in local secondary schools. This includes training for staff and lesson plans for children in year 9 to understand mental health, tackle stigma and know how and where to seek help. A pilot of lesson plans for primary schools is currently in progress.

Using the available evidence base, a consortium of partners including Public Health, Child and Adolescent Mental Health Services, Educational Psychology, School Improvement and many local schools, have developed a resilience framework which outlines the elements of whole school practice that effectively support pupils' mental health and resilience.

The framework has generated a lot of interest from local schools and four schools were selected to take part in a pilot project running through 2015-2016 to develop, pilot and evaluate the whole school resilience framework. Each school has made a proposal to develop an area of practice of their own choosing. Proposals range from improving the attendance of children from families who are experiencing mental health issues to developing challenge and mistake-making as positive tools in teaching - seeing mistakes as a positive opportunity for learning and change. The schools involved include primary, and special schools.

Each school has audited their existing practice against the framework and is piloting a new way of working chosen by the school itself. The schools are supported by a project officer and are using quality improvement techniques to evaluate their approaches, supported by the academic health science unit, UCLPartners. The learning and good practice from the project will be shared across all Islington schools as the framework develops.

Deprivation and inequalities

The link between social disadvantage and health is now universally accepted. [5] This, and the economic consequences of not tackling these issues, applies as fully to mental health as to physical health. Environmental, social and economic circumstances can be as influential as individual attributes and behaviour in the development of mental illness. Thus, social deprivation is a considerable risk factor for mental illness. To some extent, the overall deprivation in Camden and Islington explains the high levels of mental illness observed in each. Across the boroughs, there is a 'social gradient' in mental health; those who experience greater deprivation are at higher risk of experiencing mental health conditions. A further complexity is that the relationship between mental health and deprivation is cyclical; factors such as poor housing, poverty, unemployment and other causes of deprivation increase the risk of mental illness but are also caused or exacerbated by mental health conditions.

The complex relationship between income inequality and health at a societal level was illustrated in The Spirit Level; [6] as income inequality increases, health outcomes become poorer for the whole population, rather than only those at the lowest end of the income gradient. The authors found that:

- Almost everything - from life expectancy to mental illness, violence to illiteracy - is affected not by how wealthy a society is, but how equal it is
- Societies with a bigger gap between rich and poor are bad for everyone in them - including the well-off.

Though the methods of the analysis were the source of some controversy, international comparisons tend to show that the prevalence of mental health conditions is higher among societies where income inequalities are greater. Following this, the high level of income inequalities in both Camden and Islington are likely to be a contributing factor to the high levels of mental health conditions and to affect overall levels of wellbeing in both boroughs.

More locally, the Cripplegate Foundation, looked in depth at the impact of poverty on local residents in Islington. [7,8]

The report found a highly divided society and high levels of ill-health, including mental ill-health, amongst those living in poverty. Growing polarisation and inequality were further sharpened by the impact of austerity measures and benefit cuts. The report also cites many examples of the spiralling impact on mental health of unemployment, insecure or low paid work, poverty, loss of benefits and poor physical health.

In Camden, there were similar findings from the Young Foundation in their 2012 report on the impact of the cuts on some of the most vulnerable people in Camden. The combined effects of a deep recession, rising costs of living, changes to benefit entitlements, and local service changes had left people feeling victimised and unable to control their situation. The focus of the report was on young people, families on low incomes and disabled people. For many of the people they spoke to, the changes to local services and the lack of disposable income meant they were becoming increasingly isolated. [9]

Societal understanding of mental health

There is an additional barrier in promoting mental health and preventing mental illness that generally does not exist to the same degree in relation to most physical health issues. Although mental health problems are very common, they are often poorly understood, untreated and stigmatised. Nine out of ten people who experience mental health conditions say they have faced stigma and discrimination as a result of their condition. [10] These create an additional burden alongside the symptoms of living with a mental health condition, prevent people from talking openly about their problems or seeking help, and hinder recovery.

This may be due to:

- A lack of understanding of mental health, mental illness and its treatment
- No consensus over the conceptual models and beliefs about mental illness, and subsequent confused messages and terminology
- Mental health conditions may involve social, cultural and religious taboos, especially around suicide and serious mental illness
- Negative community experiences of treatment services, particularly for people from Black Caribbean, Black African, Black British and Irish communities, who have faced the challenges of multiple discrimination and exclusion, and have been over-represented in secondary care services
- Services for mental and physical health care have traditionally been commissioned and provided separately, and mental health services have not been given priority.

This means that taking action to improve people's understanding of mental health and to improve access to services must be a part of a public mental health approach. Mental health needs "parity of esteem" with physical health promotion and treatment. Mental health awareness programmes are designed to tackle stigma and discrimination, and to increase public understanding of mental health and awareness of mental health services. Programmes involving a mix of social marketing techniques and skills and awareness-based training have been used in both Camden and Islington to target specific groups, where stigma has been recognised as high, as well as to increase universal awareness. Working with communities and service users helps to identify some of the issues contributing to stigmatisation. For example, Camden Child and Adolescent Mental Health Services (CAMHS) were rebranded as 'Open Minded' after consultation with local young people and users of the service (see Chapter 6). These approaches have contributed to shifts in public attitudes and understanding, but the need to reduce stigma continues.

Mental health awareness in Camden and Islington

The recent Camden mental health mandate commits to developing a programme of training, education and awareness across health, social care and the general public. The CCG have recently commissioned the delivery of Mental Health First Aid courses to front-line staff as a part of this commitment.

Mental health promotion services in Islington include free mental health first aid training (MHFA) and mental health awareness training for anyone in the borough, a network of mental health champions, and a direct action project to address stigma and awareness amongst youths and young adults. Over 600 adults received MHFA training in Islington in 2014.

Community development services in both boroughs work with BME communities that have poor access to existing services.

Similar approaches are being used in dementia, where 'ageism' is an additional contributing factor to the stigma of a mental illness. Such local approaches include delivery of 'Dementia Friends' training, a nationally-designed, accessible one-hour course to enable anyone to understand a bit more about dementia, and small ways to help people with dementia live better lives within their local communities. The Camden Dementia Plan commits the borough to becoming 'Dementia Friendly': a place where everyone is aware of and understands more about dementia, people with dementia feel included in their community and are supported by local communities to live well and with greater choice and control. A Dementia Action Alliance has formed in Camden led by Camden Carers and Age UK Camden to take these objectives forward with participation from people with dementia and their carers. More recently, a similar alliance has been formed in Islington.

Wellbeing and mental health

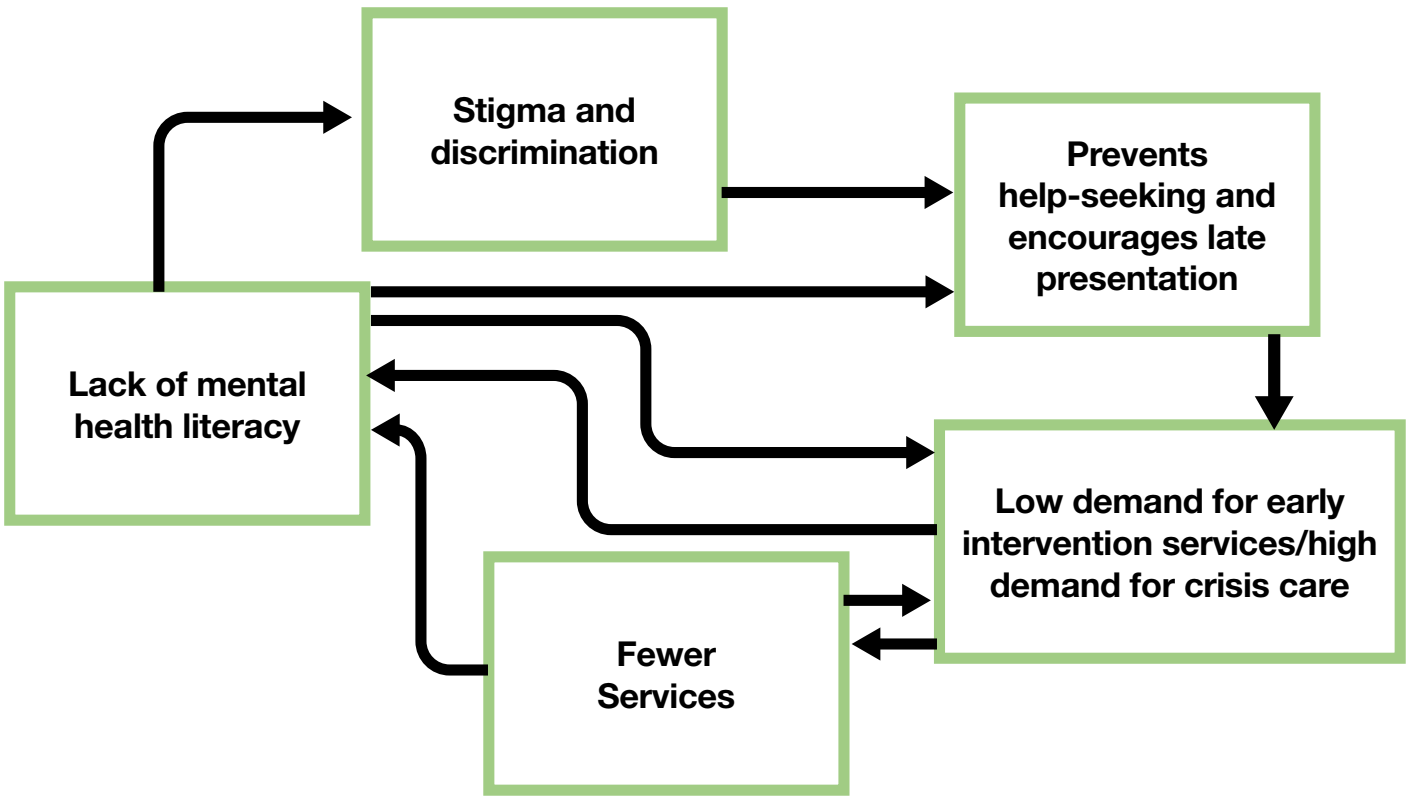
In the mental health field, wellbeing is an increasingly recognised phenomenon, and is sometimes used interchangeably with 'mental health'. While various definitions exist, wellbeing is a subjective measure, whose core attributes include feeling good and functioning well, both individually and socially. This builds on advances in the field of positive psychology, which has shown links between positive emotions, happiness and health status.

It follows that wellbeing and mental health conditions are linked. However, their relationship is not linear, but is subtle and complex. Generally, those with abundant wellbeing have fewer mental health conditions, while people with low wellbeing are more likely to have mental health conditions. However, this is not always the case at an individual level; many people living with mental health conditions lead productive and fulfilling lives, while those deemed to have good mental health may have poor wellbeing, or are 'languishing' rather than flourishing.

As with mental health, wellbeing has important, positive links with physical health and social outcomes, such as educational attainment, productivity, cognitive ability, physical health, social participation, resilience to adversity, risk of mortality, mental illness and suicide and health behaviours such as smoking. [11]

It is a common misconception that wellbeing is pre-destined, in other words that we are born with a 'glass half-full' or a 'glass half-empty' approach to life. The field of positive psychology indicates that traits such as happiness and optimism are influenced by both nature and by nurture. The evidence suggests that between 40% and 50% of the influence on happiness is genetic, and that the remainder is influenced by experience and, importantly, can be learned. The potential for people to increase their level of wellbeing represents an opportunity for those striving to improve public mental health. Volunteering and exercise are both ways to enhance individual wellbeing.

Figure 1.2 How stigma contributes to poorer mental health outcomes



A spotlight on... volunteering and connecting with others in Camden and Islington

GoodGym matches people in Camden and Islington who like to run, with people who need physical tasks doing or isolated older people.. Providing company for the older person can alleviate isolation, and the runner also benefits from engaging with their partner.

"I don't live near my grandma, and [my GoodGym partner's] life stories are fascinating. I can offer a bit of help in a small way with immediate things. I'm committed to him and the running is a by-product... He said 'I'll miss you' when I went on holiday. I wasn't expecting that."
www.goodgym.org

The New Economics Foundation considered the factors that help individuals and communities to flourish, focusing on mental capital and mental wellbeing rather than physical resources or wealth. The 'Five Ways to Wellbeing', are evidence-based components to maintaining wellbeing. They were designed for action at an individual level, but also reflect features of communities that enhance mental health. (12)

The Five Ways to Wellbeing

Connect… with the people around you

Be active… in regular physical activity

Take notice… of the world around you and the here and now

Keep learning… try something new at any age

Give… do something nice for a friend, or a stranger

The ideas that underpin the concept of wellbeing can also be applied to those with a mental health condition. The personalisation agenda focuses on increased self-determination, self-worth and greater integration of physical and mental health, all of which can improve wellbeing. The concept of promoting good wellbeing, even in the presence of a mental health condition, is consistent with the recovery model, now widely used in the care and support of people with mental health problems. The recovery model aims for people to stay in control of their lives despite experiencing a mental health problem.

Wellbeing in a policy context

Wellbeing is becoming recognised in national and local policy. Wellbeing surveys show that like other health outcomes, a social gradient exists in wellbeing, and that it is associated with factors such as age, gender and ethnicity. (13)

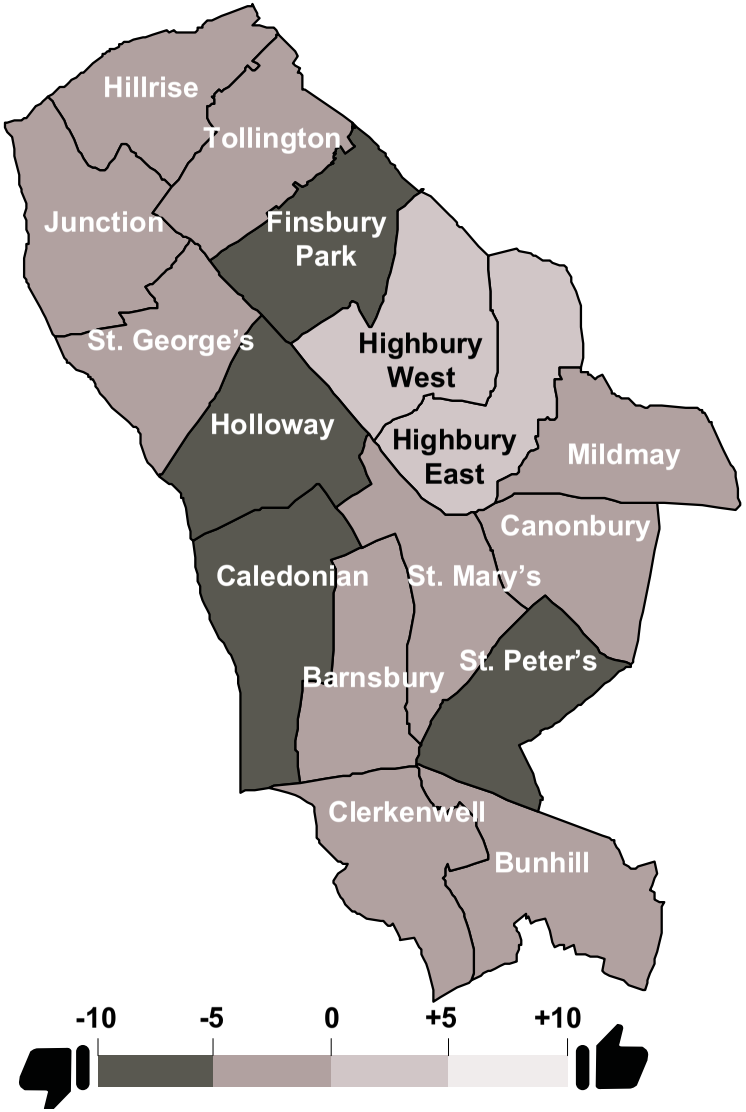
There has been increasing national interest in recent years in the concept of wellbeing as an additional way of measuring the outcomes of social and economic policy. There is recognition that wealth or productivity are not enough unless they are accompanied by some sense of improved wellbeing in the population, for example, through improvements in social capital, the environment or subjective wellbeing (or happiness). Both the physical and psychological benefits suggest that promoting wellbeing at the societal level is a worthwhile activity, and Local Authorities have a responsibility for improving the wellbeing of local communities, through action across a broad range of determinants including environmental, social and economic.

Measurement of wellbeing is at an early stage of development, but provides some opportunity to take into account the impact of a range of factors on the wellbeing of local people. Recently, the All Party Parliamentary Group on Wellbeing Economics recommended that all new policy should be assessed for its impact on wellbeing. (14)

Determinants of Wellbeing

Wellbeing scores were calculated for each ward and the borough overall from a combination of 11 wellbeing indicators. Scores over 0 indicate a higher probability that the population on average experiences a positive wellbeing, according to these indicators. These can be compared to the England and Wales average, which is zero.

Overall wellbeing scores for Islington wards



Wellbeing scores for individual indicators

Note: For three indicators there is no England & Wales value available, so scores have been compared against London.

Islington

Determinants of Wellbeing

Wellbeing scores were calculated for each ward and the borough overall from a combination of 11 wellbeing indicators. Scores over 0 indicate a higher probability that the population on average experiences a positive wellbeing, according to these indicators. These can be compared to the England and Wales average, which is zero.

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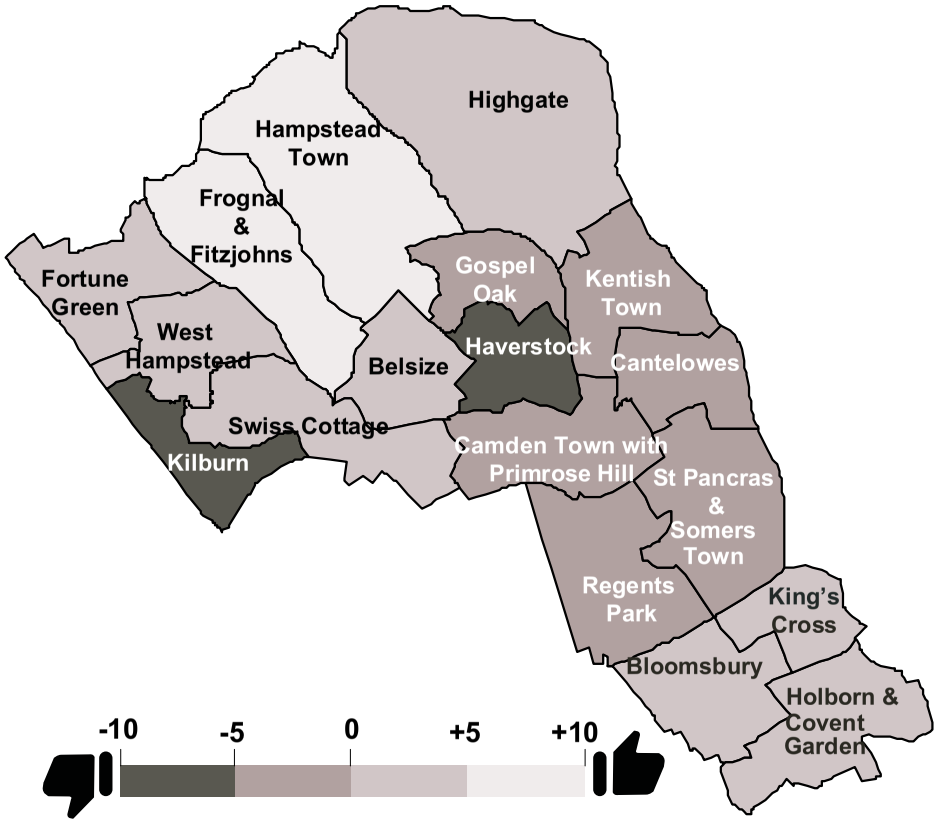
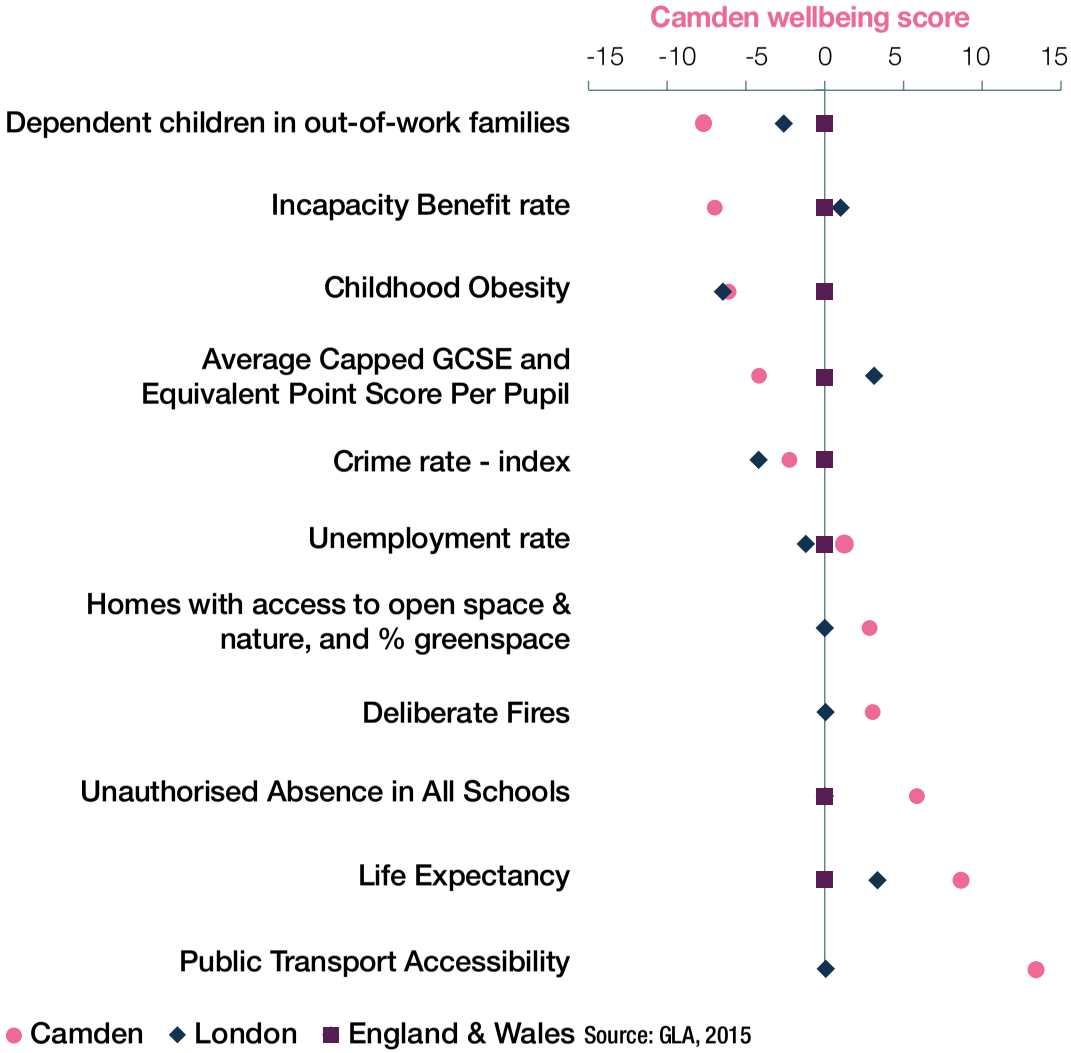


Wellbeing scores for individual indicators



Note: For three indicators there is no England & Wales value available, so scores have been compared against London.

Camden

The Public Health Outcomes Framework includes four measures of adult subjective wellbeing, covering self-reported satisfaction, worthwhileness, happiness and feeling anxious.

However, data at a borough level is based on very small sample sizes, which reduces its reliability. The availability of such measures gives us the opportunity to measure the value of non-market goods such as planning, transport, arts and culture programmes. Children's wellbeing is measured in Camden through the Schools' Health Related Behaviour Questionnaire and is being measured in Islington in 2015.

The Greater London Authority (GLA) has developed a combined measure of 12 wellbeing indicators. [15] These are measures that influence wellbeing such as economic security, safety and access to open space. The indicators chosen match closely some of the key risk and protective factors for determinants of local mental health shown in Table 1.1. The GLA data looks at the determinants for wellbeing at a ward level. Variations in wellbeing between wards broadly mirror different levels of deprivation seen within Camden and Islington and can be seen to have more variation across Camden than in Islington.

A spotlight on... older people getting the most out of the borough in Camden

Our Camden

Our Camden is a membership scheme for older people in the borough encouraging members to try new things, meet new people and get the most out of the borough. It links local people together and to local activities and businesses, offering discounts from local shops and businesses as well as social activities for members. The range of activities is broad to appeal to a wide range of people. Many events are free, and others are available at discounted rates through partnership with local businesses.

"Sometimes we'll be trying a new sport like fencing or croquet. Other times we'll go all cultural and go off to the theatre. We like eating at Our Camden, so you might find us at a restaurant you've never been to before".

www.ourcamden.org

Plan for population mental health: how do Camden and Islington respond to these determinants?

It is clear that social and public policy, not just health services, have a major role in supporting improved mental health for the whole population and of vulnerable groups. Key priorities and action in both the Camden Plan and the Islington Fairness and Employment commissions can be mapped to the determinants of population mental health to demonstrate how they impact on population mental health. Understanding these links is one of the themes of public mental health as it aims to support more psychologically aware and skilled public and community services and to create a wider strategic audience for mental health. The tables on the following pages explain the Councils' approaches to addressing this.

The Camden Plan

The Camden Plan is the Council's response to inequality in the borough which has grown in recent years due to changes in the economy and in government policy such as welfare reform. It seeks to help people on low to middle incomes continue to live and thrive in the borough. The Council's budgets have been and will continue to be under considerable pressure so it must prioritise activities which have the most impact on the outcomes of the Camden Plan. The focus of the plan is on employment and education; reducing health inequalities, particularly through reducing childhood poverty and the provision of better homes; investment in strong, cohesive and sustainable local communities through the provision of community investment, reductions in crime and a personalised approach to social care. These outcomes, and particularly the priorities recognised by the Equality Taskforce of employment, educational attainment, and suitable and affordable housing, can be recognised amongst the determinants of good mental health in the table below. All the elements of the Camden Plan contribute to these priorities, and many actions from the plan will have a positive influence on population mental health in the borough.

Domain & risk/protective factors	Individual Attributes			Families and Social Circumstances						Community Factors				Environmental Factors			
Protective factors / Examples of implementation	Improves self-esteem	Improves physical health	Good communication skills	Reduces poverty/ improves economic security	Decrease early neglect/promote good parenting	Reduce exposure to violence and abuse/ promote physical security and safety	Decrease unemployment	Decrease loneliness	Educational achievement for all	Connected communities, social cohesion, strong voluntary sector	Decrease anti-social behaviour	Local community influence	Improved physical surroundings	Equality of access to basic facilities	Easy, equitable access to health services	Social justice	Social and gender equality
Introduction of the London Living Wage	✓			✓												✓	✓
Support schools to maintain improvement through Schools-Led Partnership									✓	✓				✓			
Free nursery places for 2 and 3 year olds			✓	✓			✓		✓	✓				✓			✓
Better quality homes for social and private tenants		✓		✓		✓							✓				
Maintain social mix through good supply of affordable housing		✓		✓		✓				✓				✓			✓
Support for families with complex needs (+ school inclusion & employment support)	✓			✓	✓	✓	✓		✓	✓				✓			
Free healthy lifestyle services (e.g. smoking cessation)		✓													✓		
Local support for youth employment through apprentice programme, work experience projects	✓			✓			✓			✓							✓
Introduction of school breakfast clubs & flexible employment to support mothers to regain work	✓			✓			✓	✓									✓
Investment in physical & social infrastructure through community Investment programme										✓		✓	✓			✓	
Revised housing allocation scheme which prioritises children and families, cohesive communities, health and wellbeing and fairness	✓	✓		✓		✓		✓		✓				✓			

Islington Fairness Commission and Employment Commission

The 2010 Islington Fairness Commission, inspired by the 'Spirit Level' argument, aimed to tackle poverty and inequality. It was commissioned at a time of national austerity and with the prospect of implementing cuts that might impact most on those with the least resources. The commission made 19 recommendations to make the borough a fairer place, focussing on 7 priority areas: income, work, families, community, safety, housing and health. These are important determinants of mental health, and the actions that have resulted from the report will have a positive influence on population mental health in the borough.

Recognising that poverty makes the greatest contribution to inequalities in the borough and is concentrated amongst people who are unemployed, the Islington Employment Commission was commissioned in 2014 and recently published its findings with three major recommendations. The contribution of employment to mental health and resilience is well evidenced. Action to implement the findings of the report takes forward some aspects of the Fairness commission and will have a major impact on population mental health within the borough.

Domain & risk/protective factors	Individual Attributes			Families and Social Circumstances							Community Factors				Environmental Factors			
Protective factors / Examples of implementation / Islington Fairness Commission	Improves self-esteem	Improves physical health	Good communication skills	Reduces poverty/ improves economic security	Promotes ante-natal maternal health	Decrease early neglect/promote good parenting	Reduce exposure to violence and abuse/ promote physical security and safety	Decrease unemployment/increase work satisfaction	Decrease loneliness/social support	Educational achievement for all	Connected communities, social cohesion, strong voluntary sector	Improve physical surroundings	Reduce anti-social behaviour/increase physical safety	Local community influence	Equality of access to basic facilities	Easy, equitable access to health services	Social justice	Social and gender equality
Fair Pay Council pay ratio down to 1:10, all Council employees and 98% Council contracts receive LLW, promoting uptake of LLW amongst local businesses	✓			✓				✓									✓	✓
Dealing with Debt New planning powers to restrict pay-day lenders, Credit Union provides 4,000 affordable loans,10,000 grants through Residents Support Scheme, independent debt advice	✓			✓														
Secure, decent, affordable housing 1,729 new affordable homes since 2011, estate regeneration, support for down-sizing and relief from overcrowding		✓		✓			✓				✓	✓		✓	✓			
Supporting people into work Over 2,000 people supported into paid employment since 2011, youth employment halved to less than 1,000	✓			✓				✓	✓	✓	✓							✓
Tackling crime and anti-social behaviour New ASB hotline allows intelligence-led response and identification of repeat victims							✓					✓	✓	✓				

Domain & risk/protective factors	Individual Attributes			Families and Social Circumstances							Community Factors				Environmental Factors			
Protective factors / Examples of implementation	Improves self-esteem	Improves physical health	Good communication skills	Reduces poverty/ improves economic security	Promotes ante-natal maternal health	Decrease early neglect/promote good parenting	Reduce exposure to violence and abuse/ promote physical security and safety	Decrease unemployment/increase work satisfaction	Decrease loneliness/social support	Educational achievement for all	Connected communities, social cohesion, strong voluntary sector	Improve physical surroundings	Reduce anti-social behaviour/increase physical safety	Local community influence	Equality of access to basic facilities	Easy, equitable access to health services	Social justice	Social and gender equality
Islington Fairness Commission (cont.)																		
Improving children's life chances Implementation of the 'First 21 Months programme', 91% schools with Ofsted 'good' or 'outstanding'		✓	✓		✓	✓			✓	✓	✓				✓	✓		
Giving something back Over 1,500 local volunteers through new 'Here To' website. Islington Giving develops and supports local communities through volunteers	✓								✓		✓			✓				
Promoting a cleaner, greener environment 3,700 homes insulated and 2,700 new boilers installed since 2011, 17 gardening groups set up on local estates	✓	✓							✓		✓	✓		✓				
Reducing health inequalities Weight management programmes for adults and children, smoke-free mental health sites from March 2015, 47% of access to smoking cessation services from BME communities.	✓	✓			✓											✓		✓
Islington Employment Commission																		
Targeting support at those who most need it iWork team offer 1-1 supports residents facing additional barriers into employment (e.g. lone parents, people with disability)	✓			✓				✓	✓								✓	✓
Enabling employers to recruit locally Single point of contact for local employers to enable local employment offers and work training for local people	✓			✓				✓			✓			✓				✓
Creating change for the next generation Apprenticeships within the Council (800 by 2018) and support for local employers to increase apprenticeships, targeted work in schools to identify and support those at highest risk of NEET, developing post-16 education and training offers	✓		✓	✓				✓	✓	✓	✓		✓					✓

Conclusions

Public mental health affords us a focus on the wide-ranging, multi-dimensional risks and resilience factors of mental health conditions. Through this perspective, we can promote better mental health, reduce the risks of mental illness, and promote the access to effective help, treatment and recovery discussed later in this report.

Locally, deprivation and income inequalities are important in explaining higher levels of mental health conditions at a population level, and the cyclic relationship between these must be addressed.

Alongside this, public health and the wider community must address the stigma and misconceptions surrounding mental health, and in doing so, make mental health everybody's business. While attitudes are changing, there are still improvements to be made.

Locally, mental health can be improved through the social and community changes to reduce risk and boost resilience described in the Camden Plan and the Islington Fairness Commission and Employment Commission. Central to the success of this, is recognising that mental illness is a consequence of but also a cause of many negative social and economic outcomes. Thus, action to address mental health needs will also help to reduce social and economic adversities and inequalities. Similarly, wellbeing is important in a wide range of health and social outcomes, not only in terms of mental health conditions. Available measures of wellbeing suggest that there is generally a correlation between lower levels of wellbeing and higher levels of deprivation.

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2

Mental health conditions in Camden and Islington

This chapter describes the prevalence of mental health conditions in Camden and Islington, in children and young people and in adults. It compares the diagnosed prevalence of mental health problems with the estimated underlying prevalence, and identifies some of the key demographic groups affected. The chapter goes on to assess the economic impact of mental health conditions in the two boroughs.

The prevalence of mental health conditions

One-in-seven adults in Camden and one-in-six in Islington (30,600 and 32,209) have been diagnosed in primary care with one or more mental health conditions, including common mental health disorders (CMD), serious mental illness (SMI) or dementia. Taking comorbidities into account (i.e. people with more than one mental health diagnosis), this means that there are about 42,000 separate diagnoses in Camden and 44,000 in Islington. In each borough, there are also about 1,500 children and young people under 18 in treatment for mental health conditions (4.2% and 5.9% of children in Camden and Islington, respectively). [1, 2]

In addition to the numbers already diagnosed, it is estimated that a significant proportion of mental health conditions go undiagnosed: among adults, there are an estimated 22,000 undiagnosed mental health conditions in Camden and 16,000 in Islington, and among children and young people, 1,600 in Camden and 1,760 in Islington. To determine this gap between diagnosed and expected (or total) prevalence, estimates have been produced, adjusted for local population and deprivation factors (particularly age, gender and ethnicity), where possible.

Mental health conditions in children and young people

It is estimated that half of all lifetime mental health conditions start by the age of 14, and three quarters by the mid-twenties. [3] In response, national and local policy is putting greater emphasis on early diagnosis and intervention, effective transition from child to adult services, and on the mental health of mothers during pregnancy and the first few years after birth. [4, 5]

Estimated prevalence of mental health conditions in children and young people

In Camden and Islington, Public Health England (PHE) estimates that about one-in-ten children aged 5-16 have a diagnosable mental health disorder, based on a major national survey carried out in 2004. Adjusted for age, sex and social class, it is estimated 2,408 children and young people aged 5-16 in Camden have diagnosable mental health conditions (9.1%, slightly lower than the national average), and 2,378 in Islington (10%, slightly higher than the national average).

In the local context, housing tenure is likely to be a better indicator of need, given the links to child poverty and other related risk factors for mental health conditions. Prevalence estimates adjusted for housing tenure gives what is known as the “preferred prevalence”. Children and young people living in social housing are significantly more likely to have a mental health disorder than average, and over twice as likely as those living in a house owned by their parents or caregiver. With 52% (20,279) of children in Camden living in social housing, and 63% (23,039) in Islington, compared with 31% in London and 21% in England and Wales, this will impact on the level of need in both boroughs.

Taking this into account, prevalence estimates for Camden and Islington are 33% higher in Camden and 30% in Islington, compared to national averages (Figure 2.1 and Figure 2.2). Overall, this methodology gives the preferred prevalence of 13% (3,230) in Camden and 14% (3,190) in Islington.

Boys are also more likely to be affected by mental health conditions than girls (nationally 11% of boys experience a mental health disorder, compared with 7.8% of girls); this is mainly linked to higher rates of conduct disorders and Attention Deficit Hyperactivity Disorder (ADHD) in boys. There are also ethnic differences in diagnosable mental health conditions, with Black communities having higher rates, and Asian communities lower levels, than the population average.

How many children are in treatment for mental health conditions?

The most recent data from Camden and Islington Child and Adolescent Mental Health Services (CAMHS) indicate that about 3,000 children and young people were being treated for mental health disorders, across the range of services offered.

In Islington about 1,430 children were being treated by CAMHS in 2011-2012, 5.9% of children and young people aged 5-17. Where recorded (about two-thirds of all service users), 40% of children were White, and 30% were from a Black ethnic group. A recent health equity audit, which compares use of services with estimates of need in different population groups, found that children aged 5-10 were significantly more likely to be seen by services than 11-16 year olds, and a lower proportion of need was seen in Black and Asian groups, although ethnicity recording was incomplete.

About 1,630 children and young people were being treated in Camden by CAMHS services in 2013-2014, about 4.2% of children and young people. Children and young people from White communities made up over half (53%) of all those in treatment, where ethnicity was recorded.

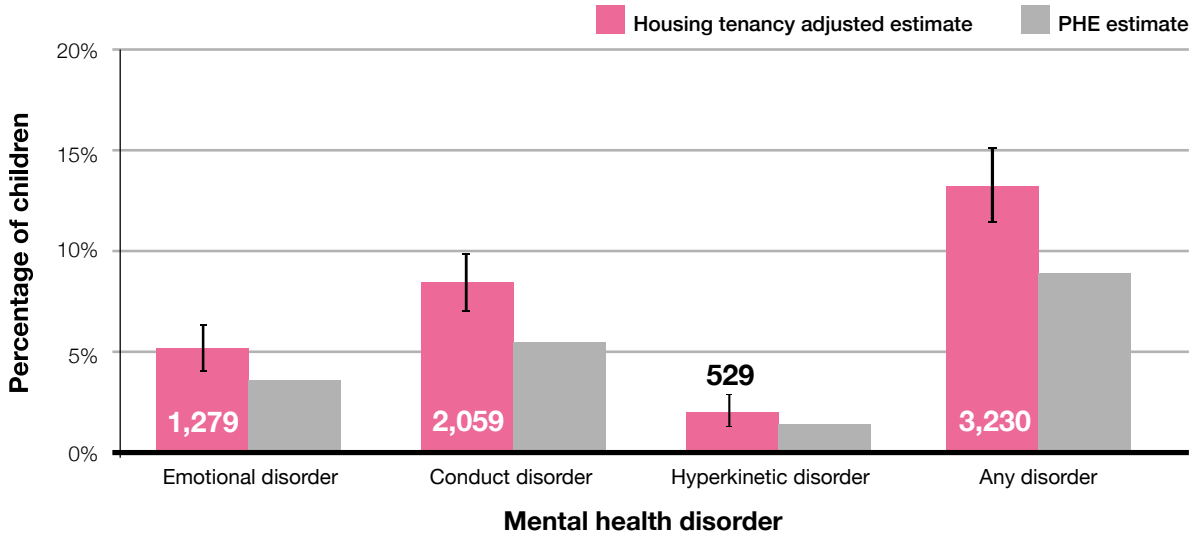
Diagnosed and estimated prevalence

Expected prevalence models are used for long term conditions to better understand the true scale of diagnoses. For this report, diagnosed (or recorded) prevalence is defined as the percentage of people living with diagnosed mental health conditions. For CMD, this will be people registered with a Camden or Islington GP practice and recorded as having any of these conditions in September 2012, the date of extracting the data from primary care records. For SMI and dementia, this is the number of people reported as being on GP practice registers as part of national reporting of the Quality and Outcomes Framework (QOF) in 2014-2015.

Estimated (total or expected) prevalence is a statistical estimate of the percentage of people who might be living with mental health conditions, regardless of whether it has been diagnosed or not. Estimates compare community prevalence with prevalence in primary care settings (e.g. QOF), usually at a GP practice level. As the true number of people living with an undiagnosed mental health condition is unknown, the estimate is obtained by statistical modelling, published literature, or nationally recognised estimates. Models differ in the factors adjusted for, but usually include deprivation, age, sex and ethnicity. In mental health conditions, estimates are based on studies carried out several years ago. There are concerns that they may not reflect current trends, for example the impact of austerity or social changes.

The proportion of people living with undiagnosed mental health conditions is the gap between diagnosed and estimated prevalence. The data presented are only an estimate of the numbers likely to be diagnosable with a condition at any point in time, and it is important to note that not everyone with the condition seeks, or wants, treatment, and some will already have received it.

Figure 2.1 Prevalence of mental health disorders among children aged 5 to 16 years, housing tenancy adjusted prevalence compared to PHE estimates, Camden resident population, 2014

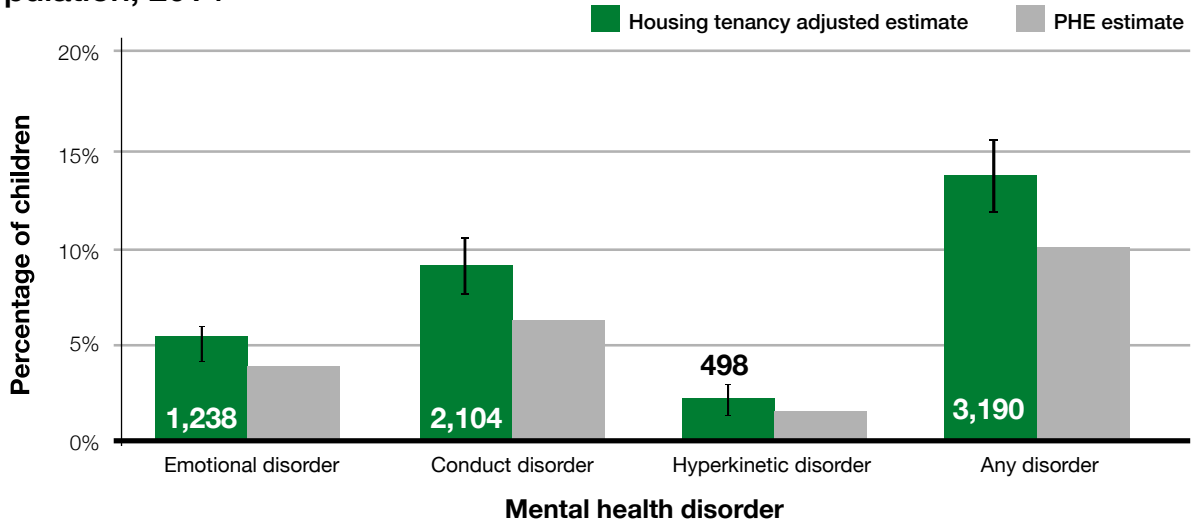


Note: Uncertainty estimates are not published by PHE for these estimates.

Source: Mental health of children and young people in Great Britain, 2004, ONS; 2011 Census; 2014 GLA; PHE Children's and young people's mental health and wellbeing profiles, updated October 2014

Camden

Figure 2.2 Prevalence of mental health disorders among children aged 5 to 16 years, housing tenancy adjusted prevalence compared to PHE estimates, Islington resident population, 2014

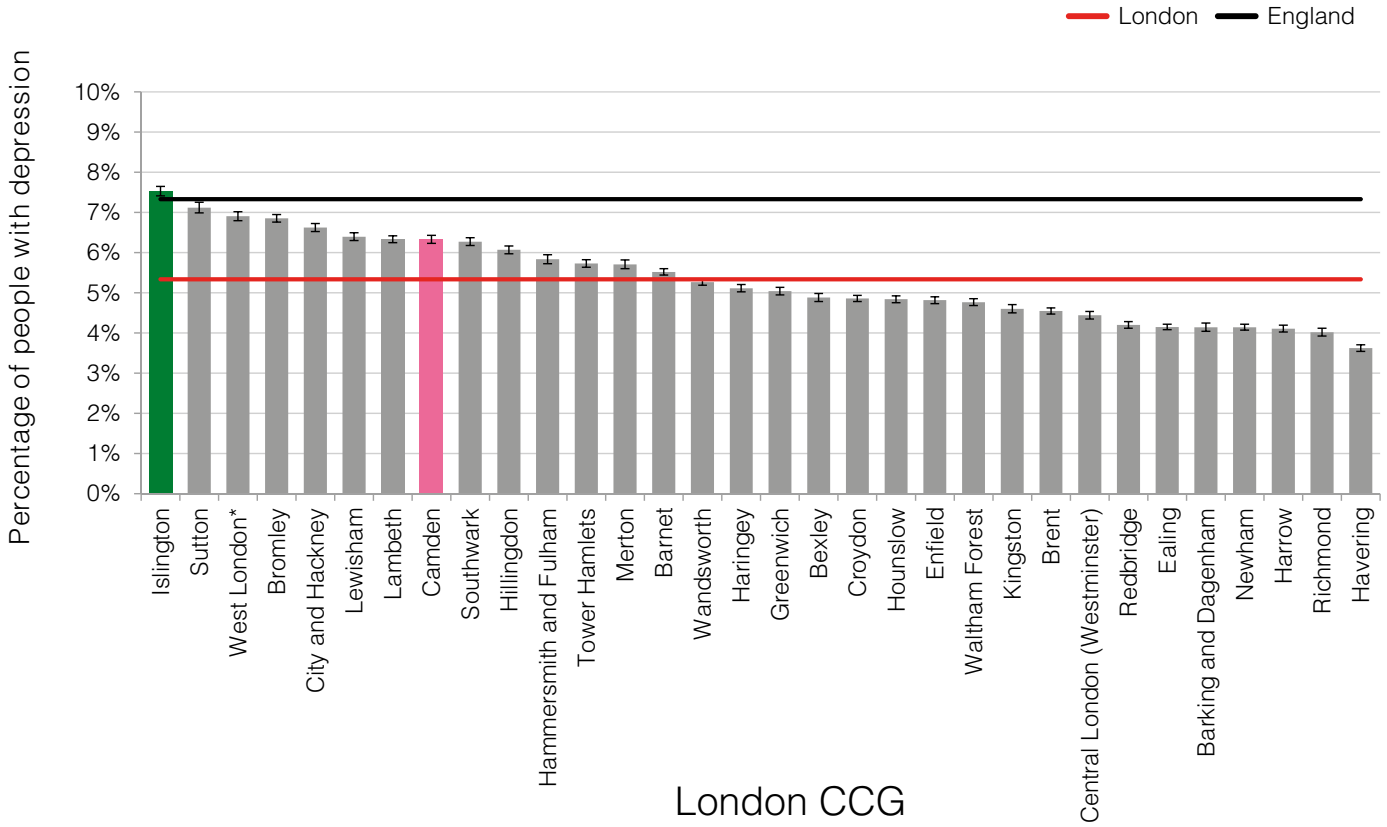


Note: Uncertainty estimates are not published by PHE for these estimates.

Source: Mental health of children and young people in Great Britain, 2004, ONS; 2011 Census; 2014 GLA; PHE Children's and young people's mental health and wellbeing profiles, updated October 2014

Islington

Figure 2.3 Prevalence of diagnosed depression, diagnosed since April 2006, London CCGs, compared to England, 2014-2015.



Source: HSCIC, Quality and Outcomes Framework (QOF), for April 2013 - March 2014
*Includes Kensington and Chelsea, Queen's Park and Paddington

Adult mental health conditions

Common mental health disorders in adults: depression and anxiety

CMDs include depression, anxiety and panic disorders. Many people have CMD at some point in their life. In Camden, local data show that 28,400 adults have diagnosed, unresolved depression or anxiety (14% of residents aged 18 and over) and in Islington, the equivalent figure is 29,900 (16%). About a third of people with diagnosed CMD have both depression and anxiety.

National data indicate that Islington had the highest diagnosed prevalence of depression, and Camden the eighth highest, in London (Figure 2.3). This national data collection from GP practices is more limited than local data. It collects depression but not anxiety, and is based only on the subset of patients diagnosed since 2006. Additionally, it is not sex- or age-adjusted and this must be considered in comparisons with other areas.

Estimated prevalence of CMD

Statistical estimates show that a large gap exists between the diagnosed and estimated prevalence of CMD, consistent with most national and international studies. Estimates for common and serious mental illnesses are based on the national Adult Psychiatric Morbidity Survey (APMS), where the probability of mental health disorders was based on a point score for a sample of households, so may not be directly comparable to actual diagnoses by a medical professional. Studies suggest that many people experiencing symptoms do not attend their GP, or if they do, they may not identify or disclose symptoms; there is also variation between different GPs, who may be more or less likely to

Mental health

How many people have a mental health condition?

Not all people living with a mental health condition have had their condition diagnosed. However, epidemiological models allow us to estimate the total number of people we would expect to have different mental health conditions in Camden (i.e. diagnosed and undiagnosed cases). This also allows us to estimate numbers of undiagnosed cases.

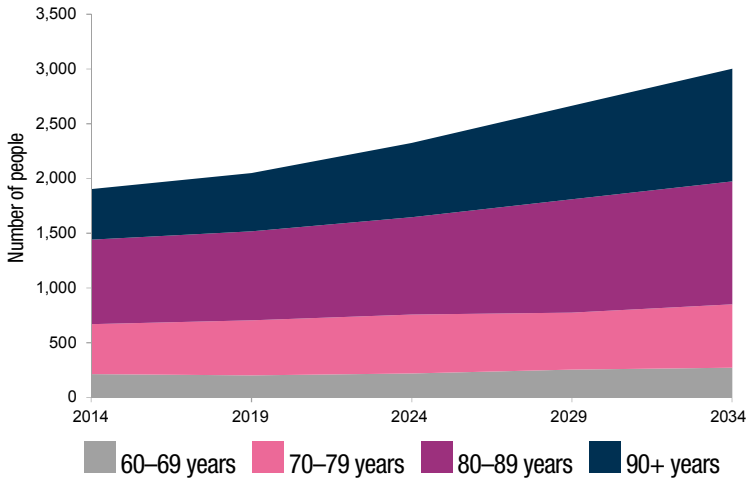
	All conditions in children (5-16yrs)*	Common mental disorders (16+)	Serious mental illness (16+)	Dementia (65+)
Percent of people **diagnosed** with condition	4%	14%	1.4%	4.53%
Percent of people **estimated** to have condition**	13%	24%	0.6%	6.59%
Number of people **diagnosed** with condition	1,629	28,397	3,668	1,071
Estimated number of people with an **undiagnosed condition**	1,601	21,424		487

Note: The borough has a **much higher rate of serious mental illness** than the UK average.

How many people might have a mental health condition in future?

The number of people with mental health conditions, particularly dementia, is expected to increase, based on predicted population growth and Camden's ageing population. Prevalence will also be affected by other factors such as increased case finding, although the effect of these changes is difficult to quantify.

Projected number of people with dementia in Camden by age group



Source: Dementia UK update, 2014 (prevalence); GLA 2014 (population estimates)

Based on **current estimates***** and projected growth in older age groups, there will be approximately **1,100** additional people with **dementia** in Camden in 20 years' time. There will be very significant growth in the oldest age groups.

Based on **current rates of diagnosis****** and projected population growth in Camden, in 20 years time there will be:

4,500 additional cases of **common mental disorders**

500 additional cases of **serious mental illness**

* Diagnosed number of children are aged 0-17. ** Common mental disorders: estimated applying the local prevalence estimation from Hatch SL, Woodhead C, Frissa S, Fear NT, Verdecchia M, et al. (2012) Importance of Thinking Locally for Mental Health: Data from Cross-Sectional Surveys Representing South East London and England, to GLA 2014 population estimation for ages 16 and over; Serious mental illness: PHE SMI Profile, Jan 2015 Mental ill health in children: PHE Children and Young People Mental Health Profile, Jan 2015 ***Dementia UK update, 2014; GLA 2014 population projections ****GP Public Health Dataset, 2012; GLA 2014 population projections

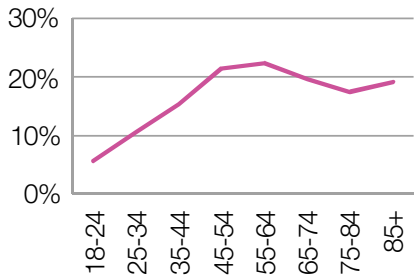
Who is more likely to be diagnosed with a mental health condition?

In addition to high mental health need locally compared to England, there are inequalities in the levels of mental health conditions between different groups in Camden. Patterns vary between conditions and also with demographic factors like age, sex, ethnicity and socioeconomic deprivation.

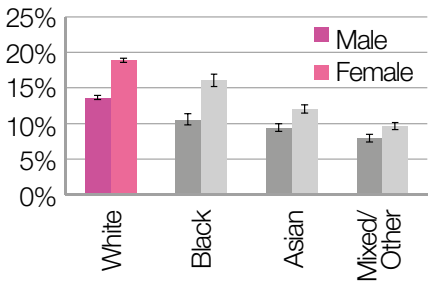
Common mental health disorders

Is more common in **middle aged and older people; women; white people and those that live in the most deprived areas**

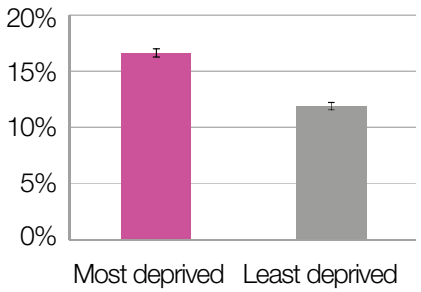
Age



Sex & Ethnicity



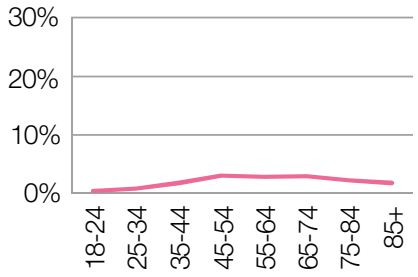
Deprivation



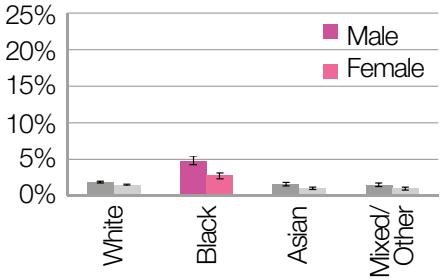
Serious mental illness

Is more common in **black men and black women** and those that live in the **most deprived areas**

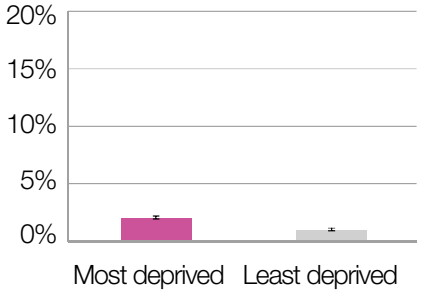
Age



Sex & Ethnicity



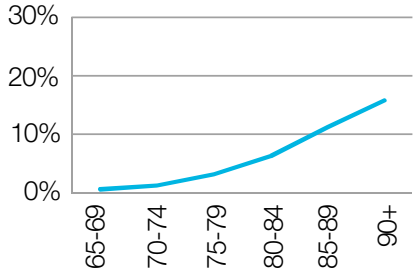
Deprivation



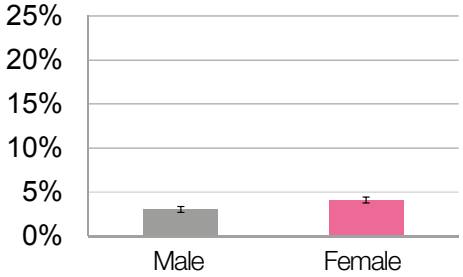
Dementia (65+)

Is more common as **age increases** and in **women**

Age



Sex



Deprivation & Ethnicity

Dementia does not show significant difference between ethnic groups and deprivation levels

Camden

Mental health

How many people have a mental health condition?

Not all people living with a mental health condition have had their condition diagnosed. However, epidemiological models allow us to estimate the total number of people we would expect to have different mental health conditions in Islington (i.e. diagnosed and undiagnosed cases). This also allows us to estimate numbers of undiagnosed cases.

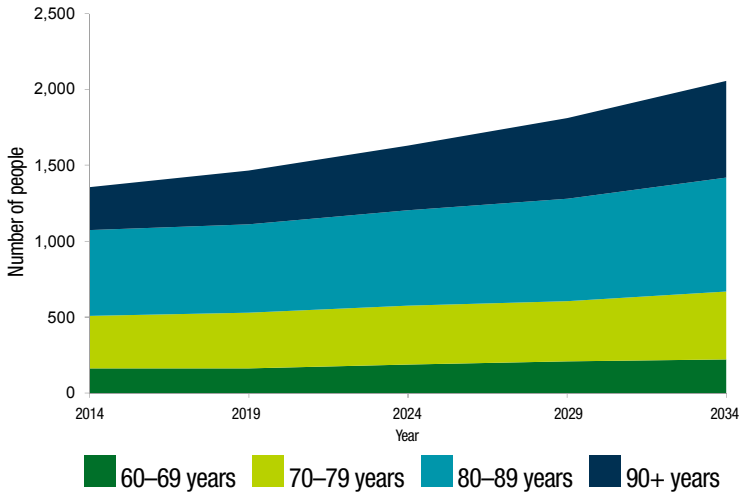
	All conditions in children (5-17yrs)*	Common mental disorders (16+)	Serious mental illness (16+)	Dementia (65+)
Percent of people **diagnosed** with condition	6%	16%	1.5%	4.97%
Percent of people **estimated** to have condition**	14%	24%	0.7%	6.39%
Number of people **diagnosed** with condition	1,430	29,942	3,498	1,030
Estimated number of people with an **undiagnosed** condition	1,760	15,897		293

Note: The borough has a **much higher rate of serious mental illness** than the UK average.

How many people might have a mental health condition in future?

The number of people with mental health conditions, particularly dementia, is expected to increase, based on predicted population growth and Islington's ageing population. Prevalence will also be affected by other factors such as increased case finding, although the effect of these changes is difficult to quantify.

Projected number of people with dementia in Islington by age group



Source: Dementia UK update, 2014 (prevalence); GLA, 2014 (population estimates)

Based on **current estimates***** and projected growth in older age groups, there will be approximately **700** additional people with **dementia** in Islington in 20 years' time. There will be very significant growth in the oldest age groups.

Based on **current rates of diagnosis****** and projected population growth in Islington, in 20 years time there will be:

5,000 additional cases of **common mental disorders**

500 additional cases of **serious mental illness**

* Diagnosed number from Islington Child and Adolescent Mental Health Services Needs Assessment. February 2013, Department of Public Health, NHS Islington and London Borough of Islington.** Common mental disorders: estimated applying the local prevalence estimation from Hatch SL, Woodhead C, Frissa S, Fear NT, Verdecchia M, et al. (2012) Importance of Thinking Locally for Mental Health: Data from Cross-Sectional Surveys Representing South East London and England, to GLA 2014 population estimation for ages 16 and over; Serious mental illness: PHE SMI Profile, Jan 2015 Mental ill health in children: PHE Children and Young People Mental Health Profile, Jan 2015 ***Dementia UK update, 2014; GLA 2014 population projections ****GP Public Health Dataset, 2012; GLA 2014 population projections

Islington

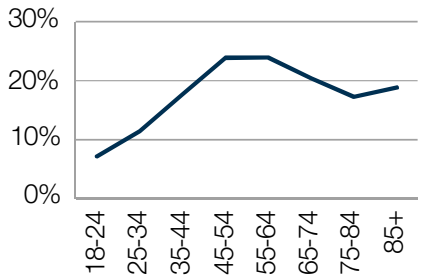
Who is more likely to be diagnosed with a mental health condition?

In addition to high mental health need locally compared to England, there are inequalities in the levels of mental health conditions between different groups in Islington. Patterns vary between conditions and also with demographic factors like age, sex, ethnicity and socioeconomic deprivation.

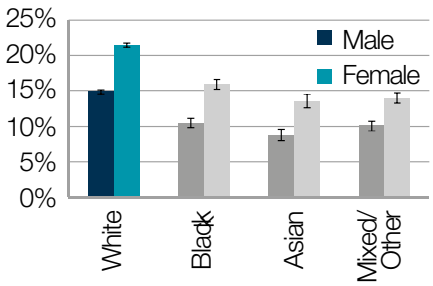
Common mental disorders

Is more common in **middle aged** and **older people; women; white** people and those that live in the **most deprived areas**

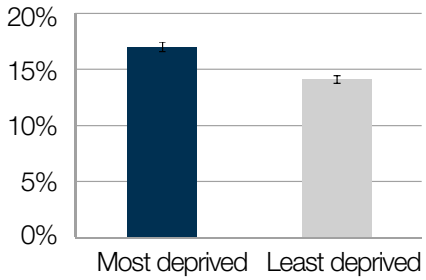
Age



Sex & Ethnicity



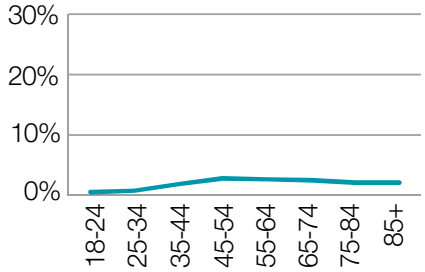
Deprivation



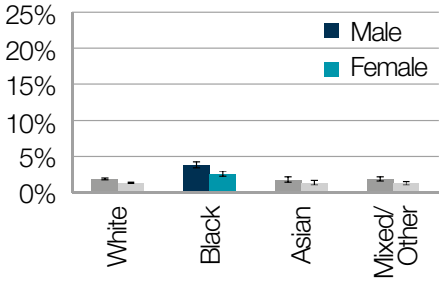
Serious mental illness

Is more common in **black men** and **black women** and those that live in the **most deprived areas**

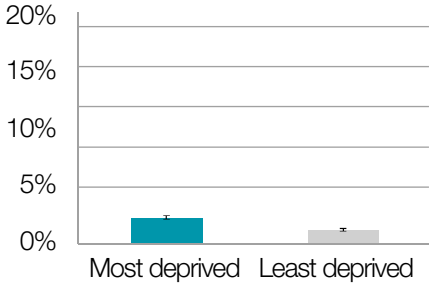
Age



Sex & Ethnicity



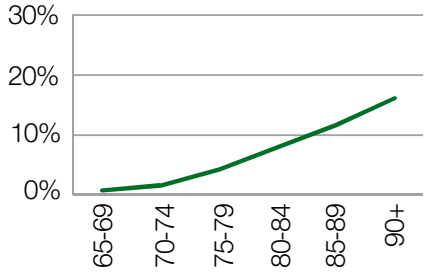
Deprivation



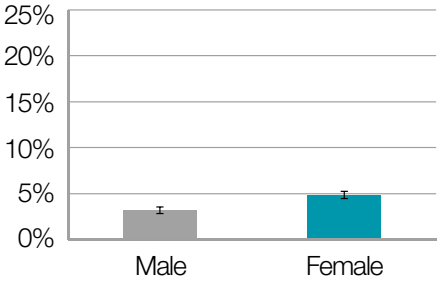
Dementia (65+)

Is more common as **age increases** and **in women**

Age



Sex & Ethnicity



Deprivation & Ethnicity

Dementia does not show significant difference between ethnic groups and deprivation levels

Islington

recognise or diagnose symptoms. [6]

Similar to children and young people, there are nationally produced estimates of local prevalence published by PHE. These are based on national surveys conducted several years ago and may not be fully reflective of local population characteristics or circumstances. The most commonly used is based on the 2000 National Psychiatric Morbidity Survey, using the 2008 population, and gives estimates of 40,670 and 33,160 adults with CMD in Camden and Islington, respectively. [7]

A more recent survey, using a similar methodology, carried out in two inner London boroughs, has therefore been used as the basis for a preferred prevalence estimate. Based on current population estimates, this calculates 49,820 residents aged 16 and over with CMD in Camden, and 45,840 in Islington. [8] This indicates that only 57% of all estimated cases of CMD in adults aged over 16 have been diagnosed in Camden, and in Islington, 65% of estimated cases. This equates to about 21,000 undiagnosed cases in Camden and 16,000 in Islington.

Who is living with diagnosed CMD?

Local data show that women are significantly more likely to be diagnosed with CMD than men in both boroughs - almost two thirds of those diagnosed. This is very similar to national surveys which find depression rates in women close to twice that of men.

Diagnosed CMDs are common in all age groups in Camden and Islington, but with significant differences, only some of which can be explained by what we know about the underlying rates of depression and anxiety from published studies. Prevalence increases until middle age – from 6% and 7% among 18 to 24 years to 21% and 24% among 45 to 54 years for Camden and Islington respectively. CMD prevalence then falls in older age groups to 17%.

Where recorded, the majority of people with CMD in both boroughs are White (77% and 79% of all adults with CMD in Camden and Islington respectively), reflecting the ethnic structures of the boroughs' populations.

There are however, differences in prevalence of CMD by ethnic group. People of all White backgrounds are significantly more likely to be diagnosed with CMD than all adults (16% compared to 15% in Camden; 18% compared to 17% in Islington). Of the major ethnic groups, prevalence of CMD is significantly higher than average among White British (20% in Camden and 21% in Islington), White Irish (23% in both boroughs) and Black Caribbean adults (18% in Camden and 17% in Islington). Furthermore, in Camden, Black women are significantly more likely to be diagnosed (16%) than women in general (14%). In both Camden and Islington, the Asian and Chinese populations are significantly less likely to be diagnosed than the average (9% for both boroughs).

Freefall into mental ill-health

Sinéad suffers from depression, which began when she separated from her husband and soon after she had to leave her job in catering. She is anxious about the Work Capability Assessment and fears she will lose her incapacity benefit. She is very keen to get another job, yet worries that she will not be able to find a suitable position with an employer who understands her illness.

Source: Cripplegate Foundation, 2013. Distant Neighbours. Poverty and inequality in Islington

There are a number of factors which could account for these differences between ethnic groups, including the distribution of healthy lifestyle behaviours (such as alcohol and drug use), differences in the level of deprivation, or ethnic and cultural variations in health behaviours and seeking treatment. Differing cultural attitudes and beliefs towards mental health conditions are also likely to play a role in help seeking or how symptoms are expressed, and how those are understood by primary care or other health and social care professionals. Language or other communication barriers may also play a role in some groups.

Duration of CMD is striking (Figure 2.4 and Figure 2.5). Among 18-24 year olds, almost three-quarters were diagnosed within the last

Figure 2.4 Percentage of people diagnosed with CMD by age group and year since diagnosis, Camden, registered population aged 18 and over, September 2012

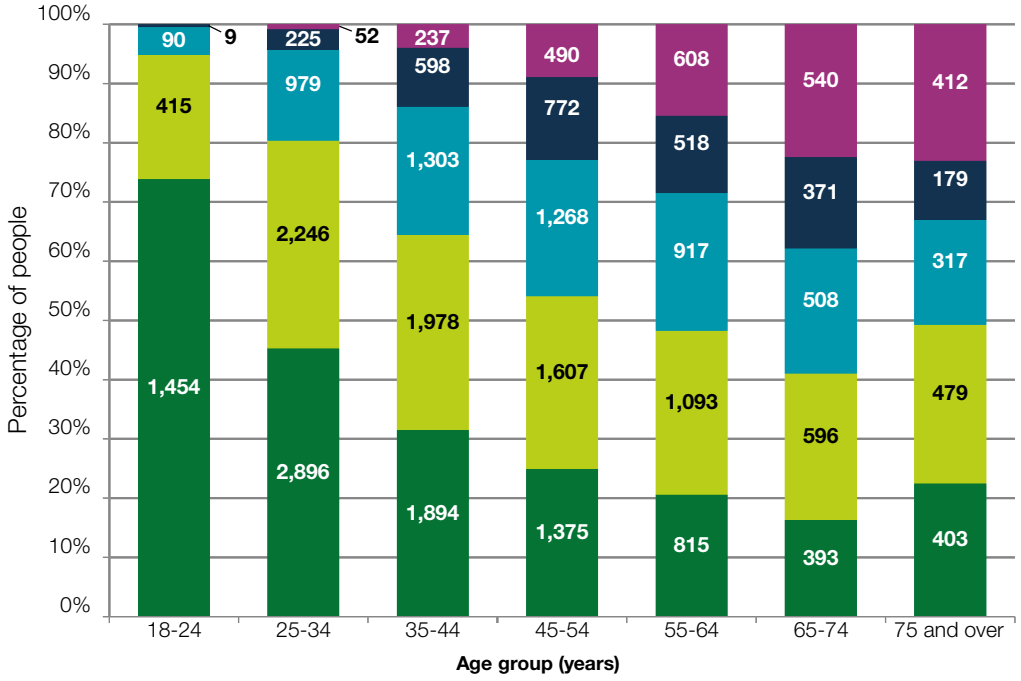
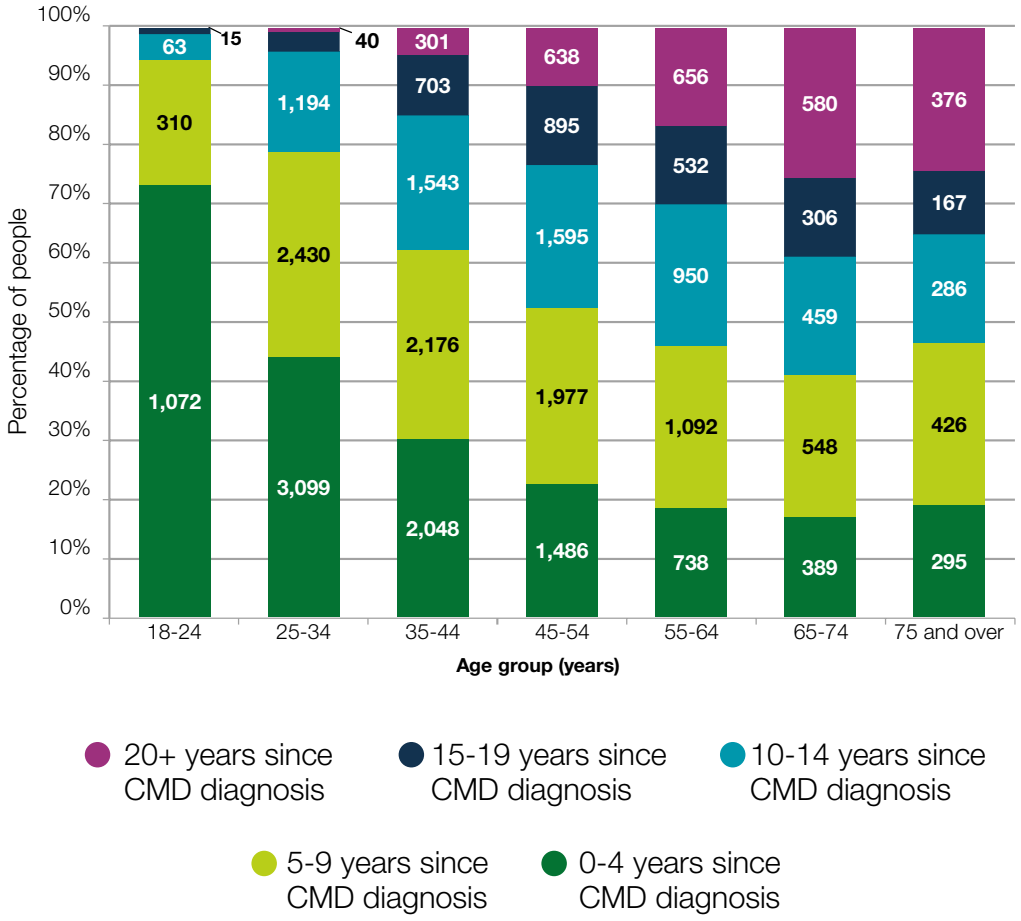


Figure 2.5 Percentage of people diagnosed with CMD by age group and year since diagnosis, Islington, registered population aged 18 and over, September 2012



Note: Numbers on the bars indicate the number of people diagnosed with CMD in each age group by years since their CMD diagnosis 245 people with incomplete data on derepssion/anxiety diagnosis dates are excluded in this analysis.
Source: Islington GP Public Health dataset, 2012 .

Source: HSCIC, Quality and Outcomes Framework (QOF) for April 2013 - March 2014

The circles show how the likelihood (odds) of having a diagnosis of one or more mental health conditions varies according to different demographic risk factors. Age group, sex, ethnicity and GP practice size all have a statistically significant effect on the odds of having a CMD, and the combination of these factors will also affect the likelihood of a diagnosis. The odds are compared to the groups of people with the lowest odds (smallest circle).

Figure 2.6 Modelling prevalence of CMD: increasing odds of diagnosed prevalence, Camden

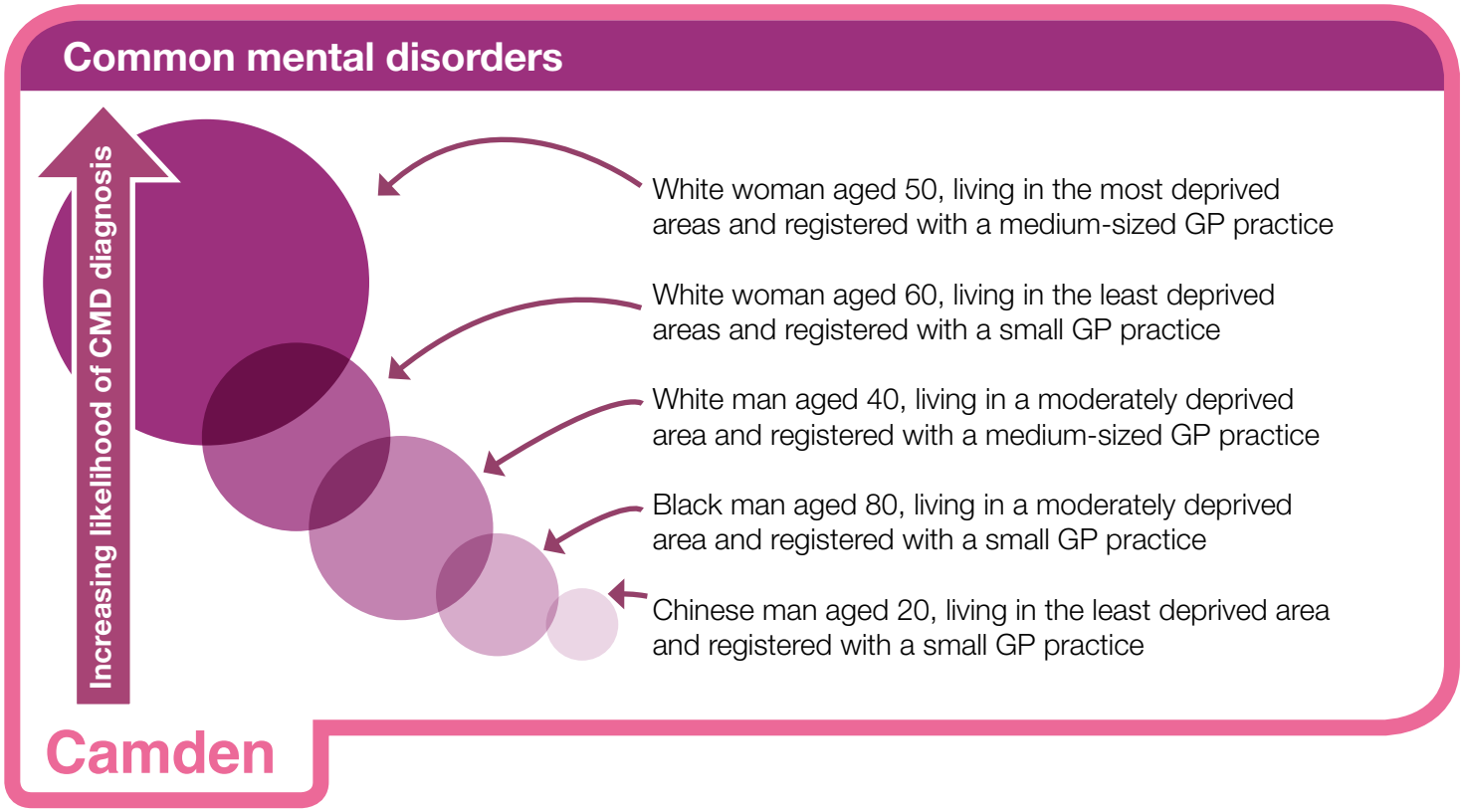
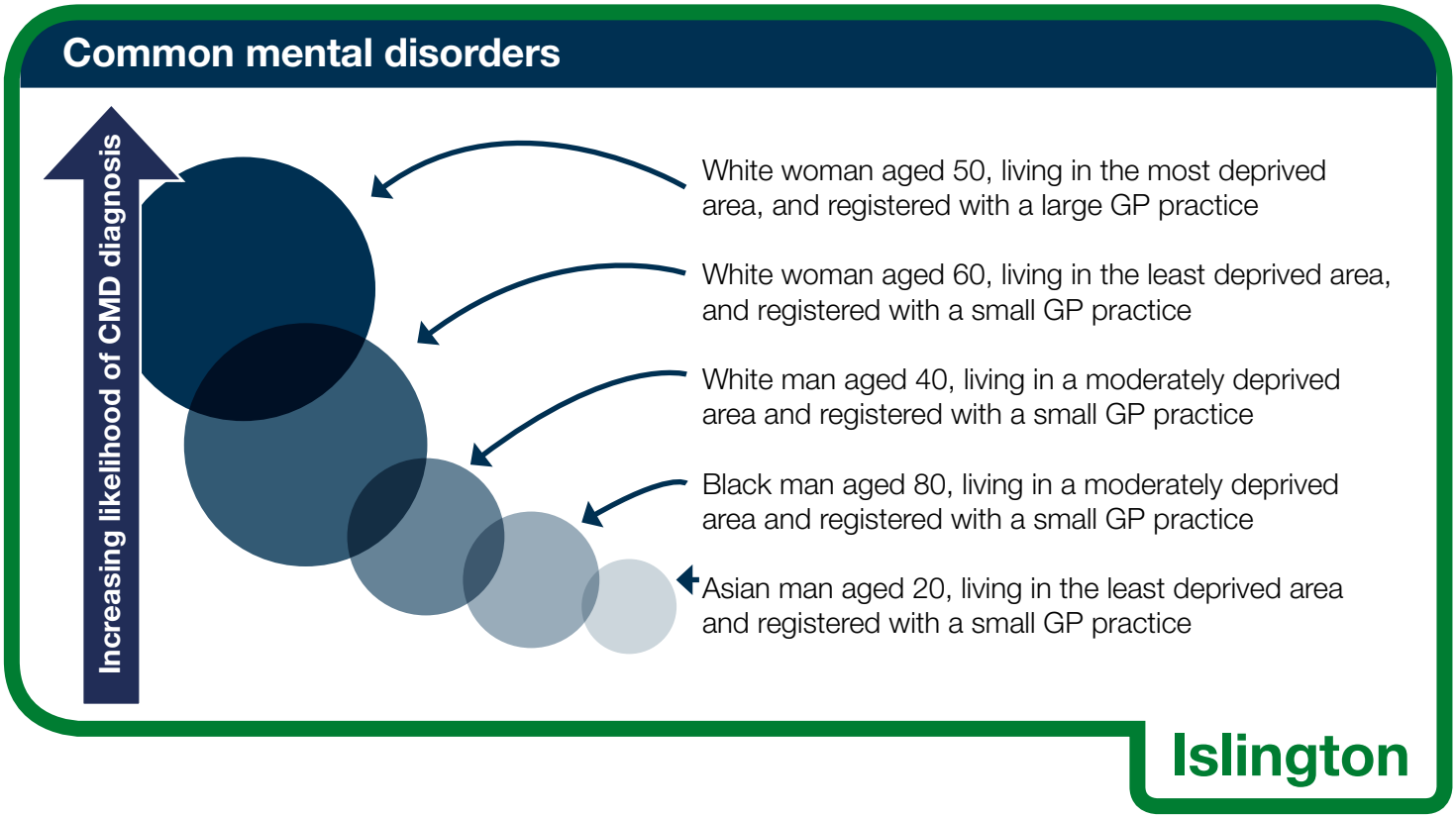


Figure 2.7 Modelling prevalence of CMD: increasing odds of diagnosed prevalence, Islington



four years. However, in all other age groups, starting with 25-34 year olds, the majority had been diagnosed for more than four years, and over half of people aged over 55 had been diagnosed for 10 years or longer.

Statistical modelling to examine the likelihood of being diagnosed with a CMD in relation to a number of characteristics, identifies some significant differences in the likelihood of a diagnosis between groups (Figure 2.6 and Figure 2.7). For example, the odds of having a CMD diagnosis for a 50 year old White woman, registered with a medium sized GP practice and who is living in the most deprived areas of Camden or Islington are 20 times and 9 times higher respectively than the group with the lowest odds (for example, a 20 year old Chinese man registered with a small GP practice who is living in the least deprived area).

People living in the most deprived areas of Camden and Islington are significantly more likely to have diagnosed CMD. Diagnosed prevalence in the most deprived areas of Camden is 39% higher than the least deprived, and in Islington it is 20% higher. Adjusting for factors such as age and sex, the odds of having a CMD diagnosis in Camden are 53% higher for people living in the most deprived areas and in Islington, with its more mixed pattern of poverty and wealth at a local level, the equivalent figure is 26%.

Of all people with diagnosed depression, 77% in Camden and 83% in Islington were on antidepressant medication, of which about half (52% in Camden and 51% in Islington) had been on medication for two years or more.

Diagnosed prevalence also differs widely by general practice, even after adjusting for age. In Camden, 7 practices had a significantly higher prevalence than average, and 17 were lower. In Islington, 14 were significantly higher than average, and 14 below. In general, referrals to IAPT services follow a similar pattern, with practices with low diagnosis rates also having lower referral rates, although there are exceptions to this. Some of the differences between practices may be explained by natural variation or other factors such as the demographic and socioeconomic profile of practice populations. It is, however, unlikely that these factors alone can account for the significant variation in diagnosis rates, pointing to the continued importance of supporting education and development for GP practices.

In 2011-2012, there were over 1,200 hospital admissions in Camden and over 1,500 in Islington for depression-related reasons, with the largest reason for admission due to poisoning and other external causes, indicating the increased risks of self-harm and risk of suicide associated with depression.

Serious Mental Illness

Serious mental illnesses (SMI) include psychotic conditions, such as schizophrenia and bi-polar disorder, and are associated with significant disability, high levels of social exclusion and significantly reduced life expectancy. People with an SMI are almost four times more likely to have depression than the general population.

Estimated prevalence of SMI

Estimates of SMI prevalence, calculated by PHE, are used to inform planning and CCG resource allocations. These estimates are based on the overall prevalence of SMI published in the Annual Psychiatric Morbidity Survey (APMS), adjusted for age, sex and mental health care available in the area. [9] For Camden and Islington, these estimates (0.6% and 0.7% respectively) are significantly lower than the diagnosed prevalence recorded in general practice, indicating a higher level of need than that used for planning purposes and a potential gap in funding based on the current recorded prevalence of SMI.

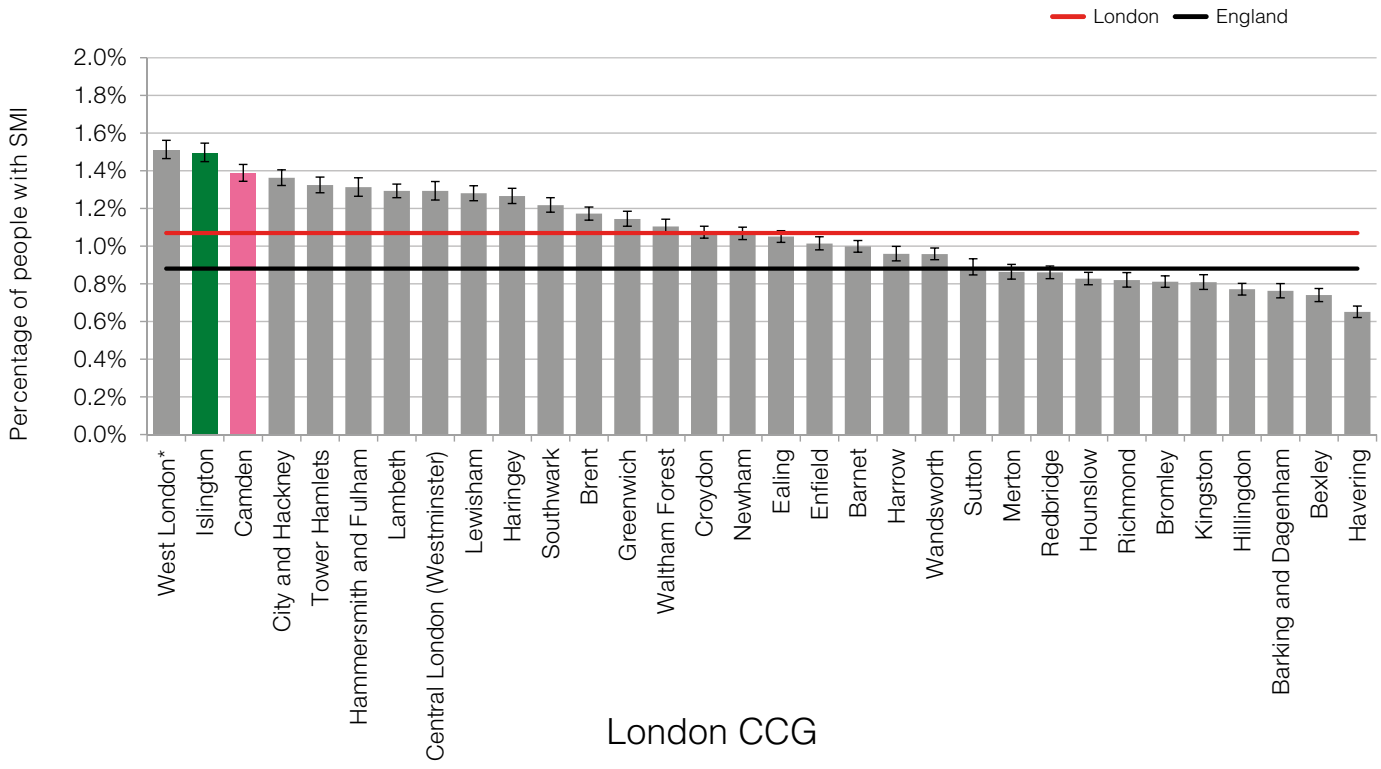
Who is living with diagnosed SMI?

In 2014-2015, Islington had the second highest diagnosed prevalence of SMI in the country at 1.50% (3,498 people), and Camden the third highest prevalence at 1.39% (3,668 people), significantly higher than the London and England averages (Figure 2.8). About 75% of people with diagnosed SMI in Camden and 80% in Islington have psychoses (including schizophrenia), while the remaining 20%-25% are diagnosed with a bipolar disorder.

Local data show that prevalence is higher in men than women in both boroughs (1.8% compared with 1.3% for Camden; 1.9% compared with 1.4% for Islington), a common pattern for SMI. The average age at diagnosis is 37 in Camden and 34 in Islington with the highest prevalence in the 45-54 age group in both boroughs. Just over a quarter of people with SMI (26% in both boroughs) were diagnosed four years ago or less; half have been diagnosed for ten years or more.

About two-thirds of people in Camden and Islington with SMI are of White ethnicity, where recorded (67%). In Islington, the prevalence of SMI within the White group is significantly lower than average for those with recorded ethnicity (1.7% compared to 1.8%), but there was no significant difference in prevalence between White people and the average in Camden. Black men and women, from Caribbean, African, Black British and Black Other groups, are significantly over-represented among people with SMI, a pattern which is seen nationally and in published literature. In Camden, and in Islington, the prevalence of SMI in Black people (3.6% and 3.1% respectively), is significantly higher compared to the general population (1.7% and 1.8% respectively) among those with recorded ethnicity – with prevalence in Black Caribbeans 5.1% in Camden and 4.5% in Islington. This pattern is further pronounced when broken down by gender – 4.8% of Black men have diagnosed SMI compared to 2.7% of Black women in Camden, with 3.8% and 2.6% in Islington. Even after adjusting for factors such as age, sex and

Figure 2.8 Diagnosed Prevalence of Serious Mental Illness, London CCGs compared to England, 2014-2015



Source: HSCIC, Quality and Outcomes Framework (QOF) for April 2013 - March 2014
*Includes Kensington and Chelsea, Queen's Park and Paddington

The circles show how the likelihood (odds) of having a diagnosis of one or more mental health conditions varies according to different demographic risk factors. Age group, sex, ethnicity and GP practice size all have a statistically significant effect on the odds of having SMI diagnosis, and the combination of these factors will also affect the likelihood of a diagnosis. The odds are compared to the groups of people with the lowest odds (smallest circle).

Figure 2.9 Modelling prevalence of SMI: increasing odds of diagnosed prevalence, Camden

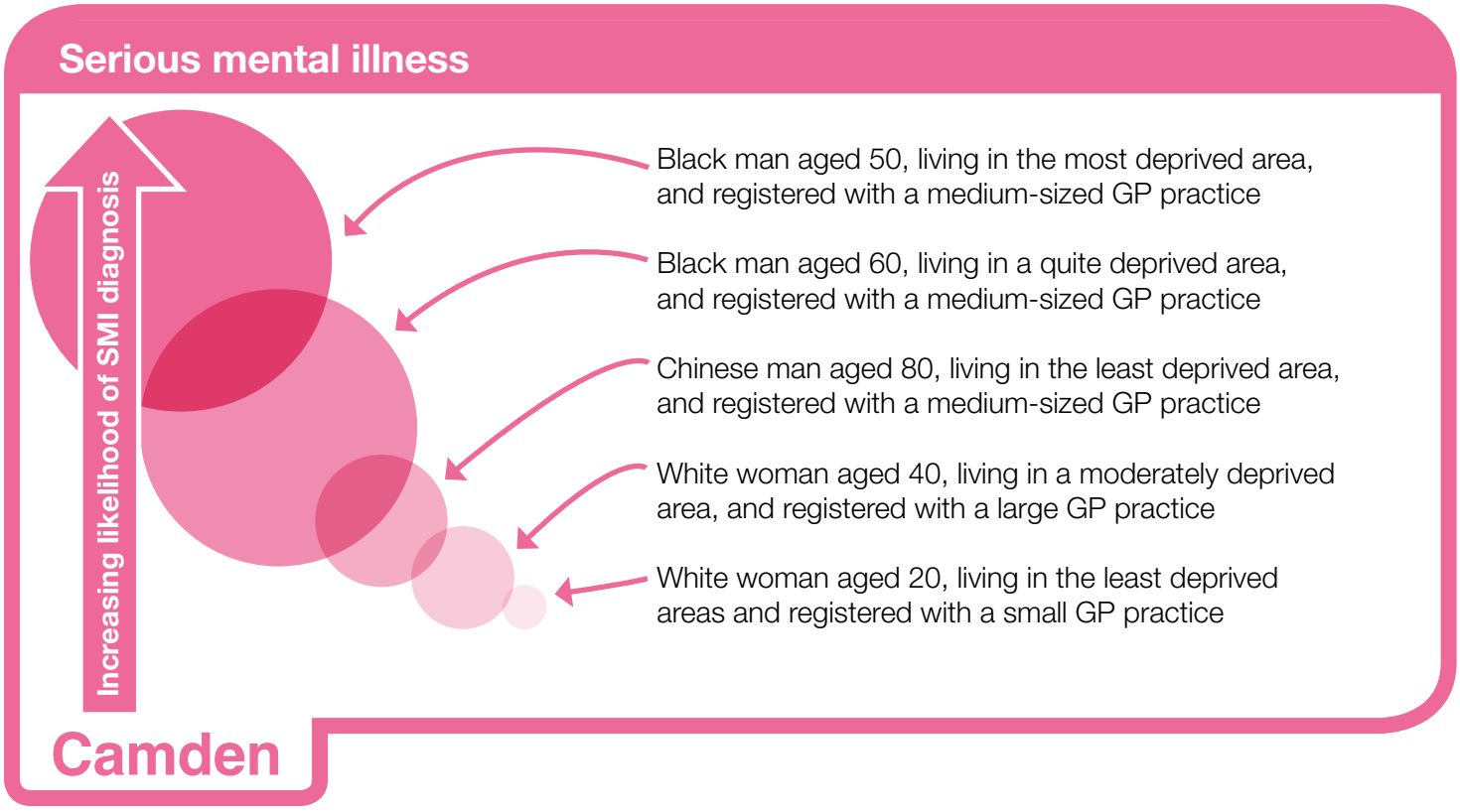
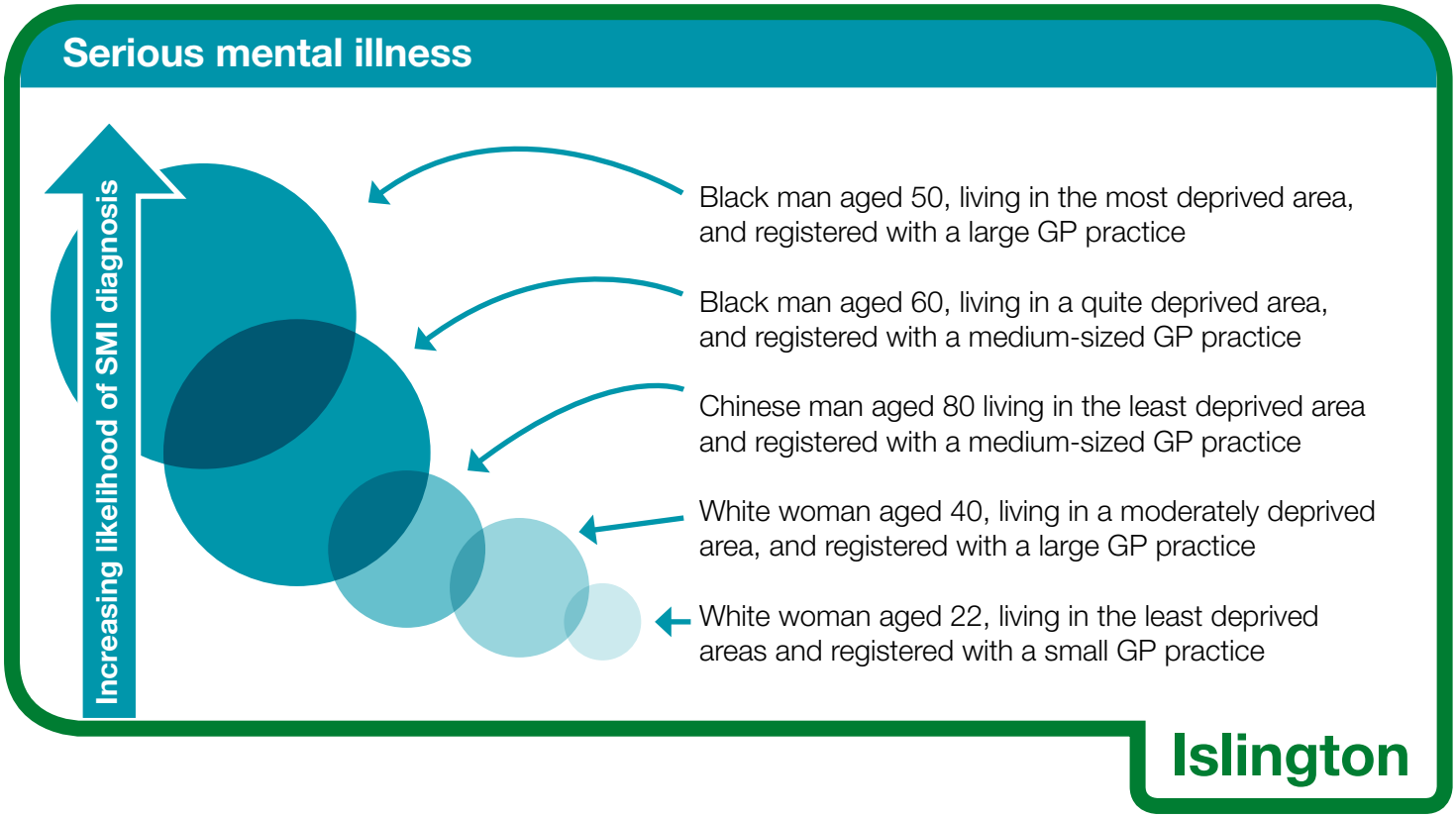


Figure 2.10 Modelling prevalence of SMI: increasing odds of diagnosed prevalence, Islington



deprivation level, Black people in Camden and Islington are still more than twice as likely as White people to have a SMI diagnosis (2.3 and 2.1 times, respectively).

People living in the most deprived areas of Camden are over 80% more likely, and in Islington 70% more likely, to have a diagnosed SMI compared to the general population. In Islington, there is a clear increase in the prevalence of SMI by density of social housing, with a significantly higher prevalence in areas with more than 80% of social housing (3.1% compared to 1.5%). This could be because people with SMI are more likely to live in social housing, rather than social housing being causally related to SMI. Similar data are unavailable for Camden.

Adjusting rates of SMI using statistical modelling shows the groups with highest odds of a diagnosis of SMI (Figure 2.9 and Figure 2.10). The odds were almost 20 times higher in Camden and 7 times higher in Islington for men in their middle ages (45-54 years) of Black ethnicity, living in the most deprived areas, registered with a large GP practice, compared to the population group with the lowest odds (White women aged under 25 years living in the least deprived areas who are registered with a small GP practice).

Dementia

Up to a third of older people are expected to develop dementia during their lifetime but, at least until recently, the condition has been significantly under diagnosed. Improving the diagnosis of dementia has been an important priority for the current government, with a national goal to increase the diagnosis of dementia to at least 65% of estimated of the estimated prevalence by March 2015. [10]

Estimated prevalence of dementia

An expected prevalence tool has been produced for dementia, using a combination of data sources including the age and sex structure of the population, as well as the size of the nursing home population. [11] The estimated prevalence of the condition rises with increasing older age, with the highest rates among people in their 80s and 90s. It is estimated that 6.59% of adults in Camden aged over 65 have dementia (1,558 people in Camden) and 6.39% in Islington (1,323), similar to the estimated prevalence for London as a whole, but lower than England. For Camden and Islington, about one in eight people with dementia are expected to be living in nursing homes (12%). According to these estimates, 69% of all expected cases of dementia had been diagnosed in Camden and 78% in Islington as at March 2015. Islington's diagnosis rate is the highest in London, with Camden tenth highest. Both boroughs are comfortably above the London and England averages (66% and 61% respectively).

Who is living with diagnosed dementia?

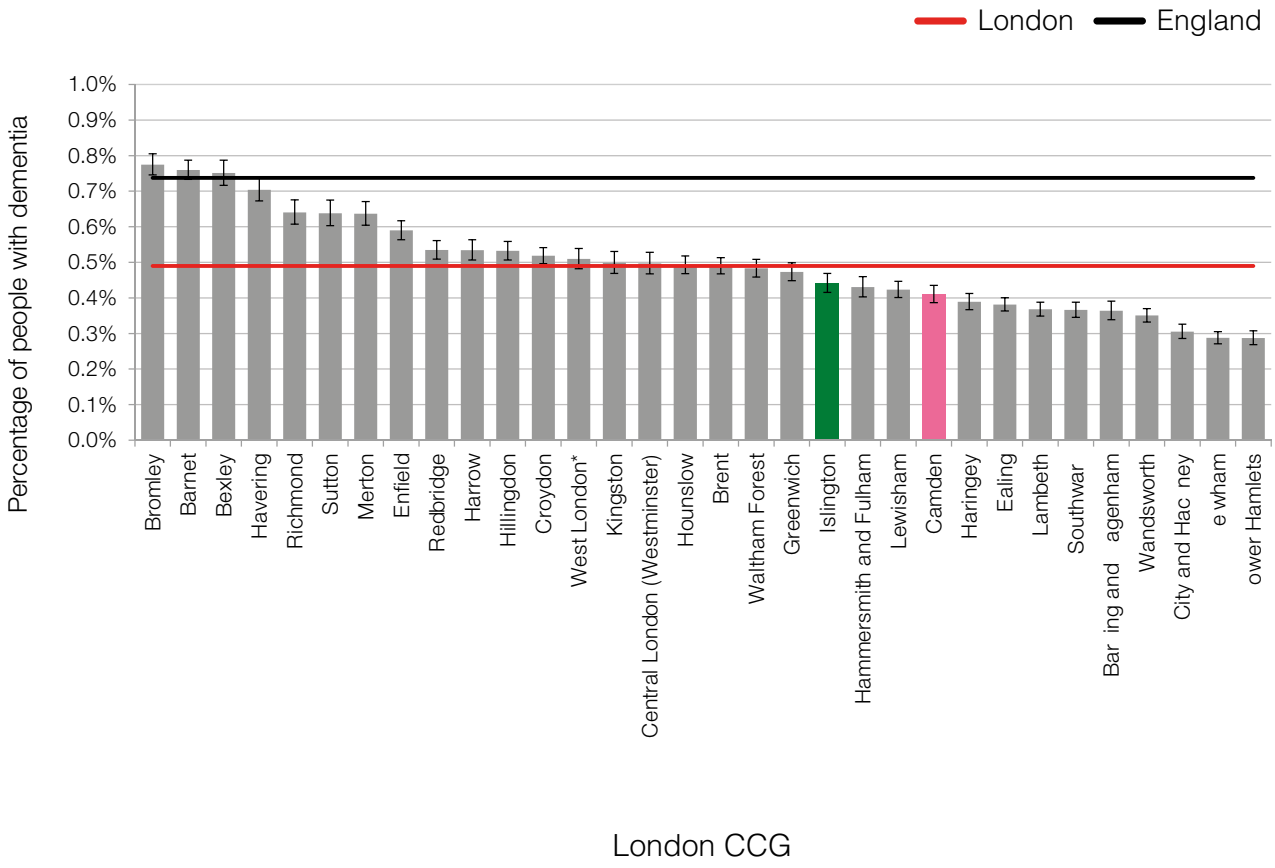
In 2014-2015, 1,071 (4.5%) people were living with diagnosed dementia in Camden, and 1,030 in Islington, 4.97% of the population aged 65 and over in both boroughs. The prevalence of diagnosed dementia in Camden and Islington (0.4% of the whole population in both boroughs) was significantly lower to the London and England averages (Figure 2.11). This is explained by the younger age structure of the populations in both boroughs when compared to England.

Women make up almost two thirds of those diagnosed in both boroughs. This is partly due to longer life expectancy compared to men and a higher proportion of expected prevalence diagnosed in women.

Average age at diagnosis is 80 in Camden and 79 in Islington: prevalence peaks in the early 80s. Prevalence does not differ significantly by ethnicity, although this may be due to relatively smaller numbers of BME groups among adults aged over 65. There is no clear trend by deprivation in either Camden or Islington; though in Islington, areas with a high density of social housing have a significantly higher prevalence of dementia among those aged 65 and over (5.8%) compared to other areas (less than 4%).

Dementia is strongly linked to older age, however early onset dementia (under 65 years old) can also occur. Across the two boroughs, there were fewer than twenty diagnosed cases of early onset dementia in 2011-2012.

Figure 2.11 Diagnosed Prevalence of dementia, London CCGs compared to England, 2014-2015



Source: HSCIC, Quality and Outcomes Framework (QOF) for April 2013 - March 2014
*Includes Kensington and Chelsea, Queen's Park and Paddington

Suicide

Suicide rates have reduced in recent years in both Camden and Islington. However, it remains an important cause of potentially preventable deaths, particularly for younger and middle-aged men, with devastating and lasting impacts on those bereaved. On average, 16 deaths per year in both boroughs are due to suicide or undetermined intent. Suicide and self-harm are covered in Chapter 7.

Future Trends

The numbers of adults with mental health conditions is expected to increase over the next 15 years. There are likely to be approximately an extra 5,500 cases in each borough, based on population growth estimates. CMD will make up the majority of the increase, but the number of people with dementia will see the largest percentage change (Table 2.1). In the long term, it is predicted that the number of people with dementia will double by 2050 with the fastest percentage growth expected amongst people aged 85 and over.

Based on current estimates of population change, and the proportion of children living in social housing remaining constant, the number of children with any mental health condition in Camden is likely to decrease by 0.4% by 2030, as the number of children resident in the borough falls (13 fewer children with a mental health condition). Conversely, Islington's population aged 5-16 will grow in that time. In 15 years there could be an additional 570 children diagnosed with a mental health condition living in Islington (3,760 in total).

The economic impact of mental health conditions

Nationally, it has been estimated that mental health conditions cost the economy over £100 billion each year. Mental health conditions are the key cause of sickness absence in the UK, accounting for about one in five of all working days lost to sickness, [12] and have further economic impacts through lost economic output, due to early death, serious disability and lower productivity, often linked to untreated or unsupported mental health conditions. [13] The combined impact on employers is about £25 billion a year, nationally.

The Greater London Authority (GLA) published its report, London Mental Health: The invisible costs of mental health in 2014. [3] This set out a methodology for trying to 'capture' and cost the known impacts of mental health conditions across the capital, in terms of health, economic and social impacts. The analysis includes direct economic measures, such as the costs to health and social care services or lost productivity and outputs in the economy, but also incorporates cost estimates for important 'non-market' impacts, in particular on quality of life or informal caring. The perspective of the GLA analysis is one that considers the overall costs across the whole community. However, it is important to remember that the greatest individual costs and inequalities are experienced by people with mental health conditions and their families and carers.

The methodology used by GLA has been repeated to estimate the annual impacts of mental health conditions in Camden and Islington, resulting in a cost estimate of £764m in Camden and £650m in Islington (Figure 2.12 and Figure 2.13). The main impacts are:

- **The treatment and care of people with mental health conditions**, which include the direct costs of mental health treatment and care in primary and secondary care services, as well as the increased physical health care costs for long term conditions and medically unexplained symptoms associated with mental ill health. Informal care for people with mental health conditions is also important. The local NHS reports the highest direct expenditure on mental health conditions in England, [14] but the analysis shows that in both Camden and Islington this forms only a small part of the total economic impacts of mental health conditions for the local communities.

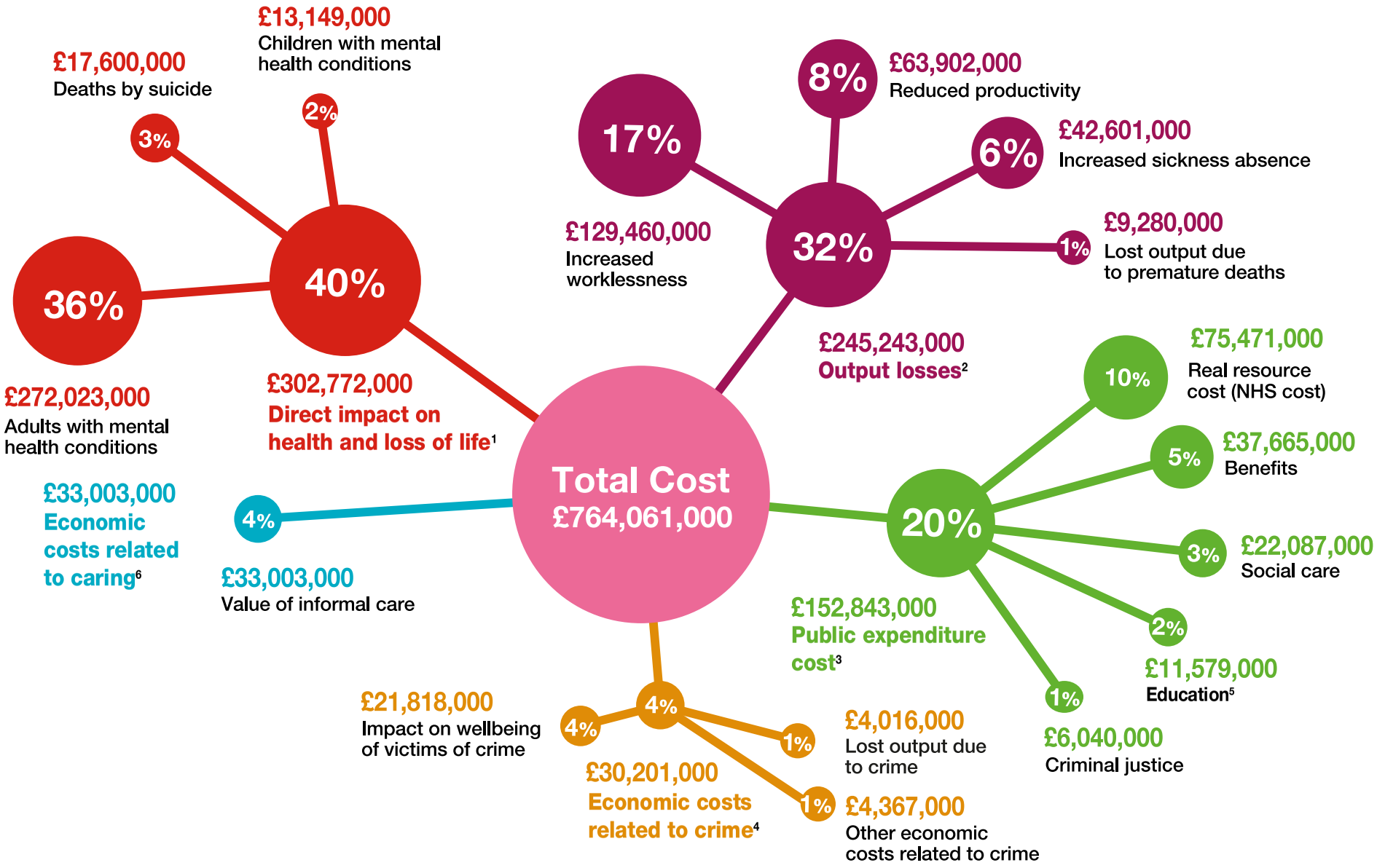
Table 2.1 Projected number of additional people diagnosed with a mental health condition by 2030 compared with 2012

Borough	CMD (ages 18+)		SMI (age 18+)		Dementia (over 65)	
	Additional people diagnosed	Percentage increase	Additional people diagnosed	Percentage increase	Additional people diagnosed	Percentage increase
Camden	4,545	16%	509	16%	271	28%
Islington	4,960	18%	511	18%	212	28%

Source: GP Public Health dataset 2012; GLA, 2014

- **Lost economic output**, which includes the impacts of higher rates of unemployment and long term worklessness, increased sickness absence and reduced productivity, and lost output due to premature deaths.
- **The impact on other public services and spending**, principally on criminal justice services and in the education sector, as well as increased spend on welfare benefits.
- **The human costs of mental health problems,** including reduced quality of life due to ill health and years of life lost due to earlier deaths. The quality of life cost estimates are based on economic costings used by government, and are consistent with values used by NICE in assessing quality of life. These are an underestimate of the impact since economic measurements of quality of life estimates for people with schizophrenia are not well developed, and so are not included.

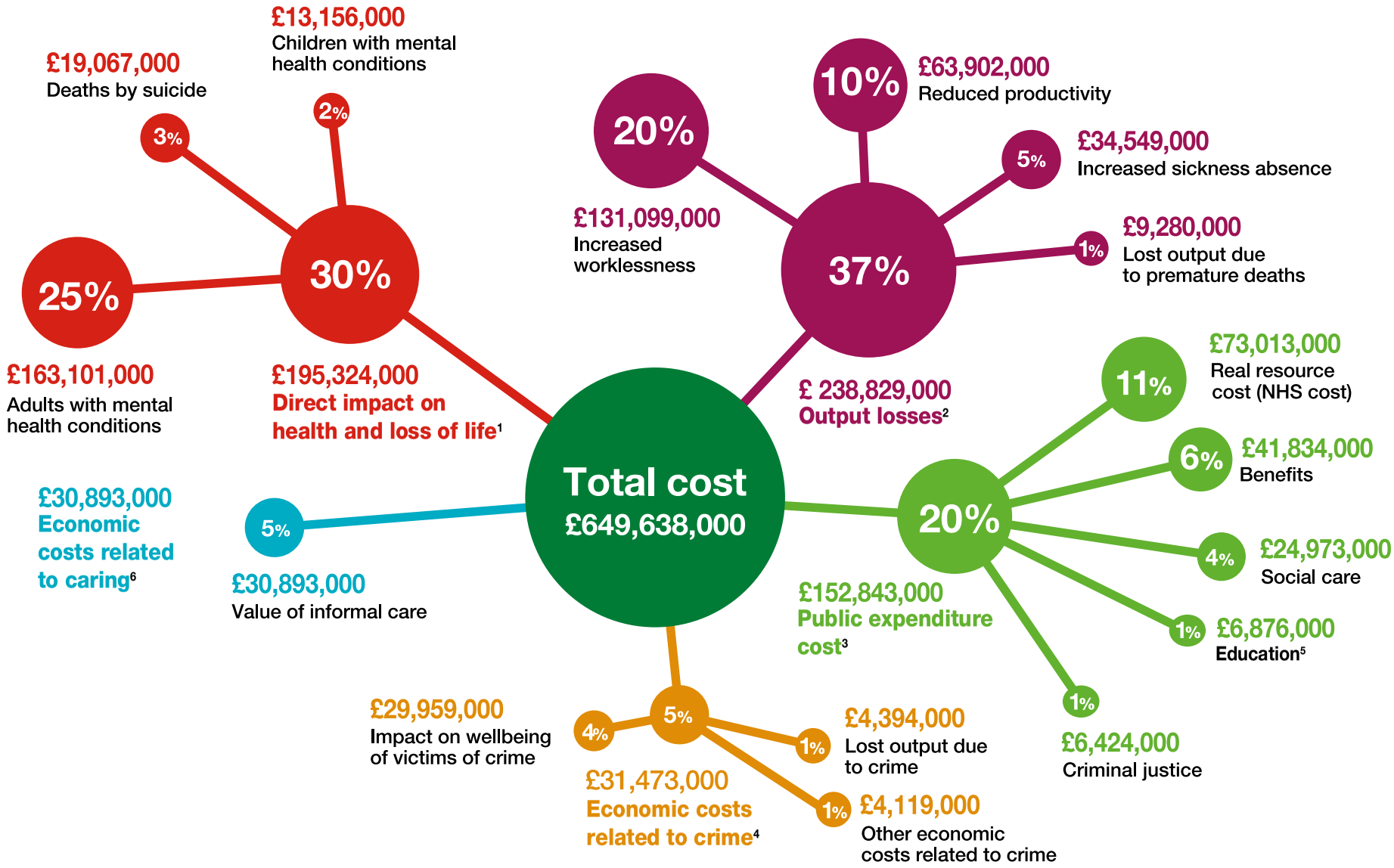
Figure 2.12 Economic estimate of the direct impacts of mental health conditions in Camden 2014-2015



Source: 1 PHE data (2011-2013); 2 Importance of thinking locally for mental health: data from cross-sectional surveys representing South East London and England. PlosOne. Dec 2012; 3 Programme budgeting bench marking tool (2012-2013). 4 Home Office review Study. Economic social cost of crime. 5 Economic impact of childhood psychiatric disorder on public sector services in Britain: estimates from national survey data Journal of Child Psychology (2013). 6 Survey of Carers in Households – England, 2009-2010. HSCIC

Note: This analysis replicates the methodology used in the London Mental Health Report (2014) – The invisible costs of mental ill health. GLA, Jan 2014.

Figure 2.13 Economic estimate of the direct impacts of mental health conditions in Islington 2014-2015



Source: 1 PHE data (2011-2013); 2 Importance of thinking locally for mental health: data from cross-sectional surveys representing South East London and England. PlosOne. Dec 2012; 3 Programme budgeting bench marking tool (2012-2013). 4 Home Office review Study. Economic social cost of crime. 5 Economic impact of childhood psychiatric disorder on public sector services in Britain: estimates from national survey data Journal of Child Psychology (2013). 6 Survey of Carers in Households – England, 2009-2010. HSCIC

Note: This analysis replicates the methodology used in the London Mental Health Report (2014) – The invisible costs of mental ill health. GLA, Jan 2014.

Islington

Mental health conditions in Camden and Islington

Conclusions

Mental health conditions are common across all age groups and almost all parts of the community in both Camden and Islington. In general, prevalence of mental health conditions are significantly higher in the most deprived areas. There are an estimated 49,820 adults in Camden and 45,840 adults aged 16 and over in Islington with diagnosable CMD, which is one in every four, compared to national estimates of about one-in-six. There were 28,300 adults with diagnosed, unresolved CMD in Camden and 29,900 in Islington, equivalent to a diagnosis rate of 57% and 65% of total expected numbers of CMDs in the two boroughs. A high proportion of diagnoses in both boroughs reflect long term CMDs. There are about twice as many diagnoses in women than men.

Camden and Islington have the highest rates of SMI in the country, affecting 3,688 (1.39%) and 3,498 (1.50%) of adults respectively. People, and especially men, from Black communities are significantly over-represented among people with SMI diagnoses. It is estimated that over two-thirds of dementia cases have been diagnosed in both boroughs. In total, there are expected to be 1,558 older people in Camden and 1,323 in Islington with dementia. It is estimated that there are 3,230 diagnosable mental health conditions in children and young people in Camden, and 3,190 in Islington, aged 5-15. Mental health conditions affect 13% of young people in Camden, and 14% in Islington, compared to one-in-ten nationally. Just under half these estimated numbers are receiving treatment from CAMHS services.

A growing and ageing population means that both Camden and Islington are expected to see an overall increase in mental health conditions. There are large variations in diagnosis rates between general practices. It is expected that the percentage growth in dementia will be particularly significant in the medium to long term.

Mental health conditions have a wide-ranging impact on a person's life, that of their families and their carers, and these wider impacts are estimated to have significant economic costs across the whole community.

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3

Mental health across the life course

Mental health across the life course

This chapter focuses on some of the key factors that shape mental health and wellbeing throughout the life course. Mental health needs change through life, from the early years, childhood and adolescence, into adulthood and then older age. By understanding these changes, we can target efforts both to reduce risk and support those protective factors most relevant to each life stage. [1] The life course approach also shows the way in which earlier life experiences affect later outcomes and how, if we want to take an approach based on prevention and early intervention, we must support, protect and promote mental health and wellbeing earlier in life. [2] Many mental health conditions in adults have their origins in childhood and even before birth. [3] In turn, there is a strong intergenerational dimension to mental health – one of the most important determinants of a child's long term mental health is the mental health of their parents.

Mental health needs throughout life are strongly influenced by social and economic factors and, as described in previous chapters, risk factors and the prevalence of mental health conditions increase with levels of deprivation and social exclusion. [4, 5]

Pregnancy, children and young people

Children and young people under the age of 18 are approximately a fifth of the population in both Camden and Islington. In both boroughs, this age group is the most ethnically diverse, is more likely to live in social housing than any other age group save older people, and faces significant inequalities and disadvantages associated with high levels of poverty.

Pregnancy, the first years of life and childhood through to adolescence, are crucial for lifetime health and wellbeing.

Pregnancy and the Early Years

The influence of maternal and parental health on a child's mental health begins in pregnancy and continues into the early years. A number of risk factors in the antenatal period are associated with the risk of mental health conditions.

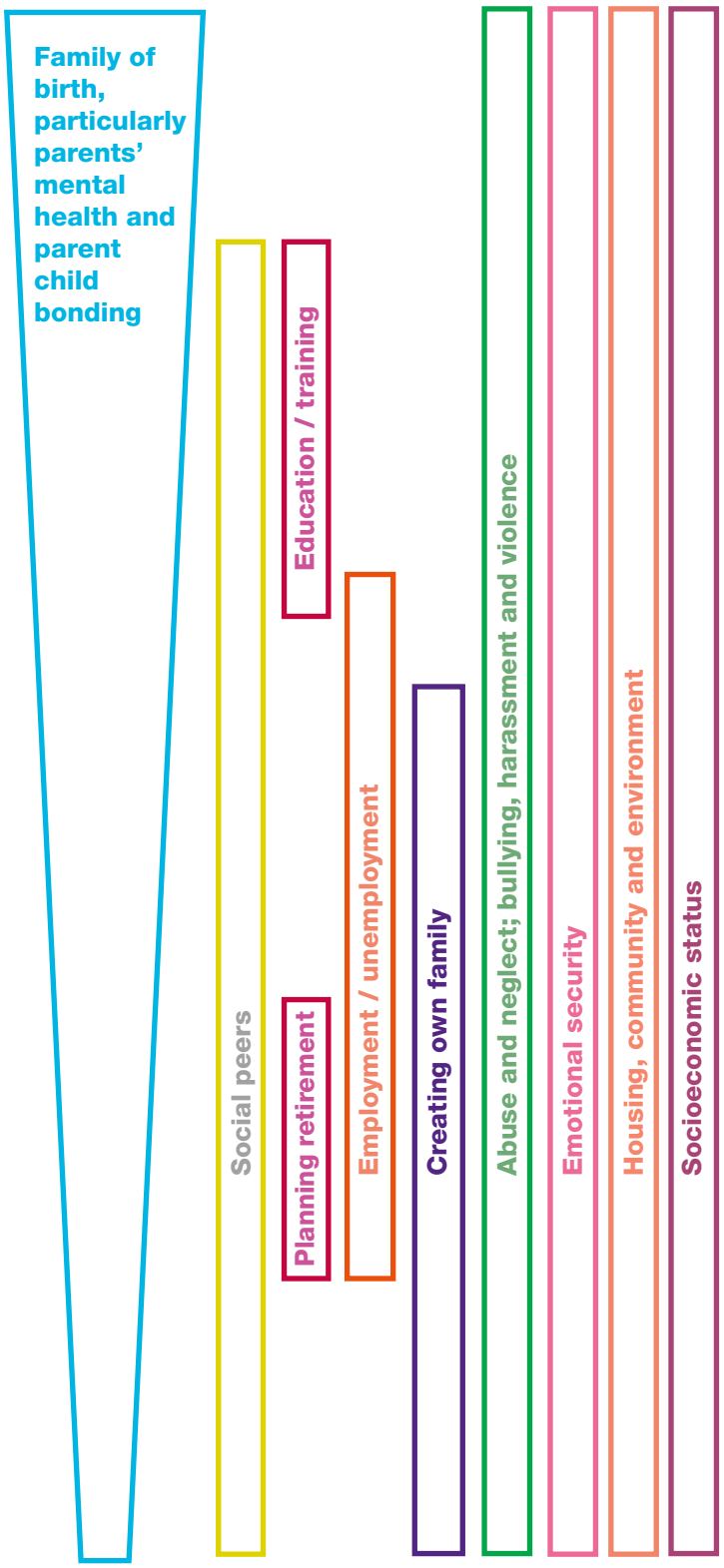
"There is now considerable evidence from prospective studies that the children of women who are depressed, anxious or stressed during pregnancy are more likely to experience a range of adverse neurodevelopmental, emotional, behavioural, and cognitive outcomes compared with children of mothers who do not experience such problems." [6]

Mental Health and the life course

Over the course of an individual's life many factors will impact on their mental health. The factors outlined below can all affect mental health either positively or negatively over the life course, and can have an impact at different stages of life, as shown in the example below (e.g. bereavement). Family life and early experiences are particularly influential on development and the risk of mental health conditions. Therefore an increased risk of mental health conditions can be carried from one generation to the next within families.

Life stage	Life events
Prenatal	Mother's diet and lifestyle Birth
Early years	Forming emotional bonds Learning language and other cognitive skills
Childhood	Starting school Developing social skills Making friends
Adolescence	Puberty Learning relationship skills Developing life skills
Young adult	Entering employment Leaving home Marriage/partnership Parenthood Childbirth Bringing up children
Middle age	Career mature Teenage children Caring for ill parent/relative Children leaving home Separation/divorce Bereavement
Older years	Developing a long term condition Becoming a grandparent Caring for ill spouse Retirement Separation/divorce Bereavement Death

Factors that impact on mental health



Source: Adapted from Mrazek & Haggerty, 1994

Camden and Islington

A spotlight on… strengthening families in Camden

The Parent Infant Project – Anna Freud Centre

The Parent Infant Project offers psychotherapy to Camden families where a baby's development is at risk. This may be linked, for example, to parental mental health problems, past or present trauma that is impacting on parenting, or illness in the baby. Acknowledging the impact that a baby has on the parent and vice-versa, the service's defining feature is to put the parent-infant relationship at the centre of the therapeutic intervention. It is based on evidence that focusing therapy only on a parent has limited benefit for their infant and the family. The Anna Freud Centre has been a pioneer of this approach, and has a team of child and adult psychotherapists and psychoanalysts specialising in early intervention. Weekly family sessions are offered to parents, infants and other family members with caring responsibilities.

Referrals are commonly made by GPs, social workers and health workers across Camden. The service sees 60 families per year.

During pregnancy, a mother's health is particularly important for the developing foetus. Environmental and social factors, physical health and nutrition, smoking, alcohol and drug misuse, and parental stress levels, all have a potential impact on the development of the foetus which can be linked to an increased risk of poorer mental health outcomes through life. Children of mothers who experience poor mental health have been found to be two to five times more likely than other children to have mental disorders. [7, 8] Depression has been found to be as common during pregnancy as in the postnatal period, affecting about 10% of women. This evidence has led to a stronger focus on identifying and addressing poor mental health in pregnancy.

Starting a family and becoming a parent is a major life event. The experience brings many life-enhancing benefits and opportunities. However, parenthood also bring major challenges and stresses, which increase the risk of depression and affect self-esteem: these effects may be relatively short-lived, but for others these may become longer lasting. Those with lower resilience or facing greater social and economic disadvantages are more likely to be vulnerable to depression and anxiety. [9] Being a teenage or lone parent generally increases these risks. [10] The incidence of postnatal depression in England shows a clear correlation with social class: 20% of mothers in the lowest socioeconomic quintile experience postnatal depression, compared with 7% in the highest socioeconomic quintile, with implications for the father's mental health, as well as that of the baby. [11]

Childhood and adolescence

During adolescence, people's needs change. Young people are at a stage in their lives where they want to forge an independent identity and are also acquiring greater skills and responsibilities in their lives. Relationships with their peers become increasingly influential. Young people may be more impressionable and likely to engage in risky behaviours. [12]

A spotlight on… supporting young people's families in Camden and Islington

Multisystemic Therapy – The Brandon Centre

Across Camden and Islington, The Brandon Centre offers multisystemic therapy (MST) to families with a young person at risk of being placed in care, custody, or a psychiatric hospital, because of extreme behavioural problems. Clients have often exhausted other available services and sources of support. The aim is to empower the family as a unit, building resilience and reducing reliance on professional support.

MST is for the whole family, and focuses on the social network of the young person which promotes antisocial behaviour. It uses different therapeutic approaches to improve parenting skills, strengthen parent-child emotional bonds, and to decrease involvement with peers who encourage antisocial behaviour.

The therapy is intensive, with sessions typically three times per week for three-to-five months. Critically, the team is flexible – the sessions take place in the community, mainly in the family home but also in school and are often out of traditional office hours. Staff can be contacted by telephone 24/7.

The Brandon Centre sees 18 families per year across Camden (13) and Islington (5), and receives referrals from various agencies. In 75% of MST families seen, the young person's removal from the family is prevented.

Main risk factors

As discussed in Chapter 1, there are genetic influences on mental health, but environment matters, too. Risk and protective factors for mental health in children have been extensively studied (Table 3.1). Risks have a cumulative impact in children and young people, so experiencing multiple risk factors increases the likelihood of a mental health condition developing. [13]

Protective factors

Building resilience in childhood is considered to be protective of mental health across the life span. This can be promoted through a range of factors such as strong family bonds and emotional attachments, social stimulation, protection from conflict, healthy social activities, educational activities and educational attainment.

Education continues to be important in building emotional resilience for young people and affects a range of later life outcomes that promote mental wellbeing such as self-esteem, opportunities for higher education and secure employment, stable and adequate income, and community participation, which are crucial for a healthy transition into adulthood. The school environment plays an important role in promoting mental health. There have been significant improvements in educational attainment in both Camden and Islington.

Based on the our understanding of the risk and protective factors described above, the groups described in Table 3.2 are thought to be at highest risk of poor mental health in Camden and Islington.

Table 3.1 Risk and Protective Factors for Mental Health [14]

Factors	Risk Factors	Protective Factors
Personal	• Genetic factors making the children more vulnerable to emotional and behavioural problems • Physical illness • Learning Disability • Communication difficulty • Low self-esteem	• Genetic factors making children more resilient • Good health and development • Good problem solving skills/IQ • Being female • Secure attachment • Good communication skills • Spirituality/religious faith • Feeling in control
Family	• Family adversity • Poverty • Mental illness in the • parents • Alcohol and substance misuse • Conflict with and between parents • Authoritarian/inflexible parenting • Death and loss • Experience of abuse	• Good relationship with parents • Affection • Supportive wider family • Lack of domestic tensions • Family involvement in activities
School and community	• Poor reading/low school attainment • Bullying in school • Disadvantaged community/ neighbourhood crime • Racial tension/harassment • Experience of care	• Supportive community • Schools with good rates of achievement, good staff approach to health and mental health, lack of bullying • Opportunities for involvement and achievement • Good housing • High standard of living • Range of positive activities
Wider world	• Economic recession • Unemployment • Housing shortage • Family breakdown • Long working hours/job insecurity	• 'Inclusive' policies

Table 3.2 Children in Camden and Islington who are at highest risk. Adapted from Nottingham City JSNA, 2011.

Children living in poverty	Childhood poverty is linked to mental health risk factors such as family stress, debt, overcrowding, poor housing conditions and parental unemployment. Exposure to these can be damaging, increasing the likelihood of developing a mental health condition. [15] The relationship between poor mental health and poverty is complex; both can influence the other, precipitating a downward spiral of worsening outcomes. Childhood poverty levels are very high locally: 30% in Camden and 35% in Islington, compared to a national average of 19% in 2012.
Victims of bullying	Bullying in schools is a common problem with potentially long-lasting consequences. A national Ofsted survey found that almost four in ten children reported they had been bullied in the previous twelve months. Bullying can cause long term damage to self-esteem, physical health and educational attainment, which all influence psychological wellbeing later in life. [16] Cyberbullying has risen in recent years, where the bullying takes place by electronic channels such as social networking websites or mobile phones, and is linked to an increased risk for depression. [17] Additionally, children and young people who are bullies are at greater risk of depression in later life. [18]
Children in care	Nearly 50% of children in local authority care and nearly 70% among children living in residential care have a diagnosable mental disorder. Nationally, studies have found they are at four times greater risk of attempting suicide compared with other young people. As of March 2014, there were 225 children looked after in Camden and 305 in Islington.
Those with learning difficulties	Over a third of children and young people with an identified learning difficulty have a diagnosable mental health condition. There were 245 children and young people with diagnosed learning difficulties in Camden, as of March 2014, and 65 in Islington.
Young offenders	Young people involved in the justice system have at least three times the prevalence of mental health conditions and an increased risk of suicide compared to the general population. [19] In 2013, there was a rate of first-time entrants to the youth justice system of 741 per 100,000 aged 10-17 in Islington, and 487 in Camden, compared to a national average of 441.
Those with a physical disability or serious chronic illness	Children and young people with physical disabilities or a serious or chronic illness are twice as likely to develop psychological problems. [20] It is estimated that this is about 7% of children and young people aged under 20 years in Camden and Islington (3,128 and 2,906, respectively).

Teenage mothers	Teenage mothers are three times more likely than older mothers to suffer from postnatal depression and mental health conditions in the first three years of their baby's life. [21] Teenage pregnancy rates have fallen substantially in recent years in both boroughs. In Camden and Islington, respectively, these were 18.1 and 30.1 per 1,000 women aged 15-17 in 2012, compared to 27.7 in England.
Lesbian, gay, bisexual people	Lesbian, gay and bisexual people are at higher risk of mental health conditions, suicidal ideation, alcohol and substance misuse, and deliberate self-harm than heterosexual people, with rates between 1.5 and 2 times general population rates. These risks are particularly high in adolescence and early adulthood. Camden and Islington are estimated to have among the largest lesbian, gay and bisexual populations in the country, with 6,176 and 5,857 residents aged over 16 years, in 2014.
Asylum seekers/ refugees	Overall rates of mental health conditions are estimated to be around three times higher. There are particular risks around emotional problems and post-traumatic stress disorder (PTSD).

Local approaches to supporting children and young people

The Councils and Clinical Commissioning Groups (CCGs) in both Camden and Islington acknowledge the importance of supporting children, young people and families in their major strategies and plans. These reflect the importance given locally by the NHS and Councils to supporting the best start in life, both for individual and societal wellbeing. Joint commissioning of children's health services between the CCGs and Councils in both boroughs supports an integrated approach to meeting the mental health needs of children and young people.

The Corporate Plans for Camden and Islington Councils were described in further detail in Chapter 1, including commitments to preventing some of the greatest risk factors described in this chapter. [22, 23] In terms of the wider social and economic determinants of children and young people's mental health, the priorities given to reducing and mitigating the impacts of child poverty; on support in the early years to improve school readiness and communication skills; and to increase, and reduce inequalities in, educational attainment are particularly influential for protecting children and young people's current and long term mental health.

Services in both boroughs provide prevention and early intervention through supporting pregnancy, developing parenting skills, access to universal and targeted support through Children's Centres, supporting school readiness and pre-school education, mental health promotion and targeted interventions in schools, and new approaches to transition from children's to adults' services. There are targeted services and interventions for vulnerable groups such as children who are looked after, young offenders and teenage parents. This list is not exhaustive, and there is considerable innovation in the services in both boroughs, for example involvement in the national initiative for improving access to evidence-based psychological therapies services for children and young people (CYP IAPT), targeted mental health services in schools and new ways of addressing parental and inter-generational mental health. CAMHS services are well established in Children's Centres and primary and secondary schools in both boroughs, promoting improved access to advice and help. It is likely that in both boroughs, a significantly greater proportion of mental health conditions in children and young people are seen and treated by CAMHS services than happens nationally, although this report still estimates that less than half of children and young people with mental health conditions are treated. The local offer of services is described more comprehensively in Chapter 6.

A spotlight on... improving mental health for mothers in Islington
First 21 Months

In Islington, the First 21 Months is a large, complex programme. It is run across multiple agencies, including the maternity services at Whittington Health and University College London Hospital, the health visiting service, primary care, CAMHS, other specialist services, and 16 children centres organised in seven clusters.

One of the key objectives is to improve mothers' emotional health during pregnancy and the first year of their child's life, and it focuses on supporting women who are not likely to access specialist clinical services, but who have actual or potential mental health needs.

Ultimately, it aims to improve future mental health outcomes for parent and child.

As part of this, four Children's Centre clusters are running pilots to improve the identification and engagement of families vulnerable to mental health problems. Their approaches are different, and include providing home visits to reach out to vulnerable families not engaged in Children's Centres, training front-line staff to identify unmet mental health needs, and support groups run by psychologists or linked to CAMHS, among others.

Additionally, improving data sharing between the multiple agencies around vulnerable women is a priority.

The Nation centre for Social Research was commissioned to undertake a formative evaluation of the programme and progress towards greater integration between health and early years services.

In particular, the evaluation aimed to:

- develop a programme logic model to support evaluation design;
- assess current service delivery in children centre clusters in order to identify key strengths and weaknesses of the integrated working approach;
- identify key indicators and measures to track progress towards stated programme outcomes.

The final report will be available February 2016.

Adults of working age

Adults of working age account for a significantly larger proportion of local residents in the two boroughs than nationally. In particular, the population under 40 is much larger. The size of this younger adult population is linked to people moving into the two boroughs from other parts of the UK and from overseas, reflecting the regeneration and social and economic opportunities available locally, and large student populations. It is a very mobile population, at least in part linked to the high and increasing costs of home ownership and private rents in the two boroughs. Housing is driving wider changes and greater local inequalities over time, with adults in social housing generally becoming more disadvantaged and those buying or owning their homes becoming more affluent.

Mental health conditions are the leading cause of disability in adults of working age, and the single largest cause of ill health. [24] Mental health conditions in adults are associated with higher levels of social exclusion, poorer quality of life and increased risk of unhealthy lifestyle behaviours, poor physical health and early, preventable death. [25, 26, 27] Childhood mental health conditions are a key risk factor for vulnerability to mental health conditions in adults, but there are many important transitions and events during adulthood which play a role in mental health, too.

The transition to adulthood

Adult mental health is further significantly shaped through the period of major transition beginning in adolescence and continuing into early adulthood, when major changes in the brain affecting cognitive and psychological functions coincide with major life and social changes in most people's lives. This period of 'psychological adolescence', beginning in the early to mid-teenage years, extends well beyond that of the physical changes associated with puberty, lasting at least into the mid-twenties. Important events during this period include leaving college and the parental home, starting employment or further training or education, developing new intimate and personal relationships, a changing role and relationship with families and peers, and may include starting a family. Cumulatively, these changes can contribute to the onset of mental illness or alcohol and substance misuse disorders, particularly in young adults where there are vulnerabilities. [28]

Mid-life

It is, however, mid-life when the prevalence of mental health conditions reach their peak in adults, and subjective wellbeing is at its lowest. The factors which are most likely to explain the increased rates of mental health conditions in people's forties and fifties include the pressures of caring responsibilities for children and ageing parents, career and work-related pressures, the gap between achievement and aspiration, increased levels of marital breakdown, the increased onset of physical health problems, and the menopause.

A spotlight on… accommodation for young people with complex mental health needs in Camden

Camden Kaleidoscope – Depaul UK

The Camden Kaleidoscope provides accommodation for 16-21 year olds with high and complex mental health needs during the transition from childhood to adulthood. It offers high level, specialist support to tackle personal challenges, develop skills for independent living and build the futures young people want.

The service aims to avoid in-patient mental health care where possible, by helping residents to re-stabilise over their stay, which is usually 1-2 years. The accommodation is in a newly refurbished building with 7 beds, a lounge, kitchen and large garden with its own vegetable patch. It is staffed 24 hours per day. It is also a social and creative place, with activities such as group cooking and crafts.

Case study

Andrew grew up in an unstable family home. He started smoking cannabis at age 13 and smoked regularly until age 18. Andrew was successful at school and did well at GCSE but, due to a decline in his mental health, did not do as well at A-level. Andrew was referred through the Early Intervention Service to Camden Kaleidoscope. Initially he worried about his future and found that his anxiety sometimes prevented him from leaving the accommodation. Camden Kaleidoscope gives Andrew a space for peace, reflection, care and support without pressure or extensive expectation. His recovery journey can progress at a rate he feels comfortable with. He feels that his anxiety is not a big obstacle now, and has had his medication reduced twice. Andrew is now enrolled on a foundation access course in nursing, which he attends regularly. He has applied to several universities to study for a degree and would like to become a doctor, eventually.

At what age do people develop mental health conditions?

Over half of people (51%) will experience a mental health condition by age 75. Most of these mental health conditions first develop in childhood, adolescence or young adult life.

Age at which percentage of projected lifetime risk* of developing a mental health condition is attained

Key

25% of people who develop a mental health condition will have done so by this age

50% of people who develop a mental health condition will have done so by this age

75% of people who develop a mental health condition will have done so by this age

A quarter of people who will develop any mental health condition will have done so by age 7

Half of people who will develop any mental health condition will have done so by age 14

Three quarters of people who will develop any mental health condition will have done so by age 24

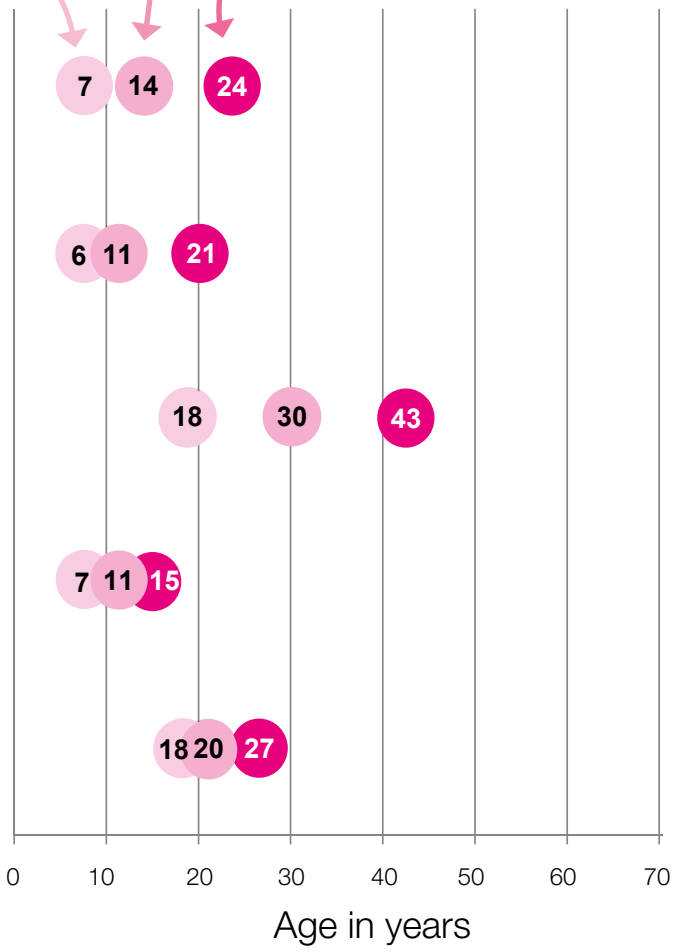
Any mental health condition
51% of people will develop any condition by age 75

Anxiety disorder
32% of people will develop this condition by age 75

Mood disorder
28% of people will develop this condition by age 75

Impulse control disorder
25% of people will develop this condition by age 75

Substance use disorder
16% of people will develop this condition by age 75



Note: *Projected lifetime risk is the probability, often expressed as a percentage, of the average person developing a condition over the course of a lifetime.
Source: adapted from: Annual Report of the Chief Medical Officer 2013 (DH 2014)

A spotlight on… supporting family practitioners to meet mental health needs in Islington

Parental Mental Health – Camden & Islington NHS Foundation Trust

Families with multiple, complex and longstanding problems are supported by a range of practitioners in Islington, including social workers, outreach workers and family support workers. These families are at a higher risk of poor mental health than the wider population, so it is essential that the staff supporting them have the appropriate skills and knowledge to identify and address mental health problems. To meet this need, the Islington Parental Mental Health (PMH) Service aims to support the staff working with such families.

The PMH team consists of three specialist psychologists who are part of the Camden and Islington Foundation Trusts' Personality Disorder Service. The team works with family practitioners to identify parental mental health problems, build care pathways, and refer to local mental health and other services. They provide direct support to both practitioners through training and consultation, and to the families through home visits and providing psychological support.

The benefit of this approach is that case-holding practitioners across the system are better equipped to support families with complex mental health problems in a more targeted and effective way, gain better overall outcomes and improve the service-user experience. As PMH staff are co-located with a number of Islington Targeted and Specialist Children's Services, support is given to a large number of practitioners with high caseloads. The service began in 2013 and in its first nine months, supported 301 family cases.

"[The PMH psychologist] offers invaluable insight into the parent's situations. Her advice and joint working comes from a knowledgeable place as well as an empathetic one." – family practitioner

Risks and associations

Gender

Depression and anxiety in women is significantly higher than in men across all age groups. Psychotic conditions and suicides are higher among men. Mental health conditions are increased in both men and women experiencing disadvantage and inequalities.

Ethnicity

There are also significant differences between ethnic groups. Men and women from Black communities and the Irish community are significantly more likely to be diagnosed with a serious mental illness and be admitted to a mental health unit than other groups, with the highest rates seen in Caribbean men. South East Asian women have higher levels of depression and anxiety, but are more likely to express these through physical (somatic) symptoms. South East Asian women are also at higher risk of self-harm and suicide compared to other groups of women. [29] Irish women are significantly more likely to be admitted to hospital for neurotic disorders.

Unemployment and insecure employment

Unemployment and low quality, insecure employment are significant risk factors in adult mental health conditions and for lower wellbeing, and are important sources of social and economic inequalities. Job loss is associated with increased symptoms of depression and anxiety. Adults with a mental health condition have higher rates of unemployment than other groups with disabilities yet they are more likely to want to be in employment. [30]

In Camden and Islington, the unemployment rates are lower than the averages for London, but there are important inequalities in both boroughs: younger adults (aged 18-24), adults from Black communities and people living in social housing are significantly more likely to be unemployed. In both boroughs, unemployment rates tend to

increase with deprivation and are higher in the more deprived wards (highest in Finsbury Park in Islington and St Pancras and King's Cross in Camden). Prolonged unemployment and long term worklessness are linked to increased levels of depression, a higher risk of suicide, especially in men under 35, and worsening mental and physical health. (31)

In Islington, 9,600 adults aged 18-64 have been claiming out of work benefits for more than 5 years (41% of the total claiming out of work benefits) and in Camden, 7,710 adults (46% of the total), and are therefore at particularly increased risk of mental health conditions.

Adults with serious mental illness (SMI) and long term, chronic depression are significantly more likely to be unemployed, and yet it is estimated that about 30-50% of people with serious mental illness could be in work. Nationally only 7-8% of people with serious mental health conditions on CPA (structured mental health care programmes) are in employment. In Camden and Islington, this is lower at 4% and 3% respectively. This means that adults with SMI are 15 to 20 times less likely to be economically active than adults of working age in the general community.

Unemployment, job loss and insecure employment are also associated with an increase in other risks which negatively impact on mental health, including the breakdown in family relationships including separation and divorce, and unhealthy lifestyle behaviours, such as smoking and alcohol consumption.

Income

Low income is an important risk factor for mental health, which may be exacerbated by wider inequalities in pay in society. Adults in households with the lowest income are three times more likely to have mental health conditions and are at greater risk of suicide than the general community. (32) Financial debt has also been established as an important risk factor for mental health conditions in low income households, and may be further compounded by stresses resulting from financial exclusion or use of high interest money lenders. (28)

Alcohol and Substance Misuse

Around half of adults diagnosed with a mental health condition also have an alcohol or substance misuse problem. These problems may not reach the level of 'dependency', but will be at levels of misuse associated with increased health risks. The relationship between mental health and alcohol and substance misuse is a complex one, since there are shared risk factors and similar parts of the brain are affected by both. A mental health condition can lead to drug or alcohol misuse as a form of self-medication, the use of alcohol or drugs can exacerbate an existing mental health condition, or their use may trigger the development of a mental health condition. (33)

Both Camden and Islington have higher estimated numbers of adults drinking at above safe drinking levels than the London averages, with 8.1% (12,100 residents) in Camden and 7.0% (10,100 residents) in Islington. Excessive consumption of alcohol is associated with higher levels of depressive and affective conditions, schizophrenia and personality disorders. (34) The risk of hazardous drinking also increases following two or more stressful life events, which may further increase vulnerability to developing a mental health condition. (35) There is scientific consensus that heavy and frequent use of cannabis increases the risk of depression and schizophrenia, and is the most readily preventable risk factor for psychosis. (36) A recent study of strong (or "skunk-like") cannabis among patients seen at a South London mental health service found that almost a quarter of cases of psychosis could have been caused by frequent and heavy use of the substance. Compared with those who had never tried cannabis, users of high potency 'skunk-like' cannabis had a three- to five-fold increase in risk of psychosis. (37)

Physical health

There is a strong correlation between physical health and mental wellbeing; physical health problems are risk factors for mental health conditions, and the risk of depression increases after the diagnosis of a long term physical health condition. These associations are discussed further in Chapter 4.

Harassment and violence

Experience of harassment and discrimination, and interpersonal violence and abuse, including domestic violence, have been shown to significantly increase the risk of a range of mental health conditions. Domestic violence is an important factor in mental health conditions in women. [28]

Offenders and recently released prisoners

Substance misuse and/or mental health conditions are prevalent among 90% of offenders. Recently released prisoners have a greatly increased risk of suicide: men are eight times and women 36 times more likely to die by suicide within a year of release from prison than the general population.

Inter-generational mental health

Parental mental health has been shown to be an important risk factor in the subsequent development of mental health conditions in their children. Factors are complex, and may include shared genetic susceptibility, shared family and environmental stressors affecting mental health, and problems in early bonding and attachment.

Adults of working age – what works to promote and protect mental health?

Important protective factors for adult mental health are financial, employment and emotional security and good physical health.

The role of employment

Job security and a sense of control at work are protective of good mental health. [38] These are described further in Chapter 5. Workplace based interventions that promote and support greater job control can positively influence mental health through reducing stress, anxiety and depression, and increasing self-esteem, job satisfaction and productivity. [39, 40] Working adults are generally more able to integrate into community networks, and employment provides an important means of access to social networks and social capital. Employment for adults with mental illness is important in promoting recovery and social inclusion and can have a positive effect on mental health. [41]

Families and social relationships

Families and relationships are an important factor in mental health and wellbeing of adults. Positive and emotionally supportive personal and family relationships and being part of social networks are protective of mental health. Both have been found to mitigate the effects of stressors for mental health conditions such as depression. A number of parenting programmes have found positive benefits for the mental health and wellbeing of mothers, as well as for the child. 'Think Family' interventions, which address the needs of parents as well as children, represent models of effective practice in addressing family problems linked to parental mental health conditions or problem drug and alcohol use. Screening for domestic violence is effective in improving recognition, and provides access to help and support that can alleviate the impacts.

Physical health

There are strong links between physical and mental health, covered in Chapter 4. Healthy lifestyles, such as not smoking, regular exercise and physical activity and healthy diets are important in long term mental health and wellbeing. Screening and brief advice for non-dependent people using alcohol above recommended safe limits is effective, and treatment services for problem drug and alcohol use have been shown to be cost effective.

Older People

Older people over the age of 65 make up a much smaller proportion of Camden and Islington's populations compared to England, about one in twelve of the population, compared with more than one in eight nationally. Older people are more likely to live in social housing than any other age group, and a substantial proportion of adults aged 65 and over live alone. In both boroughs, older people are less ethnically diverse than other age groups, although there are relatively large older Irish populations. Improved health and life expectancy is an important factor in the changing social role of older people.

A spotlight on… expanding horizons in retirement

University of the Third Age - The Third Age Trust

The University of the Third Age (U3A) is a national movement to provide educational, creative and leisure opportunities for people no longer in full-time employment. It consists of local U3As, which are charities in their own right, and are run entirely by volunteers – the only organisation to do this. Each local U3A operates as a learning cooperative, drawing on the knowledge, experience and skills of its own members to run programmes. It gives people a place to learn new things, expand horizons, share skills and knowledge, make new friends and help others to learn.

U3A offers a lot, locally. The oldest U3A in the capital is based in Camden (U3A London), while Islington's branch (Islington U3A) has been operating since October 2013. Both have hundreds of members, and offer over 180 and 40 study groups, respectively. These cover art, languages, music, history, life sciences, philosophy, computing, crafts, photography and walking.
http://www.u3alondon.org.uk/
http://www.islingtonu3a.org/

Common mental health disorders in older age

There is a common misconception that older age is associated with poor mental health, and that depression is an inevitable aspect of ageing. In fact, older people generally have higher levels of wellbeing, and lower levels of mental health conditions compared to other age groups. However, at least 10-20% of older adults will experience a short or long term mental health condition, and there is evidence that wellbeing increases again in people in their 80s and over. [42]

The prevalence of mental health conditions is significantly higher in care homes and general hospital wards, where it is estimated to be up to one-third. [43] New episodes of depression and anxiety are less likely to be diagnosed than in other age groups, and older people are less likely to be referred to, or use, psychological therapies.

The mental health and wellbeing of older people is affected by a host of changes, some of which are biological, but many of which are social and economic. Older people's mental health is particularly vulnerable to changes in social circumstances linked to social isolation and loneliness, loss of independence and poverty, which affect both mental and physical health. [44, 45, 46] People who are isolated also tend to visit their GP more, have higher use of medication, higher incidence of falls and increased risk of entering long term care. [47] Other risk factors that increase in old age include becoming a carer to a dependent spouse and bereavement. Older people may also be at risk of maltreatment by others in their homes or in care institutions. These adversely affect older people at any age, but are often especially concentrated in the very oldest people. Community support and family interactions are likely to have a protective role in the mental health outcomes of this population. [48]

Dementia

The risk of dementia increases significantly with age, with the prevalence roughly doubling for every decade over the age of 65. Earlier diagnosis is associated with improved quality of life for people with dementia and their carers, particularly in terms of planning ahead and living at home for longer. However, it also brings a long term societal change, increasing the length of time people will be living with a diagnosis of dementia. This creates new challenges for the health and social care system. Late diagnosis of dementia significantly increases the risk of institutionalisation, often following a crisis.

Risk Factors

There are three important risk factors for mental health conditions in old age.

Social isolation

The Adult Social Care Outcomes Framework in 2013-2014 showed that one in ten people aged 65 years and over in England reported that they were lonely often or all the time, and 5 million reported that television provided their main company. The risk of social isolation is increased when individuals live on their own: there were 10,113 households (just over one in ten) with a lone occupant aged 65 and over in Camden in 2011 and 7,597 (about one in every twelve) in Islington. The Carers Survey collected information from adults (of all ages) and carers in contact with social care services found that less than half had as much social contact as they would like: 45% of service users and 41% of carers. In Camden, the respective figures were 37% and 41%; and in Islington, 42% and 28%.

Fuel Poverty

Those experiencing fuel poverty have a four-fold increased risk of having depression or anxiety, and fuel poverty may increase the risk of social isolation. Across all age groups, fuel poverty was estimated to affect 8.8% of households in Camden in 2012 and 7.4% in Islington, compared to 10% nationally.

Physical Disability or Chronic Illness

People with physical disabilities and chronic illness are twice as likely to develop psychological problems and are much more common in older people. [20, 49] In 2012, more than 40% of people over 65 years old in Camden and Islington were living with two or more long term conditions compared, respectively, to 3% and 4% of adults of working age in the boroughs.

Other risks

Older men and women have different health needs, for example older women generally have lower income but better family support networks. [50] Depression and Alzheimer's disease are more prevalent among older women than men. [51] The association of mental health and wellbeing with marital status in older age also differs by gender - marriage is protective for men but associated with higher risk among women. [52]

Physical health and wellbeing is particularly important to mental health conditions and wellbeing in old age. Control of blood pressure, blood sugar and cholesterol levels are all important since they are linked to increased risk of mental health conditions. Older people with dementia and long term mental health conditions are at increased risk of being malnourished and underweight, so weight monitoring in this group is particularly important. [53]

More of the older population now live alone and many express a desire to remain independent for longer. There are therefore implications for social mobility, inclusion and supported housing arrangements that enable and promote mental health and wellbeing, autonomy and choice in this area.

Older people – what works to promote and protect mental health?

Social and family networks are protective in older people's mental health – reducing social isolation can reduce the risk of depression, and may delay the onset and symptoms of dementia. [54]
Group based social support activities, befriending and social prescribing can help to address social isolation, and have been shown to be cost-effective. These link older people at risk of social isolation into community activities and provide the means to connect with others with common interests. Schemes where older people act as volunteers benefit the health and wellbeing of the volunteers, too. Active 'case finding' or outreach to vulnerable older people is particularly important for prevention and early intervention.

Interventions that address fuel poverty and improved heating in the home are effective in promoting better mental and physical health in older people, and may help to reduce social isolation too. [55]

Adult education and lifelong learning have been found to be protective against depression and to delay or reduce the risk of dementia. [28]

Physical fitness and wellbeing is generally protective of mental health in older people, including by promoting greater mobility which helps to reduce the risk of isolation. Remaining active for longer, providing support and care in families, volunteering and remaining part of the workforce, can in turn provide benefits to mental health and wellbeing in older age.

The social inclusion of older adults can be further boosted by access to transport, improved design of buildings and the built environment, town planning, and promoting positive social attitudes towards ageing. This is an important aspect of creating 'dementia friendly communities', which aim to not only address awareness and understanding of dementia and to improve care and support, but which also involve making changes to the built environment to improve the inclusion of people with dementia and their carers.

A spotlight on... supporting people with dementia in Islington

Islington's Dementia Navigator Service – Camden & Islington NHS Foundation Trust

There are approximately 600 people living in Islington with dementia who are not in contact with the Mental Health Trust's specialist Services for Ageing and Mental Health (SAMH), and so do not receive specialist support. Historically, this has resulted in inequities in care, and considerable unmet need in this population group. To address this, Islington SAMH has been delivering the Dementia Navigator Service since July 2014. Dementia Navigators provide proactive support to people with dementia and their carers in Islington, and offer long term support to people who do not meet the threshold for accessing SAMH. The Dementia Navigator Service aims to enable people who have been diagnosed with dementia to remain living in the community for as long as possible. The intention is that with appropriate and timely support, there will be fewer admissions to hospital and less or delayed need for 24-hour care. The team of four Dementia Navigators is embedded in the SAMH care pathway, and the non-clinical Navigator's role is to improve access to services supporting activities of daily living, welfare rights, housing, and social isolation. Support is provided through initial signposting and long term follow up.

All new referrals have an initial session with a Navigator, where advice is offered. This may include information on relevant agencies, opportunities to socialise and practical issues including benefits checks, taxi card applications, and winter warmth. It will also include a sensitive discussion about future planning such as writing a will, lasting power of attorney and accessing other support as may be indicated. Navigators follow up with the client a month later to see what further advice and support they may benefit from.

After the initial session, longer-term support is offered to those who do not meet the threshold for SAMH support. The Navigators provide for face-to-face support for as long as the person lives in Islington. The frequency of contact depends on the person's level of need, which takes into consideration their risk of isolation, illness progression, and any mental and physical co-morbidities they may have.

During its first 6 months of operation, the Navigator Service worked with over 200 people, most of whom had a new dementia diagnosis, and over 70 people were offered long term support. The service has successfully engaged with a number of younger people diagnosed with dementia, a group that has not had a great deal of support from the other SAMH teams, historically.

A spotlight on… digital technology for older people in Camden

Dementia Befriending Service – Age UK Camden

Befriending services are recognised as a way to tackle the isolation and loss of confidence that often accompanies dementia and memory loss. The service matches volunteer befrienders to an older person whom they regularly visit, helping them to maintain hobbies and interests, and to enjoy the local community, and to act as a key contact, signposting onto appropriate services.

Typically, during their visits, a befriender will get to know the older person's history, and initiate conversation and activities. Age UK Camden has invested in three touchscreen tablets for use by the dementia befrienders during these visits.

Befrienders have been able to engage with their befriendees using the tablets, using them to bring memories to life through images, films and songs, to learn new things and to stimulate language and communication.

Case study

"As Mrs Sanderson liked the iPad last time, we used it again to see images of Liverpool where she grew up and her school there. I also showed her how to take a picture. She was very excited about the iPad. We also watched the Beatles on *YouTube* and sang "She loves you" and "Yesterday" together. She became emotional with tears in her eyes. She said her memory of the past came back to her and she felt overjoyed" - Dementia Befriender

Conclusions

The life course approach to mental health highlights the importance of a strong foundation at the start of life, and the inter-generational aspects of resilience and vulnerabilities to mental health conditions. Across the life course, mental health conditions are common in all age groups. There are striking variations in the risk of mental health conditions in many vulnerable and disadvantaged groups compared to the general population.

Early life experiences play a very significant role in lifetime risks for mental health conditions, but there are other factors in adulthood or old age which can play an important role in mental health and wellbeing. In the context of Camden and Islington, high levels of poverty and disadvantage represent major risks, but can be mitigated by strong family bonds, educational attainment and early intervention when problems develop.

The period of transition occurs at a key time in psychological development and increased vulnerability to the emergence of serious mental health problems and problem drug and alcohol use. Continuity of care, support and access to effective interventions throughout this key period can have long-lasting benefits.

For adults, better mental health can be promoted through employment and meaningful activities, relationships and good physical health. A secure job that provides good working conditions and a fair reward confers protection on mental health through wide reaching effects that extend beyond the individual to their social environment. These include the economic foundations for families to grow and nurture the next generation, and enables individuals the financial means to prepare for aging and retirement.

Remaining active and involved in society are key for older people in improving and maintaining good mental wellbeing. Planning ahead for retirement and old age can boost wellbeing and reduce the risk of mental health conditions. Earlier diagnosis of dementia can help improve quality of life, such as people staying independent in their own homes for longer.

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4

Physical health and mental health

Introduction

The link between mental illness and poor physical health outcomes is now well established. The life expectancy of people with serious mental illness (SMI) is estimated to be up to 20 years less than the general population. [1] In fact, it is estimated that people with serious mental health conditions have the same life expectancy as the general population had in the 1950s. [2] A range of factors contribute to this. One of these is a higher prevalence of long term physical conditions, such as cardiovascular disease (CVD), diabetes, and chronic obstructive pulmonary disorder (COPD). Nationally, it has been estimated that the NHS may spend more on the treatment of the physical health conditions of people with mental health conditions than it does on their mental health treatment, yet outcomes are significantly worse than for the general population. People initially diagnosed with a physical health condition are more likely to develop and be diagnosed with depression or anxiety, and, untreated, leads to worse outcomes including increased risk of mortality. This chapter explores the associations between mental health conditions, physical health and related lifestyle factors in Camden and Islington, and describes the efforts to address these.

Across England, people in contact with specialist mental health services – typically those with more severe or longer-term conditions – have a mortality rate 3.6 times that of the general population. [3] While suicide is an important contributor to this, physical health conditions account for a much greater proportion of early, preventable deaths. [4] A very similar picture emerges in both Camden and Islington, where deaths in this group are 2.4 times and 3.6 times higher than in the general population. [5] In both boroughs, premature, potentially preventable deaths among people with long term, severe and enduring mental health conditions are a major cause of inequalities in life expectancy.

Inequalities in health between people with and without mental health conditions are also likely to contribute to health inequalities between the most and least deprived areas of Camden and Islington. People living in the most deprived parts of both boroughs are at higher risk of premature mortality associated with poor physical health. And, in the same areas, people are more likely to be diagnosed with depression and anxiety. Thus, those living in the most deprived areas are at a higher risk of mental health problems and physical health problems separately, and these feed into one another to reinforce risk of ill health and worsen outcomes further. They are significantly more likely to access hospitals for their physical health care, and to do so as an emergency. [6]

Physical health and mental health are often unnecessarily separated by health professionals and treatment and care systems. To overcome this separation and improve health outcomes for patients, Mental Health Trusts in London have set a goal to reduce the gap in life expectancy for people with severe and enduring mental illness and the general population by 10% within 10 years. [7] To support this, they have pledged to proactively offer smoking cessation, blood pressure monitoring and treatment, cancer screening and treatment, and weight management programmes.

As well as improving quality of life, local interventions to improve the physical health of people living with mental health conditions are also likely generate cost savings in the longer term. Case finding and management of

depression and anxiety among those diagnosed with long term physical conditions should be a central part of efforts to tackle health inequalities in Camden and Islington. It is also vital that lifestyle services support health behaviour change, particularly reducing weight, alcohol intake and smoking amongst people with both diagnosed physical and mental health conditions.

Mental health conditions in people with long term physical health conditions

Just as poor physical health is seen in people initially diagnosed with mental health conditions, depression and anxiety are highly prevalent amongst people living with long term physical health conditions. Those with depression and anxiety can find it hard to manage their physical health, often leading to poorer outcomes. For instance, depression and anxiety may contribute to hospitalisations, non-adherence to medication, and can reduce healthy behaviours such as physical activity and a healthy diet. [1] Additionally, the combination of depression and a physical health condition can contribute to loss of employment and consequently loss of income. This can further compromise social wellbeing and isolation, which is itself a risk factor for poor physical and mental health. Thus, a cycle of poor mental health, physical health and wellbeing exists, where each factor reinforces the others.

The recent Chief Medical Officer's report on Public Mental Health highlights that while the relationship between poor physical health and depression and anxiety is now acknowledged, it is still often considered as inevitable, which can lead to under diagnosis and lack of treatment. [1] Diagnosis of depression and anxiety in people with long term conditions (LTCs) is important. However, evidence suggests that screening for depression is unlikely to be effective as a standalone measure, and there must be adequate treatment pathways in place, for example referral to Improving Access to Psychological Therapies (IAPT) Service.

Premature mortality amongst people with a serious mental illness

One of the main drivers of premature mortality for people with mental health conditions is the increased risk and earlier onset of long term physical health conditions, particularly cardiovascular disease and diabetes. People with schizophrenia, bipolar disorder and other psychotic disorders in particular, are at higher risk of physical ill health than the general population.

National data from 2010-2011 highlights that people in contact with specialist mental health services (aged 19-74 years) had a death rate 3.6 times higher than the general population. The rate is higher for most causes of death, but in particular for respiratory disease (3.8 times higher), diseases of the digestive system such as liver disease (4.4 times higher), and diseases of the circulatory system (2.5 times higher). [3]

Long term conditions among people with serious mental illness, and common mental health disorders

The prevalence of LTCs is much more common among people with SMI. Indeed, 15% of Camden's overall population has a LTC while among those with a SMI, the prevalence is 32%. Similarly, in Islington the corresponding prevalences are 16% and 31%, respectively.

LTCs are also more common among those with depression; adjusted for the age structure of the Camden and Islington populations, residents with depression are more likely to have COPD, chronic liver disease, dementia, or a stroke than the general population.

People with anxiety are also more likely to have one or more LTC than the general population, although the risk is lower than for people with depression or a psychotic disorder.

Age plays a role in these relationships. Of people with more than one diagnosed LTC, those aged 50-59 years are more likely to be diagnosed with depression first, whereas those over 60 years are more likely to be diagnosed with another LTC before being diagnosed with depression, suggesting that in this older age group depression occurs as result of living with a LTC. Young people (aged 20-49 years) account for the majority of people suffering chronic depression (chronic depression includes patients who have a current diagnosis of depression that has lasted two years or more, and are on medication) without any other LTC diagnoses.

A spotlight on... rehabilitation for people with psychosis

Integrated Mental Health Rehabilitation and Accommodation Team – Camden & Islington NHS Foundation Trust

Using a recovery-based approach, the Integrated Mental Health Rehabilitation and Accommodation Team works with people with long term psychosis who live in high-support accommodation within Islington. It provides multi-disciplinary care co-ordination to improve service users' physical health outcomes and promote recovery. As well as psychosis, service users may have other complex needs, such as treatment resistance, difficulties with everyday living, substance misuse, and/or physical health problems.

The multidisciplinary team consists of a rehabilitation psychiatrist, mental health and primary care nurses, psychologists, social workers, occupational therapists, and support and activity workers. It provides regular support directly to service users and the people that care for them, with whom they create tailored care plans to facilitate service users' transition from higher to lower levels of support. The latter includes carers, accommodation staff, GPs, and community matrons. In this way, service users' mental and physical needs are met more effectively, and they are supported more effectively towards their recovery goals and living more independently.

Around 150 service users living in Islington accommodation have their care co-ordinated by the team, and approximately 50 more are supported in out of area placements. A real strength in meeting the physical health needs of clients is the service's close work with the community matrons working with LTCs. As a result, the number of annual reviews conducted with service users has increased and now reach the target of 70%. The number of health care plans specific to physical health conditions has also increased.

Case study

Over the three months of working with a community matron, Jamie, who has a psychosis, has had several physical health checks undertaken. During these, Type 2 Diabetes and hypertension were diagnosed. On-going education and support towards a healthier lifestyle were provided, and Jamie has since lost over a stone in weight. His mobility and physical health have improved, and he has now allowed district nurses to attend to his leg ulcers on a daily basis.

A joined-up approach to physical and mental health care needs

A key challenge is to ensure that pathways for people with a physical LTC and mental health conditions address the needs of patients holistically. Screening for depression in a LTC, for example, is not enough in itself to improve outcomes without further support and intervention. Such an approach needs to be integrated across all care settings including primary, secondary, and tertiary services and also within community services and voluntary sector provision. Mental wellbeing should be considered of equal importance to physical and social wellbeing in the design and delivery of any preventative and early intervention measures by Camden and Islington Councils, Camden and Islington CCGs, and the voluntary and community sector.

Lifestyle risk factors and mental health conditions

Lifestyle risk factors are significantly more common among people with mental health conditions than the general population. Notably, these are smoking, poor physical activity, unhealthy diets, and excessive alcohol intake, as well as unsafe sexual health behaviours and poor oral health. These increase the risk of developing a LTC and contribute to poorer outcomes in those who already have a LTC.

Psychological approaches in a LTC management

Psychological interventions and support are increasingly recognised as an important part of the care and treatment of physical conditions. The introduction of care planning for people with long term physical and mental health conditions, and the availability of a range of self-management programmes, highlight the local commitment to these approaches.

The principles of self-management have been derived from psychological and behavioural models. These acknowledge that a sense of control can give people confidence, and motivation to take on, and continue with new and often difficult tasks, as many people have to do when diagnosed with a LTC.

Both Camden and Islington CCGs commission a number of self-management programmes for people with LTCs, including DESMOND for diabetes, pulmonary rehabilitation and breathlessness support groups for COPD and cardiac rehabilitation for people with CVD. The Expert Patient Programme is a self-management programme which aims to support people by increasing their confidence; improving quality of life and helping them manage their health more effectively. The programme includes a focus on coping with depression.

Peer support is another approach that can include emotional and/or psychological support and have been developed to better support people to manage their physical and mental wellbeing. Peer support is discussed further in Chapter 6.

Not only are people with mental health conditions more likely to have a long term physical health condition, they are also more likely to be at risk of developing a LTC in the future due to lifestyle factors.

There is a lack of robust data available on physical activity levels in this population but a number of small studies suggest that people with mental health conditions are more likely to be sedentary or inactive than the general population.[8] Physical activity can also play a role in enhancing psychological wellbeing and mental health. For this reason it should be considered as part of both prevention and treatment for mental health conditions.

Medication, in particular antipsychotics, prescribed to treat mental illness and its symptoms carry a risk of weight gain, especially among young people experiencing a first episode

A spotlight on… physical activity for residents with poor mental health in Camden

Physical Activity Pathway for Mental Health – Camden Council

The Active Health Team in Camden Council offers a physical activity programme that targets those living with poor mental health in the borough. Eligible residents must be over 18 years old, registered with a Camden GP, want to exercise, and have a clinical diagnosis of a mental health illness where the diagnosis has persisted for at least six weeks.

The service proactively engages with mental health services across Camden. This is a source of referrals and self-referrals which compliments the more established referral route via Camden GPs. It offers people an assessment of physical health need, a physical activity programme tailored to clients' preferences, monitoring of progress and long term follow-up.

It aims to:

- **reduce the health risks associated with mental illness**
- **have a holistic approach to patient care**
- **help patients to understand and use physical activity as a tool to manage their health condition**
- **support individuals to make behaviour changes to maintain healthier and more active lifestyles**
- **be a high-quality, safe, reliable, and efficient service that is user-centred and offers patient choice**
- **target mental health inequalities by addressing health conditions that are known to be directly related to low socioeconomic status**
- **contribute to building the evidence base for mental health and exercise referral programmes**
- **work with partners to ensure that mental health and exercise is included in part of the care pathways.**

There have been 511 referrals in the last year, and over half of these come from Camden's priority wards.

The Active Health Team also works with health care professionals in the borough to support their patients in accessing physical health tools such as Green Gyms, Outdoor Gyms and Walking classes.

of psychosis. Side effects can also cause physical health problems. NICE recommends that people with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme which can improve their physical health and quality of life. [9]

The impact of mental health on children and young people's physical health

Nationally, more than 75% of adults who access mental health services had a diagnosable disorder prior to the age of 18. [10] As described in Chapter 2, it is estimated that 13% of children aged 5-16 have a diagnosable mental health disorder in Camden and Islington. Like in adults, physical health is linked with mental ill health in children. [11] It is important this is not overlooked, and that children with any health condition are offered psychological support.

Specific challenges include emotional disorders, which are more likely to affect young people and children's physical health in later life through higher risk behaviours and compromised educational and employment prospects. Furthermore, side effects of antipsychotic and attention deficit hyperactivity disorder (ADHD) medications can affect long term physical health.

The physical health of children and adolescents with mental illness should be regularly monitored, especially those on mental health in-patient wards, those with serious mental health conditions, or on antipsychotic medication. Health promotion interventions such as smoking cessation and exercise in particular should also be available. [12]

Dementia and physical health in older people

While age remains the most important non-modifiable risk factor for dementia, there is

A spotlight on… psychiatric liaison services in Whittington Hospital

Integrated Liaison and Assessment Team – Camden & Islington NHS Foundation Trust

Unmet mental health needs can result in poorly-managed physical health, and can complicate hospital admissions. For example, an older patient with dementia who falls, fracturing a hip, may require more specialist support on hospital admission through to their recovery.

The Integrated Liaison and Assessment Team (ILAT), established in November 2013, builds on the existing psychiatric liaison services delivered in the Whittington Hospital. It brings specialist mental health assessment and treatment skills into the hospital to enable effective treatment for people who have both physical and mental health needs.

The team comprises of professionals in psychiatry, medical trainees, nurses, occupational therapists and social workers, who are co-located in A&E. Staff members carry a pager and are able to respond quickly and at any time of day. As well as assessment, the team provide treatment, discharge planning and clinical advice, and provide a programme of training to ward and A&E staff at Whittington Hospital.

Whittington staff can refer anyone to be screened by the team. Per month, around 60 referrals are made on the wards and 140 on A&E. Initial data from the service's first twelve months of operation showed that ILAT referred patients have 3 days fewer in average length of stay, and 8% lower hospital readmission rates, when compared to patients at the Whittington with a mental health condition who are not referred to ILAT.

evidence that minimising lifestyle risk factors may have a protective role in dementia. These are particularly linked to vascular risk factors. Thus, diet, exercise, alcohol consumption, and smoking are all important factors in mitigating the risk of dementia onset. Other important risk factors for dementia are low educational attainment and depression. [13]

Ensuring that the health needs of people with dementia are met is complex; people diagnosed with dementia have a higher proportion of co-morbidities than the general population over 65 years, and with increasing life expectancy, there are growing numbers of older people with dementia who are physically frail. In Camden and Islington, people with dementia who are aged over 65 are more likely than others of the same age without dementia to have a range of LTCs including high blood pressure, stroke, atrial fibrillation, chronic kidney disease and chronic depression. The physical health care needs of people with dementia are therefore a key part of holistic pathways of care for people with dementia.

People with dementia are likely to suffer from depression; therefore it is important that people are screened in order to introduce treatment. In Islington people with dementia are less likely to have a depression screen (after they were diagnosed with dementia) than the general population aged 65 years and over (32% vs 36%). In Camden the picture is different – there is no difference between people with dementia and the general population aged 65 years and over in the proportion who have had a depression screen (after the dementia diagnosis) (both 29%). A fairly high proportion of people with dementia in both Camden and Islington are already diagnosed with depression before the dementia diagnosis (18% in Camden and 20% in Islington).

Lifestyle and behaviour change services

Camden and Islington Councils and CCGs commission a number of services aimed at improving lifestyles and promoting and supporting behaviour change. These include

A spotlight on… removing smoking areas on Trust sites in Camden and Islington

Camden and Islington Foundation NHS Foundation Trust

A third of all cigarettes smoked in England are smoked by people with a mental disorder, and rates of smoking for people with psychotic disorders are as high as 80%. Smoking kills 50% of lifetime smokers through causing cancer, heart disease, and lung diseases, and is the single most important contribution to excess mortality in people with SMI. Smoking can exacerbate symptoms and can impair the effectiveness of some medications.

Currently, within Camden and Islington NHS Foundation Trust sites, smoking by service users exposes other service users and staff to second-hand smoke and requires considerable staff-time to facilitate smoking. NICE guidelines (2013) recommend that mental health trusts should support their patients who smoke in the same way that general hospitals do, should provide access to support to help people to abstain from smoking, should remove all smoking areas, and stop all facilitated smoking breaks.

In response to these issues the Trust has agreed a new and comprehensive nicotine management strategy which ensures the provision of smoking cessation support to all service users, continuity of support on discharge and the introduction of completely smoke-free in-patient sites from March 2015. The implementation of the policy ensures full compliance with NICE guidelines and better health for service users.

Long term conditions and mental health

Poor mental health can lead to physical ill health, and poor physical health can lead to mental ill health

Mental health condition

At the time of diagnosis, 9% of people diagnosed with a physical long term condition had previously been diagnosed with CMD

At the time of diagnosis, 11% of people diagnosed with CMD had previously been diagnosed with a physical long term condition.

Other LTCs

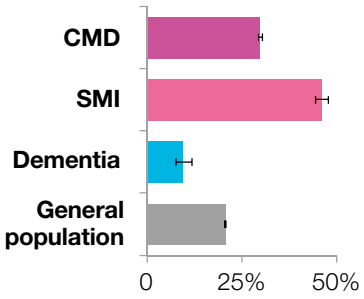
People with mental health conditions are more likely to experience deprivation and social exclusion, and may be less likely to live a healthy lifestyle.

This means they are more likely to develop long term physical health conditions than people without a mental health condition. They may also have greater difficulty in managing their conditions.

There is also the opposite relationship: people with long term physical health conditions are at a higher risk of developing CMD and, for some conditions, increased risk of dementia.

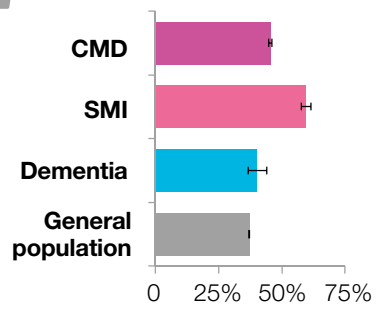
Lifestyle risks in people with mental health conditions are, in general, higher than the population overall, leaving people with mental health conditions at higher risk of developing long term conditions related to these risk factors.

Smoking



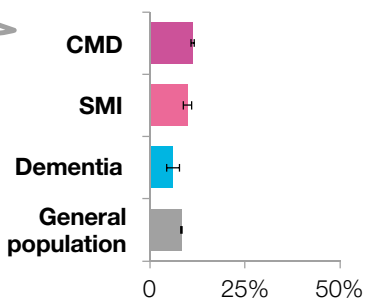
Smoking is more than twice as common among people with SMI as the general population

Obese/overweight



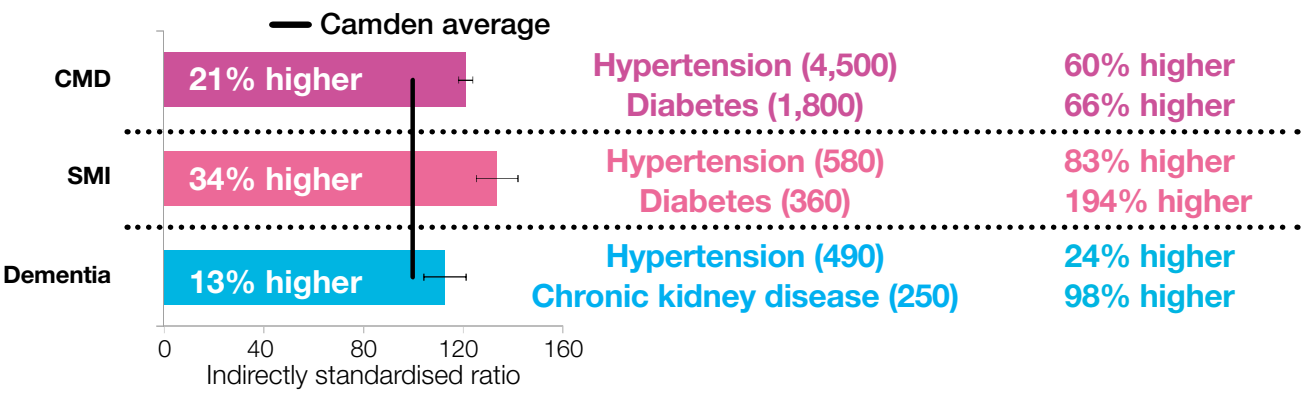
People with SMI are more likely to be overweight or obese

Higher risk drinking



Higher risk drinking is more common among people with CMD and SMI

Compared to the general population, people with mental health conditions are more likely to have long term physical health conditions.



Source: All data from Camden GP PH dataset, 2012

Camden

Long term conditions and mental health

Poor mental health can lead to physical ill health, and poor physical health can lead to mental ill health

Mental health condition

At the time of diagnosis, 8% of people diagnosed with a physical long term condition had previously been diagnosed with CMD

At the time of diagnosis, 11% of people diagnosed with CMD had previously been diagnosed with a physical long term condition.

Other LTCs

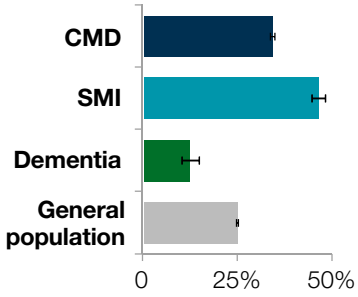
People with mental health conditions are more likely to experience deprivation and social exclusion, and may be less likely to live a healthy lifestyle.

This means they are more likely to develop long term physical health conditions than people without a mental health condition. They may also have greater difficulty in managing their conditions.

There is also the opposite relationship: people with long term physical health conditions are at a higher risk of developing CMD and, for some conditions, increased risk of dementia.

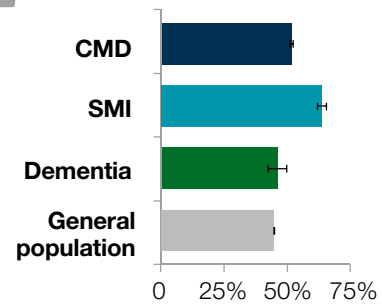
Lifestyle risks in people with mental health conditions are, in general, higher than the population overall, leaving people with mental health conditions at higher risk of developing long term conditions related to these risk factors.

Smoking



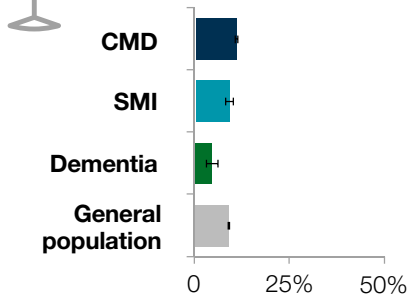
Smoking is more than twice as common among people with SMI as the general population

Obese/overweight



People with CMD and SMI are more likely to be overweight or obese

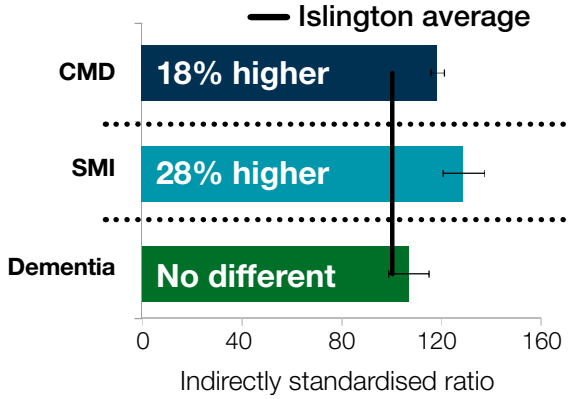
Higher risk drinking



Higher risk drinking is more common among people with CMD

Compared to the general population, people with mental health conditions are more likely to have long term physical health conditions.

Indirectly standardised rate of one or more LTCs, other than MH conditions	Most common long term physical health conditions (and number of cases)	Prevalence compared to the general population
CMD – 18% higher	Hypertension (4,700)	44% higher
	Diabetes (2,100)	46% higher
SMI – 28% higher	Hypertension (520)	54% higher
	Diabetes (410)	175% higher
Dementia – No different	Hypertension (480)	11% higher
	Diabetes (250)	27% higher



Islington

Source: All data from Islington GP PH dataset, 2012

adult weight management, stop smoking services, and exercise on referral, among others. Interventions to improve lifestyle factors in people with mental health conditions, including smoking cessation, have been found to be cost-effective according to the NICE threshold. For instance, the cost per quality adjusted life year (QALY) gained from ten-week pharmacological treatment in combination with cognitive behavioural therapy (CBT) and Nicotine Replacement Therapy to support smoking cessation, is estimated to be £1,255. [14]

The cost per QALY gained from group-based lifestyle interventions to reduce weight in people with schizophrenia and Type 2 diabetes is £700. Further studies are needed to understand whether the health impacts of these physical health interventions can be sustained over a longer period of time.

People with mental health conditions are likely to be more vulnerable to wider social issues which are risk factors for poor physical health, such as poor housing, homelessness, unemployment, and low income. These same wider social issues are a 'double' risk factor for physical and mental ill-health. SHINE (Seasonal Health Interventions Network) in Islington and WISH+ (Warmth, Income, Safety and Health service) in Camden are referral hubs provided by each Council to enable people to access services and advice in a range of areas including warmth, fuel, debt, income, housing repairs, safety and security. More details of these interventions are in Chapter 5.

Stop smoking support

There is good evidence that smoking cessation interventions are both clinically and cost effective for people with mental health conditions. Smoking cessation does not exacerbate symptoms of mental disorders and that people with mental health problems are as motivated to quit as the general population.

In Islington, the stop smoking service provides smoking cessation support for the general population, but incentivises service providers to proactively target people with mental health conditions to quit. Although the number of people with a mental health condition accessing the stop smoking services in Camden and Islington is relatively small, there is no significant difference in successful quit rates between the service users with and without a mental health condition. [15]

NHS Health Checks

The NHS Health Check programme offers an assessment of people's cardiovascular risk, provides lifestyle advice and referral into appropriate services, and facilitates clinical follow up of those found to have higher risk. In Islington, NHS Health Checks are offered to people aged 35-74. In Camden, they are offered to those aged 40-74 (or 30-74 for people of South Asian ethnicity). Locally NHS Health Checks are available through GPs, some pharmacies and in a number of community settings.

Providers are incentivised to actively target people on practice registers with SMI and learning disabilities. As a result, in Islington, people eligible for an NHS Health Check with a mental health diagnosis (including those with a learning disability) are significantly more likely to have had an NHS Health Check than those eligible in the general population (22% versus 16%). In Camden, people who are eligible for an NHS Health Check with a mental health diagnosis are as likely to have had an NHS Health Check than those eligible in the general population (6% versus 5%). However, in Camden practices have only recently been incentivised to target high risk patients, unlike the Islington programme. It is likely the number of people with a mental health diagnosis receiving an NHS Health Check in Camden will increase in the future.

Primary care

Nationally, around 40-50% of people with an SMI are seen by specialist mental health services in coordination with GP practices, with the remaining 50-60% under primary care only. One of the biggest challenges in improving physical health in people with mental illness is ensuring an effective link between primary care and secondary services in the management of their patients. Primary care has a very important role to play in providing an integrated and holistic assessment and care pathway.

National frameworks for improving the physical health of people with psychoses

A national CQUIN (Commissioning for Quality and Innovation) incentive for Mental Health Trusts has been introduced to ensure comprehensive up-to-date records of physical and mental health diagnoses for service users, which are communicated between primary care and specialist mental health clinicians and with the service user. This is intended to reduce premature mortality, improve patient safety, patient experience, quality of life, and promote recovery through better identification and management of physical health needs alongside mental health conditions.

NICE guidelines recommend annual and comprehensive monitoring of physical health for people with schizophrenia and psychoses in primary care, especially cardiovascular disease, diabetes, obesity and respiratory disease.

For patients under the care of mental health trusts, this information should be shared with the care coordinator and be in medical records.

Local frameworks

In Islington, the CCG commissions a locally commissioned service (LCS) which aims to improve case finding, early diagnosis and management of LTCs. This LCS incentivises case-finding of depression in people with specific LTCs (diabetes, COPD, chronic kidney disease, chronic heart disease).

At present, there is no LCS addressing the specific needs of people with SMI, however, a 'value based commissioning' (VBC) programme (see below), offering holistic care for those living with psychosis, is being developed.

Value based commissioning for people with psychosis

Camden and Islington CCGs are currently working together to introduce a new VBC programme focusing on improving the physical health and reducing premature mortality among people with psychotic conditions, described below. The CCGs will work with providers and service users to improve the experience and outcomes of care for people living with psychosis, addressing both their physical and mental health needs and enabling people who live with psychosis to live "longer, healthier, happier lives". The programme recognises the importance of improving the quality and care of people's mental health conditions as part of an overall approach to increasing life expectancy and quality of life, alongside physical health measures. A central aspect of VBC is the reorganisation of selected services into an 'integrated practice unit' to enable greater integration of care, and improve patient experience and outcomes.

This involves aligning objectives and incentives across all parts of the system of care to achieve this overall objective and the identified outcomes, so that all services are working together towards shared goals. This is likely to be complex for services for people with psychotic conditions since so many different organisations are involved. From a practical point of view, health and social care staff and service users 'navigating' the system require

Table 4.1 Physical health outcomes included in value based commissioning IPU model for SMI

Area of physical health	Outcome measures
Smoking	Reducing the level of smoking.
Substance Misuse	Reducing the number of people misusing substances including alcohol, illicit drugs and other substances.
Diabetes	Reducing the gap between observed and estimated diabetes prevalence.
Diabetes control	Improving the emotional wellbeing and perceived control in those managing diabetes.
Acute Respiratory Disease	A reduction in the number of emergency admissions for an acute respiratory condition that should not usually require hospital admission.

Adapted from North Central London Serious Mental Illness (SMI) Summary of Outcomes Measures.

excellent signposting and simplified pathways between services.

A range of outcomes have been developed collaboratively between commissioners, clinicians and service users as part of the integrated practice unit (IPU) model, including number of physical health outcomes. These are outlined in Table 4.1.

These five physical health indicators have been selected as key outcomes that would improve physical health and reduce premature mortality over the next five years. However, they are not intended to be exhaustive and action in other physical health areas will be needed to achieve them. For example, actions that focus on diabetes are closely linked to weight management and risk factors for cardiovascular disease; action that focuses on smoking and substance misuse should contribute to longer term reductions in cancer risk; and reducing admissions for acute respiratory disease such as COPD is closely linked to heart failure.

Conclusions

The inequalities directly due to mental health conditions already described earlier in this report are amplified by physical health impacts. These are starkest in people with serious mental health conditions, for whom life expectancy is 15-20 years lower than the general population. However, people living with common mental health disorders, especially chronic depression, have increased physical health risks, too. In addition, most people with diagnosed dementia are living with multiple physical co-morbidities. People with mental health conditions have substantially higher levels of some LTCs, including cardiovascular and respiratory conditions and diabetes. Lifestyle factors such as smoking, weight and, in depression, alcohol intake, increase the risk of developing LTCs and contribute to poorer outcomes in people with existing LTCs.

Recognising and acting on the links between physical health and mental health conditions is therefore key to reducing health inequalities in both Camden and Islington, and for improving the health of the overall population.

Based on parity of esteem, the physical health of people with both common and serious mental health conditions should be regularly monitored to prevent the development of LTCs. The responsibility for this should be shared and well communicated across both primary and secondary care organisation and care providers.

Developing pathways for the care of people with all mental health conditions, including depression and anxiety, that include a complementary focus on lifestyle changes and preventing and managing LTCs will contribute to better overall health outcomes.

People with LTCs should be screened for depression, however it is vital this is accompanied by appropriate intervention and treatment.

Physical activity should be promoted as both prevention and treatment for mental health conditions.

A continued focus on reducing smoking should be maintained in the general population but specifically amongst people with mental health conditions who are more likely to smoke and also be heavier smokers.

Reducing weight and also alcohol intake in people with mental health conditions should be a priority for health care professionals and lifestyle service providers.

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5 Place

The homes we live in, the places we work and play in, and our wider physical and social environments can be protective or harmful to our mental health in a variety of ways. Good mental health and wellbeing is complex and approaches to improving mental health must include action at the environmental and societal level as well as the individual level.

National and international policy and research supports this approach. The national strategy 'No Health Without Mental Health' recognises that social inequality contributes to mental ill health, and highlights that people with worse mental health or wellbeing are likely to have poorer employment prospects and housing. [1] Internationally, the World Health Organisation calls for a multi-layered response to mental health which incorporates housing, transport, and employment, as well as health and education services. [2]

Locally, efforts have been made to make Camden and Islington places that promote wellbeing and good mental health. These include improvements to housing, commitments to a high quality and supportive built environment and public spaces, and action to ensure that our workplaces promote mental health through their actions and policies.

This chapter looks in more detail at the interface between the individual and their environment, and how this may influence wellbeing and mental health. Three main elements will be considered: homes, the environment and workplaces.

Homes and mental health

A person's home has a profound influence on the way they feel. A home that is dry, warm, affordable, secure and large enough for the occupants has been shown to support better mental health and wellbeing. High quality research evidence shows that improvements to the warmth of individual homes can improve mental health. [3, 4] Evidence has also shown that re-housing people living in overcrowded areas can improve mental health outcomes in the longer term. [5]

All of these challenges are important locally. Both Camden and Islington are densely populated boroughs and are home to some of London's wealthiest and poorest people. Significant redevelopment and regeneration is taking place and population growth is expected in both boroughs. The pattern of housing is changing, with access to high quality affordable housing a major issue. The cost of housing is among the highest in the country, and owning or privately-renting a home is out of the reach of the majority of residents. There have been significant improvements in the quality of social housing through the Decent Homes Programme, but increased demand within the private rented sector has led to falling standards as well as increasing prices. Both boroughs have also seen an increase in "buy-to-leave" properties. These are new homes sold as investments, often marketed off-plan overseas, and left to stand empty. Overcrowding, homelessness and the suitability of housing to meet the needs of an ageing population are other important local challenges.

A spotlight on…reaching people in most need in Camden and Islington

SHINE and WISH+ – Camden and Islington Councils

Camden and Islington Councils each have their own teams to target people in most need, and co-ordinate referrals to the right services. These are, respectively, the Warmth, Income, Safety and Health (WISH+) service and Seasonal Health Interventions Network (SHINE). The effectiveness of both teams relies on strong and enduring partnerships with a wide range of internal and external partners. They work closely with other council teams such as Public Health and Adult Social Care; and they refer to and receive referrals from local voluntary sector services and NHS providers.

SHINE – The SHINE team sits within Islington Council's Environment and Regeneration Directorate. In 2013-2014, it received 2,830 referrals, a mixture of self-referrals and third party referrals, including from the local hospitals and GP surgeries. The service signposts people to around thirty interventions, including advice on saving energy, grants for heating and insulation, support with bills and energy debt, benefit checks, falls prevention, befriending services, air quality alerts for people with respiratory diseases, NHS services, and other support to people to remain safe and independent in their own homes.

WISH+ – The WISH+ service is located in Camden Council's Housing and Adult Social Care directorate, which enables targeting of the borough's most vulnerable residents. Referrals are received mostly from frontline housing teams, GPs and other community health organisations. During 2013-2014 the team received 1740 referrals and made 2150 onward referrals to other services. These include home energy efficiency improvements, energy advice, home safety and security advice, cardiovascular health checks, help with anxiety and depression, and support to maximise income.

Around one-in-three households have some level of over-crowding (at least one fewer bedroom than needed for the number of residents) in Camden and in Islington. This is notably higher than the national and London averages.[6] Efforts are being made in both Councils to promote down-sizing within the social-rented sector to ease over-crowding. The Coalition Government's under-occupancy charge or 'Bedroom Tax' limits the amount of housing benefit that council and housing association tenants can claim and is intended to relieve over-crowding by reallocating larger homes to those households with more members. Both Camden and Islington are offering incentives for people to downsize or assistance with letting their spare rooms.

Council-rented and social rented housing account for more than 40% (40,000 households) of housing tenures in Islington and 30% (33,000 households) in Camden, proportions which are among the highest in the country. The prevalence of mental health conditions in those living in social housing is significantly higher than for those living in privately-owned or rented homes.

Increasing the number of affordable and decent homes in Islington remains a key corporate priority for Islington Council. Moreover, the Islington Housing Strategy 2014 to 2019 sets a clear priority to improve health and wellbeing through housing, whilst the Islington Housing Asset Management Strategy 2013-2043 identifies priorities for investment in homes and estates in the longer term. Islington is pioneering new ways for councils to tackle the problems of housing quality in the private-rented sector: including a council-run lettings agency; a letting agent redress scheme; and a scheme to require

landlords along two of the borough's busiest streets to apply for a licence for properties that have been divided up and are occupied by three or more people. This is stricter than that currently required nationally and is designed to be more relevant to the local situation.

The Camden Housing Strategy 2011-2016 makes the case for high quality affordable homes in Camden and provides the detail of how the ambitions laid out in the Camden Plan will be delivered. The Plan acknowledges the fundamental impact that poor quality housing has on health and wellbeing, and sets out the ambition that no-one in Camden should have to live in sub-standard housing. There is a further focus on securing 'the right house for the right person', with specialist homes for those who require them, including people with serious mental health conditions.

Despite high levels of overcrowding, single person households are relatively common in both Camden and Islington with around four in ten households made up of one person living alone, of whom a third are aged 65 or over. [6] The chances of experiencing isolation are increased when a home is not shared. Older people living alone are particularly at risk and this is increased further where a person has poor mental health. A lack of social networks can cause a decline in a person's mental health and also pose difficulties for recovery. Less than half of those who use mental health services in Camden and Islington report having as much social contact as they would like.

Specialist housing services for those with mental health conditions who require accommodation support are provided through supported housing and other floating or flexible services. Help available includes the provision of accommodation, adaptation of existing homes, and on-going support in the home. The aim is to provide a bridge between institutional living and independent living, and to support continued independence in recovery. The large majority of people in contact with mental health services are living independently in both Camden (74%) and Islington (76%). [7]

Keeping warm at home is important for good mental health. Interventions to improve the warmth of homes may contribute to a reduction in depression and anxiety amongst residents. These improvements may be due to: lower energy bills through improved energy efficiency relieving the threat of debt; a greater feeling of control; an expansion of the domestic space used during cold periods; and improved familial relations. [4] As energy bills rise, an increasing number of people are at risk of fuel poverty in Camden and Islington.

Homelessness

The term 'homeless' can encompass many situations and is associated with increased levels of mental health conditions. In Camden and Islington in 2013-2014 there were, respectively, 125 and 410 households accepted as statutorily homeless, and a further 654 and 1,008 households living in temporary accommodation. These households may have multiple occupants, including children. The mental health needs of this group are often high: moving into temporary accommodation can be the result of domestic abuse or severe life problems including mental health crises.

Levels of need are highest among those who are living on the streets, in squats or in hostels. Support for mental health conditions is the predominant care need of this group and may often be the cause of their homelessness. [8] The reasons for this are complex but it is known that people with mental health problems are more likely to find themselves in a situation where they require emergency housing due to rent arrears, an unexpected hospital admission or other unanticipated crisis. In addition, the chances of recovery from a pre-existing mental health problem are hampered by unsuitable housing or homelessness.

The total number of people sleeping rough in Camden is the second highest in London. In 2013-2014, there were 501 rough sleepers counted in Camden, a figure that has been rising each year for at least four years. Over half were new rough sleepers. In Islington, there were a total of 163 rough sleepers during the year. [8]

Most rough sleepers are successfully housed, but the increase in street homeless seen across the capital in recent years illustrates how tough economic conditions and welfare changes have impacted on the most vulnerable.

Camden is currently working to implement a toolkit developed for people working with rough sleepers who are suffering with mental health issues. This toolkit helps professionals to make capacity assessments and make in-roads with the most entrenched individuals, many of whom have repeatedly resisted assistance from agencies. The toolkit challenges the capacity of these individuals to make decisions in their own interests and raises awareness of the safeguarding duty of local authorities toward these people. [9]

Communities and Regeneration

The design of public space plays an important role in the mental wellbeing of a community. The prevalence of depression has been found to be associated with features of the built environment beyond the individual or household level. In a research study conducted in Camden, factors such as limited recreational space, disused buildings and graffiti were associated with an increased prevalence of depression. [10] Shared public spaces where people can congregate, relax and play contribute to a thriving community, social connectedness and higher levels of wellbeing.

The Healthy Urban Development Unit (HUDU) has made mental health a priority in their research on spatial planning and health. Its report on Delivering Healthier Communities highlights four key mental health risk factors that planning can address: neighbourhood quality; housing design and density; housing quality; and fear of crime. HUDU suggest that practical improvements can be made, including improving contact with nature, encouraging physical activity, improving lighting and encouraging social interaction. The report highlights Russell Square in Camden as a best-practice example of a shared urban green space. [11]

Camden and Islington's Core Strategies set out each borough's vision of how physical space is used, and both refer to the importance of the environment to physical and mental health. The Islington Corporate Plan (2012) sets a priority that open spaces be welcoming and accessible and designed in a way that encourages their use and provides opportunities for residents to be more active and healthy. The Islington Fairness Commission recommends that all unused communal space in Islington, especially on estates, be made accessible for use by the community.

Regeneration is on-going in a number of Camden and Islington estates and the principles and aims of the corporate strategies are reflected in these developments. In addition, Camden's Community Investment Programme (CIP) aims to improve residents' health and wellbeing by investing in physical assets across the borough such as community centres and shared spaces. Building works are underway at nine CIP sites, including Bacton Low Rise, Maiden Lane and Plender Street. There will be new homes, business space, improved open spaces and community facilities.

Russell Square

Packington Estate

The Packington Estate in Islington has seen significant redevelopment over the last few years and once complete (Summer 2016) 538 lower quality flats will have been replaced with 791 mixed-tenure houses and flats. 62% of the new homes will be for social rent, many of which will be three, four, five and six bedroom family homes to suit Islington's current population. The work is being part-funded through cross-subsidy sale of 300 properties on the open market. The redevelopment includes 1,640m² of non-residential space, including a canal side park, community centre, adventure playground and youth centre.

Health Impact Assessments are used to identify the effects of regeneration and development projects, including the construction phases, on the health of local people and communities. They should consider the range of impacts, ranging from access to health and social care services, other local amenities such as leisure facilities, access to healthy food and green space, noise and air pollution, as well as other factors such as impacts on community safety, social connectedness and privacy. Mental health and wellbeing are affected by changes in the built environment and should be a key consideration in the assessments. Actions to mitigate negative aspects or to boost positive benefits to health can then be identified and implemented based on the assessments.

The mental health impact of High Speed 2 development in Camden

High Speed 2 (HS2) is a large scale rail development proposal that will have a significant impact on Camden residents during a construction phase that will last many years, and a continuing impact once operational. Camden Council opposes the current proposals for HS2.

Camden and Islington's Public Health Department undertook an independent evaluation of the Health Impact Assessment and Environmental Statement carried out on behalf of HS2 Ltd. The evaluation concluded that little attention had been paid to the potential impact on residents' mental health, and on those residents who already experience mental health conditions. In particular the Health Impact Assessment noted the following potential impacts relating to mental health and wellbeing:

- **the significant mental health impact of rehousing affected residents**
- **the need for noise mitigation to be provided for those with mental health issues**
- **the mental health impact on employees working over-night on the project**
- **the loss of green space and use of those spaces, including children's play areas**
- **the lack of quantification of the number of people with mental health problems who would be affected in proposals.**

Overall the evaluation concluded that HS2 will, in the short-term at least, have a negative impact on the mental health and well-being of affected Camden residents. This illustrates the importance of considering impacts on mental health based on a clear understanding of the local population and its needs in order to better address and reduce any potentially harmful or detrimental impacts on health and wellbeing.

For this, and a range of other important reasons, Camden Council opposes plans for HS2 as currently proposed. In its fight for the best deal for Camden's communities and residents the Council has issued a list of requests to mitigate the effect on residents should the project go ahead and negotiations are ongoing.

Stay up to date on this issue at www.camden.gov.uk/hs2

Green spaces

Access to green space, for example parks, playgrounds or nature reserves, is important for improving or sustaining mental health in crowded urban areas. Green space is associated with overall improved health and a recent evidence review identified the positive benefits on mental health. [12] Recent research has also suggested that individuals who move to greener urban areas have significant and long-lasting improvements in mental health. [13]

Islington has the second lowest amount of green space per person of all local authorities in England, so making the most of the available green space, through creative and accessible use, is a priority. Islington's Core Strategy and Housing Strategy both recognise that encouraging the use of green space will increase physical activity and improve mental health and wellbeing. Camden has some of London's most iconic and well-loved open spaces, but there is also inequality in the distribution of green space across the borough.

Evidence-based interventions to improve access to, and use of, green spaces include Green Gyms, education and information on the availability of green spaces, reclaiming or restoring green space on estates, and activities to draw people toward them. The Camden Green Gym programme is now in its sixth year. It gives opportunities to residents to get involved in physical activity and improves their mental wellbeing through volunteering in the natural environment. Participants have reported a significant increase in individual mental wellbeing and physical activity levels and they are now working with referral programmes including iCope and WISH+ to reach more residents.

Union Square

The Growing for Health project was launched in 2014 and will run for two years across both Camden and Islington. The aim of this project is to use food growing as an engagement tool for hard to reach and vulnerable groups including those with mental health problems and socially isolated groups including older people. Around half of the food growers currently engaged with the project have a mental health problem and the project helps them to socialise, exercise, improve their diet, learn new skills and gain confidence.

Addictive Environments

There is increasing evidence of the negative impact on wellbeing of 'addictive environments'; these are areas where addictive or harmful products and services are easily and legally available. Typically, these are alcohol, gambling and fast food; more recently, there is growing recognition of 'legal highs'. The exposure of young people to an addictive environment is of particular concern to long term mental health - the earlier the age at which a person first tries drinking alcohol, gambling or using other substances, the higher the chance they have of developing an addiction later in life. Genetics are only one element of addiction, and it is now known that environment plays a strong role too. [14]

Islington has one of the densest concentrations of licensed premises for alcohol in London including a high number of 24-hour alcohol licences. Similarly in Camden there is one licensed premise for every 101 resident adults, reflecting the busy night-time economy. Gambling can also be psychologically addictive and the proliferation of betting shops is an

increasing concern to residents. Betting shops are often concentrated in areas of higher deprivation and gambling is associated with debt, poverty and poor mental health.

Both Camden and Islington have proactive approaches to alcohol licensing and strive to balance the interests of residents against the benefits of a thriving night time economy. Both areas have cumulative impact policies which place the onus on new applicants for alcohol licences to demonstrate how they will not add to the negative impact of alcohol in the designated cumulative impact areas. In 2014 Islington also introduced a Late Night Levy which funds additional police and council resource to tackle issues arising from late opening venues. Islington is also exploring the introduction of supplementary planning guidance to reduce the negative impact of over-concentration of gambling and alcohol outlets. The introduction of a Late Night Levy is also under consultation in Camden, and Trading Standards are exploring how existing legislation can be used to tackle the sale of 'Legal Highs' in the borough.

Work and Workplaces

How someone spends their time, in particular the work that they do, is an important part of their identity, and can have a significant impact on mental health. The relationship between work and mental health is complex; poor mental health can lead to employment difficulties, and employment issues can also lead to mental health problems. A fulfilling and rewarding paid job or voluntary position can contribute to a person's mental health and the financial reward of employment enhances the chances of a person maintaining or gaining good mental health. Recovery from mental health conditions is affected by being out of work, with the long term unemployed less likely to recover or see an improvement in their mental health compared with those in employment.

Primrose Hill

Nationally, the nature of employment opportunities is changing, and many people are struggling to maintain a regular or sufficient income. Locally, the Islington Employment Commission has a vision that everyone is given the help that they need to get the job and career they want, deserve and that they will enjoy. The Camden Plan sets similar goals and gives particular focus to unemployment amongst young people in the borough. Both boroughs recognise that resident unemployment is too high and has made action on local employment for residents a top priority.

Around two thirds of people with mental health conditions are in work, but people with mental health conditions often report lower pay, poorer management, and greater job insecurity in the work that they do. [15] For those in contact with mental health services, typically those with long term or severe mental health problems, the picture is considerably worse with only 4% in Camden and 3% in Islington in paid employment, compared to an average of 7% nationally.

The best way of reducing unemployment amongst those who develop mental health problems is by keeping them in the jobs they have when they develop them. The stigma associated with mental health however remains high and this can stop people disclosing their mental health concerns or health problems to their employers, leading to problems in the

Impact of Place on Mental Health

Our homes, workplaces and our environment are wider determinants for mental health. For example, good quality housing, job security and access to green space can positively impact our residents' mental health, whereas the converse can negatively impact mental health. For those with a mental health diagnosis, we highlight areas where inequalities may exist such as opportunities for employment.

Determinants of mental health

Our homes

33% of households are social rented properties, significantly higher than London (24%). [a]

32% of households are overcrowded, significantly higher than London (22%). [a]

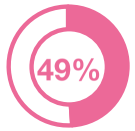
There are **0.76** homeless households per 1,000 total households, significantly lower than London (5.03 per 1,000). [b]

Our workplaces and schools

7% of residents are unemployed and looking for a job, this is similar to London (7%). [c]

15% of residents are in a routine and manual job; significantly lower than London (22%). [a]

12% of secondary school pupils in Camden said they had been bullied at school in the last 12 months; this is significantly lower than the reference sample taken from other boroughs (31%). [f]



49% of pupils in Camden said they thought their school takes bullying seriously; this is significantly lower than the reference sample taken from other boroughs (55%). [f]

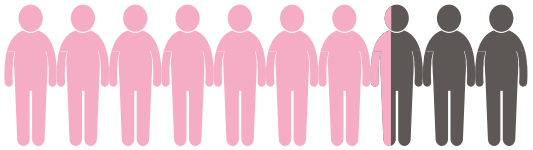
Our communities

21 noise complaints per 1,000 residents; significantly higher than London (18 per 1,000). [b]

In Camden, there is **18%** green space, lower than the London average (26%). [d]

10% of residents use outdoor space for exercise, similar to London (12%). [e]

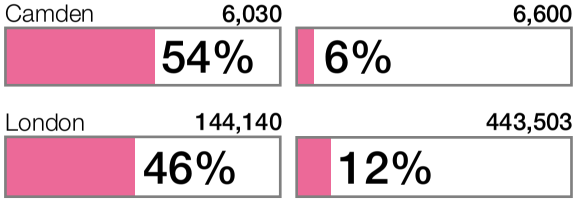
Inequalities of mental health



74%
of people in Camden who are in contact with secondary mental health services live independently. [g]

There are higher levels of mental health and behavioural disorders in people that are unemployed. [h, i]

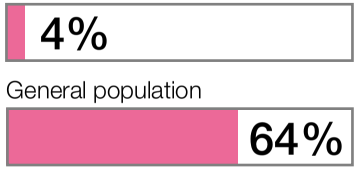
% reporting mental health and behavioual disorders



*Incapacity benefits / severe disablement and employment and support allowance

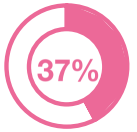
There is a **60%** gap in employment rate for adults with a serious mental health problem on the Care Programme Approach compared to the general population. [b]

Employment rate



Social inclusion for people who use secondary mental health services. [g]

58% felt safe and secure



37% reported they had as much social contact as they would like

Source: a: Census, 2011, b: PHOF, 2015, c: APS, 2014, d: Richardson et al, 2010, e: PHOF, 2013-2014, f HRBQ survey, 2013, g: ASCOF, 2013-2014, h: DWP, 2012-13, i: APS, 2012-2013

Camden

Impact of Place on Mental Health

Our homes, workplaces and our environment are wider determinants for mental health. For example, good quality housing, job security and access to green space can positively impact our residents' mental health, whereas the converse can negatively impact mental health. For those with a mental health diagnosis, we highlight areas where inequalities may exist such as opportunities for employment.

Determinants of mental health

Our homes

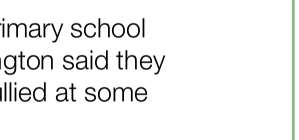
42% of households are social rented properties, significantly higher than London (24%). [a]

29% of households are overcrowded, significantly higher than London (22%). [a]

There are **4.10** homeless households per 1,000 total households, similar to London (5.03 per 1,000). [b]

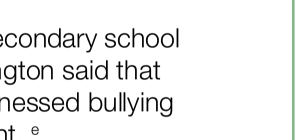
Our workplaces and schools

7% of residents are unemployed and looking for a job, this is similar to London (7%). [c]



57% of primary school pupils in Islington said they had been bullied at some point. [d]

17% of residents are in a routine and manual job; significantly lower than London (22%). [a]



74% of secondary school pupils in Islington said that they had witnessed bullying at some point. [e]

Our communities

21 noise complaints per 1,000 residents; significantly higher than London (18 per 1,000). [b]

In Islington, there is **9%** green space, lower than the London average (26%). [f]

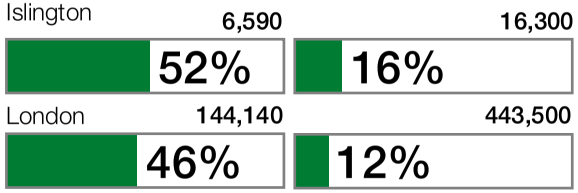
12% of residents use outdoor space for exercise, similar to London (12%). [g]

Inequalities of mental health

76% of people in Islington who are in contact with secondary mental health services live independently. [h]

There are higher levels of mental health and behavioural disorders in people that are unemployed. [h, i]

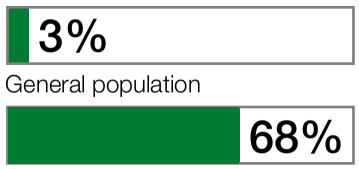
% reporting mental health and behavioual disorders



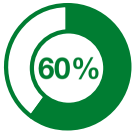
*Incapacity benefits / severe disablement and employment and support allowance

There is a **64%** gap in employment rate for adults with a serious mental health problem on the Care Programme Approach compared to the general population. [b]

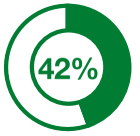
Employment rate



Social inclusion for people who use secondary mental health services [h]



60% felt safe and secure



42% reported they had as much social contact as they would like

Source: a:Census, 2011, b: PHOF, 2015, c: APS, 2014, d: Primary School Anti-Bullying Survey Results 2013, e: Anti-Bullying Secondary School Student Survey 2013, f:Richardson et al, 2010, g: PHOF, 2013-2014, h: ASCOF, 2013-2014, i: DWP, 2012-2013, j: APS, 2012-2013

Islington

long run. The role of workplace interventions in improving the mental health of staff is gaining attention. The London Health Commission 2014 reports that employers in London lose £1.1 billion due to stress, anxiety or depression each year. The Chief Medical Officer's Report 2013 reported that, in the last 5 years, the number of sick days lost to stress, depression and anxiety has increased by a quarter and that the number lost to serious mental illness has doubled.

There is a strong economic imperative for employers to become more informed and involved in supporting their staff's mental health and wellbeing. It is recommended that workplace mental health interventions should focus on preventative approaches, such as flexible working and work-life balance, as well as fair pay, job security, defined roles, and respect for staff welfare. (15) Promoting mental health in the workplace is considered cost-effective and improves work performance as well as reducing stress and sickness rates. (16) Islington Council is working toward achieving the London Healthy Workplace Charter. These workplace standards outline what should be in place to assure the health of the workforce, including mental health, through a mix of policies, management training and support mechanisms. Camden Council is also developing a programme of work focused on workplace wellbeing, with mental health and stress a key area of focus.

Nationally in 2012-2013, 46% of benefits claimants who were out of work due to long term sickness had mental health as their primary reason. This figure is higher in both Camden and Islington, where just over half of claimants have mental health as their primary reason for being long term sick. Being out of work for a prolonged period can further impact on mental health, reduce confidence and self-esteem and make returning to work difficult. Individual Placement and Support is an evidence-based intervention endorsed by NICE that has been shown to be very effective in helping people with long term and serious mental health conditions to gain and then remain in employment. (17) Tailored employment support for people with mental health problems is available in both boroughs.

Since 2012, both Camden and Islington Councils have been London Living Wage employers. By influencing all suppliers to follow suit and engaging with other local businesses on the issue Camden and Islington Councils are improving incomes and working conditions for employees within the borough. Furthermore, Camden was the UK's first TimeWise council and has now been joined by Islington. TimeWise employers drive forward new approaches to flexible working.

Islington Council recently announced the first council-commissioned care home in the UK to pay all staff the London Living Wage and both Camden and Islington are signatories to the Unison Ethical Care Charter which promote the recruitment and retention of a stable care workforce through more sustainable pay, conditions and training.

A spotlight on… employment support for people with mental health needs

Mental Health Working – Hillside Clubhouse, Remploy and Twining Enterprise

The majority of people with mental health conditions want to work, but need support to overcome the barriers they face getting in to work. Mental Health Working is a specialist employment service for such people. Run as a partnership by Twining Enterprise, Remploy and Hillside Clubhouse, it supports people on their journey back into the labour market, through training, education, employment or volunteering.

The service is for adult residents in Camden and Islington with a mental health condition, who need help in becoming more financially independent. People can access it through any of the three partnership organisations.

The service has a lot to offer; it has links with employers to whom service users are put forward for job roles ahead of other applicants; it arranges work placements, to build experience for CVs; and it supports both clients and employers once a client starts work, to reduce the risk of employment failure.

In 2013-2014 Mental Health Working supported 201 Camden residents, and 165 Islington residents to enter full- or part-time work, or self-employment. This was 18% and 19%, respectively, of those registered to the service; this is a higher proportion than many other employment services for people with mental health conditions.

Owen's story

At 36, Owen self-referred to Mental Health Working at Hillside Clubhouse. At the time, he was not sure of his career path and was suffering from depression and anxiety. As part of the support from the service, he was offered voluntary work in the Hillside Clubhouse kitchen. Gradually, he became more independent in the kitchen tasks and the supervisors gave him more responsibility and began to rely on him. Later, he was encouraged to apply for a paid vacancy that arose, supported in the application process, and offered the full-time position.

Conclusions

Mental health may be impacted during all phases of planning, development and regeneration work from inception to evaluation. Mental health impact on residents should be included in Local Development Frameworks and other forward planning documents and considered early in the planning process. Healthy design principles encourage developers to put forward proposals that will help to promote mental health and wellbeing. Evaluations of major developments can help to assure and evaluate the impacts on mental health.

The priority given by both Councils to warm, safe, affordable, and appropriately sized accommodation for all borough residents is important to the long term mental health and wellbeing of the community. With a rising number of street homeless people in London, we must understand and support the mental health needs of this population group..

Promoting the use of freely accessible green space wherever possible, encouraging visitors and users from all backgrounds, and opening it up to a wide range of uses promotes physical activity, relaxation, overall wellbeing and social cohesion.

Promotion of good employment practices including flexible working, a supportive environment and the reduction of stigma are an evidence-based and cost-effective way to minimise the impact of mental health on both employers and employees.

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6

Mental health services

Previous chapters have focused on the promotion of better mental health and prevention of mental illness, and the impacts on physical health. This chapter focuses on the third major factor in improving population mental health: timely access to effective treatment and support services which promote recovery.

Mental health conditions account for the single largest area of spend of any group of health conditions in the NHS in England. It is estimated that about 28% of all ill health in England is directly attributable to mental health conditions, but that treatment and care of mental health conditions accounts for only 13% of the national NHS budget. Moreover, the majority of mental health spending is concentrated on the 10% of people with a mental health condition who access inpatient and specialised care. [1] It is estimated that only a quarter of people with mental health conditions receive an intervention, in comparison to physical health conditions (of similar health impact) where almost all people receive treatment. [2]

Camden and Islington have the highest per capita NHS spend on services for mental health conditions in the country. However, with levels of need and demand for mental health services significantly higher too, both areas face many of the same challenges as the rest of the country: how to improve access and early intervention, deliver better outcomes and patient experience, tackle inequalities in access and outcomes (particularly for disadvantaged and under-represented groups), and make the best use of limited resources.

Alongside these challenges, expectations about the scope, choice and quality of public services are increasing. Nationally, the Government has set out a programme of initiatives and standards for mental health services, and national policy articulates a clear requirement for parity of esteem in the commissioning and provision of mental health and physical health services. [3] Working in the context of increasingly constrained resources, services are under growing pressure to deliver improvements to mental health outcomes and to the experience of service users and their families and carers.

Prevention and early intervention

Access to effective services and help is an essential component of prevention and early intervention and can lead to economic savings in the short and long term for health, social care, criminal justice and other public services. [4] Recognising mental health conditions early and providing access to support at the right time are both key. Action to reduce stigma and discrimination (discussed in Chapter 1) is also important as it impacts upon people's willingness to talk about their mental health, and to seek help.

Children and young people

As described in Chapter 3, the onset of mental health conditions before the age of 18 is a major risk factor for adult mental health conditions. This risk is greater if conditions are untreated in childhood, yet nationally only 25% of children and young people (CYP) with a diagnosable condition access a mental health service. Additionally, overall Child and Adolescent Mental Health Service (CAMHS) expenditure in some parts of the country has reduced, although locally this is not the case. [5] Locally, a health equity audit undertaken in 2013 found that an estimated 45% of diagnosable mental health conditions were seen by services in Islington, although with significant difference by age group (57% of need among 5-10 year olds and 37%

among 11-17 year olds). Similar audits have not been carried out in Camden, but overall referral and activity levels indicate that, similar to Islington, a significantly higher proportion of CYP with diagnosable mental health need are seen by services in the borough, compared to the national figure of 25%. Whilst the percentage of unmet need is lower in Camden and Islington than the national picture, more than 50% of CYP who could potentially benefit from services are not being treated. At the current time, services are reporting increasing complexity in the CYP being seen, and some, although not all, services are reporting increased waiting times.

A spotlight on... using young people's views to shape services in Camden

Minding the Gap – redesigning services

Young people's needs tend to be intertwined and each one cannot be addressed in isolation, so providing holistic support is essential. After feedback from service users and providers, it was clear that young people transitioning between Camden's child and adult mental health services felt less supported at age 18. Many of those who transitioned to adult services reported that they felt 'bounced around' between services. Responding to this, Camden Council and Camden CCG initiated the 'Minding the Gap' project. The project has two elements:

1. **A youth base to provide opportunities for development as well as access to holistic support. A team operates from the base and across the borough to build relationships with young people who do not seek help, provide holistic support, and help young people into higher levels of support where needed.**
2. **A redesign of mental health services to improve the transition between child and adult services. This includes a case review mechanism for 16-24 year olds to ensure they are supported to engage with the correct services, and the creation of 'transitions champions' in adult and children's mental health teams to support people in transition and drive a culture change within organisations. A participation worker involves young people and carers in ensuring that these measures lead to a real difference. Crucially, there is capacity added for those who do not meet adult mental health services thresholds, but still require support.**

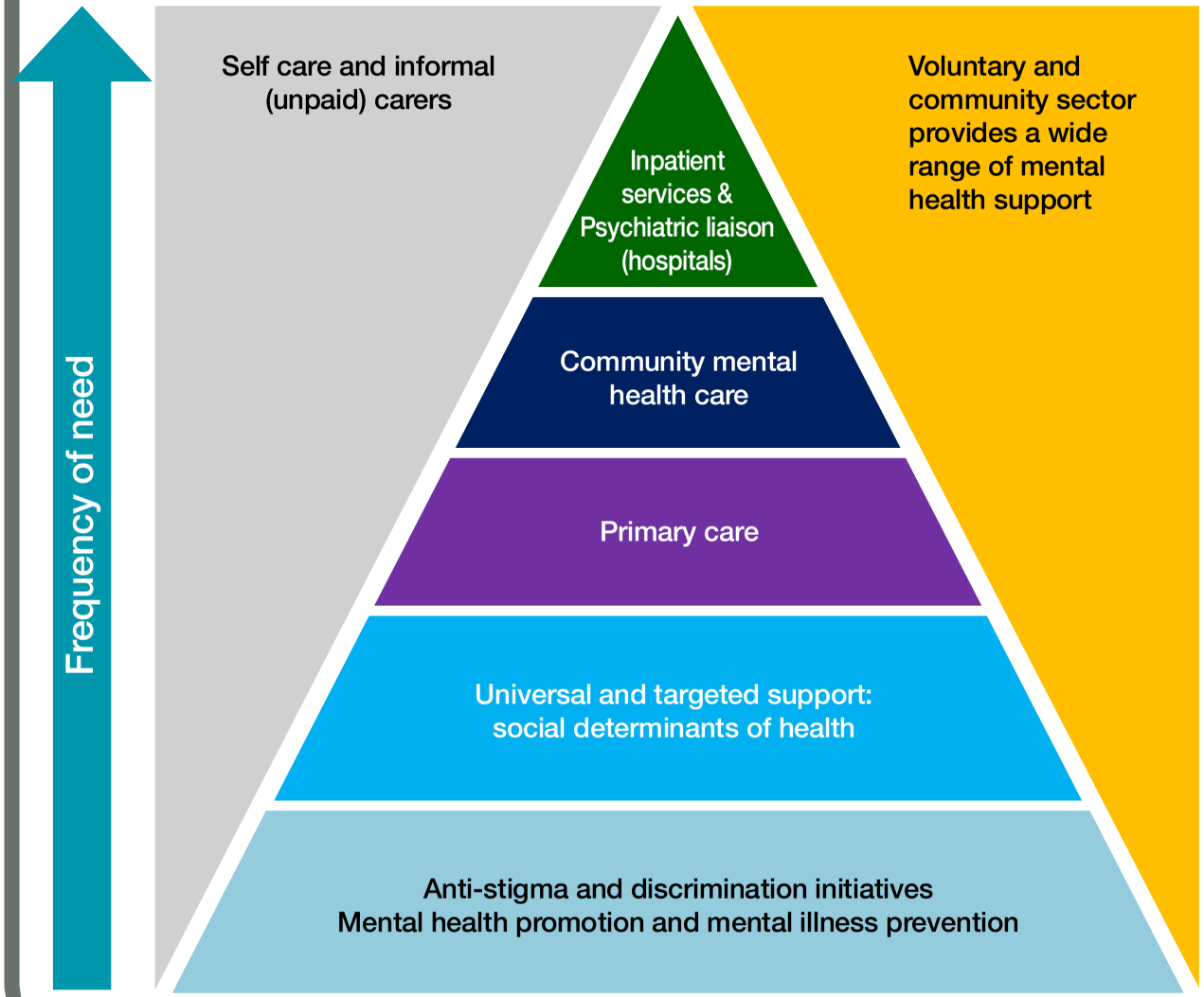
A panel of young people forms an integral part of this project, co-designing solutions with commissioners and providers. This has included facilitating events with their peers and potential service providers, participating in the procurement process and visiting services with similar objectives. The young people involved have created a documentary of their journey with the project.

Open Minded – rebranding CAMHS

In a similar vein, local research in 2012 found that young people in Camden found the traditional name of 'Child and Adolescent Mental Health Services' stigmatising and not meaningful to them. To address this, competitions were launched first to rename the services, and later to redesign its logo. These competitions were advertised in schools and the local media, with entries shortlisted by focus groups, and the winners voted on by service users, their families, carers and friends. The new branding was launched in July 2014 with an event organised by young people.

Adult mental health services & support

Adults with mental health conditions can access support in a variety of ways, ranging from over the phone to residential care, depending on how much support they need. Many different services are involved and this diagram represents a very simplified picture. The large majority of people receive community based support for their condition in general practice or through other community based services. A small proportion of people, with the most complex and severe needs, will need inpatient care. People can access emergency psychiatric support during a crisis via their GP or A&E.



Specialist care for complex patients staying in psychiatric treatment units.

Assessment and specialist support for people with complex mental health needs involving secondary care. These include:

- Psychosis services - recovery and rehabilitation; outreach
- Community mental health service
- Crisis response and home treatment services
- Services for ageing and mental health

iCope/IAPT: Treatment for CMD for people registered with a Camden or Islington GP

General Practice: GPs give support and treatment for mental health conditions to individuals and their family members/carers

Midwives and health visitors: Mental health support and screening for expectant and new mums

Services that contribute to improved mental health and wellbeing such as:

- Children's centres
- Housing services
- Employment support
- Universal community activities
- Advice services

Services that promote good mental health and awareness such as:

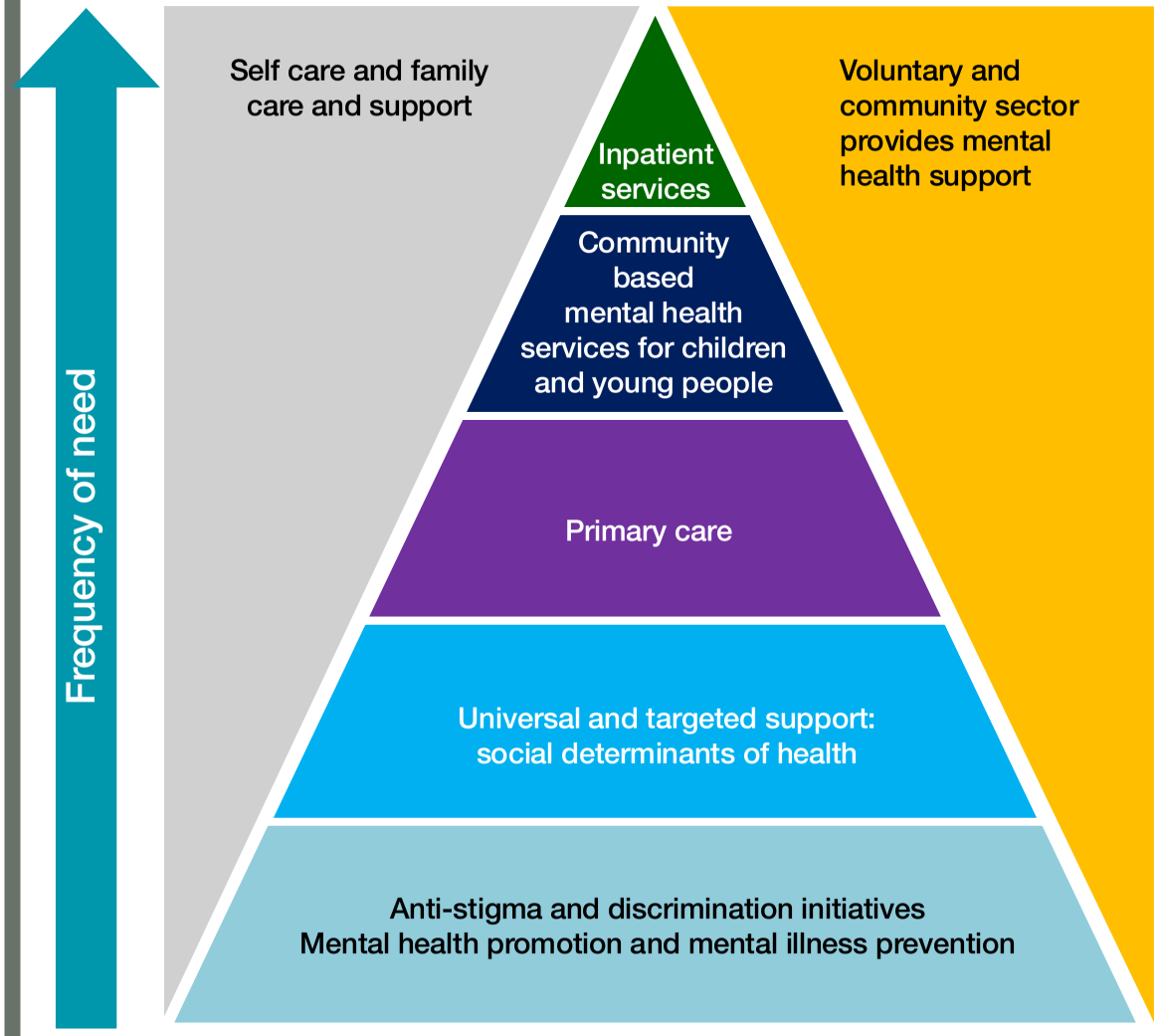
- The Hub – Camden mental health wellbeing centre
- Islington mental health promotion services
- Training in Mental Health First Aid & Youth Mental Health First Aid

Adapted from: WHO/Wonca (2008) and NHS London (2011)

Camden and Islington

Child mental health services & support

Children and young people with mental health conditions and their families can also access support in a variety of ways, depending on how much support they need. Many different services are involved and this diagram represents a very simplified picture. The large majority of patients receive community based support for their condition in general practice or through other community based services. A small proportion of patients with the most complex and severe needs, will need inpatient care. Children and young people can access emergency psychiatric support during a crisis via their GP or A&E.



Specialist care for children with complex mental health needs staying in psychiatric treatment units.

Minding the Gap transitions service (Camden): offers support to mental health service users aged 16-25 and helps move young people into adult services where appropriate.

Early Intervention in Schizophrenia (EIS) Service. Child and adolescent mental health service (Islington) and Open Minded (Camden): Specialist support for children and young people with mental health conditions delivered in schools, GP practices and health centres.

Targeted support for complex families, looked after children, young offenders and other vulnerable groups.

Adolescent Multi-Agency Support Service (AMASS): offers intensive support to young people in foster care with serious behavioural difficulties.

General Practice: GPs give support and treatment for mental health conditions to both children and their families and carers.

Health visiting and school health services

Services that promote good health, including mental health such as:

- Children's centres
- Housing services
- Universal community activities
- First 21 months programme
- Targeted youth services
- Schools and other education settings

Services that promote good mental health such as mental health promotion in schools

Adapted from: WHO/Wonca (2008) and NHS London (2011)

Camden and Islington

A spotlight on... perinatal mental health

Perinatal Care Pathway - Camden and Islington NHS Foundation Trust

All pregnant women should be asked whether they have current or previous mental health conditions as an early part of their maternity care. At Whittington Hospital, women can then be referred into the Perinatal Mental Health Pathway, which is a specialised service provided by Camden and Islington NHS Foundation Trust. Around 350 women are referred to the service every year, which constitutes just under 10% of women giving birth at the hospital.

The pathway aims to ensure that the mental health needs of women who are pregnant or with a child up to 6 months old are monitored and met, to ensure that women receive safe, high quality care according to their needs. The team assesses all patients who are referred, and either provides support to them directly or facilitates access to other psychological services where they are indicated.

Parent and Baby Psychology service - Islington CAMHS

The Parent and Baby Psychology service provides assessment and evidence-based therapeutic interventions for parents with a baby under one year of age or expectant parents, with mild to moderate depression and anxiety related to the transition to parenthood. The service links with the Health Visitors and Midwives Mental Health Pathway, and with local mental health services provided by Camden and Islington NHS Foundation Trust. For the 54 cases that were treated last year, parents showed improvements in wellbeing, problems, and functioning, and a reduced risk, as measured by the Clinical Outcomes Routine Evaluation. Their relationship with the baby also improved, as measured by the 'My Baby' perinatal mental health questionnaire. The service also offers consultation to Health Visitors to support their clinical work with parents with emotional difficulties.

Spotlight on Islington ... CAMHS in Children's Centres in Islington

Islington Community CAMHS – Whittington Health

Islington CAMHS Under Fives Team work with sixteen Children's Centres in Islington, focusing on prevention and early intervention for children under five years old and their families. This includes parent workshops on emotional and behavioural issues affecting under-fives, individual appointments for parents concerned about their child's development, behaviour or emotional wellbeing, and consultation and training to staff to improve psychological understanding of under-fives. Feedback has been positive of these cross-agency relationships, and suggests that joint work has effectively provided psychologist knowledge to the Children's Centre staff. In 2013-2014, there were 283 staff consultations, and 126 children were seen in individual appointments with a CAMHS clinician.

To address the stigma surrounding access to mental health services, Camden's CAMHS have worked with children and young people to create a more meaningful, less stigmatising 'brand' for their services: Open Minded (see box). This is one step in helping to improve access to CAMHS and changing attitudes and understanding about seeking help for mental health conditions among children and young people. The rebranded services in Camden are comprehensive and integrated into almost every universal, targeted and specialist service, including GPs, children's centres, primary and secondary schools, social care (safeguarding children with complex needs and disability), special educational needs, youth diversion and youth offending. In 2013-2014 96% (of 436 respondents) reported a positive experience of the service. Three-quarters (of 248 respondents) demonstrated clinical improvement on the Goal Based Measure.

Traditionally, CAMHS has adopted a wide range of treatment and service models with little standardisation. The national CYP Improving Access to Psychological Therapy (IAPT) programme is an initiative which aims to support transformation in CAMHS services. It aims to increase access to NICE approved approaches, including training for parents of 3-8 year olds with behavioural problems; cognitive behavioural therapy (CBT) and interpersonal therapy for adolescents with depression; and systemic family practice for adolescents with depression, conduct problems, eating disorders and those who self-harm. This programme has a strong focus on better outcomes, and empowering young people to take control of their care, establish treatment goals, choose treatment approaches and take opportunities to improve their own health.

A spotlight on... targeting mental health in schools in Islington

Islington Community CAMHS – Whittington Health

The Targeted Mental Health in Schools service in Islington aims to improve support for CYP experiencing emotional and behavioural problems in school. It seeks to increase early identification and treatment of mental health conditions through a mixture of proactive screening and participation in pastoral care meetings in schools. By locating clinical sessions and CAMHS professionals within the schools, CAMHS is made more accessible to CYP, their families and staff. Offering direct appointments within schools has proven to be particularly helpful for children and families who may otherwise find it more difficult to engage with services provided in health or other settings.

The service works in an integrated way, through collaboration with social care, education and the voluntary sector. The programme also involves sharing skills with other groups of staff: regular training and workshops are held to help develop the ability and confidence of other staff to identify and support CYP with emotional and behavioural problems.

In 2014-2015, the service provided clinics in 59 mainstream and special schools, with 945 sessions held in primary schools, 1104 clinics in secondary schools and 163 in special schools. 240 children and young people were seen in the year.

As part of the CYP IAPT programme in Camden five therapists completed their training in 2013 and are based across the NHS, the voluntary sector and Camden Council. In Islington four therapists, two managers and two supervisors have been trained. A key feature of the development of CYP IAPT in Islington has been an increasing shift towards co-design of services with children, young people and their parents, through workshops, surveys, sitting on interview panels, and the development of a CAMHS youth council. Increasingly, many CAMHS services are also developing the ways in which they can support children and families to improve outcomes by realising and drawing on their own strengths (and the strengths of their schools and communities) to build resilience.[6]

The move towards more joint working continues. For example, in Islington, children's Multi-Disciplinary Teams of GPs, community doctors and other community health services involve CAMHS professionals to ensure the mental health needs of children with long term physical health conditions or who are frequent A&E attenders can also be met.

Think Family

Inter-generational or 'Think Family' initiatives recognise that parental mental health conditions are an important risk factor for children's mental health conditions, especially when there are other problems and needs in the family, such as antisocial behaviour, domestic violence, and inter-generational disadvantage. However, parents may not meet the threshold for specialist mental health services, which can act as a barrier to meeting the needs of the child. New approaches to parental mental health services in both boroughs are seeking to address this challenge.

For example, the Parental Mental Health service in Camden saw 172 parents and children in 2013-2014. There was improved mental health among 90% of parents and 66% of children discharged from the service, and 98% reported improved parent-child relationships. This service is now working to improve links with Camden's IAPT service (iCope) to ensure adults and parents receive the right interventions, and a website for parental mental health is being developed to provide better information for parents and referrers.

The Islington parental mental health service supports universal services to work with families. Three psychologists offer consultancy and training to support the wider system to work more effectively with people presenting with complex and challenging mental health conditions.

This ensures that practitioners working in a wide range of settings are able to identify parental mental health issues, and are supported to develop the skills, knowledge and confidence

Future in Mind - national policy

A recent report published by the Department of Health and NHS England addresses mental health in CYP. Of note, it describes the significant variation in access, and argues for service redesign and reconfiguration, and sets out a case for 'invest to save' in early mental health intervention among CYP.

It has a number of national aspirations which include: tackling stigma and discrimination; making services more visible, accessible, and built around the needs of CYP and families; improving care in a crisis; improving system accountability, and better training for staff who work with children.

https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people

necessary to offer advice and support when working with families. The service began in November 2013, and during its first nine months, provided support to 113 staff members and reached 301 families.

Improving outcomes for families with complex needs, which often include mental health conditions, is a key commitment in the Camden Plan, and Complex Families (part of the broader Resilient Families Programme) is one of the three priorities identified in Camden's first Joint Health and Wellbeing Strategy. As part of the national Troubled Families programme, the aim is to improve outcomes and reduce demand on high-cost, statutory services by ensuring families' needs are supported early, before problems escalate, and improve the 'whole system' of support to families across the continuum of need. The programme developed a partnership approach to integrated case planning and delivery across services, and actively engages families in developing and making the changes needed to improve outcomes and build resilience. By the end of February 2015 all 755 had been identified and offered help, and approximately 80% had shown significant improvements in key areas of change, including school attendance, crime and antisocial behaviour, and welfare dependence and employment. As part of its wider Resilient Families Programme, Camden began phase 2 in April 2015. It now has a wider criteria which will enable a wider cohort to be reached, including those with mental health and other complex needs.

Islington has a similar programme, called Stronger Families, which is also part of the national Troubled Families programme. In September 2014, 848 families had been identified as being eligible for the programme. Islington launched an expanded version in January 2015, which reaches out to families with a broader range of problems, including those affected by domestic violence and abuse, and with younger children who need help with a range of physical and mental health needs. Rather than focussing on the small number of people identified using the national criteria, this programme is being used to change the way that all services support families to achieve better outcomes.

The transition to adult services

There is national recognition of the need to improve the transition of young people with mental health conditions from CYP to adult services. The Children and Families Act 2014 has introduced a system of support from birth to 25 for children and young people with special educational needs (SEN) or special educational needs and disability (SEND). The reforms require the development of coordinated assessments; single Education, Health and Care (EHC) plans; improved cooperation between all services; and greater choice and control over personalised support for children and their parents.

This emphasis on coordinated, integrated services joined up around the needs of young people and their families is particularly important in mental health. The transition from CAMHS to adult services occurs at a time when young people's mental health needs are high and changing. It is a period when the early stages of serious mental health conditions, such as schizophrenia, may be beginning to develop. Therefore, the transition between services should be safe, understanding of, and tailored to each young person's needs. However, young people and their families often struggle to move between child and adult services, and feel poorly supported at this time. [7] Different eligibility thresholds in service models between CAMHS and adult mental health services can leave a gap in early adulthood where previously services would have been available. Bridging this gap at this key stage in people's lives has been shown to improve short and long term outcomes, which can also generate cost savings in the long term, especially when impact on employment and education is taken into account. [8]

Adults

Primary care services

For most adults, primary care services are fundamental to the early recognition and treatment of mental health conditions, and are where most conditions are diagnosed, treated and managed. [9] This covers the whole spectrum of need, from short term, mild to moderate mental health conditions through to severe and enduring conditions. It is estimated that 90% of mental health care in the NHS is provided through GP practices: about one in three GP consultations involves addressing the patient's mental health. [10] There is, however, significant variation in the diagnosis of mental health conditions such as depression and anxiety between GP practices. Patients with more complex or serious mental health conditions are supported through primary care working in collaboration with secondary care and specialist services, [11] though primary care is playing an ever-greater role in this group. This coincides with increasing pressure on primary care resources more generally. [10] Primary care has an important role in ensuring mental health has parity of esteem with physical health, through its holistic approach to health needs.

The training and education of primary care staff improves the identification, support and treatment of mental health conditions. [4]

The Chief Medical Officer has called for changes to the content and structure of medical training to include a much greater mental health component, including extending GP training by one year. [12]

Both Camden and Islington CCGs are developing new ways of supporting people with mental health problems through primary care, such as the 'team around the practice' approach, which ensures that GPs and their teams have adequate support. For instance, Camden CCG is commissioning a service to support GP practices by:

- Providing direct therapeutic interventions to people who cannot or will not engage with other mental health services.
- Coordinating access to other services.
- Identifying, quality-assuring and facilitating access to social support/non-medical interventions in the community.
- Providing capacity, capability and bespoke training to general practice staff to enable them to better manage care and interventions for service users with mental health issues and their families. [13]

Improving Access to Psychological Therapies

IAPT is a national initiative designed to help people access appropriate psychological therapies. Accessing the right therapy at the right time can have a huge impact on mental health outcomes. Provision of psychological therapies is a largely low cost activity, and investment in earlier treatment means significant cost benefits in the long term. [14] Camden and Islington NHS Foundation Trust provides IAPT services locally, through the well-established iCope service which offers talking therapies across a range of settings, including GP surgeries and community centres. Additional local IAPT services are

iCope – service user experience

"My life was, to all outward appearances, extremely nice. I looked as if I had a good life. But, I could find myself feeling quite isolated and found that people were looking past me. Even my family didn't realise that I was feeling so bad, and I was certainly covering up. I went to my GP and she picked up on the fact that I was probably needing some help.

"Being able to come into this space (iCope)–and talk to somebody who was not jumping up and trying to make it alright, who wasn't trying to tell me I had no good reason to be sad–helped me tremendously."

provided by Camden Psychological Therapies Partnership, Lea Vale Health, and IESO Digital Health.

A national target of IAPT services reaching at least 15% of people experiencing anxiety and depression is based on national prevalence estimates. In 2013-2014 the Islington and Camden services reached 14% and 11% of eligible people respectively. In Islington, social marketing initiatives have been used successfully to improve access for men, people living in deprived communities, people from Black Caribbean and Irish groups. However, there is a continuing need to maintain and improve access for marginalised groups in both boroughs.

Both services are working towards achieving the national target of 15% by the end of 2014-2015. Waiting times in Islington and Camden have reduced in recent years (in Q3 of 2014-2015, the median wait time in Islington was 23 days and in Camden it was 18 days). Improving recovery rates remains a challenge locally, which is shared with much of London. Both Islington and Camden are below the national target of 50% of service users recovering after a period of IAPT intervention and support (46% and 41% respectively in Q3 2014-2015).

A spotlight on... opportunities for digital mental health

The internet offers the potential to transform aspects of mental healthcare delivery. At its best, digital technology can give patients greater choice and control, widen access and may help to encourage self-monitoring and improve self-management.

Social media platforms may improve access in those who do not usually access traditional services, particularly younger people. Such platforms (when suitable risk management and clinical governance arrangements are in place), can provide a community of peer-support, validated information, screening, structured self-help and referral to other support, where necessary.

Online psychological therapy, either through a video-link or text communication, could be a useful addition to traditional face-to-face therapies. For some, it provides a flexible and convenient format of support, offering 24/7 delivery and access through mobile devices.

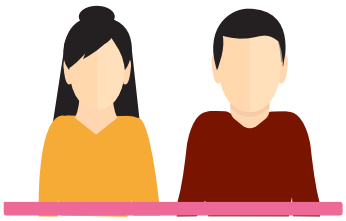
As with any new service model, there are some risks and uncertainties. The evidence base supporting many of these approaches is currently limited, often not peer-reviewed and unpublished. There is as yet little evidence to show that digital technology improves access among groups under-represented in current services. Additionally, widespread adoption may risk creating a "digital divide", and exclude those who already access services the least. The governance of patient safety, quality and confidentiality is a major issue. NHS England is currently working on a framework for the regulation of mobile health apps for which there are currently no clinical standards.

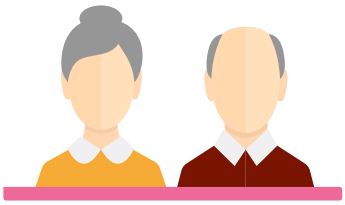
Both Camden and Islington have started exploring digital opportunities for mental health service delivery. The iCope service has a dedicated website with information about the service, downloads and on-line referral. Camden's service provided by IESO Digital Health uses secure instant messaging to provide therapy and has proven effective for CBT. Also in Camden, the CCG, as part of its mental health work programme (or 'mandate') is commissioning an on-line peer support and individual therapy service for those who do not respond well to, or prefer not to engage with, traditional services.

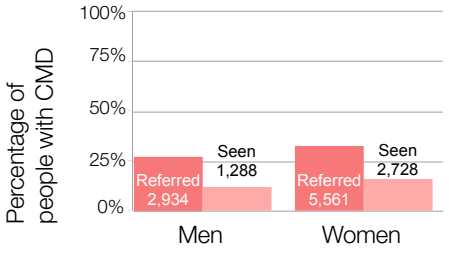
Access to mental health services in Camden: iCope

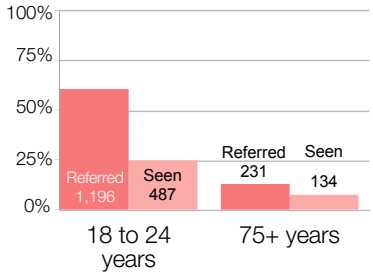
iCope is part of Camden and Islington's IAPT programme, which offers treatment to people with CMD in GP practices or community settings. There were over 9,000 referrals to iCope in 2012-2013, with 4,200 people using the service that year. People can either refer themselves to iCope, or be referred by their GP.

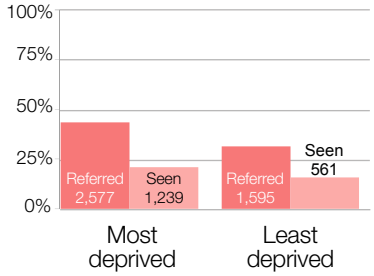
Rates of referrals to iCope and service contacts in people diagnosed with CMD, Camden, 2012-2013











Men who are diagnosed with CMD are **less likely to be referred** to iCope than women, and **less likely to take up** the opportunity once referred.

Older people with CMD are **much less likely to be referred** than those in younger age group. However, **younger people** who are referred to iCope are **less likely to attend** a session. These differences may be due to generational attitudes about talking therapies, as well as referrers' beliefs about appropriate treatment.

People diagnosed with CMD who live in the **most deprived** areas are **more likely** to be referred to iCope. There are similar **rates of uptake** of the service in people in the most and least deprived areas.

There are no significant differences in rates of referral to iCope between people from White, Black and Asian communities in Camden. There are similar rates of uptake of the iCope service between these ethnic groups.

Further research

Historically, lesbian, gay, bisexual and transgender people; refugees and asylum seekers and people with disabilities have been underrepresented in mental health services. Further data collection and analysis of characteristics in the future would provide a better understanding of the current local picture.

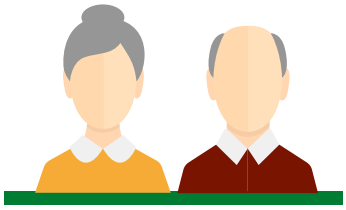
Source: Camden's GP PH dataset, 2012; IAPT Data, 2012-2013

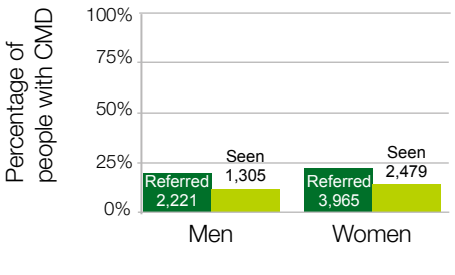
Camden

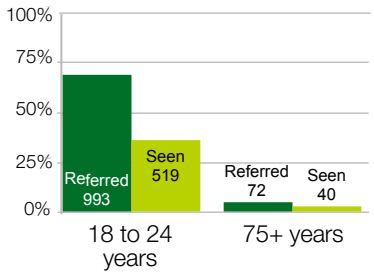
Access to mental health services in Islington: iCope

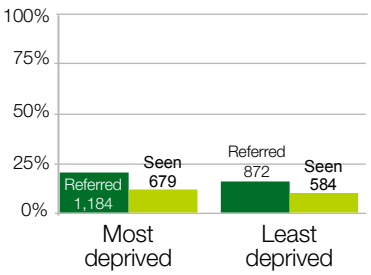
iCope is part of Camden and Islington's IAPT programme, which offers treatment to people with CMD in GP practices or community settings. Over 6,700 people registered with an Islington GP were referred to iCope in 2012-2013, with 4,000 people using the service that year. People can either refer themselves to iCope, or be referred by their GP.

Rates of referrals to iCope and service contacts in people diagnosed with CMD, Islington, 2012-2013









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Older people with CMD are **much less likely to be referred** than those in younger age groups. This may be due to generational attitudes about talking therapies, as well as referrers' beliefs about appropriate treatment.

Once referred to iCope, there are **similar rates of uptake** of the service in older and younger people.

People diagnosed with CMD who live in the **most deprived** areas are **more likely** to be referred to iCope. There are similar **rates of uptake** of the service in people in the most and least deprived areas.

There are no significant differences in rates of referral to iCope between people from White, Black and Asian communities in Islington. There are similar rates of uptake of the iCope service between these ethnic groups.

Further research

Historically, lesbian, gay, bisexual and transgender people; refugees and asylum seekers and people with disabilities have been underrepresented in mental health services. Further data collection and analysis of characteristics in the future would provide a better understanding of the current local picture.

Islington

Source: Islington's GP PH dataset, 2012; IAPT Data, 2012-2013

A criticism of the national IAPT programme has been the limited choice of treatment, [14] which has strongly focused on CBT. This criticism has been acknowledged, and the programme is being diversified to meet the needs of older people, people with long term conditions, people with medically unexplained symptoms and people with serious mental illness. iCope currently offers a range of interventions, which include CBT, counselling and interpersonal therapy. Services in both Camden and Islington are working in partnership with services for older people to improve access, and deliver outreach sessions. There are a range of interventions for people with long term conditions including group sessions and brief interventions.

Voluntary and Community Sector

The voluntary and community sector (VCS) plays an important role in supporting people with mental health conditions, both as a provider of services and as a representative of local communities, particularly those whose voices are often not heard. In the latter role, the VCS can act as a bridge between communities and the health system – including commissioners and providers.

Camden and Islington are home to a large number of VCS organisations, and the range of services and activities offered provide support to people across the mental health spectrum, from prevention to supporting recovery. Local organisations can be the first point of contact and provide opportunities for early intervention, for instance through counselling and therapies. They can also be valuable to people who would not otherwise access mental health services, such as those not eligible for other secondary mental health services or who might not readily engage with health services, or for those waiting to receive other support. Some organisations target specific groups of people or deal with complex issues, such as domestic violence or sexual abuse.

Additionally, the VCS provides other general services which are protective of mental health and wellbeing. These include social support, advocacy, employment, volunteering or welfare benefits advice.

Service users must have access to information if they are to exercise choice and control over the support they receive. [15] To ensure this, social prescribing can support people to identify and access the most appropriate services. An example of this locally is iCope's Community Links service which supports people to access local organisations, reduce social isolation and provide support for practical issues, such as welfare benefits advice, much of which is offered through the community and voluntary sector. Another is Voluntary Action Camden's health advocates service. Advocates are based in GP

The Healthy Minds Fund - Camden Council

Camden Council is developing new preventative and early intervention approaches to reducing the incidences and impact of mental health challenges through the Healthy Minds Fund.

This has been developed by a cross-sector partnership, including the Council, the Clinical Commissioning Group and Camden and Islington Foundation Trust. The fund will focus on developing new support that:

- **Supports new mothers to promote their mental health and the best start in life for Camden children**
- **Develops personal and community resilience by providing access to early and local help for people that need it and promotes volunteering and peer to peer support**
- **Works with major employers to promote health workplaces that boost wellbeing.**

This is part of Camden Council's role in promoting wellbeing and improving outcomes for residents through innovative approaches to commissioning.

surgeries to assist with non-clinical enquiries and to signpost patients to local services. Age UK in both Camden and Islington also run a Care Navigators scheme, which similarly signposts people with a wide range of physical and mental health conditions to local services.

In Camden Council, the Market Development Strategy is aimed at providers of social care, including those in the VCS, and highlights a role of working in stronger partnership to deliver services differently.

Earlier diagnosis and help for people with dementia

The impact of dementia at an individual and societal level could be significantly reduced with better diagnosis, treatment, care, and support for people with dementia and their carers. [16]

The National Dementia Strategy and the Prime Minister's Challenge on Dementia are committed to raising awareness and understanding of dementia, increasing the proportion of people who receive timely diagnosis and service interventions, and ensuring that people receive services which improve quality of life. [16, 17] Dementia is under diagnosed and too many people are only diagnosed when they reach a crisis point. This often leads to a hospital admission or a premature move into a care home. If diagnosed early, a person can be supported to live independently and in their own home for as long as possible.

A dementia care pathway has been developed in Islington, with Memory Assessment Services and a range of dementia support, to improve recognition and diagnosis and provide earlier intervention, treatment and planning. Camden and Islington NHS Foundation Trust has been working closely with under-referring general practices in Islington to increase appropriate referrals, and referrals to the memory service have been increasing year on year since 2010-2011, when there were 415 referrals, compared to 582 in 2013-2014.

A spotlight on… a smooth transition to mental health services in Camden

6-8 Weeks at The Hub – Holy Cross Centre Trust

The Hub is a new wellbeing centre run by the Holy Cross Centre Trust. It offers the 6-8 Weeks service, which provides short-term, tailored support for people with a mental health problem in Camden. People can self-refer, and during an initial assessment will decide with staff what support they need, both from The Hub and from elsewhere. This is reviewed every week.

The Hub supports people to stay well by linking in and establishing responsive preventative support networks within the community, with the aim of reducing the dependence/ demand for people to have specialist on-going mental health care packages. Making creative use of its space, it offers its facilities to other providers, from psychotherapists to the Citizens' Advice Bureau to yoga teachers. 'Mainstreaming' the building in this way makes these services easier to access for 6-8 Weeks clients, should they benefit from them. The Hub also has strong links with other partner organisations such as the Social Care Assessment Team, employment support services, IAPT, Recovery College, and other wellbeing services. Additionally, The Hub hosts Health and Social Care trainees as integral members of the team, who accompany clients to meetings and appointments for other services.

The aim of 6-8 Weeks is to give clients a smooth transition into the services which will meet their mental health, and other, needs. This helps them engage meaningfully with parts of the system appropriate to their circumstances, and in turn benefit from them fully.

The service began in February 2014, and aims to support 10 new people per month.

Similarly in Camden, the Dementia Plan aims to improve dementia care by working with GPs to ensure people with dementia are identified early and referred to the Camden Memory Service. Referrals to the Memory Service have increased in recent years, from 283 in 2009-2010 to 477 in 2011-2012. In the first half of 2014-2015 the service received 176 referrals. The vision set out in the Camden Dementia Plan is that people with dementia and their carers should be able to enjoy a good quality of life, remain independent and in control, stay in their own home for as long as possible, and be valued as members of the community.

Working to improve access and outcomes for Black and Minority Ethnic Groups

Inequalities exist across ethnic groups in mental health diagnosis and access to services. The most striking of these in Islington, are high diagnoses of psychosis among Black population groups, and higher inpatient admissions among White Irish and Black population groups. [18]
In Camden, Black populations are over-represented in adult community mental health team and assertive outreach services. There is lower than expected use of secondary mental health services among Asian groups, while people of Irish and Somali descent, Bangladeshi women and older people are under-represented in services for common mental health disorders. [19]
The causes for these inequalities are complex, and relate to long term disadvantage and discrimination.

To address some of these issues, Community Development Workers in Camden work with the Bangladeshi and Somali communities and with statutory services. Their role is to raise awareness and build capacity within communities so that they know how they can support people with mental health problems and signpost to specialist services. In Islington, the Community Development Service increases awareness of mental health and wellbeing in minority communities, reducing the barriers to accessing care and making services more sensitive to cultural needs.

Additionally, in Islington, the mental health promotion programme works with hard-to-reach and hard-to-influence groups to reduce stigma and discrimination and encourage people to access help. Mental Health First Aid training is a programme which engages groups that are disproportionately affected by mental health conditions and less likely to access services, and is offered in both Camden and Islington.

Recovery

For mental health, recovery means living a meaningful and rewarding life, with or without symptoms of a mental health condition. It involves feeling valued, included and safe, having meaningful occupation, being able to make a contribution to society, and having economic security, a home, and social relationships. Supporting recovery is a key focus of the strategic commissioning plans for mental health in both boroughs.

The 'recovery model' acknowledges the value of lived experience of service users in managing their own health and care and in the design, commissioning and delivery of services. It represents a shift towards a holistic approach to outcomes, rather than the narrower notion of recovery being based around the the alleviation of symptoms. This perspective leads to services designed to support outcomes which are more aligned to service users' priorities.

Recovery-focused services:

- Aim to rebuild lives rather than alleviate symptoms
- Change the role of a mental health professional from an expert defining problems and prescribing treatments, to a person sharing knowledge
- Recognise 'lived experience' as equally important as 'professional expertise'. Co-production and shared decision making are part of this
- Take an asset-based approach which enables individuals and communities to recognise their own resources and resourcefulness.[20]

The Recovery and Rehabilitation Service at Camden and Islington NHS Foundation Trust is currently working with around 2,000 service users and this number is predicted to grow. These services support people as they gain or regain confidence and skills in everyday activities, a process which can take months or even years. A major aspect of rehabilitation services is the continuous promotion of therapeutic optimism - in other words, a belief in and focus on recovery.

Supported housing is an intervention which has been shown to be effective in helping people to develop life skills and move on to more independent living. These services reduce the use of inpatient care and A&E services. [8] In Camden, accommodation pathways have been developed with local housing providers and the Council to support the early discharge of patients to less restrictive and more recovery-oriented services in the community. The development of a greater range of accommodation options (from 24-hour intensive supported living, to floating support in people's own homes to help them maintain their tenancy) has led to a reduction in out-of-area treatments and inappropriate residential care placements. This reconfiguration of the pathway has delivered efficiency savings and better outcomes for patients.

Changes in the allocation of points for social housing is supporting people to move out of the accommodation pathway and into their own tenancy. In Islington, similar initiatives have also helped people to develop and retain independent living skills, and have demonstrated similar outcomes.

A spotlight on... reablement in Islington

Islington Mental Health Reablement – Camden & Islington NHS Foundation Trust and Hillside Clubhouse

Islington's Reablement service offers intensive, short-term community support to increase independence for adults in Islington with mental health conditions, and reduce reliance on longer term services. The service is aimed at individuals at a transition point in their level of support. This could be someone entering or leaving secondary mental health care, moving from supported accommodation or being discharged from hospital.

The service is a partnership between Camden and Islington NHS Foundation Trust and Hillside Clubhouse, a local voluntary organisation. The team consists of a manager, an occupational therapist, five full-time support workers and two part-time sessional support workers. Two of the full-time support workers and the sessional workers are previous Hillside Clubhouse service users with lived experiences. The team also has access to reflective practice sessions and advisory input from a clinical psychologist. Together, they provide mental health and wellbeing support delivered in a goal-focused and collaborative approach with the service user to maximise independence in their daily lives.

The goals of service users relate to a range of areas of life, from housing, financial, domestic activities (e.g. shopping, cooking or cleaning), accessing and engaging in community services (including primary care), leisure, education and employment.

Over the first six months of the 2013-2014 financial year, the service worked with 59 clients. Of these, 52 were diverted from longer-term services or supported to be discharged from hospital earlier. Twenty-two clients were supported to avoid mental health admissions to hospital, and 20 were successful.

Recovery College – Camden & Islington NHS Foundation Trust

The Camden and Islington Recovery College, launched in 2014, helps people with mental health problems on their journey to recovery by providing peer-led group education and training programmes within mental health services.

With co-production at its core, it uses two types of expertise – professional and lived experience – to deliver a curriculum of aspirational courses over each term. These rely equally on professionals and people with experiences of mental health or physical health challenges. The courses are based on providing knowledge and practical skills.

Students can develop Individual Learning Plans with a Peer Support Worker, to ensure learning needs are met. Anybody using Camden and Islington NHS Foundation Trust services can enrol on the Recovery College courses, as can their carers, family and friends.

The College delivered 86 courses in 2014-15, with 430 people registered with the service.

Examples of the courses delivered include:

- Recovery journeys – introduction to recovery
- Telling your story – tree of life
- An Introduction to anxiety
- Assertiveness for all
- Ways of understanding and relating to experience of 'psychosis'
- A guide to mental health tribunals
- Understanding drug and alcohol use
- Getting a good night's sleep
- Beginners mindfulness
- Assertiveness for all
- Storytelling and narratives
- Forming and maintaining healthy relationships
- Better money management

Feedback from attendees includes:

"The Recovery College has opened a door to a whole new experience for me, thanks to the college I am on a wonderful adventure, making friends, learning new things and exploring new worlds. I am excited and optimistic about life now"

"Attending the Tree of life course and the recovery college helped me see that I really did have something to offer, I was personally inspired by individuals - both tutors and students"

Recovery Colleges

Recovery Colleges offer a way for mental health services to move from 'traditional' services into recovery focused services. [20, 21] The concept was first developed in the USA and has been shown to significantly improve service user experience and outcomes. [22, 23]

Educating people about their conditions and supporting self-management are an effective way to promote empowerment and to build knowledge and confidence to participate in shared decision-making. [24, 25] A study of the first UK pilot, based in Merton and Sutton, found that 70% of Recovery College graduates had become mainstream students, gained employment or become a volunteer, and over 70% of them showed a significant reduction in the use of community mental health services compared to those who did not attend. Two-thirds felt more hopeful for the future and most (81%) had developed their own plan for managing their problems and staying well.

Peer Supporters

There are significant benefits of peer support in mental health services. [26] Peer support benefits both service user and the peer supporter; being a peer supporter builds confidence, self-esteem and the opportunity for meaningful occupation, while the service user can feel empowered. This supports recovery and provides future employment opportunities. [20] In addition to accessing peer support through the local recovery college, in Camden Voiceability is piloting a Mental Health Peer Mentoring Service (funded by Camden CCG). The service aims to recruit 36 peer mentors, who will work with service users to identify and achieve a specific need or goal.

Conclusions

Timely access to effective help is a key part of population mental health: early intervention and uptake of effective treatment and care improves outcomes and reduces the duration of ill health, and can prevent conditions from becoming more severe and enduring. This chapter has highlighted a range of initiatives and service developments locally that are focused on the goal of improving access, and bringing a new focus within the spectrum of mental health services on better outcomes and recovery.

Providing services in universal settings such as children's centres and schools, as well as in targeted services, such as youth offending and looked after children services, has helped to increase access for under-represented groups of CYP and helps to build the capability and capacity of non-specialist services to recognise and respond to mental health conditions. There is increased focus on the inter-generational aspects of mental health between parents and children, with a number of universal and targeted initiatives in place in both boroughs. New service models are being developed for transition, which is a key period of risk in the development of many mental health conditions.

There has been a sustained expansion of IAPT services for adults experiencing depression and anxiety in both Camden and Islington, promoting significantly increased access to talking therapies and guided self-help and offering greater choice over the treatments available through GP practices. There is an ongoing need to improve recovery rates in both boroughs, and to promote and improve access to some BME groups and older people.

People with dementia in Camden and Islington are much more likely to have been diagnosed by local memory assessment services than their London or national counterparts, with Islington having the highest diagnosed prevalence rate in the country. There are pathways in place for diagnosis and ongoing support of people with dementia, and very positive feedback about these services. However, earlier diagnoses will mean that people live for much longer with a diagnosis of dementia, with wider implications for other health and social care services of the future.

New models of recovery-oriented services for people with serious mental health conditions, developed in partnership between health and social care professionals and people with lived experience of mental health conditions (co-production), bring a holistic focus on the outcomes that matter to service users.

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7

Suicide and self-harm

Introduction

Suicide is a major public health issue. The most obvious direct impact is the loss of life associated with the suicide, however it has impacts that reach even further; family and friends bereaved by suicide are at increased risk of mental health and emotional problems and may be at higher risk of suicide themselves. [1] Others affected by suicide include those who witness an event, are involved in the aftermath, or have previously provided support or care to the deceased. [2] The impacts of suicide may be experienced years after the death, and can be magnified by the stigma and taboos that still surround suicide.

Although suicide risk can be difficult to predict in individuals, there are clear strategies and interventions that can help to identify and reduce the risk. Most suicides are in people with diagnosable mental health conditions, highlighting the important role that health services play in suicide prevention and early diagnosis of mental health conditions. However, almost a quarter of suicidal deaths are in people who had not been in contact with general practice or specialist mental health services in the year prior to their death. [3] A wider multi-agency response is needed to help address and prevent suicide.

This chapter sets out the national and local context, trends in data, outlines the evidence of what works in preventing suicide and self-harm, and describes what is being done locally in response.

Suicide

Suicide often represents the end point of a complex history of risk factors, distressing events and adversity. Unlike some causes of death, suicide is not a result of a single disease process or cause. It is a consequence of not only a range of mental health conditions, but may also be a response to serious physical illness, pain or loss of independence or quality of life. [4] Significant risk factors for suicide include depression, schizophrenia, substance misuse, self-harm, suicidal ideation, economic and family crises and bereavement by suicide. [5] The final decision to make a suicide attempt can occur during a relatively short period of extreme psycho-social crisis by people who might otherwise wish to live. It can also be difficult to determine whether a death was intended to be a suicide: a completed suicide may have been

Stigma and language considerations

Concepts and language often perpetuate stigma, constrain thinking and shape behaviour, and can be unhelpful in providing timely care to at-risk individuals and support for those bereaved by or otherwise affected by suicide.

The term "commit" suicide has criminal overtones which refer to a past time when it was illegal to kill oneself. It has also historically implied involuntary incarceration in a mental institution. The term "successful suicide" implies that death is a positive outcome, whilst "failed suicide attempt" suggests that the person themselves has failed.

Using alternative terms such as "died by suicide", "took his/her own life" or "attempted to end his/her life" help to reduce stigma and encourage people who may be thinking of taking their own life to seek help and support.

an attempt intended to fail or be discovered, and an act of self-harm may result in an unintended death.

Suicide represents a relatively small proportion of deaths, accounting for 1.62% of all deaths in Camden (53 of 3,264) and 1.78% of all deaths in Islington (55 of 3,092) between 2012 and 2014. However, many are potentially preventable. Suicide is a particularly important factor in the higher rate of premature deaths among people with serious mental illness (a crude rate of 87.0 per 100,000 mental health service users, compared with 10.1 per 100,000 in the general population). [6] Suicides disproportionately affect younger and middle-aged adults, accounting for a much higher proportion of years of life lost across the population than the number alone would suggest. Injuries associated with suicide attempts can also be very significant, causing long term disability and ill health.

An important purpose of the coronial system is assisting in the prevention of future deaths by reporting the findings and/or making recommendations to the relevant authority or organisation involved in the circumstances of the deceased's death. This can assist in preventing future suicide attempts.

Suicidal ideation refers to thoughts about suicide without the suicidal act itself. Although most people who experience suicidal ideation do not take their own lives, some go on to make suicide attempts, hence it remains a significant risk factor for suicide. The range of suicidal ideation varies greatly from fleeting thoughts to long-lasting and detailed planning. Suicidal ideation is much more common than suicide. Nationally, 15% of adults said they had considered suicide at some point in their life, and 3.9% in the past year. This compares with 4.4% of respondents who said they had ever attempted suicide, and 0.5% who had attempted suicide in the past year. [7]

Recording deaths by suicide and undetermined intent

Most deaths are certified by a medical practitioner; however, suspected suicides must be certified after a coroner's inquest. A coroner records a verdict of suicide when they have decided that there is evidence beyond reasonable doubt that the cause of death was self-inflicted and the deceased intended to take their own life. Open verdicts include cases where the evidence available to coroners is not sufficient to conclude that the death was a suicide (beyond reasonable doubt) or an accident (on balance of probability). They include those cases where there may be doubt about the deceased's intentions. Open verdicts are generally coded by the Office for National Statistics as deaths from injury or poisoning of undetermined intent.

Self-harm

Self-harm is when somebody intentionally damages or injures themselves. This may be a way of coping with or reducing internal tension, distraction from intolerable situations, as a way of communicating distress or difficult feelings, or to self-punish. In addition to an increased risk of suicide, self-harm is strongly associated with the onset of mental health problems and substance misuse in adolescence and early adulthood. [8]

The national emergency admission rate (all ages) for self-harm was 191 per 100,000 population in 2014-2015, compared with 88 per 100,000 and 119 per 100,000 in Camden and Islington respectively. [9] Hospital admissions for self-harm in children and young people aged 10 to 24 years are substantially higher than in the general population. In England there were 352 admissions per 100,000 population between 2010-2011 and 2012-2013 compared with 143 per 100,000 and 249 per 100,000 in Camden and Islington respectively. The trend is rising, and admissions for self-harm were 6.9% higher nationally in 2010-2011 to 2012-2013 than in 2007-2008 to 2009-2010. [9] In Camden, over the same period admissions for self-harm amongst 10 to 24 year olds rose 29%, whilst in Islington there was a 17% reduction. Significantly more girls and young women are admitted compared to their male counterparts, by a ratio of 8:1 among 10 to 14 year olds and 5:1 among 15 to 19 year olds. [10]

Self-harm and suicide have a complex relationship. An act of self-harm is not necessarily an attempt or even an indicator of intent to take one's own life. Some people who self-harm can regard it as a form of self-preservation. However, self-harm is an important marker of risk for suicide. The risk of suicide in the first year following an act of self-harm is 64 times that of the general population for men, and 90 times for women. Repeated self-harm and increasing age are associated with higher risk of subsequent suicide, as is the method of self-harm; more severe or violent methods such as hanging and jumping confer a higher risk of eventual suicide. [11]

Therefore, responding to self-harm and follow-up care is an important part of suicide prevention. The Royal College of Psychiatrists has reported that some vulnerable people who have self-harmed often discharge themselves from A&E because of long waiting times, whilst others may be discharged prematurely after a self-harm episode or suicide attempt. [12]

The national and local context

The national suicide prevention strategy, "Preventing suicide in England", has two overall objectives: a reduction in the suicide rate in the general population in England; and better support for those bereaved or otherwise affected by suicide. [2] It identifies six key areas for action to support these objectives:

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

Public Health has an overall responsibility for the local suicide prevention strategy, because of the close links to population mental health and wellbeing. However, responsibilities and actions cover a wide range of commissioners and service areas, hence the requirement within the strategy for multi-agency working.

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness examines suicide and homicide in people who have been in contact with secondary and specialist mental health services in the previous 12 months. It also examines the deaths of psychiatric inpatients which were sudden and unexplained. The Inquiry undertakes other related projects, the first of which examines the contact with primary care services of those who later completed suicide. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness has been running since 1992, publishing annual reports and a range of recommendations over the years.

Key findings of the most recent Inquiries [3,4] include:

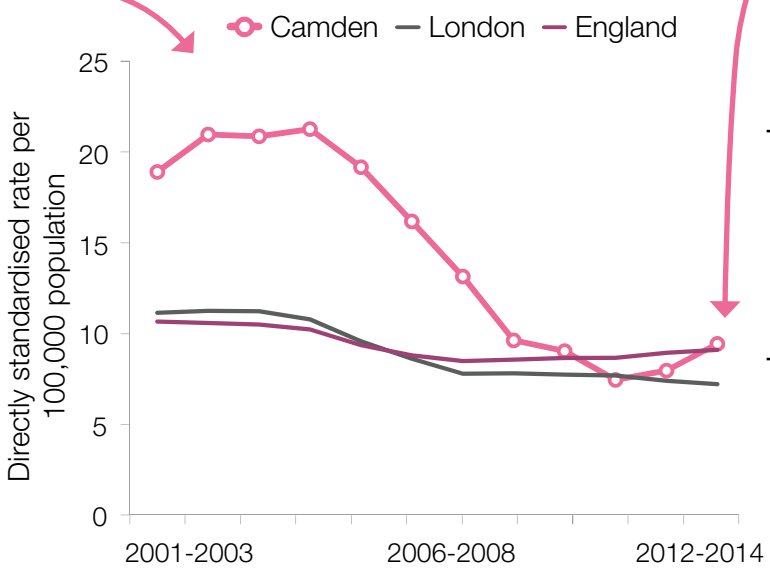
- As a proportion of all suicides, patient known to mental health services suicides have increased from 27% in 2003 to 30% in 2013. This may similarly reflect a rise in patient numbers, though safety problems in care may contribute
- Between 2002 and 2011, there was a 50% reduction in the number of in-patient suicides
- Suicides by patients under crisis resolution/ home treatment (CR/HT), however, have increased, and there are now three times as many suicides under CR/HT as in in-patient care. The first three months after discharge from inpatient wards remains a time of substantially increased risk
- 77% of individuals had seen their GP in the year before suicide; 45% in the preceding month
- The most common type of drug taken in fatal overdose by mental health patients is now opiates.

Suicide and self-harm

Over the past 11 years the death rate from suicide and undetermined intent has fallen significantly in Camden, and is now similar to rates for London and England

34 deaths per year

among Camden residents from suicide or undetermined intent 2001-2003



18 deaths per year

among Camden residents from suicide or undetermined intent 2012-2014

51% decrease in the rate, equating to

16 fewer deaths per year

from suicide in Camden compared with a decade earlier.

62% of deaths in Camden were in men, compared to 75% of deaths in London and 76% in England*

Highest rate of deaths was in residents aged 55-64 2006-2013

55-64

Men and women born in Ireland are over represented among local deaths

The most common means of suicide are*:

- Hanging, strangulation and suffocation
- Poisoning
- Jumping or lying before a moving object

This reflects the national trend.

National Suicide Prevention Strategy: Who is at higher risk of suicide?

- Middle-aged men and women (locally) and young men (nationally)
- People in the care of mental health services, including inpatients
- People with a history of self-harm
- People in contact with the criminal justice system
- Specific occupational groups, such as doctors, nurses and veterinary workers.

Hospital admissions for self-harm

88 hospital admissions per 100,000 residents

(202 admissions in total) per year for self-harm. This is lower than the England average (191 per 100,000). 2014-2015

143 admissions per 100,000 children and young people aged 10-24

This is lower than the England average (352 per 100,000). 2010-2011 to 2012-2013

Note: *based on an audit of deaths in Camden since 2006.

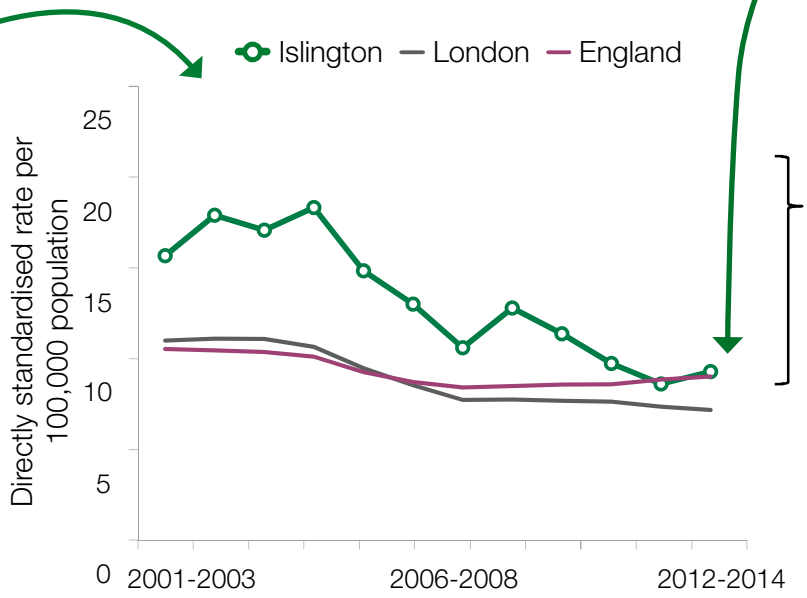
Camden

Suicide and self-harm

Over the past 11 years the death rate from suicide and undetermined intent has fallen significantly in Islington, and is now similar to rates for England

31 deaths per year

among Islington residents from suicide or undetermined intent [2001-2003]



18 deaths per year

among Islington residents from suicide or undetermined intent [2012-2014]

42% decrease in the rate, equating to

12 fewer deaths per year

from suicide in Islington residents compared with a decade earlier.

67% of deaths in Islington were in men, compared to 75% of deaths in London and 76% in England*

Highest rate of deaths was in residents aged 45-64 [2006-2013]

45-64

Men and women born in Ireland are overrepresented among local deaths

The most common means of suicide are*:

- Hanging, strangulation and suffocation
- Poisoning
- Jumping or lying before a moving object

This reflects the national trend.

National Suicide Prevention Strategy: Who is at higher risk of suicide?

- Middle-aged men and women (locally) and young men (nationally).
- People in the care of mental health services, including inpatients
- People with a history of self-harm
- People in contact with the criminal justice system
- Specific occupational groups, such as doctors, nurses and veterinary workers.

Hospital admissions for self-harm

119 hospital admissions per 100,000 residents

(279 admissions in total) per year for self-harm. This is lower than the England average (191 per 100,000). [2014-2015]

249 admissions per 100,000 children and young people aged 10-24

This is lower than the England average (352 per 100,000). [2010-2011 to 2012-2013]

Islington

Note: *based on an audit of deaths in Islington since 2006.

Previous findings of the Inquiry have informed national and local mental health strategies, and continue to provide definitive figures for suicide and homicide related to mental health services in the United Kingdom. The Inquiry provides important recommendations and indicators for commissioners and providers of mental health services to take action to reduce suicides.

The Mental Health Crisis Care Concordat

The Mental Health Crisis Care Concordat, published in February 2014, describes national standards for 24/7 access and help for people who are experiencing a mental health crisis. The report highlights that care for mental health crises should be equivalent to that for a physical health emergency. There are significant numbers of people experiencing, or at risk of, crisis in Camden and Islington. During the first six months of 2014-2015 there were 2,506 referrals to Crisis Response Teams (1,190 in Camden and 1,316 in Islington).

Not all people who are at risk of, or are experiencing, a mental health crisis will be suicidal, but the risk of self-harm or suicide is significantly increased. Therefore, improving access to services for people experiencing a crisis and ensuring a strong, joined up pathway between services is an important aspect of helping to reduce the risk of suicide.

The Concordat sets out key principles of good practice together with an action plan that local partnerships and services should use to improve local outcomes. The four key themes are:

- Access to support before a crisis begins
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises.

The Concordat focuses on people who experience an acute mental health crisis, and spans health, social care and criminal justice systems whilst also being relevant to other areas of service provision such as housing providers and the community and voluntary sector. Locally, Camden and Islington are working together on the implementation of an action plan to achieve these standards. Both boroughs recognise the challenges and opportunities provided by joint working across the very broad range of partners involved in crisis care. Embedding the plan within the strategic frameworks of these partner organisations will be key to successful implementation of the plan. Identified challenges include the governance of effective information sharing across organisations, that those with a dual diagnosis will receive an equal standard of care to those without substance misuse needs, better experiences of inpatient care and an improved quality of response when people are detained under the Mental Health Act 1983.

A key Camden Mandate work stream that will support Concordat delivery is a crisis care feasibility study which will review local crisis care and consider options for future investment. Islington will use the learning from this exercise to build on its existing crisis models of care review.

National trends in suicide

Suicide rates in England fell to their lowest level over the period 2007-2009, but had increased by 7.6% by 2012-2014 This increase is likely to be linked to the economic downturn and austerity. [13] Previous economic downturns have tended to be associated with increases in suicide among young men under 35 years old who experience high levels of unemployment. The increase in the most recent period has been largely associated with middle-aged adults (men aged 45-64 and women aged 45-54 years).

There are an average of 4,500 – 4,800 deaths a year from suicide and undetermined intent in England. Deaths from suicide are much more common among men – accounting for three-quarters of all deaths, and in the 25-29 year age group, 4 times as many deaths compared to women. The highest rates are in the 45-54 year age group. Deaths from hanging or strangulation account for 55% of suicides in men, and 42% in women. The other major means of death among women is poisoning, which accounted for 37% of suicides in women.

Suicide in Camden and Islington

Deaths from suicide and undermined intent have declined substantially over the last decade in Camden and Islington. In both boroughs, the rate is now similar to the rates in London and England, although the proportion of local deaths among women is higher than nationally.

In Islington, the highest suicide rates are among 35-64 year olds for both men (21.4 per 100,000) and women (9.4 per 100,000), which reflects the national pattern. In Camden, the highest rate among men is among 35-64 year olds (16.1 per 100,000), but for women it is among 65-74 year olds (14.2 per 100,000, compared with 3.9 per 100,000 in England).

Local suicide audits form an important part of local suicide action plans, and can help to identify trends and vulnerabilities, particularly in terms of population groups, geographic locations and means of death. An audit covering 2006 to 2013 reviewed 293 deaths from suicide and undetermined intent among Camden and Islington residents (135 Camden residents, 152 Islington residents, and six people with no fixed abode).

- People born in the Republic of Ireland appeared to be at higher risk of suicide compared with the general population, particularly middle-aged and older adults, although caution is required as overall numbers were small
- Most suicides occurred in or close to people's homes. A number of locations had three or more suicides by residents over the period of the audit. As well as health care settings, these were HMP Pentonville, a housing estate, and a number of mainline and underground stations
- Compared to England, more deaths were due to drug-related poisoning among men in Camden, and among both men and women in Islington. A greater percentage of local deaths were caused by jumping or lying before a moving object, which is likely to reflect suicides at underground stations
- The audit did not find a link between local suicide rates and deprivation.

In 2014-2015, the rate of hospital stays by patients admitted due to self-harm among Camden residents was 87.8 per 100,000 and among Islington residents was 118.6 per 100,000. This represents 202 and 279 stays per year respectively, and both rates were better than the rate for England (191.4 per 100,000). [9]

Suicide and self-harm in the criminal justice system.

The rates of both self-harm and suicide are known to be far higher among prison populations compared with the general population, and both are higher among women prisoners compared with men. [15]

There are two prisons in Islington: HMP Pentonville for men and HMP/YOI Holloway for women. At HMP Pentonville, which has a population of about 1,300 prisoners, on average, 19 prisoners self-harm each month and about 60 prisoners are on suicide and self-harm management procedures at any one time. [16] **The local suicide audit found seven deaths from suicide recorded at the prison between 2006 and 2013. At HMP Holloway, with an average population of 500 prisoners, there are an average of 63 self-harm incidents each month, with no deaths from suicide since 2007, a significant fact given that there had been six such deaths in the previous five years. Important aspects of suicide prevention in prisons are: improved screening at reception to identify potential suicide risk, training for prison staff, access to primary care and mental health services, and improved management of risk, including care plans for those at high risk (via multi-disciplinary Assessment, Care in Custody and Teamwork arrangements). Prison service risk factors that contribute to increased risk of self-harm and suicide include significant levels of overcrowding, related pressures on staffing, and the very high level of mental health conditions and vulnerabilities, including personality disorders, and drug use among the prison population.**

A report by Her Majesty's Chief Inspector of Prisons in 2014 found that HMP Pentonville was seriously overcrowded, running at over 35% above capacity. The report found that risk of suicide and self-harm in the early days of custody were high. Prisoners who were the most vulnerable to self-harm received reasonable support, but most prisoners identified as being at risk required more consistent case management. A similar report for HMP/YOI Holloway in 2013 highlighted that action plans had been developed to address recommendations from other death in custody investigations, and the safer custody team worked proactively to identify risks and reduce isolation. Recently released prisoners are also at a much greater risk of suicide than the general population, especially in the first few weeks after release. In all age groups, suicide rates are higher in recently released prisoners than in the general population, with around 21% suicides occurring in their population within the first 28 days after release. The risk of suicide in recently released prisoners is close to equalling that seen in people discharged from psychiatric inpatient units. [17]

There are also increased risks associated with police custody. The Independent Police Complaints Commission investigated 68 apparent suicides following police custody in England and Wales in 2013-2014, of which two thirds were reported to have mental health concerns. [18] **This is was the highest number since 2008-2009.**

Locally, the Criminal Justice Link Service provides support to people before and after release from prison, on probation caseloads, or identified as having a mental health need whilst in police custody. The service supports people to access both primary and secondary mental health services, and social support.

Suicide prevention: what works?

A combination of preventive approaches, which address different risk factors at different levels, is required. These need to take account of local population characteristics, social, cultural and socioeconomic circumstances, together with intelligence on other local risk factors, such as high risk locations.

Awareness and prevention

Mental health promotion is the cornerstone of suicide prevention, playing an important role in reducing stigma and challenging myths associated with mental health conditions. Mental health promotion is also important in developing skills in supporting people towards recovery, including self-help strategies, and improving signposting and access to appropriate services.

Training for "gatekeepers" such as teachers, faith leaders, and care workers, who are in contact with vulnerable groups on recognising risk factors is essential. They must be able to recognise warning signs for suicide and know the availability of appropriate services to signpost to. [19]

At locations where there have been multiple suicides there is also evidence to show that measures to encourage help-seeking such as signs, information, posters and telephone lines can reduce suicides. In addition, increasing the likelihood of intervention by a third party through, for example, training police and station staff and installing CCTV, can also reduce suicides. [20]

Locally, suicide risk and prevention is a core component of training in mental health awareness and skills for non-mental health workers (whether in the statutory or non-statutory sector) and the general public. Mental Health First Aid and Youth Mental Health First Aid are evidence-based programmes that aim to provide the basic skills and knowledge to recognise and offer effective help to a person developing a mental health problem or in a mental health crisis. The programmes have been offered in Islington for a number of years and in 2013-2014, just under 650 employees, students, volunteers, and residents in Islington were trained. In Camden, these programmes are a key part of Voluntary Action Camden's mental health programme. Camden Clinical Commissioning Group has recently commissioned a range of mental health skills and awareness training to be offered and rolled out across key staff groups and settings. The Islington Faith Forum hosted a suicide prevention workshop in February 2014, bringing together over 90 representatives from a range of community and statutory organisations to increase understanding and responsiveness to suicide risk, how to access help and services, and to share information and good practice.

A spotlight on… the Samaritans

Central London Samaritans welcomes visitors to its Soho branch every day of the year, between the hours of 9am and 9pm. A volunteer will see you as soon as possible in a quiet room where you will be able to talk in privacy, and complete confidence, to a volunteer who will listen and support you.

365 days per year, by phone.

08457 90 90 90
020 7734 2800

An email service answers within 24 hours.

jo@samaritans.org

Central London Samaritans, 46 Marshall Street, London W1F 9BF

Identification and treatment

People with a history of mental health conditions are often in contact with their family doctor prior to suicide, and often frequently: on average seven times in the year prior to completing suicide. Improved identification and treatment of depression with anti-depressants in primary care has been shown to reduce suicide rates, whilst psychotherapy has also shown benefit. [19]

Policies recommending mental health services follow-up patients over the first 7 days of psychiatric hospital discharge and robust discharge planning appear to have been associated with reductions in hospital re-admissions for self-harm in the immediate post-discharge period. [21]

Medication for people with severe mood disorders and schizophrenia has been shown to have an anti-suicidal effect. [22]

Implementing the recommendations from the National Confidential Inquiry reports is associated with reduced levels of deaths due to suicides in mental health trusts.

Reducing access to the means of suicide

Reducing access to the means of suicide and attempted suicide is effective in reducing suicide rates. Examples include: legislation reducing the pack sizes of over-the-counter medicines such as paracetamol and aspirin and prescription medicines such as coproxamol; [23, 24] physical barriers such as platform edge doors at Underground stations, and fencing or nets on bridges [25] and the removal of ligature points in high risk areas such as mental health inpatient wards and in criminal justice settings. [26, 27]

Evidence suggests that although some people may seek other methods, many do not. Those who do seek other methods often choose less lethal methods. [28]

A spotlight on... places of safety in a crisis in Camden and Islington

Crisis Houses are community based houses that provide residential and non-residential support to people in crisis, providing a mix of social and emotional support. They act as a place of safety and support in a home-like environment for people in crisis, or who are at significant risk. People can self-refer or be referred through health and social care professionals. Crisis houses can provide an alternative to hospital admission for some people who otherwise could not be treated or supported at home. They have been found to lead to improved recovery outcomes, including better management of mental health conditions, identity, self-esteem, hope, and self-care. [22] Crisis houses are increasingly co-located with other services, such as integrated community teams, crisis response teams, and supported accommodation services.

There are four crisis houses in Camden and Islington: two six-bedded units in Camden – North Camden and Rivers Crisis Houses – and Highbury Grove and Drayton Park in Islington. Drayton Park Crisis House was the first women-only residential mental health crisis facility in the UK, and can accommodate mothers with their children when necessary.

Islington is also home to the Maytree suicide respite centre, which is the only centre of its type in the UK. Maytree offers a four night/five day residential sanctuary to people in a suicidal crisis in a calm, safe house, as well as telephone and email support. The centre befriends residents and provides time and space to talk and reflect in a supportive, non-medical environment.

Media reporting

The media has a significant influence on behaviour and attitudes. Media portrayal of suicides can influence suicidal behaviour, with evidence that news stories on suicides can increase the overall number of suicides. The media influences the use of particular methods of suicide, particularly when detailed or graphic information is reported. However, research shows that when the media has followed responsible reporting guidelines, there have been positive outcomes, potentially reducing the number of deaths and increasing information about access to help.

The Samaritans has produced media guidelines for reporting suicide, which includes avoiding detail or technical information such as the method used, avoiding dramatic headlines and photographs, avoiding speculation on the trigger for suicide, and including references to where people who may be suicidal can find help. [29]

A spotlight on... preventing suicide on the Underground and railway

There were an average 24 fatalities per year on the London Underground network between 2010 and 2013, with the vast majority resulting from a suicide attempt. Although suicide attempts occur across the network, there are higher numbers at some stations. Data from Transport for London show that at Camden stations, 41% of "person under a train" incidents were fatal, and 28% of non-fatal incidents resulted in major injury. In Islington, 57% of such incidents were fatal and 30% of non-fatal incidents resulted in major injury.

Public Health, in partnership with Transport for London, the British Transport Police (BTP), Samaritans and the Rail, Maritime and Transport (RMT) Union, developed a 2 hour training course for London Underground staff and British Transport Police covering Islington stations. This includes joint training for London Underground and BTP staff in suicide prevention, and joint working with mental health professionals to ensure that vulnerable people have timely access to mental health services.

There was high attendance from local staff and BTP officers. The course evaluation and feedback revealed that almost all 44 participants had witnessed suicides or been involved in the follow-up. Participants were able to identify actions that they would take to contribute to suicide prevention on the Underground.

Conclusions

Suicides have reduced significantly in both Camden and Islington over the past ten years, but they remain an important cause of death in younger and middle-aged adults. There are substantial population risks and vulnerabilities in both boroughs.

Most suicides are potentially preventable, although it can be difficult to predict suicides at an individual level because risk factors are relatively common. Suicides often occur during periods of acute psycho-social distress, in people who would otherwise probably wish to live.

Many people who kill themselves will have been in contact with primary care or mental health services, however about a quarter will not have been in contact with either in the previous 12 months. This presents a huge opportunity for public mental health prevention.

An updated suicide prevention pathway is being developed locally, based on national guidelines and linked to the Crisis Care Concordat. This pathway will help to identify priorities for future development of services and the workforce for preventing and responding to suicides, including support for people bereaved or affected by suicide.

There are interventions that can reduce the risk of suicide, including:

- Earlier diagnosis, treatment and support for mental health conditions through primary care and mental health services assessing and managing risk
- Acting on the findings and recommendations of the National Confidential Inquiry and local investigations of suicide
- Greater awareness and prevention across services and the community
- Reducing access to the means of suicide, including local places of risk
- Responsible media reporting, following national guidelines.

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Conclusions and recommendations

This report has shown that there are very high levels of mental health conditions in children and adults in Camden and Islington compared to London and England. There are stark inequalities in the distribution of risk factors and in outcomes across the population. The drivers of these inequalities are complex and not fully understood. These are marked by significant differences between genders, age groups and ethnic groups, and economic, health and social adversities; children, in particular, and adults experiencing deprivation and poverty, unemployment, physical disability, long term physical health problems, homelessness and problem drug and alcohol use are at greater risk. In general, mental health conditions are highest in people and communities who are experiencing deprivation, disadvantage or discrimination, and the risk of mental health conditions increases cumulatively with the number of risk factors.

Many of these factors are not mutually exclusive and often drive each other, as well as mental ill health. Furthermore, while they are risk factors, they are also the consequence of mental health conditions; people can be drawn into a vicious cycle of mental health decline. For instance, it is not difficult to imagine an event such as a person being evicted or having a relationship break down, triggering a period of poor mental health, which then affects their ability to work. Their mental health could then further decline, making it much harder to find or hold down a job.

The inter-generational nature of mental health risk factors further complicates mental health distribution in the population; parental mental health conditions increase risk in their children throughout life. Risks to mental health are cumulative, which means that mental health conditions are particularly common in children and adults with complex needs and in those experiencing multiple disadvantage. Additionally, there are also major, long term inequalities in access to services, especially among Black and Minority Ethnic (BME) groups.

These complex interactions between mental health, social adversities, physical health, and engagement with or benefit from the services, all reinforce the inequalities in mental health risk and outcomes.

As well as the personal impact of mental health conditions, there are vast economic and societal costs. The direct and indirect costs of mental health conditions across Camden and Islington combined are estimated to be around £1.3 billion per annum and there may be still more costs not captured in this estimate. The local NHS is the highest direct investor in mental health services, but in fact represents a minority of the overall economic costs of poor mental health; many other public services are affected, including many council services, such as housing, adult and children's social care, as well as schools and colleges, the police and criminal justice services. Voluntary and community services see many people with mental health conditions, whether as the main reason for contact or as an underlying issue. Thus, mental health conditions are a 'cross-cutting' issue, affecting many different services, sectors and communities, but where, for any individual commissioner or service provider, the benefits of improving outcomes often accrue to many other public services too.

Recommendations are made below to improve mental health and wellbeing in Camden and Islington. These reflect the analyses and key messages presented in this report, and draw on evidence of 'what works' to improve population mental health. It is particularly important that there is a focus on addressing inequalities between groups and acting on the underlying drivers of mental health inequalities described above. The recommendations are grouped into four themes: giving children and young people the best start in life, addressing the wider economic conditions associated with mental health, improving mental health in the community, and addressing physical and mental health problems more holistically.

The best start in life

As discussed in this report, many of the foundations of mental health are established early in life. Pregnancy, the early years and the period of 'psychological adolescence' lasting from the teenage years to early twenties are crucial periods in this sense. During this period, families and carers play a key role, and certain risk factors are particularly influential. Children who experience poverty, abuse, parental mental health conditions, and other family adversities are at higher risk of poor mental health throughout life.

Impacts on emotional health and wellbeing can be detected very early on in children's development. It follows that there are many opportunities to promote the protective factors and ameliorate the risk factors described in chapter 3 during this period. In doing so, resilience throughout life can be enhanced. There are significant service innovations underway to better meet local needs, as well as building on effective services, which are important to support long term outcomes for children and their families.

R **Recommendation:** Promoting better mental health and wellbeing, and effective early intervention for children, families and carers should be a priority for both councils, the local NHS and other partners, in spite of increasingly limited resources. The Local Transformation Plans for Children and Young People's Mental Health and Wellbeing present an important opportunity for improving outcomes, including access to services. It is important that a long term view is taken on the benefits from this investment. There should be a particular priority given to pregnancy and the early years, addressing inter-generational mental health and the key period of transition.

R **Recommendation:** There is increasing recognition of the importance of support in pregnancy to women with current, or histories of, mental health conditions for safety of care and improved long term outcomes. Support for local perinatal mental health services should be a priority, including both specialised and community services as well as the links into 'best start in life' programmes and the new health visiting responsibilities of local authorities.

R **Recommendation:** High priority and visibility should continue to be given to developing access and outcomes for Child and Adolescent Mental Health Services (CAMHS), in line with the Local Transformation Plans. The same high profile should be given to CAMHS access, waiting times and outcomes, as is given currently to national reporting requirements for Improving Access to Psychological Therapies (IAPT) services and dementia diagnoses and care.

R **Recommendation:** Local action to continue to develop and improve successful transition from CAMHS to adult mental health services is particularly important, given the evidence of high and changing levels of need and vulnerability experienced during the period from adolescence through to early adulthood.

R **Recommendation:** Alongside feedback and engagement from service users and their families, and from children and young people more generally, Health Equity Audits should be used to assess how equitably needs are being met across different population groups in CAMHS services, and to support improvements in access where indicated.

R **Recommendation:** The importance of schools and other children and young people's settings for improving mental health should continue to be emphasised locally. Improving educational outcomes for groups with lower educational attainment is also an important determinant for better mental health. Emotional and mental health promotion interventions, anti-bullying measures (including cyber-bullying) and location of CAMHS services in such settings increase access to effective preventive and treatment interventions for mental health conditions in children and young people.

Economic conditions

Economic conditions have an important influence on mental health. In particular, having a good, secure job with fair remuneration is one of the most important protective factors for mental health and wellbeing, and confers a range of other social and psychological benefits.

Conversely, mental health outcomes can deteriorate during recessions, when risk factors such as unemployment, poverty and personal debt increase. Recessions have become longer and more severe, which further increases these negative effects. The need for public services and welfare benefits, including for people with mental health conditions, increase but resources become more constrained and services are cut. Additionally, the impacts of recession are often greater on more economically vulnerable people, such as those in insecure employment, on low incomes and on welfare benefits. Thus, a number of national reports and charities have warned of increases in new cases of mental health conditions in children and adults, linked to the economic climate and austerity measures. People who experience poverty and other deprivation are at greater risk of mental health conditions, and those affected by benefit cuts, lower wages, insecure employment, unemployment, poor housing and rising housing costs are all factors driving the increase in demand for mental health services. An increase in suicides nationally since 2006 has also been linked to the economic downturn.

R **Recommendation:** Continued priority should be given to reducing the numbers of young people who are not in education, employment or training (NEET) to reduce the risks of long term mental health problems linked to social exclusion and poverty.

R **Recommendation:** Ensuring access to advice on personal debt, welfare benefits and employment support should be a key part of action to mitigate increased mental health stresses associated with financial hardship, and will also help to reduce pressure on front line services.

R **Recommendation:** The London Living Wage (LLW) policies pursued by Camden and Islington Councils and Islington CCG can be considered an important component of improving mental health and wellbeing for people on low incomes and in the workplace. Employers across the public and private sectors in both boroughs should be encouraged to pay the LLW and pursue a LLW policy in their own supply chains.

A high proportion of people who are long term unemployed and workless in both boroughs have severe and enduring mental health conditions. Many more will be at increased risk of common mental disorders (CMD). There are very low levels of employment among people with serious mental illness (SMI) compared to the general working age adult population. During the current period of austerity, the gap in rates of employment between people with mental health conditions and the general population has widened.

As welfare reform and employment policies increasingly concentrate on those people who are 'furthest' from employment, it will increase attention on mental health conditions as a major cause of long term exclusion from employment. There are effective interventions proven to make a difference, but there is also the need to test out and evaluate new approaches to increasing employment among the long term unemployed with mental health conditions. Preventing the loss of employment due to mental health conditions is also very important. Timely access to help and support for people with mental health conditions, including workplace adaptations, can significantly reduce the risk that people who develop mental health conditions lose their jobs in the first place. As well as considerations of equity and fairness, there is a strong economic case for pursuing workplace mental health interventions and policies, with an estimated nine-fold return on investment.

R **Recommendation:** Increasing employment among people with mental health conditions who are long term workless, together with training, education and volunteering opportunities that build pathways back into work, is an important part of improving outcomes and reducing social exclusion for this group. Taking a 'whole system' approach will help to achieve gains in employment outcomes.

The role of primary care and mental health services to encourage and support employment among patients, building on pathways between health and employment services already developed, is particularly important. Reducing the gap in employment between people with SMI in Camden and Islington and those with SMI in London and nationally should be a priority, given the extent of the inequality in employment faced by this group.

R **Recommendation:** With the right support, people with mental health problems can find and keep a job. Locally, public sector bodies should be in the vanguard of employers adopting employment policies and practices that are protective of mental health. This will help to prevent employees experiencing mental health conditions from falling out of work, and help prevent the associated loss of productivity, talent and experience in the workforce.

Promoting mental health with communities

Social relationships are fundamental to mental health. Those of greatest influence are within the family and other close personal relationships. However, the social fabric of communities – the quality of the relationships and links that people have within neighbourhoods and between communities – are also determinants of mental health and wellbeing. For example, feelings of trust, perceived safety, environmental quality and level of participation are protective attributes of neighbourhoods and communities. Generally, these are seen less often in more deprived neighbourhoods. While social capital in such areas may mitigate higher mental health risk to some degree, it follows that this relationship plays a part in the mental health inequalities described throughout this report. Additionally, in communities where these protective factors are present, those who are excluded in some way, perhaps through social isolation or feeling marginalised, may be a greater risk of mental health conditions.

Community strengths can also influence the outcomes of those experiencing a mental health problem. Many people experiencing mental health conditions will first seek help or advice within their community, and from local voluntary and community sector services. However, this is not the case for many people, especially in communities where mental health remains widely misunderstood and stigmatised. Although, as discussed in Chapter 1, misunderstanding and stigma is endemic across the entire population, it is especially true among BME groups. This further isolates people with mental health conditions and their families, delays people seeking help, and further drives the inequalities in mental health outcomes in these groups.

There are a number of interventions, including community development approaches and social marketing initiatives, which engage with communities, particularly BME communities, to increase understanding and access to help and support for mental health conditions. Anti-stigma and discrimination actions are effective in changing attitudes and understanding about mental health conditions, including specific initiatives for dementia. 'Social contact' interventions that 'bridge' contacts between people with lived experience of mental health conditions and those without have an important role in these initiatives. Training and awareness programmes, such as Mental Health First Aid and Dementia Friends, can make a contribution to building the capability and resources of communities: helping to increase knowledge and skills, tackle stigma and increasing the confidence of community members to respond to the mental health needs of others, as well as their own.

Additionally, increasing understanding and skills of non-mental health public services and the voluntary and community sector, to recognise and respond to mental health conditions and signpost or refer to help is similarly important, and helps to improve access to support. Such an approach is consistent with policies that promote 'No Wrong Door' and 'Every Contact Counts', developing the ability of front line services to respond confidently to a wide range of presenting needs.

R **Recommendation:** Anti-stigma and discrimination, mental health skills-based training and awareness-raising should be a priority for the Health and Wellbeing Boards in both boroughs. Initiatives should be promoted to the general community, public services such as housing, employment, community safety and customer services, and voluntary and

community sector services. These initiatives make a sustained and practical contribution to creating resilient and more inclusive communities, better able to respond to people experiencing mental health conditions or in distress.

R **Recommendation:** The benefits of breaking down social isolation should be recognised across the Councils and the wider system. These benefits include preventing mental health conditions, and improving the wellbeing of those with mental health conditions.

R **Recommendation:** There should be continued importance given to working with, and targeting of, BME and other vulnerable communities to ensure that services are delivered and used equitably. This aims to facilitate and directly increase access to help for people with mental health conditions, and to build the knowledge and skills within communities to tackle stigma.

R **Recommendation:** Better knowledge of the extent of mental health needs and conditions across the community is important, rather than relying on estimates based on national, and often quite old, surveys. Qualitative information from community engagement and service users is also important. As and when resources become available, local population surveys to assess the levels of diagnosable mental health conditions should be considered in order to better understand and target services to local need.

Social isolation worsens mental as well as physical health. Those at risk include older people those living in poverty, homeless people, ex-offenders and those already living with a mental health condition. There are a range of practical measures that can help people to get better connected with others. These include befriending and volunteering initiatives, social prescribing schemes that engage people who are isolated in social activities and community resources, and reducing fuel poverty.

The design of the built environment, quality of housing and use of public spaces, including green spaces, can help to facilitate better mental health and reduce isolation. Through design it is possible to promote shared use of community spaces, encourage people to 'get out and about', making walking and greater physical activity easier, promote access to important amenities such as healthy food, leisure facilities and community resources, and design public spaces that are safe, age-friendly and well maintained. Together, these measures help to foster a greater sense of community cohesion and hence better wellbeing.

Poor housing quality is linked to increased risks of social isolation, with particular impact on older people and vulnerable children and adults; in children and young people it is associated with increased behavioural problems, particularly where there is a lack of personal space or overcrowding. Poor housing co-exists with other forms of deprivation, making for example large families living in social housing at higher risk.

R **Recommendation:** Health Impact Assessments should be used to support planners and local communities to increase the mental health benefits from major developments and regeneration programmes, and mitigate or reduce negative aspects. It is important that the potential for housing and neighbourhood developments to positively promote mental health is taken into account in the design and construction phases, as well as in the long term maintenance.

Improving health and life expectancy in adults

The impact of mental health on the health of the population is very significant in both Camden and Islington, not only in terms of the psychological effects of mental health conditions, but also the impacts on physical health and on early preventable deaths. Parity of esteem (or equality) in commissioning and providing services for mental health with those for physical health is essential. This applies to services meeting the physical health care needs of people with mental health conditions, and vice versa.

Encouraging earlier help-seeking for people with mental health conditions increases timely access to support and effective treatment. This helps to reduce the duration and severity of mental ill health and improve outcomes. One measure of access is the proportion of mental health conditions in the population that have been diagnosed. In Camden and Islington this

proportion of diagnosed mental health conditions is significantly higher than for London or nationally. There has also been a major expansion in access to psychological therapies for adults with CMD in recent years. However, there is substantial variation at individual general practice level in the diagnosed prevalence of CMD, even after adjusting for demographic differences between practices. Of note, as deprivation increases due to worsening economic conditions, risk of CMD and SMI increases.

R **Recommendation:** Improving diagnosis of CMD and referrals to IAPT for those GP practices that have rates significantly below the average should be a priority in the development of local primary care in both boroughs.

The poorer physical health of people with serious, long term mental health conditions is a major factor in inequalities in life expectancy in both boroughs, and is largely due to higher rates of long term physical health conditions in people with SMI. Lifestyle risk factors, including higher levels of smoking, obesity and problem drug and alcohol use, poorer access to effective services and deprivation all contribute to poorer outcomes and lower life expectancy for people with mental health conditions. Actions to improve physical health through behaviour change interventions and health service re-design to join up services around the holistic health needs of people with mental health conditions, will help to improve health outcome and life expectancy. These need to be accompanied by actions to address the social determinants of health, such as employment support and anti-poverty measures.

Depression and anxiety worsen outcomes for people diagnosed with physical long term conditions. It is important that screening for CMD should be a part of care for physical long term conditions, and that psychological support should be an integral part of managing and supporting people affected by physical ill-health.

R **Recommendation:** A high priority should be given by Camden and Islington Health and Wellbeing Boards to improve mental and physical healthcare outcomes for people with SMI. Recent work undertaken by Clinical Commissioning Groups (CCGs), using value-based commissioning approaches to improving physical health outcomes for people with SMI provides an important foundation for future action. Trajectories should be agreed to reduce this major health inequality over time.

R **Recommendation:** The IAPT offer for people with CMD and long term physical health conditions should be further developed in order to help improve outcomes, and may also help to increase use of psychological therapy services among older people with CMD.

R **Recommendation:** Actions to reduce smoking and promote physical activity among people with mental health conditions should be prioritised, with particular priority for people with SMI.

R **Recommendation:** The comorbidity of alcohol and substance misuse with mental health conditions is a cross-cutting issue for health and a wide range of other services. Services should work holistically with each other to address alcohol and substance misuse among those with mental health needs, and vice versa. It should be recognised that the local health system, directorates across the Councils, and agencies in the wider public and voluntary sectors, all have contributions to make in addressing this.

Deaths from suicide and undetermined intent have fallen in both boroughs, but remain an important factor in lower life expectancy for people with SMI in particular. Certain groups are affected by suicide more than others; suicide remains the single largest cause of death in younger and middle-aged men. Other groups at higher risk are people in contact with the criminal justice system, and, locally, those born in Ireland. Suicide is a major cause of preventable deaths among people with SMI.

Most suicides are potentially preventable and there are effective strategies that can significantly reduce the risk.

R **Recommendation:** The Health and Wellbeing Boards in both boroughs should champion implementation of the Suicide Prevention Strategy, once approved.

Acronyms

A&E	Accident and Emergency Department
ADHD	Attention Deficit Hyperactivity Disorder
APMS	Annual Psychiatric Morbidity Survey
BME	Black or Minority Ethnic
BMI	Body Mass Index
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive behavioural therapy
CCG	Clinical Commissioning Group
CKD	Chronic Kidney Disease
CLD	Chronic Liver Disease
CMDs	Common Mental Health Disorders
COPD	Chronic obstructive pulmonary disorder
CPA	Care Programme Approach
CQUIN	Commissioning for Quality and Innovation
CRT	Crisis Resolution Team
CVD	Cardiovascular disease
CYP	Children and Young People
DH	Department of Health
DSR	Directly Standardised Rates (suicide and undetermined injury)
EIS	Early Intervention Service
GLA	Greater London Authority
GP	General Practice or General Practitioner
HIV	Human immunodeficiency virus
HMP	Her Majesty's Prison
HS2	High Speed 2 (railway line)
HSCIC	Health & Social Care Information Centre
HWB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Therapies
iCope	Camden and Islington IAPT Service
IMD	Index of Multiple Deprivation
IPU	Integrated Practice Unit
JHW(B)S	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LCS	Locally Commissioned Service
LLW	London Living Wage
LSOA	Lower Super Output Area
LTC	Long term condition
MHFA	Mental Health First Aid
MSOA	Middle Super Output Area
NEET	Not in Education, Employment or Training
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
ONS	Office for National Statistics
PHOF	Public Health Outcomes Framework
QALY	Quality Adjusted Life Year
QOF	Quality and Outcomes Framework
SHINE	Seasonal Health Interventions Network
SHLAA	Strategic Housing Land Availability Assessment
SMI	Serious Mental Illness
STI	Sexually transmitted infection
VBC	Value Based Commissioning
VCS	Voluntary and Community Sector
WEMWBS	Warwick Edinburgh Mental Wellbeing Scale
WHO	World Health Organisation
WISH +	Warmth Income Safety Health Referral Scheme Plus (WISH Plus)
YMHFA	Youth Mental Health First Aid
YOI	Youth Offender Institute

Glossary

Anxiety Disorder	A group of disorders including generalised anxiety, panic, irrational fears and obsessional thoughts or behaviours. When these persist, cause lasting distress or start to interfere with everyday life, they are classed as pathological.
Asset Based Approach	An approach to health improvement that seeks positively to mobilise the assets, capacities or resources available to individuals and communities which could enable them to gain more control over their lives and circumstances. The approach focuses on working with people and communities as active participants rather than passive recipients of health or social care programmes
Attention Deficit Hyperactivity Disorder	Developmental disorder consisting of core dimensions of inattention, hyperactivity and impulsiveness.
Bipolar Disorder	A mental health condition consisting of extreme mood swings. Sufferers experience episodes of severe depression and of mania. The episodes last for several weeks or often for months, and many people do not experience a "normal" mood very often if at all. Some sufferers develop psychotic symptoms at some times.
Care Act (2014)	Sets out national thresholds for adult care and details the care and support that Councils must provide to promote wellbeing, prevent future need, provide advice and guidance, and manage the provision of local services. The act comes into effect in April 2015
Care Programme Approach	The system that is used to organise many people's care from 'secondary mental health services'. Those eligible should get a full assessment of health and social care needs, a care plan and regular reviews, and have a named care coordinator. Eligibility is usually for those with severe mental illness, complex needs or problems looking after themselves that will affect access to treatment and care.
Child and Adolescent Mental Health	A general term used to describe mental health conditions of childhood and adolescence. It is often used to refer to the most common conditions of childhood: conduct disorders, emotional disorders and hyperkinetic disorders.
Cognitive Behavioural Therapy	A therapeutic model which looks at the interaction between thoughts, feelings and behaviours.

Common Mental Health Disorder	"Common mental health disorder" is often used as a global term to include depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder, post–traumatic stress disorder and social anxiety disorder. These conditions are very common, jointly affecting up to 15% of the adult population at any one time. There is considerable variation in the severity of common mental health disorders, but all can be associated with significant long term disability in some people.
Conduct Disorder	Conduct disorders are characterised by repetitive and persistent patterns of antisocial, aggressive or defiant behaviour that amounts to significant and persistent violations of age-appropriate social expectations. Conduct disorders, and associated antisocial behaviour, are the most common mental and behavioural problems in children and young people affecting 5% of children and young people aged between 5 and 16 years, and are significantly more common in boys.
Coproduction	Co-production refers to the contribution of service users to the provision of services. It is an approach to services which recognises the value of lived experience, with commissioners and providers working alongside service users to plan, develop and deliver services.
Commissioning	The process of assessing need, planning, agreeing, purchasing and monitoring services.
Community	A group of people living, working or studying in a geographically defined area (geographical community) or who have a characteristic, cause, need or experience in common (community of interest).
Dementia	Dementia is a word used to describe a group of symptoms including memory loss, confusion, mood changes and difficulty with day-to-day tasks. There are many causes of dementia, with Alzheimer's the most common. It is a progressive condition usually affecting people over 65, and increasing in prevalence with age.
Depression	A common mental health disorder that presents in a variety of ways but can include low mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. These problems persist and can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities.
Deprivation	The damaging lack of material benefits considered to be basic necessities in a society. Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial.
Discrimination	The unjust or prejudicial treatment of different categories of people, on the grounds of disability (in this case mental illness) or other protected characteristics such as race, age, or sex.

Early Intervention	The provision of treatment at the earliest possible stage or at the first episode of a mental health disorder. In many cases this can prevent escalation of the illness.
Eating Disorders	Eating disorders are characterised by an abnormal attitude towards food that causes someone to change their eating habits and behaviour. Eating disorders cover a range of conditions including anorexia nervosa, bulimia nervosa and binge eating, which generally have an onset in childhood or adolescence.
Excess Under 75 Mortality Rate	Rate of mortality in people aged 18 to 74 suffering from a particular condition compared to rate of mortality in the general population
Fuel Poverty	A person is regarded as living "in fuel poverty" if s/he is a member of a household living on a lower income in a home which cannot be kept warm at reasonable cost.
Green Space	Land that is partly or completely covered with grass, trees, shrubs, or other vegetation that is considered an amenity to the public. Green space includes parks, community gardens, and cemeteries.
Health And Wellbeing Board	Health and Wellbeing Boards are a forum for local commissioners across the NHS, public health and social care, elected representatives, and representatives of health service users. They work together to improve the health and wellbeing outcomes of the people in their area.
Health Behaviour	The combination of knowledge, practices, and attitudes that together contribute to motivate the actions we take regarding health. Health behaviour may promote and preserve good health, or if the behaviour is harmful, eg. tobacco smoking, may be a determinant of disease.
Health Equity Audit	A health equity audit (HEA) is a tool used to identify and address inequalities, focusing on how fairly resources are distributed and accessed in relation to the distribution of health needs of different groups. HEA specifically investigates issues around access to healthcare according to epidemiology and demographic group and is used to inform policymaking, strategies and service design.
Healthy Lifestyle Behaviour	Lifestyle and behaviour choices around factors influencing health (see health behaviour). The combination of maintaining a healthy weight, safe levels of alcohol consumption, not smoking, physical activity and maintaining emotional wellbeing are considered key health behaviours.
Hyperkinetic Disorder	Attention deficit disorder, attention-deficit hyperactivity disorder, hyperkinetic disorder, and hyperactivity are various terms that can sometimes cause confusion. All the above terms describe the problems of children who are hyperactive and have difficulty concentrating.

Index Of Multiple Deprivation (IMD)	Multiple deprivation is based on the idea of distinct domains of deprivation which can be recognised and measured separately. Seven domains of deprivation are combined to produce the overall Index of Multiple Deprivation. IMD combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. This allows each area to be ranked relative to one another according to their level of deprivation.
Inequalities In Health/Health Inequalities	The virtually universal phenomenon of variation in health indicators (infant and maternal mortality rates, mortality and incidence rates of many diseases, etc.) especially those associated with socioeconomic status and ethnicity.
Interpersonal Therapy	Interpersonal Psychotherapy is a type of individual therapy that is time-limited and structured. Its central idea is that psychological symptoms, such as depressed mood, can be understood as a response to current difficulties in relationships and affect the quality of those relationships.
Joint Health And Wellbeing Strategy	A high level plan to tackle health inequalities, owned by the Health and Wellbeing Board, that influences the commissioning and delivery of services.
Life Course Approach	A way of analysing health outcomes as the product of risk behaviours, protective factors, and environmental agents that individuals encounter throughout their entire lives. These factors often have cumulative, additive, and even multiplicative impacts on outcomes.
Life Expectancy (at Birth)	The average number of years that a newborn is expected to live if current mortality rates continue to apply. This is distinct from age-specific mortality rates.
Lifestyle	The set of habits and customs that is influenced, modified, encouraged, or constrained by the lifelong process of socialisation. These habits and customs include use of substances such as alcohol and tobacco, dietary habits, exercise, etc. which have important implications for health and are often the subject of epidemiologic investigations.
Local Deprivation Quintile	Calculated by ranking small areas within each local authority based on how deprived they are and then grouping the areas in each local authority into five groups (quintiles) with approximately equal numbers of areas in each. Quintile 1 corresponds with the 20% most deprived small areas within that local authority, whereas quintile 5 represents the least deprived group.

London Living Wage	The London Living Wage is currently £9.15 per hour at May 2015. It is set annually by the Living Wage Foundation and calculated by the Greater London Authority, covering all boroughs in Greater London. The wage is calculated by combining an assessment of the cost of achieving an adequate standard of living with a threshold (60 per cent) of the median London income of representative London households. This wage level is a recommendation to employers and not the same as the Minimum Wage which is a national statutory requirement.
Long Term Condition	An illness which cannot currently be cured but can be controlled and managed by medication, other therapies, and adoption of healthier behaviours.
Memory Assessment Services	A secondary mental health service facility specialising in the diagnosis and initial management of dementia. In Camden and Islington this is the single point of referral for people with a possible diagnosis of dementia
Mental Disorder	See “mental health condition”
Mental Health	A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. It is more than the absence of illness.
Mental Health Act (2007)	The Mental Health Act 2007 (which includes amendments to the 1983 Act) is the law in England and Wales that allows people with a ‘mental disorder’ to be admitted to hospital, detained and treated without their consent – either for their own health and safety, or for the protection of other people. One of the advances of the 2007 amendments was the inclusion of supervised community treatment (community treatment order), following a period of compulsory treatment in hospital.
Mental Health Condition	Mental health conditions comprise a broad range of problems, with different symptoms. They are generally characterised by some combination of abnormal thoughts, emotions, behaviour and relationships with others which result in clinically significant distress. Examples are schizophrenia, depression and disorders due to drug misuse. There are effective treatments and support for most of these disorders.
Mental Illness	See mental health condition
Mental Wellbeing	A dynamic state in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society.
Morbidity	Any departure, subjective or objective, from a state of physiological or psychological well-being (i.e. illness).
Mortality	Death

Overcrowding	Overcrowding is a formal definition measured either by the number of people who must sleep in a room or the amount of space in the home and the number of people living in it. There are defined criteria for each of these depending on age, gender and composition of the household. If the household exceeds these criteria it is considered to be overcrowded.
Parity Of Esteem	Valuing mental health equally with physical health.
Partnership	A partnership (for health) is an agreement between two or more organisations or groups to work cooperatively towards a set of shared health outcomes.
Peer Support	Peer support occurs when people provide knowledge, experience, emotional, social or practical help to each other. It commonly refers to an initiative consisting of trained supporters characterised by the fact that the supporter is similar in fundamental ways to the recipient of the support.
Personality Disorder	A long-standing disorder in which parts of an individual's personality make it hard to live with themselves and/or other people. There is often a disparity between their behaviour and the prevailing social norms. Personality disorder is associated with various degrees of subjective distress, relationship difficulties and problems of social performance. Some people with personality disorder may cause harm or distress to others.
Poverty	Lack of income sufficient for an individual or family's material needs and when these circumstances exclude them from taking part in activities which are an accepted part of daily life. It is defined relative to the standards of living in a society at a specific time.
Premature Mortality	Deaths occurring before the age of 75. Many of these deaths are preventable.
Prevalence	The total number of cases of a given disease or other condition, in a given population at a designated time.
Prevention	Actions aimed at eradicating, eliminating, or minimising the impact of disease and disability, or if none of these is feasible, delaying or reducing the progress of disease and disability.
Primary Care	The collective term for all services which are people's first point of contact with the NHS (including GP services).
Proportionate Universalism	Universal actions to reduce inequalities in health that vary in level of intensity, allowing greater resource to go to the most disadvantaged.

Psychosis	A mental health problem that causes people to perceive or interpret things differently from those around them. This might involve hallucinations, delusions or thought disorders. The cause of psychosis may be a specific mental health condition such as schizophrenia, bipolar disorder or severe depression. Psychosis can also be triggered by traumatic experiences, stress, some physical conditions or as a result of drug or alcohol misuse.
Psychosocial	Encompassing aspects of social and psychological dimensions.
Public Health	The science and art of preventing disease, prolonging life, and promoting health through organised efforts of society.
Public Health Outcomes Framework	A set of indicators for tracking progress in public health within the four domains of health protection, health promotion, living well with illness and preventing premature mortality, and the wider determinants of health.
Public Mental Health	Public mental health focuses on wider prevention of mental illness and promotion of mental health across the life course.
Quality of Life	The degree to which persons perceive themselves able to function physically, emotionally, and socially. It is sometimes measured through the use of quality adjusted life years – QALYs. These are calculated by estimating the years of life remaining for a patient following a particular treatment or intervention and weighting each year with a quality of life score (on a zero to 1 scale). It is often measured in terms of the person's ability to perform the activities of daily life, freedom from pain and mental disturbance.
Recovery	The concept of recovery is about individuals staying in control of their life despite experiencing a mental health problem. Professionals in the mental health sector often refer to the 'recovery model' to describe this way of thinking. It moves away from a focus on treating or managing symptoms to the belief that it is possible for someone to regain a meaningful life, despite serious mental illness.
Recovery College	The provision of a range of courses, seminars and workshops which cater for people with diverse needs and preferences. It is an approach that focuses on education rather than therapy involving co-production between people with personal and professional experience of mental health problems. Recovery colleges have a physical base (building) and are not a substitute for traditional assessment and treatment or for mainstream colleges.
Resident Population	A population with a usual address within a given geographical boundary (for example in Islington).
Registered Population	The population registered with a general practice within a defined area.
Resilience	An individual's ability to adapt to stress and adversity.

Risk Factor	An aspect of personal behaviour or lifestyle, an environmental exposure, or an inborn or inherited characteristic, that on the basis of epidemiologic evidence, is known to be associated with health related condition(s) considered important to prevent.
Secondary Mental Health Services	Refers to a service provided by medical specialists who generally do not have first contact with patients. Usually, a general practitioner or other health professional will refer someone to a secondary care service.
Self-Harm	Self-harm is when somebody intentionally damages or injures their body. It is a way of coping with or expressing overwhelming emotional distress. Self-harm can include cutting, poisoning, mis-use of drug or alcohol, or eating disorder. Most people who self-harm do not want to end their lives, but may seriously hurt themselves and are at higher risk of suicide.
Serious/Severe Mental Illness	The term serious mental illness is sometimes used to refer specifically to schizophrenia, other psychoses or bipolar disorder. Severe/serious mental illness can also be used as a general term to describe more long-lasting, persistent and severe types of mental illness. These may also include severe depression or personality disorder.
Shared Decision Making	Shared decision making is the conversation that happens between a patient and their health professional to reach a healthcare choice together. This conversation needs patients and professionals to understand what is important to the other person when choosing a treatment.
Social Capital	Social capital describes the pattern and intensity of networks among people and the shared values which arise from those networks. Greater interaction between people generates a greater sense of community spirit. Definitions of social capital vary, but the main aspects include citizenship, 'neighbourliness', social networks and civic participation.
Social Determinants Of Health	The social determinants of health are the social and economic conditions in which people are born, grow, live, work and age. These conditions and their effects on people's lives determine their risk of illness and the actions taken to prevent them becoming ill or treat illness when it occurs. The social determinants of health play a very important role in health inequalities - the unfair and avoidable differences in health status seen within and between different demographic groups, communities and geographies.
Social Housing	Housing that is let at low rents on a secure basis to those who are most in need or struggling with their housing costs. Normally councils and not-for-profit organisations (such as housing associations) are the ones to provide social housing.
Socio-Economic Deprivation	See Index of Multiple Deprivation

Statutory Homelessness	Where a household has been defined as homeless by a local authority – i.e. the household falls within the terms of the homelessness legislation. Where a household is in priority need and not intentionally homeless, it is the duty of the local authority to offer the household accommodation.
Stigma (In Mental Health)	Negative stereotypes and prejudice about people with mental health conditions that result from misconceptions about mental illness. Stigma (beliefs) frequently leads to discrimination (action) that jointly prevent people seeking help, impairs recovery, isolates people and stops people getting jobs.
Substance Misuse	Use of a substance for a purpose not consistent with legal or medical guidelines, as in the non-medical use of prescription medications.
Suicidal Ideation (Thoughts)	Thoughts about how to kill oneself, which can range from a detailed plan to a fleeting consideration and does not include the final act of killing oneself.
(Death By) Suicide & Undetermined Intent	A coroner records a verdict of suicide when they have decided that there is evidence beyond reasonable doubt that the cause of death was self-inflicted and the deceased intended to take their own life. Where a coroner has insufficient evidence to record either a verdict of suicide (beyond reasonable doubt) or accidental death the death is coded by the Office for National Statistics as "death from injury or poisoning of undetermined intent". The two verdicts are often considered together when presenting information about suicide.
Systemic Family Practice	A type of psychological therapy which believes that the family context within which young people live may cause, trigger, and maintain the psychological difficulties that they experience. Systemic family practice has been particularly developed within children and young people's IAPT services.
Schizophrenia	Schizophrenia is a long term mental health condition that causes a range of different psychological symptoms, including hallucinations, delusions, muddled thoughts based on the hallucinations or delusions and changes in behaviour. It is often described as a psychotic illness, meaning that sometimes a person may not be able to distinguish their own thoughts and ideas from reality.
(Death from) Undetermined Intent	See (Death By) Suicide & Undetermined Intent
Wellbeing	See Mental Wellbeing

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