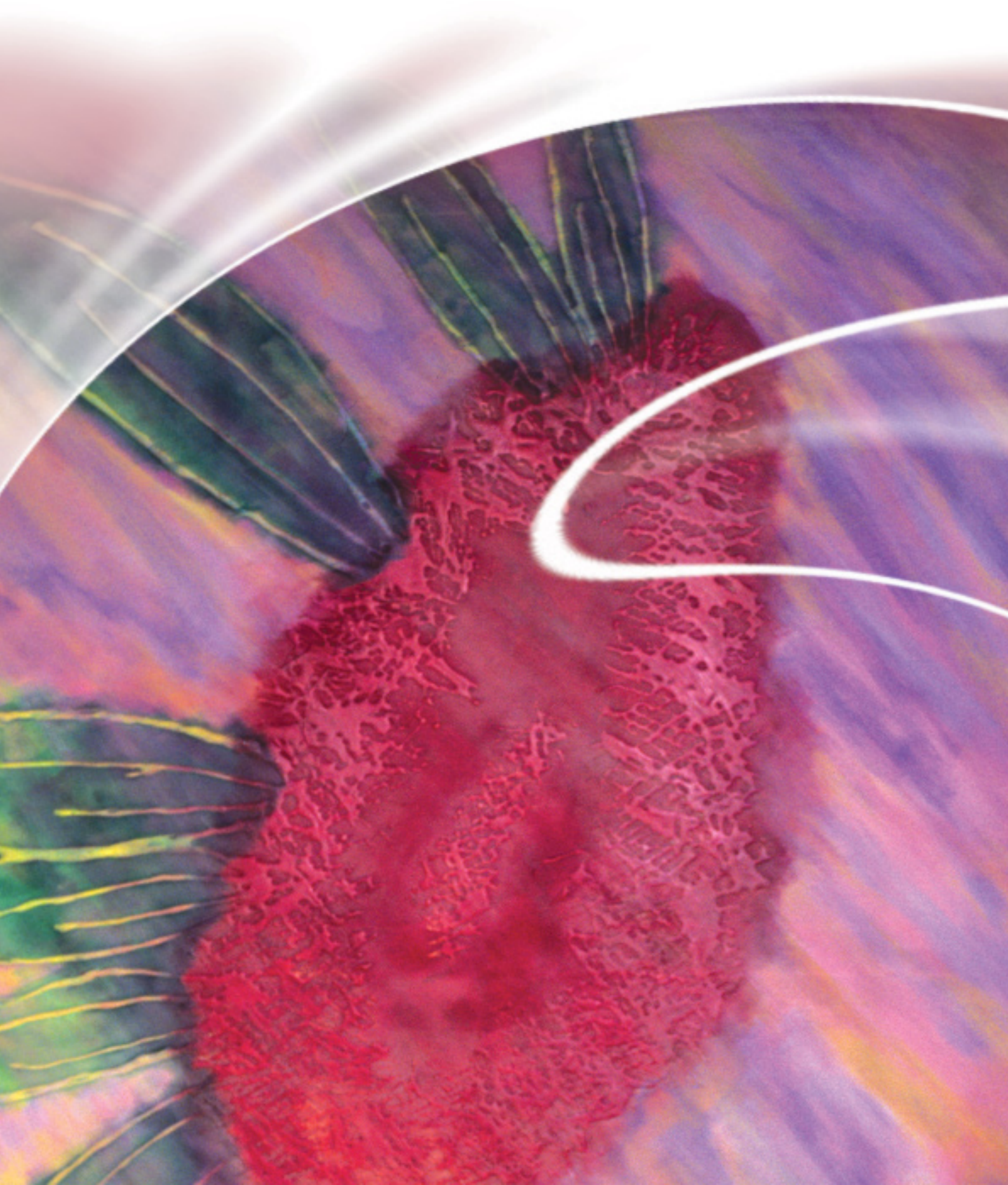


Haringey Health Report 2004

MENTAL HEALTH





Michaela Binks



Vicky Lamb



Vicky Lamb



Vicky Lamb



Paulette Ng

Acknowledgements:

Authors

This report was developed by Kirsty Beatt, Sheena Carr, Michele Daniels, Julian Elston, Vicky Hobart, Dave McCoy, Linda Somerville, Gerry Taylor, Graeme Walsh (Haringey Teaching Primary Care Trust) and Gerard Leavey and Clara Wessinger (Barnet, Enfield and Haringey Mental Health Trust).

Artwork

The artwork in this report has been provided by:

Michaela Binks (The Clarendon Centre)

The Clarendon Centre provides opportunities for local artists with mental health problems to express their talents using a number of different mediums. These include jewellery design, screen-printing, needlecraft and ceramics as well as more conventional art forms. Artists are able to sell their work at local events. For more information please contact the centre. (Telephone 020 8489 4871)

Paulette Ng and Vicky Lamb (Halliwick Day Centre)

The Halliwick Day Centre provides a range of psychological services, and encourages its clients to participate in art and ceramic activities as part of their therapy.

Quotations

The quotations cited in this report are drawn from the following sources, unless otherwise stated. Further details available on request.

- Mental health and social exclusion, Social Exclusion Unit, 2004
- Life on the wards, Matrix Research Group, 2004
- MIND, www.mind.org.uk



Foreword

I am pleased to be able to present the 2004 Haringey Health Report. Last year's report provided an overview of health and the determinants of health for Haringey people. This year's report focuses on the particular issue of mental health.

We decided to focus on this issue for a number of reasons. Mental illness is very common, with up to one in four people being affected. Mental illness has a significant impact on those immediately affected, and on their family and friends. Yet services for people with mental illness are often considered as insufficient and inadequately integrated to properly meet the needs of those affected and their carers.

Most important is the stigma associated with mental illness. As somebody who has personally experienced mental illness in the past, I understand how alienating it can be. It takes you out of mainstream life, is lonely and isolating, and the stigma surrounding the illness makes it difficult to acknowledge in day-to-day life. A silence exists around the nature and extent of mental illness in this country. Families remain quiet about its effects, sufferers are marginalised from other members of society and employers, friends and families are embarrassed. The media plays a significant role in continuing to

mystify mental illness, often demonising the individuals affected as dangerous. The reality is that those with mental illness are more likely to be victims of crime than its perpetrator.

The ethnic diversity of people in Haringey also presents particular local challenges in supporting mental health. Rates of mental illness differ between black and minority ethnic communities, such that some communities are more at risk of developing mental illness than others, and yet the reasons for this are poorly understood. Culture has an influence on the presentation of mental illness, and so health professionals need to be able to recognise different patterns of illness symptoms between different communities. Health services also need to ensure that care is provided in culturally appropriate ways.

In preparing this report we were confronted by the major obstacle of the absence of data with which to describe the nature, extent and severity of mental illness in Haringey. Mental health services have particularly poor quality data, which may reflect the marginalised status and historical lack of interest in the detail of these services. However from the available figures some striking things can be noted. In terms of mental well-being there are many factors in Haringey which

contribute to an elevated risk of developing mental illness. These factors are notably present in the east of the borough, and include housing conditions, unemployment and the environment in which people live. Haringey residents have very high admission rates for mental illness, much higher than what might be expected for a population of its size and composition. A significant proportion of these people have very long stays in hospital.

This report cannot be as comprehensive as we would like. It does not cover the full range of issues or affected groups. However I hope that it will stimulate widespread discussion about mental health in Haringey, and support efforts to identify what can be done to promote people's mental health and well-being. I also hope that it will encourage people to consider what we need to do to develop modern and appropriate treatment services that meet the changing needs of our population. Finally I hope it can trigger renewed efforts to stop the isolation, marginalisation and social exclusion experienced by people with mental illness, and lift the stigma and silence that surrounds this form of suffering.

I would like to thank all those who contributed in the preparation of this report, including members of my team and contributors from Barnet, Enfield and Haringey Mental Health Trust. Thanks also to those who commented on earlier drafts of the report, including local authority colleagues, Matrix Research Group, and local mental health service user representatives. Finally, I would particularly like to thank the artists, local mental health service users, whose art work is presented throughout this report.

Dr Ann Marie Connolly

*Director of Health Improvement
Haringey Teaching PCT*



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Understanding mental health

Mental health and illness

Mental health is understood in many ways, but most definitions assume that being mentally healthy is more than just the absence of mental illness. Good mental health is a state in which a person is able to fulfil an active functioning role in society, interacting with others and overcoming difficulties without suffering major distress, abnormal, or disturbed behaviour. Our mental health enables us to form and sustain relationships, and to manage our lives. It also affects our capacity to cope with change and transitions, such as having a baby or losing a loved one. Mental health is central to our health and well-being because how we think and feel also has a strong impact on our physical health.

It is estimated that between 1 in 4 and 1 in 6 of the general population has common mental health problems at any one time.¹

The dividing line between what we accept as a 'normal' mental state or response, and a condition or mental illness requiring some form of active intervention or care, is difficult to define. Diagnostic criteria have been developed over the years to identify and describe a number of different mental illnesses with a range of underlying causes. Mental health problems can be anywhere along a continuum, from something temporary to something enduring or permanent. They can

also result from an accumulation of things that happen to you that make it difficult to function at all. Several forms of mental illness are referred to in this report. Further information on mental illness, and sources of help and support, are available through the contacts listed at the end of this report.

Official figures suggest that 20% of women and 14% of men in England have some form of 'mental illness'² – at least 18,000 women and 12,000 men in Haringey.

There is an ongoing debate about the validity and usefulness of diagnostic labels for mental illness, some arguing that while they classify and describe certain behaviour, they do not necessarily shed any light on the nature and cause of symptoms. However, we can say that mental illness is common, can often be severe, and includes a significant number of people with an extreme or debilitating sense of sadness, stress, anxiety or nervousness. Good mental health, like physical health, is a resource we need to promote and protect.

Stigma and discrimination

There are many negative stereotypes associated with the symptoms or diagnosis of mental illness, and the individuals affected generally lack the power to change the way they are seen by others. There is also

considerable prejudice against people with mental illness, based on fear, misunderstanding and intolerance. Individuals may be treated unfairly and denied opportunities. They may face rejection by friends, relatives, neighbours and employers, and this stigma and discrimination can affect people long after the symptoms of mental health problems have been resolved.

"I didn't want anyone to think I was weak. It's only now I realise how strong you have to be to be able to ask for help". Frank Bruno in The Guardian, November 5th 2003.

In 2003, The Sun's headline 'BONKERS BRUNO LOCKED UP', covering the story of ex-boxer Frank Bruno's sectioning under the Mental Health Act, caused such an outcry, not only from mental health organisations, but also from members of the public, that it was rapidly withdrawn and changed to 'SAD BRUNO IN MENTAL HOME'.

In some cases this stigma and discrimination may attach to family or friends associated with a person with mental illness, and consequently they may also experience harassment, stress and social exclusion.

"When I sought an injunction against a man who had been violent to me for 15 years, I was subject to psychiatric reports to establish my credibility as a witness. My human rights are something I fight daily to have recognised"

Such stigmatisation is detrimental to recovery from mental illness, and may affect a person's ability to access services and support within the community. It can lead to elevated feelings of isolation, loneliness and depression, and other illnesses brought on by feelings of shame and guilt. It may also result in a delay in seeking out appropriate services and support.

Evidence suggests that 1 in 4 people with 'mental illness' have not consulted a professional about their mental health.³

In a 1996 survey of people with mental health problems in England, 47% had been abused or harassed in public, and 14% had been physically attacked; 21% said they had been attacked or harassed by neighbours; and 26% had been forced to move because of harassment.⁴

This stigma is often reinforced by excessively negative portrayals of mental illness in the media. For example, the media has created an unfair and incorrect association between mental illness and criminal behaviour, such that in 1996 almost half of national press coverage on mental illness linked it to violence and criminality⁵. In reality, the majority of those with mental illness are more likely to be victims of crime than its perpetrator.

The media can make an important contribution to reducing stigma and discrimination in society. It is therefore important that we challenge misrepresentations of mental illness in the media, and promote a wider understanding of its nature and impacts.

"I find my mental health problems are my best kept secret because even close friends and family have been influenced by the media"

'Start with the scary statistic that someone is killed by a mental patient every fortnight. It sounds like confirmation of the psycho-killer myth – but it hardly survives scrutiny. For the roughly two dozen homicides by mental patients are a tiny fraction of the nearly 700 murders in Britain every year. Tabloid tales of 'crazed killers' are statistical flim⁶.'

The Guardian 21st January 1998

Impacts of poor mental health

Mental illness can have a profound and debilitating effect on health and quality of life, affecting an individual's ability to engage in meaningful relationships, employment and daily activities. It also impacts on the health and well-being of families and carers, both through the direct care responsibilities they face, and through the stigma and discrimination they may experience in fulfilling this role.

Mental illness impacts on physical health. For example, depression increases the risk of heart disease four-fold, even when other risk factors like smoking are taken in to account, and has been consistently linked to mortality following a heart attack.

Around one third of all GP consultations in England and Wales are the result of psychological and social problems.⁷

An increasing body of evidence identifies the high costs of mental illness to society as a whole, including its impacts on educational achievement, employment, crime and disorder, and economic productivity⁸. For example, depression can result in symptoms that are severe enough to interfere with daily activities such as work, relaxation, eating and sleeping, and therefore has a large social impact.

By 2020, depression will be second only to chronic heart disease as an international health burden (in terms of cause of death, disability, incapacity to work and the toll on medical resources).

Why do people experience mental health problems?

Sometimes the underlying cause of a mental illness is a problem with the brain or nervous system. Such physical conditions can be inherited, present at birth, or acquired during

the course of life, for example through an injury. Mental illness may also result from intoxication with drugs or poisons, although this is generally temporary.

The experience of mental illness may follow significant life events. Depression may develop after having a baby, or losing a loved one. Post-traumatic stress syndrome may develop following a shocking or painful experience such as witnessing the murder of a loved one, or being the victim of sexual abuse or physical torture. While many of these life events cannot be avoided, there are psychological therapies available to help people cope with the transitions involved.

One in ten new mothers are estimated to experience post-natal depression.⁹

But our mental health is affected by far more than our biological make up, or a single event. A range of factors contribute to the development of mental health problems, or can trigger an episode of mental illness. Wider social, economic and environmental factors have a significant impact on mental health.

Poverty and deprivation

There is a strong association between poor mental health and the experience of poverty and deprivation, both at individual and population level^{10,11}. People in good mental health are more likely to be, and remain, in work and financially independent. People with mental illness are more likely to experience poverty¹², and poverty is both a cause and consequence of poor mental and physical health. Analysis of social class suggests that people in the lower social classes are nearly twice as likely to suffer from mental distress than those in higher social classes – 10 per cent of social class 1 compared with 18 per cent of social class V¹³.

People with mental health problems are nearly three times more likely to be in debt¹⁴.

Haringey has significant levels of deprivation in the east of the Borough, but also some pockets of deprivation in central wards. Eight of the nineteen wards in Haringey contain small areas of deprivation that rank within the five percent of most deprived areas in England and Wales.

“On a low income it is a very stressful life”

A recent report commissioned by the Mayor of London¹⁵ demonstrates an association between deprivation (estimated by deprivation score of the patient’s ward of residence) and the frequency of admission to hospital for schizophrenia, disorders due to use of alcohol, and disorders due to use of other psychoactive substances (see figure 2). There is also an inverse association with admissions for mood disorders, dementia and learning disability, which decrease with deprivation. While this demonstrates a clear association

between the level of deprivation and patterns of hospital admission within a geographical area, it does not explain the extent to which these stem from differences in the prevalence of mental illness itself, or differential access to and use of hospital services.

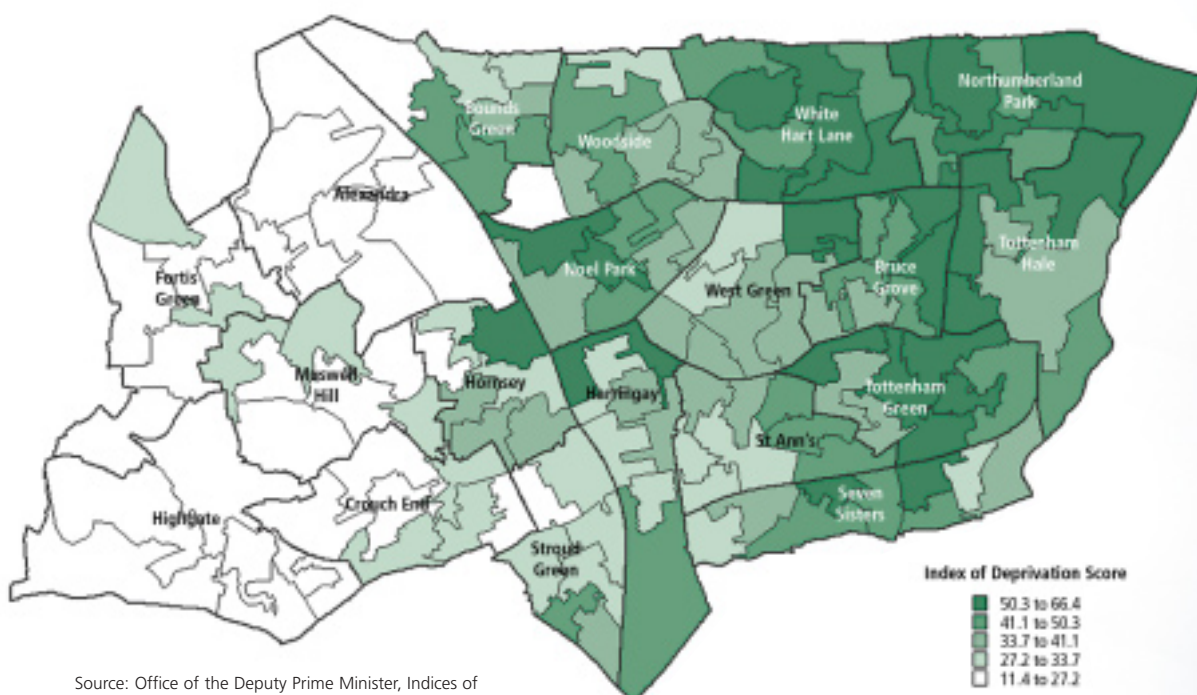
People with mental health problems are at more than double the risk of losing their job than those without.⁸

Work and unemployment

Paid work provides an income, and with it some scope for decision making and control. But work also provides more than an income in that it offers an opportunity to exercise skills and creativity, a source of externally generated goals, variety, security and social support networks¹⁶. Many people with mental health problems want to work, and it can give them feelings of self-esteem and self-worth⁸. Several mental health service users consulted in the development of this report suggested that they found volunteering more rewarding for self-esteem than unskilled paid employment.

Figure 1:

Deprivation index scores of small (super output) areas in Haringey, 2004



Source: Office of the Deputy Prime Minister, Indices of Deprivation 2004

Only 24% of adults with long-term mental health problems in England and Wales are in work – the lowest employment rate for any of the main groups of people with disabilities.¹⁷

“You’ve no idea what it means to be able to say ‘I’m working’”

“We’re not accepted when we go back to work, no matter that you can do the job”

The trauma of unemployment can trigger or aggravate a range of mental illnesses, including depression. Loss of income also exacerbates existing health problems resulting from poor housing, nutrition etc. Therefore people with mental health problems who are unable to work may find that their physical health also deteriorates¹⁸. Significant numbers of Haringey residents experience unemployment over the short and long-term. In May 2004, 7.5% of economically active Haringey residents (excluding students) were unemployed, higher than the London average

of 4.7% and more than double the England and Wales average of 3.1%. At 17.2%, Northumberland Park ward in east Haringey has the highest unemployment rate of all wards in London. More than one in twelve (8.8%) of unemployed people in Haringey have been unemployed for two years or more, compared to a London average of 6% and an England and Wales average of 4.9%.

Work is also a source of mental stress, and supporting mental health in the workplace can make a significant contribution to both health and well-being and improved economic productivity.

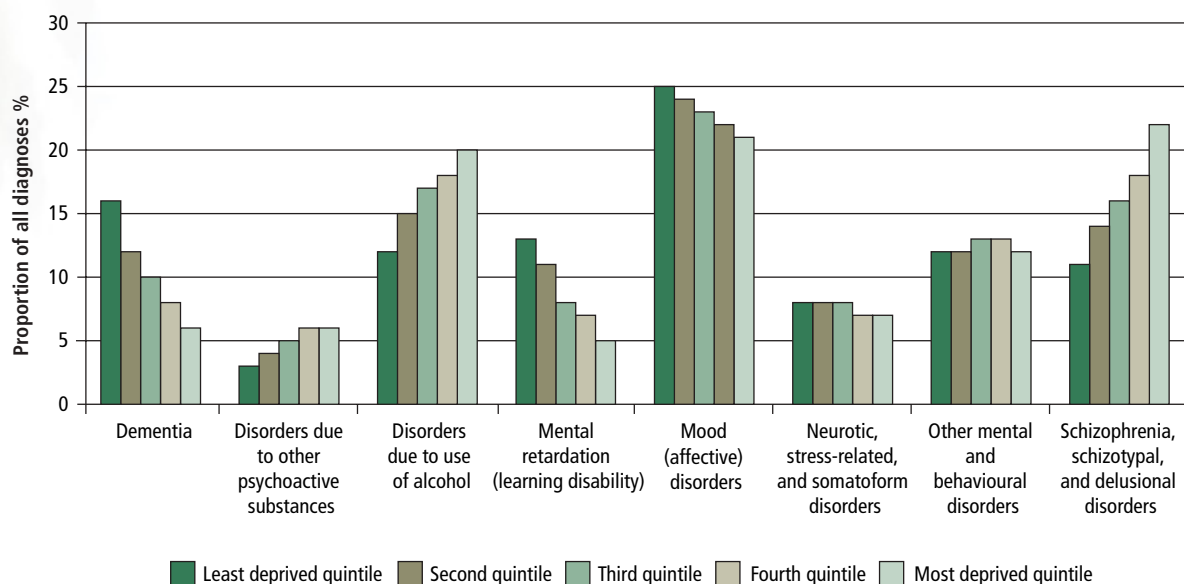
Stress-related absences account for half of all sicknesses from work in the UK¹⁹.

What can employers do to promote a mentally healthy workplace²⁰?

- Improve communication and staff involvement
- Tackle the effort/reward imbalance that many employees experience

Figure 2:

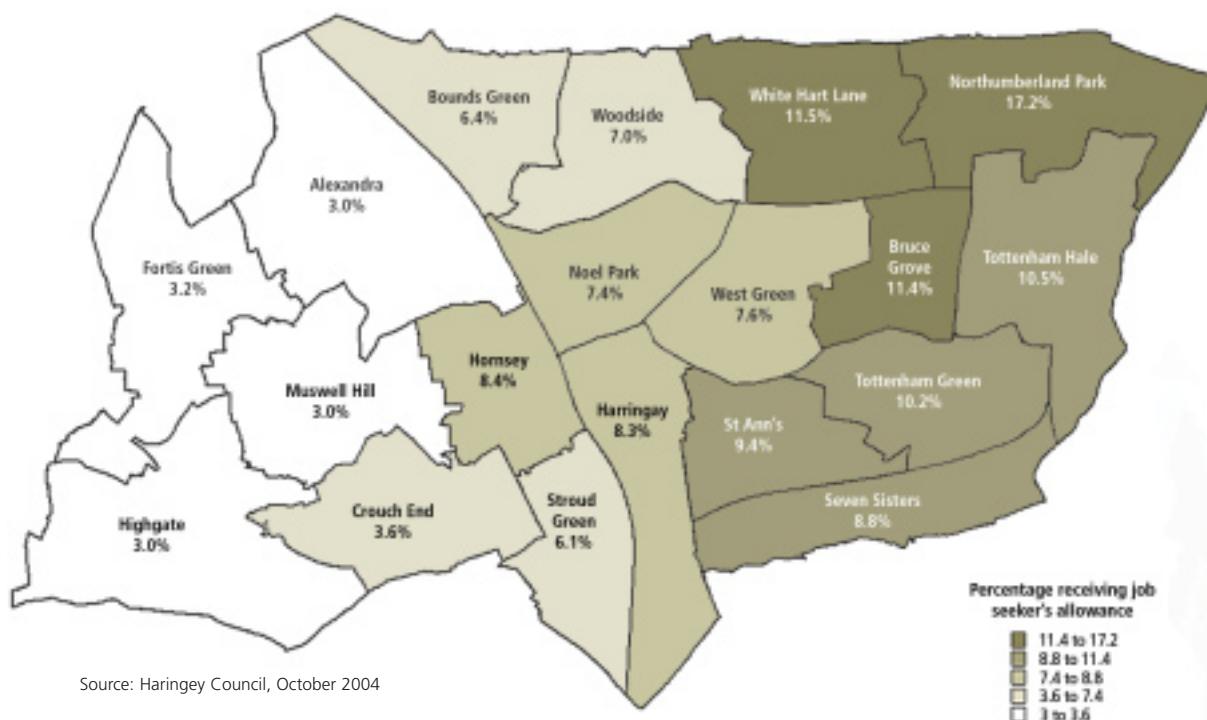
Diagnosis by deprivation of ward of residence of inpatients in London



Source: Foster, D. R. Availability of mental health services in London. Greater London Authority, 2003

Figure 3:

Proportion of economically active residents claiming job seeker's allowance in Haringey May 2004



Source: Haringey Council, October 2004

- Enhance social support from peers as well as management
- Address bullying in the workplace
- Increase job control and opportunities for decision making
- Assess job demands and reduce where too high
- Increase general mental health awareness by ensuring that staff are given information about how they can look after their mental health at home and at work and the sources of help available

Housing and homelessness

Housing makes an important contribution to health and quality of life. Unstable or inappropriate housing make it difficult for people to work and take part in community life, and contribute to worsening mental health. Overall, nearly a third of households in Haringey consider their home as unsuitable²¹. In Haringey there are nearly

five thousand homeless households living in temporary accommodation (July 2004²²). These households are amongst those most likely to experience disadvantage and social exclusion.

"I feel alone on the estate – they all know about me and they shut me out"

People with mental health problems are more likely to live in insecure housing, twice as likely to say they are very dissatisfied with their housing or that it is in a state of poor repair, and four times more likely to say their health has been made worse by their housing²³. Although there are relatively few rough sleepers in Haringey, studies have consistently shown that 30-50 % of rough sleepers have mental health problems²⁴, with suicide accounting for one in four deaths of homeless people²⁵. Housing support is an important mental health promotion strategy, helping to reduce the incidence and

prevalence of mental illness and unnecessarily long stays in institutional settings.

One in four tenants with mental health problems in England and Wales have serious rent arrears, and are at risk of losing their home.²⁶

Environmental quality

The physical environment can have a significant impact on mental health. Unattractive, built-up or derelict areas lacking green open spaces can lead to worsening mental health, as can dirty streets, litter, graffiti and dilapidated properties. Some studies have shown that proximity of green space improves social and cognitive functioning, and decreases violence²⁷. In Haringey environmental issues such as crime, litter and traffic are amongst residents' top concerns²⁸.

Education

Prevention of mental health problems in young people is particularly important as there is a risk of problems continuing into adult life. The Department for Education and Skills recognises the role of schools in promoting mental health²⁹, in particular strengthening the ability of young people to cope with transition and change. School interventions can also make an important contribution to reducing the impact of wider inequalities³⁰.

Pyramid Clubs in Haringey are aimed at children in Year 3 (ages 7-8), and consist of a 10 week programme designed to boost self-esteem and develop social skills. The programme provides a routine check of children's emotional health needs, so that difficulties can be tackled early and effectively. The Clubs involve children in a range of activities including arts, cookery and play.

Crime and community safety

Haringey's crime rate is the tenth highest in London³¹. Crime and fear of crime have a significant impact on people's mental health, as feeling unsafe creates anxiety, isolation, and mental distress. Studies have consistently shown that people tend to overestimate their risk of being a victim of crime³², but that being a victim of crime can have a significant impact on mental health. In addition to the trauma of the crime itself, mental health may be adversely affected by the way the crime is investigated. Feelings of anger or vulnerability may arise from investigations that do not achieve a desired result, or result in a sense of injustice.

People with mental health problems may be at increased risk of being victims of crime. Mental health service users consulted in the development of this report indicated that several residential care homes have earlier curfews for women than men, due to fear of crime. The police have an important role in protecting the mental health of the community. Visible policing may help people feel safer in the area in which they live, and by paying special attention to how victims of crime are treated the police can help lessen the trauma associated with being a victim of crime.

Culture

Culture may be viewed as the knowledge and values shared by a society. As such, it provides a way of perceiving and understanding how and why things happen in the world. Cultural traditions determine, in part, how individuals view their mental and physical health. What is considered 'normal' or healthy in one society can sometimes be viewed as 'abnormal' or unhealthy in another. Therefore although mental illness is present in all cultures, the form and expression of these illnesses, and stigma associated with them,

may vary in relation to the cultural belief systems of different groups.

The varying presentation of mental illness from one culture to another adds to the complexity of diagnosis and treatment. For example, some communities will more commonly express their depression in the form of physical symptoms (such as headaches and joint pains) rather than in terms of a low mood. If these complaints are taken at face value, without recognising the underlying depression, it will result in patients being subjected to unnecessary and expensive physical investigations, prolonging the symptoms and reinforcing beliefs in their physical nature³³.

Haringey is one of the most ethnically diverse boroughs in London and the UK, with a rich cultural diversity. Mental health care services must therefore be responsive to cultural interpretations of mental illness.

“There does not seem to be a single area of mental health care in this country in which black and minority ethnic groups fare as well as, or better than, the majority white community. Both in terms of service experience and the outcome of service interventions, they fare much worse than people from the ethnic majority do. In addition, disease burden associated with mental disorder appears to fall disproportionately on minority ethnic populations³⁴”

Ethnicity

People from minority ethnic groups appear to be more vulnerable to severe mental illness than white UK-born people³⁵. Ethnicity appears to be a significant factor in determining rates of mental illness, but gaps in our understanding of the ethnic profile of service users and their needs continues to be a stumbling block when planning services.

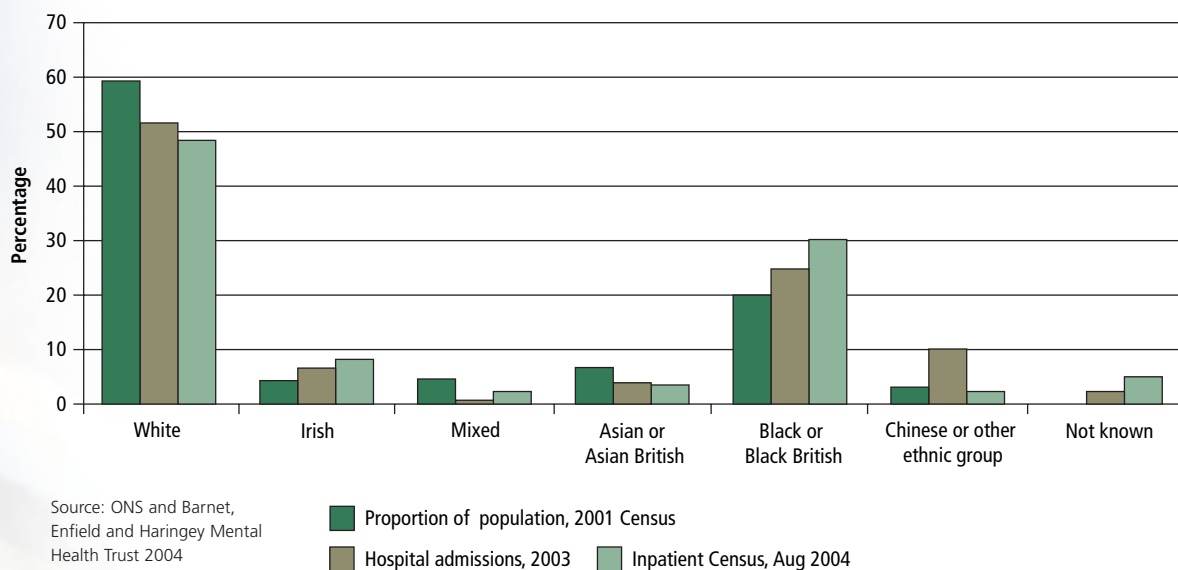
Evidence from the UK over the past thirty years indicates that African-Caribbeans are more likely than other groups to suffer from psychotic illness, including schizophrenia, than other population groups^{36,37}. A major study undertaken in Haringey also showed that African-Caribbeans with a psychotic illness are likely to have poorer health and social outcomes³⁸. There are no clear answers as to why this might be, but any explanation for high rates and poor outcomes is likely to be found in a complex mix of social adversity, racism, culture and negative contact with services.

Data from several services within Barnet, Enfield and Haringey Mental Health Trust is not robust enough to adequately describe service use within Haringey. Currently only hospital admission data records ethnicity systematically. Figure 4 shows the ethnic profile of patients admitted to mental health services in Haringey in 2003, and the profile of patients recorded during a one day census of hospital admissions in August 2004, and compares this to the ethnic profile of Haringey in the 2001 Census. It suggests that ethnicity may affect the likelihood of hospital admission for mental illness, as the White group is slightly under represented while the Black group is slightly over represented. It does not reveal the extent to which this reflects differences in the prevalence of mental illness in different ethnic groups, or differences in the detection, treatment and care of mental illness.

“Being an ethnic minority as well as the mental stigma makes things difficult. I can’t mix properly with my own ethnic community”

Figure 4:

Comparison of the ethnic profiles of Haringey residents in the 2001 census, patients admitted to mental health services in Haringey in 2003, and the one-day inpatient census in August 2004



Social exclusion

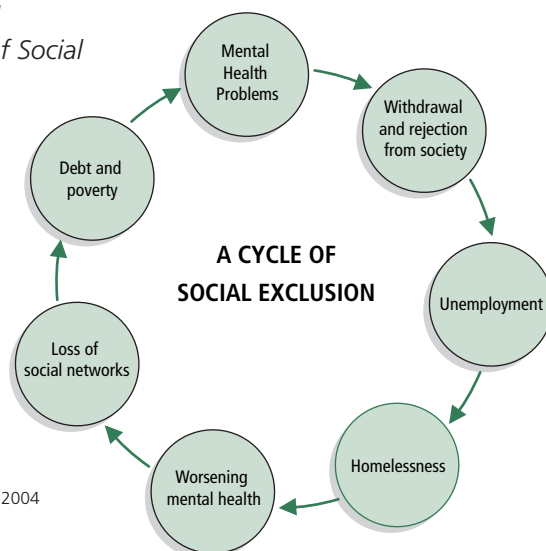
Social exclusion occurs when people find themselves excluded from many of the things that the rest of the population take for granted, like work and social participation. Social exclusion and mental health problems may reinforce each other, the risk being cumulative and linked in a vicious circle as illustrated in Figure 5.

“Mental health problems are lonely illnesses – it’s the quickest way I know to lose all the people around you who aren’t paid to care for you. You need people to be with you, to stick by you, to talk about something other than what’s going on inside your head. If you’ve got something like that, you’ve got a good chance”

“As a hospital manager... I see first hand how quick we are to remove people from society and how reluctant we often are to return them because we worry about the harm they may do to themselves. Yet we do not view the isolation, exclusion and removal of human rights as harmful”

People with mental health problems and their carers are particularly likely to experience social exclusion due to the stigma and discrimination they face. This is exacerbated by a narrow focus on the medical symptoms of mental illness, and the absence of co-ordinated support services and social networks.

Figure 5:
A Cycle of Social Exclusion



Mental illness in Haringey

Mental health is fundamental to our health and well-being. People exhibit signs of mental health everyday in the way that they cope with daily events. Measuring this positive concept of mental health is complex, and beyond the scope of this report. But understanding the prevalence of mental illness is also problematic. Many people suffer in isolation without accessing services or treatment, so their needs are never documented. Of those that do access health services, relatively little information is collected on a routine basis.

One *in* four

Partner	Colleague	Boss
Sister	Parent	Uncle
Neighbour	Nephew	Best friend
Doctor	Child	Me

We know very little about the demand for mental health services in primary care in Haringey, although this may improve as practices develop registers of patients with long-term mental illness under the new general medical services contract for GPs. Data on medication prescribed for a range of mental illnesses is available, showing a continuing increase in expenditure on these drugs, but interpretation of this trend is hampered by lack of information on

prescribing patterns during this period. We understand more about the mental illness needs of those accessing specialist mental health services, and this is outlined in the section below.

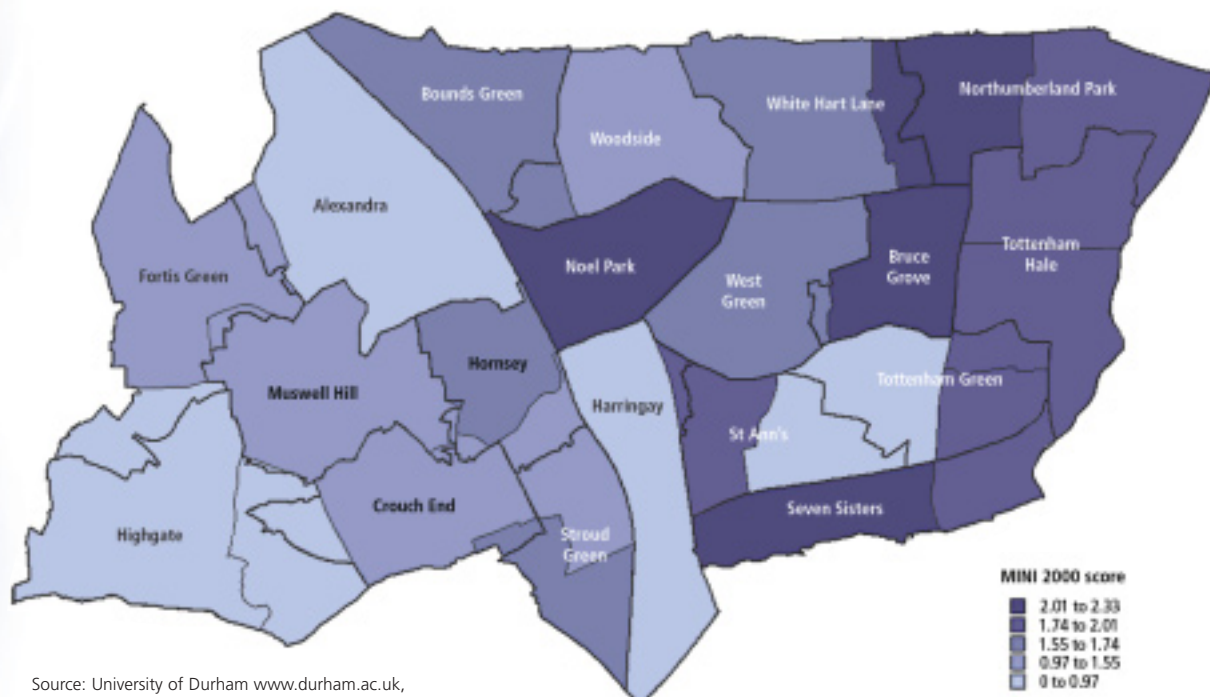
Estimating the need for hospital services

A number of models have been developed to estimate the need for mental health services, based on socio-demographic indicators of mental health need. These are generally relative rather than absolute measures, that is they predict the level of mental illness need in one area or population group compared to others.

The University of Durham developed a mental illness needs index (MINI) to estimate the relative need for specialist mental health services for severe mental illness³⁹, including schizophrenia and affective disorders, amongst adults aged 16-59. The model is based on population characteristics that have been shown to contribute to variation in hospital admissions, including indicators of deprivation, long term illness and disability, and the numbers of people living in a hostel/lodging house.

The MINI model was developed in 2000, and is therefore based on the old ward boundaries. A MINI score of 1.0 suggests that the need for mental health services is the

Figure 6:
MINI 2000 scores in Haringey



Source: University of Durham www.durham.ac.uk, accessed October 2004
Mapped using pre-2002 ward boundaries, with current ward boundaries overlaid

same as the national average, whilst a score of more than 1.0 indicates a greater need for mental health services.

The model suggests that the need for mental health services in Haringey (MINI score 1.16) is higher than the national average, but similar to the London average (MINI score 1.15). It also suggests considerable variation in mental illness need within Haringey, such that need in some wards may be more than twice the national average. (See figure 6).

Understanding hospital admissions

Hospital admission rates vary considerably between London boroughs, and a recent report⁴⁰ examines the extent to which this variation can be explained by underlying indicators of socio-demographic need within the population. The report suggests that Haringey has by far the highest acute admission rate in London at 854 per 100,000 people in 2002-3, compared to the lowest of 241 per 100,000 in Havering. The study uses

a more sophisticated factor analysis model incorporating a wider range of socio-demographic indicators of mental health need than the MINI index, including crime, ethnicity, and a measure of the number of asylum seekers in the population.

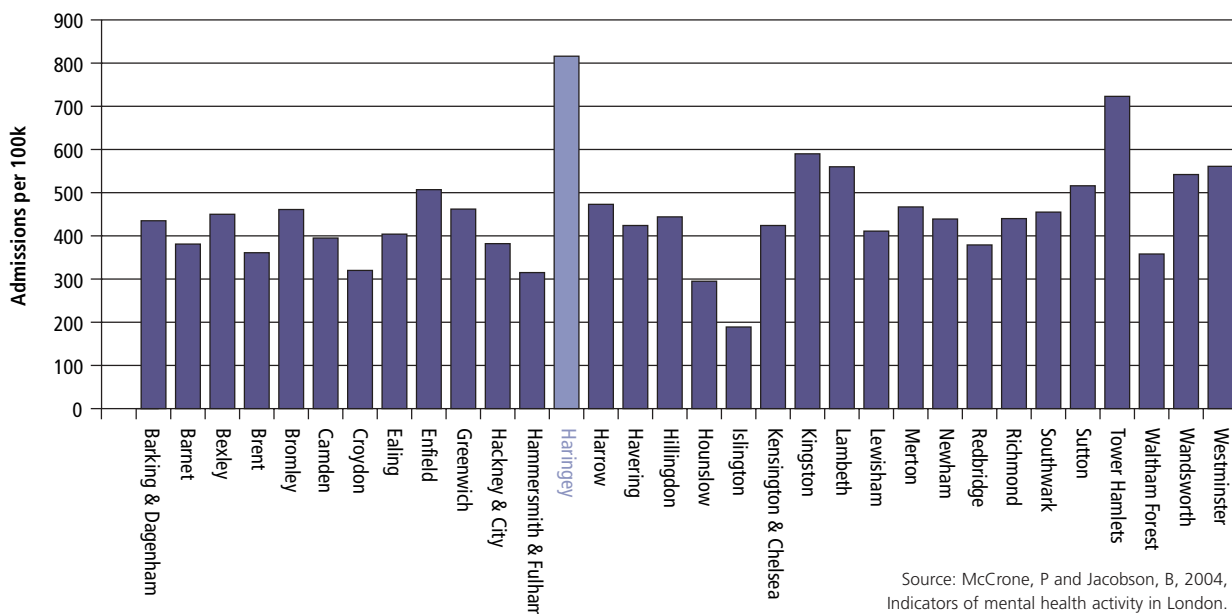
The report suggests that the set of socio-demographic factors used in the model were only able to explain about 60% of the variation in acute admission rates across London, and that large differences in hospital admission rates remained after they were adjusted to take these factors into account. For Haringey this suggests that these socio-demographic indicators alone cannot explain the relatively high acute admission rate, a finding that requires further discussion and interpretation.

The prevalence of severe mental illness

The complex interactions between the determinants of mental health and illness

Figure 7:

Acute mental health admissions in London boroughs per 2002 – 2003, adjusted for need



Source: McCrone, P and Jacobson, B, 2004, Indicators of mental health activity in London.

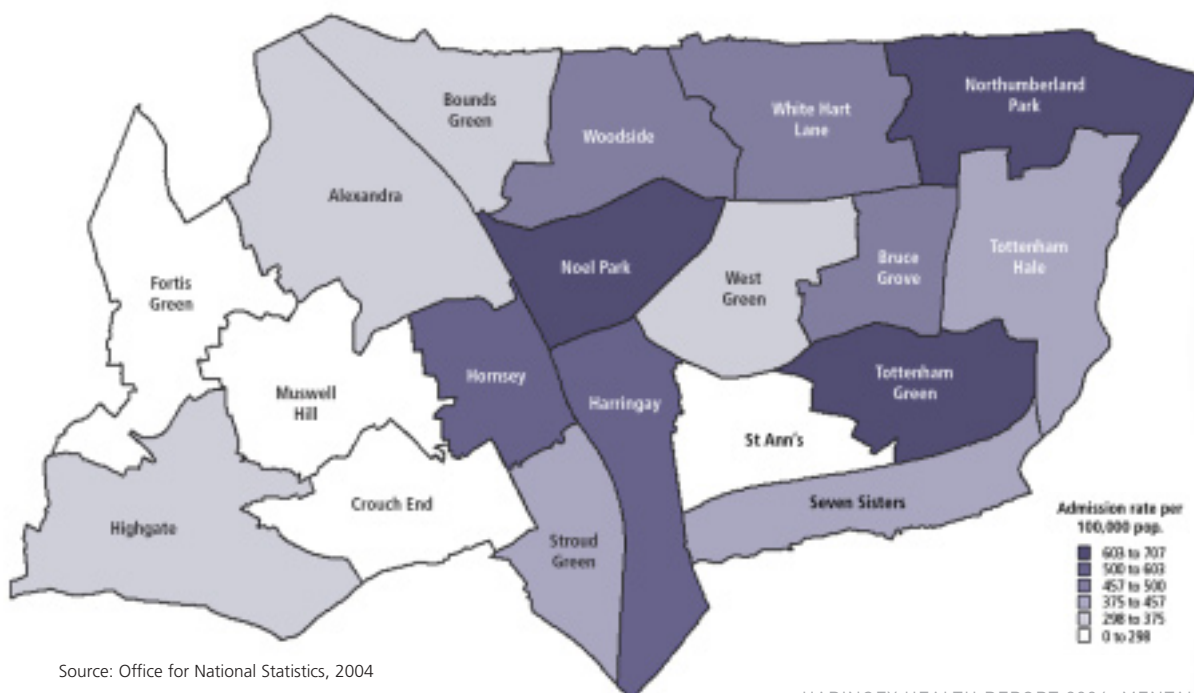
result in differences or inequalities in the mental health of different communities. This is notable when comparing mental health between men and women, and between different ethnic groups. It is also apparent when comparing different geographical areas.

Hospital admissions data are amongst the most robust of the limited information available to understand mental illness in

Haringey. They provide some insight into the distribution of mental illness within Haringey, and the symptoms that patients present with upon admission. Hospital admission rates for mental illness vary considerably between different wards in Haringey, and were significantly higher in Northumberland Park, Noel Park, and Tottenham Green in 2002-2004. Refer to Figure 4 for the ethnic profile of those admitted.

Figure 8:

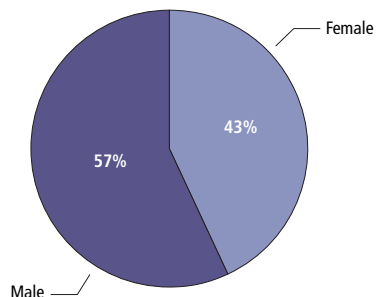
Mental health admission rates in Haringey, 2002-2004



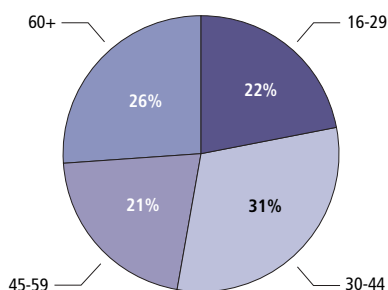
Source: Office for National Statistics, 2004

Figure 9:
Inpatient census profiles, 12th August 2004

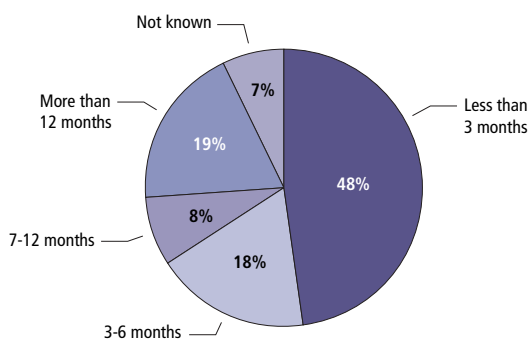
Sex



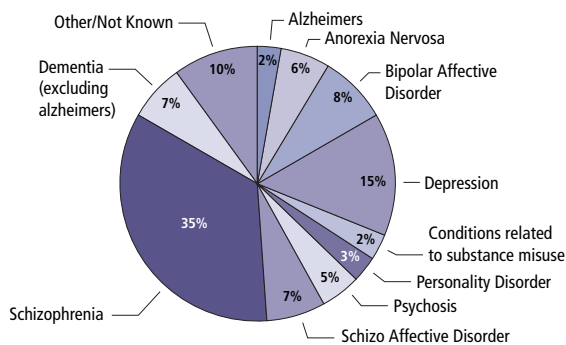
Age



Length of stay



Diagnosis



Source: Barnet, Enfield and Haringey Mental Health Trust 2004

In order to develop a better understanding of who is admitted to hospital with mental illness a census of all adult patients on hospital wards on 12th August 2004 was undertaken by the Mental Health Trust. A profile of the 341 Haringey residents with mental illness present on wards on that day was systematically recorded, providing information that is not routinely available. (See figures 4,9 and 17) The most frequent diagnosis was schizophrenia, affecting more than a third of those admitted. Diagnosis was not recorded in 10% of patients. Nearly half of those admitted had been there less than 3 months, but nearly one fifth had been in hospital for more than one year.

A significant number of patients did not have English as a first language (17%), and nearly one in ten (8.5%) were unable to speak English. This presents significant challenges in establishing a case history and diagnosis, and can be particularly stressful and upsetting for a patient unable to communicate or understand what is happening. It also emphasises the importance of adopting trans-cultural methods within mental health services.

This census provides a snapshot of acute mental illness need in Haringey. The findings should be treated with caution as they may not be representative of service activity, and do not reveal any underlying trends. But they do highlight the need for mental health services to collect robust information on which to plan services that reflect the range of complex needs in Haringey, particularly in terms of age, ethnicity, culture and language, and length of stay.

Suicide

Another source of information about the prevalence of mental illness is the suicide rate in Haringey. England and Wales has a relatively high suicide rate compared to the rest of Europe, of which about a quarter might be preventable⁴¹. Between 1971 and 1996 the suicide rate for women in the UK almost halved, while in the same period for men it almost doubled.

Over 5,000 people take their own lives each year in England and Wales – around one person every 90 minutes⁴².

Suicide rates are substantially higher amongst people diagnosed with mental health problems, particularly those diagnosed with schizophrenia and affective disorders, and those who experience recurrent depressive illness. Suicide in older people is strongly associated with depression.

Two-thirds of men under the age of 35 with mental health problems who commit suicide are unemployed⁸.

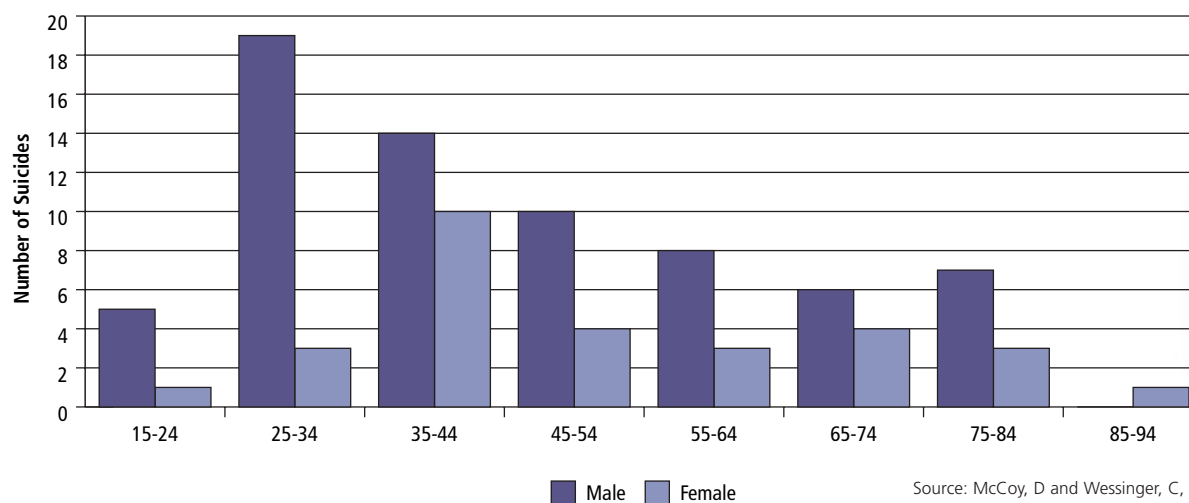
Initial analysis of suicides in Haringey since 2001 suggests that approximately 35 Haringey residents commit suicide every year, which is at least 50% higher than the national suicide rate. This can be explained in part by the relatively high level of factors increasing the risk of suicide in the borough such as unemployment, substance misuse and social exclusion, and by the relatively large number of people with mental illness.

It is notable that approximately three quarters of those individuals who committed suicide in Haringey since 2001 had had no contact with mental health services in the previous twelve months. This suggests a need to improve the ability of a range of health and other services to identify and support individuals at risk of suicide. It also reinforces the need to address the stigma and discrimination that individuals fear from seeking support.

The 3:1 national ratio of male to female suicides seems to be mirrored in Haringey, with the highest rates amongst men aged 25-30. Information on employment,

Figure 10:

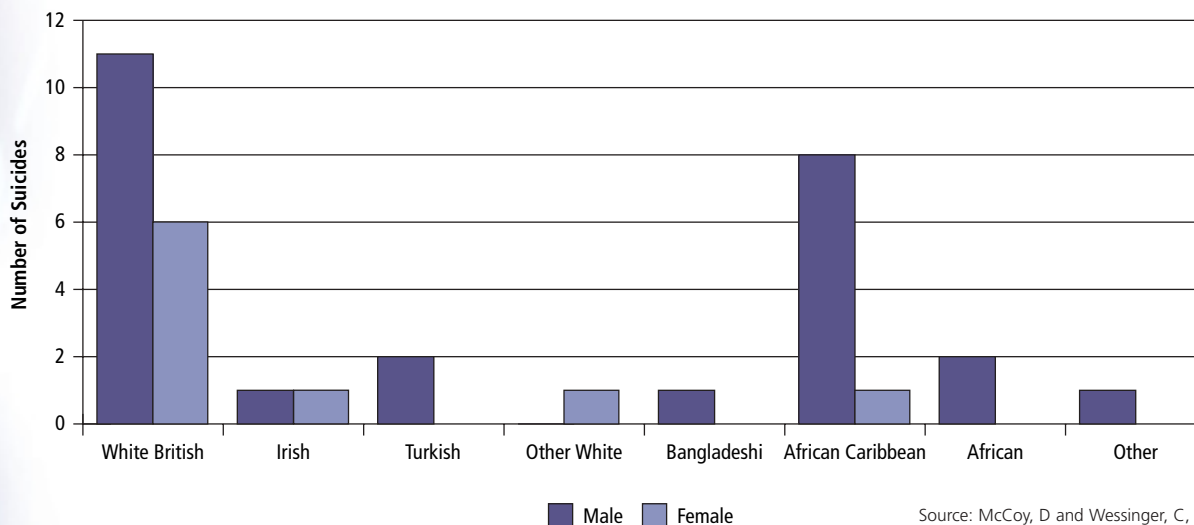
Age and sex profile of people who committed suicide in Haringey, Jan 2001 – Aug 2004



Source: McCoy, D and Wessinger, C, Suicide in Haringey, 2004

Figure 11:

Ethnic profile of people who committed suicide in Haringey Jan 2001 – Aug 2004



Source: McCoy, D and Wessinger, C, Suicide in Haringey, 2004

substance abuse history, and personal situation is not routinely available in cases of suicide, but work is currently underway to develop an understanding of the suicide profile in Haringey.

Relatively little is known about differences in suicide rates between different ethnic groups, largely because death certificates in Britain have not routinely recorded details of an individual's ethnicity. However, we do know that cultural and religious beliefs have an impact on suicide rates in different ethnic groups. For example, one study found that the suicide rate in 16-24 year old women of Asian origin in the UK was three times that of 16-24 year old women of white British origin⁴³. The health status of some minority ethnic communities may be associated with

the experience of being refugees or recent migrants, who have been dislocated from social networks. Refugees who have experienced torture and psychological trauma are particularly vulnerable to mental illness and feelings of despair and depression, which may lead to suicide. There was a disproportionately large number of suicides among African-Caribbean men in Haringey between 2001 and 2004 (see figure 11).

So what do we really know?

Although there is little hard data on mental ill health locally, all the indicators we have suggest that it is a significant problem for the health and well-being of people in Haringey. The following section examines how mental health care services are developing within Haringey to meet local need.



Towards holistic care

The way that people with mental health problems are treated and cared for in society has changed over time.

For centuries, religious or spiritual explanations of mental disorders determined the way in which people with mental illness were treated. During the Middle Ages mental illness was associated with supernatural causes, including demonic or divine possession.

17th century: explanations of mental illness in the form of a physical state were proposed, but these did not encourage compassion or tolerance as they implied mental illness was self-inflicted, caused by, for example, an 'excess of passion' or 'impure' thoughts. This was used to justify punishment and brutal treatment.

18th century: humanitarianism saw the reform of some of the more brutalising forms of treatment and incarceration. However, many institutions still focused on providing treatment to correct the 'moral deficiencies' of people with a mental illness. Moral treatment programmes led to the building of many asylums, which over time effectively became custodial institutions.

20th century: saw a shift in emphasis from custody and protection to care and treatment, and a greater recognition of the rights of people with mental illness. Research demonstrated that mental asylums had little therapeutic impact, sometimes exacerbating mental illness. This led to reductions in the number of chronic patients living in mental hospitals, and the development of community mental health services as alternatives.

Mental health services in the 21st Century

Despite having an impact on so many people's lives, mental illness has not been given the same attention as other types of physical illness in our society. To an extent this may be due to the medical profession's bias towards curable diseases, and to misconceptions and ignorance about mental illness. This ignores the fact that much can be done to reduce the severity of symptoms and distress caused by mental illnesses. Improved understanding of how poor mental health affects people and society in general should result in action to address the gap between the need for care and treatment, and its provision.

Myth *or* Fact?

People with mental health problems never recover

Myth Fact

Myth: With the right support, most people with mental health problems can manage their problems and get on with their lives. Many recover completely.

Recent developments in the provision of mental health services have been supported by the National Service Framework for Mental Health, published in 1999⁴⁴. It proposes national standards for mental health treatment and care, and aims to drive service improvement and modernisation. Haringey is in the process of developing a mental health strategy that will incorporate services from a range of specialist mental health and primary care practitioners into a single integrated plan for mental health treatment and care.

Holistic treatment, management and care

The clinical treatment and care of mental illness aims to cure or minimise the debilitating effect of symptoms. It includes use of medication, counselling, and behavioural, cognitive and physical therapies. This clinical care should be sensitive to the individual's physical health status, and GPs have an important role in ensuring that those with mental illness receive appropriate, holistic health care.

Around two and a half thousand Haringey residents are referred to the Psychological Therapies Service each year. These services are available to those aged over 18 years, through teams working in both community and hospital settings. They offer a range of brief and longer-term interventions to individuals, couples, families, and groups. The evidence based

therapeutic models used include psychoanalytic, group analytic, cognitive behavioural, cognitive analytic, and interpersonal psychotherapy. Nearly 90% of service users are under 50 years old.

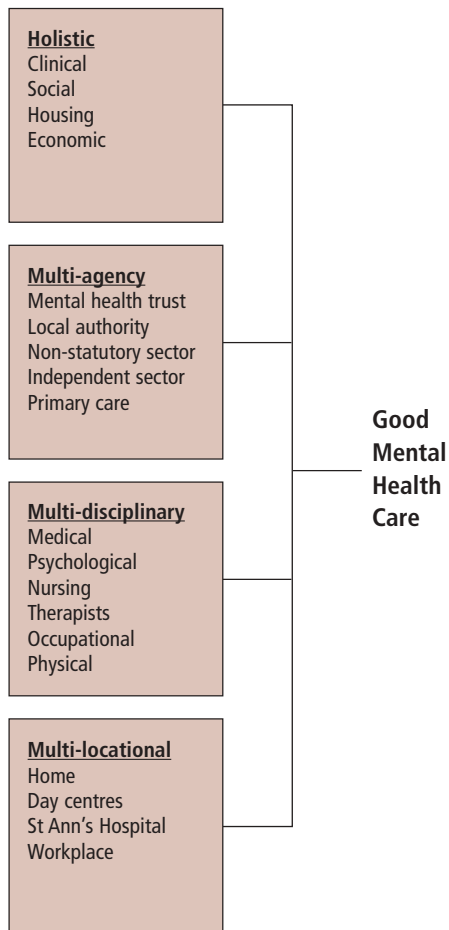
The Halliwick Psychotherapy Unit at St Ann's provides a specialist treatment service tailored to the specific needs of patients with severe personality disorder⁴⁵. A package of group and individual treatment is offered, either within a day hospital or an intensive outpatient programme. Patients are also offered a self-booking psychiatric clinic to discuss medication. Research suggests that this psychoanalytically oriented care model is more effective than standard psychiatric treatment⁴⁶.

The social environment of people with mental illness is critical to their recovery from acute episodes of illness, and to their general well-being. Good mental health care includes the provision of a variety of psycho-social interventions, including housing and tenancy support, help in gaining meaningful employment, or support in accessing grants and benefits. The re-establishment of social relationships and networks are also important in the recovery process, including maintenance of personal relationships and care responsibilities.

In Haringey, most clinical mental health care is provided by the Haringey branch of the Barnet, Enfield and Haringey Mental Health Trust. The most visible component of this service in Haringey is St Ann's Hospital, where in and outpatient care and treatment services are provided. It also provides care through community mental health teams, which provide on-going multidisciplinary care and support to those with severe mental illness.

Mental health services are increasingly multi-disciplinary – in other words, care is provided by a team of professionals including psychiatrists, general practitioners, psychologists, nurses, occupational therapists, counsellors, and social workers. In addition, family members are often the primary carers of people with mental illness, and are therefore an important part of the mental health care system.

Figure 12:
The elements of good mental health care



The following section illustrates how this approach is being developed in Haringey for people with schizophrenia.

The care and treatment of schizophrenia

Schizophrenia is characterised by severe

disruptions in thinking, typically beginning in late adolescence or early adulthood. While almost half of all people with schizophrenia can expect a full recovery, in some patients it can follow a chronic or recurrent course. Some people with schizophrenia may suffer only one or two acute attacks of disorganised thought and hallucinations. Other patients may suffer from a more intractable and severe form of illness that may result in serious limitations to daily activities, and recourse to long term care and treatment. Early and effective treatment can diminish the risk of recurrence or long term complications.

People with severe delusional behaviour and hallucinations may be admitted to hospital, and given medication to relieve symptoms and make thinking more ordered and functional. Other therapies, such as cognitive behavioural therapy, can be effective in reducing symptoms, particularly for those individuals who do not respond fully to anti-psychotic medication⁴⁷.

Once the acute symptoms are controlled, usually with the help of medication, other therapies can help to rehabilitate the individual back into a near normal state of functioning. These therapies can be offered in the hospital setting, or through outpatient services once the individual is able to return home.

Crisis assessment and treatment teams (CATTs) provide intensive treatment and support to individuals living in the community at times of crisis, with the aim of avoiding the need for admission to hospital. Interventions that educate families about schizophrenia, provide support, and offer training are now known to reduce rates of relapse, and contribute to improved patient functioning and family well-being.

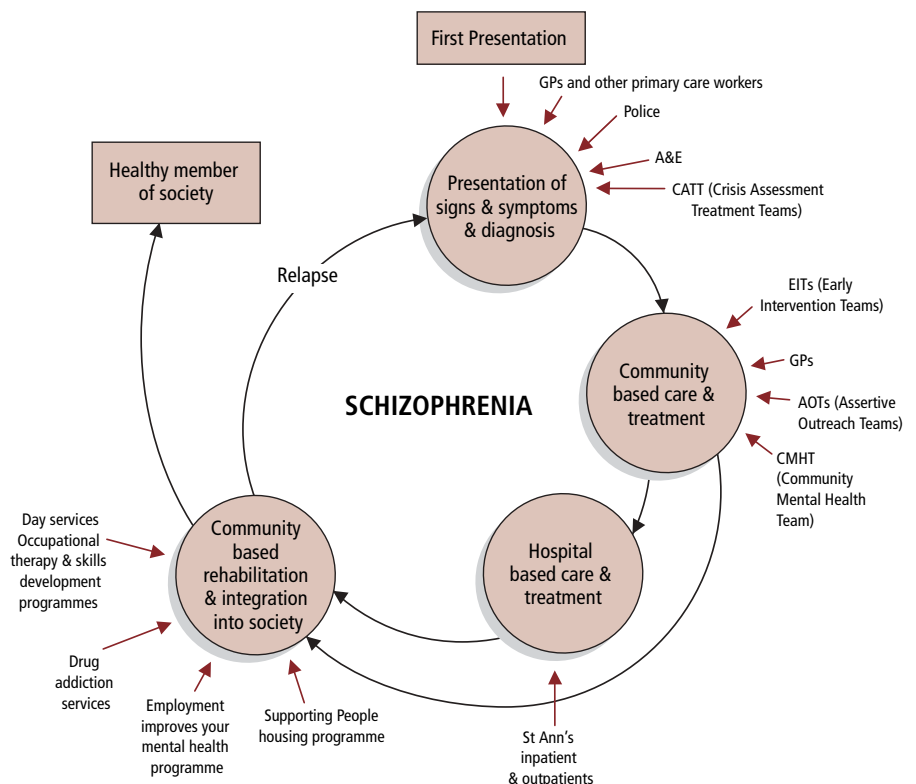
Diagnosing and treating schizophrenia as early as possible is important in reducing the severity of the condition. Early intervention teams are being established in Haringey to ensure appropriate care for people aged between 14-35 years with a first episode of serious mental illness. The success of these teams will depend on increased awareness of the early signs and symptoms of mental illness, as the onset of symptoms may be ignored or denied, resulting in delayed treatment. By reducing the level of stigma associated with mental illness, patients and families can seek treatment quickly, resulting in a better outcome.

Two assertive outreach teams have been established in Haringey to support severely mentally ill people living in the community who are at high risk of hospital readmission and who do not engage with standard community-based treatment. In particular, they aim to support individuals who find it difficult to engage with other services, including those at high risk of harming themselves and others, those with complex needs such as substance misuse, and those with severe and enduring mental illness (including schizophrenia). These teams provide a range of services outside normal working hours, including an out of hours duty help-line to provide support and advice in emergencies to clients and carers.

This care model, combining the traditional approach of medication with a broader multi-dimensional support system, requires a multi-disciplinary approach that provides a range of skills and experience to support an individual through to recovery. There are four community mental health teams in Haringey aiming to provide this approach. They help to prevent the "revolving door" phenomenon of patients being discharged from hospital in to the community, and then being readmitted in part due to a lack of community-based support and rehabilitation.

Once individuals are stable, ongoing support from health service providers, family and friends is essential to re-integrate individuals as functional and dignified members of society, and prevent relapse. Supported employment and housing opportunities, for example, can be crucial in ensuring that individuals do not slip into another episode of mental illness.

Figure 13:
Key elements of holistic care for people with schizophrenia





Meeting the needs of vulnerable groups

Children and young people

Children frequently experience the impacts of mental illness when it affects their carers. This may result in them taking on many of the care responsibilities themselves.

"I hate it when mum is ill. It's like she's the child and I'm the adult. I'm being like a mum myself, only I don't always want to be. Sometimes I just want to be like a little baby again and have someone look after me"

Children also experience their own mental health problems. These can be relatively mild and self-limiting, while others are more serious, and some, such as self-harm or eating disorders, can be life threatening. There is evidence that difficulties faced in childhood can lead to mental and social problems in later life⁴⁸ and may affect a child's development, capacity to make long-term relationships and to parent their own children. Mental health problems can interfere with education, leading to poor educational attainment, low self-esteem and reduced employment opportunities⁴⁹.

55% of young people in UK say that if they had a mental health problem, they wouldn't want anyone to know.⁸

Mental health problems in children are broadly classified into two types: disorders of

psychological development e.g. dyslexia or autism; and behavioural and emotional disorders e.g. attention deficit / hyperactivity disorders (ADHD) or conduct disorders. Both types require care that links together families, schools, hospitals and outpatient facilities.

Around one in ten children between the ages of 5 and 15 in the UK are experiencing mental health problems serious enough to require professional help^{50,52} – at least 3000 children in Haringey.

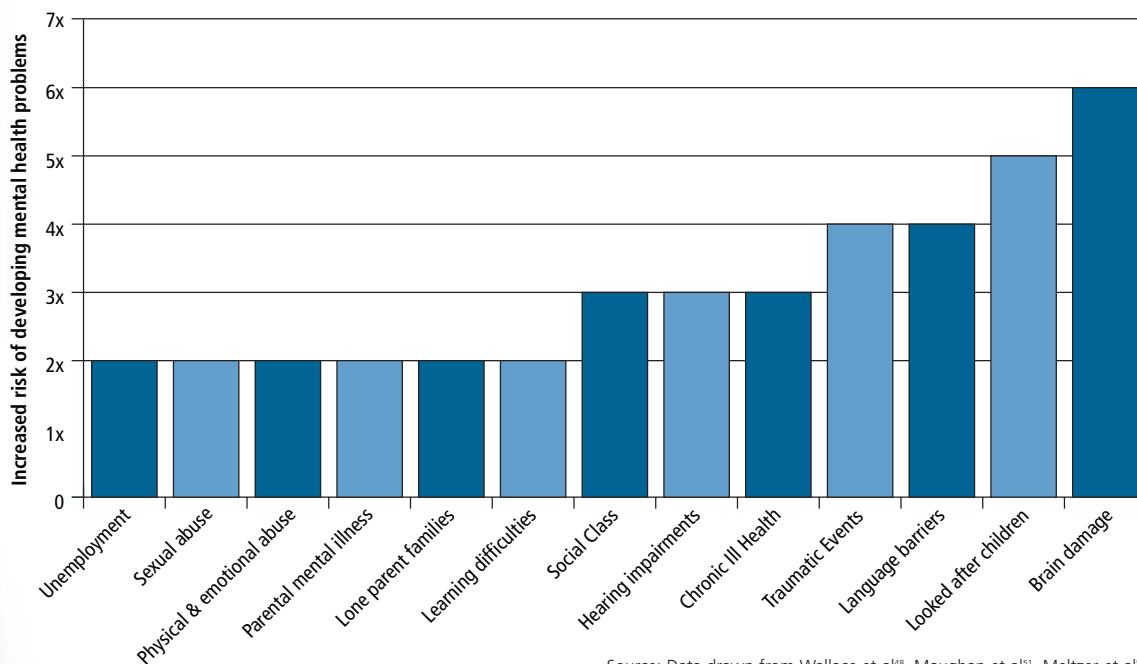
Many people experience their first episode of mental health problems in their late teens or early twenties, which can have serious consequences for their education and employment prospects.

There is evidence to suggest that many forms of mental illness in young people are becoming more frequent including depression, self-harm, delinquency and substance misuse⁴⁹.

Although the demand for child and adolescent mental health services is increasing, there is relatively little information available on the mental health needs of children and young people in Haringey. There were 72 admissions for mental health problems amongst young

Figure 14:

Factors influencing the development of mental health problems in young people.



Source: Data drawn from Wallace et al⁴⁸, Maughan et al⁵¹, Meltzer et al⁵²

people in Haringey between 2002 and 2004, while the Educational Support Team counselled 170 children during 2003/04, two thirds of whom were girls.

The mental health of young people is closely intertwined with their physical health and wider environment. Figure 14 represents the relative risk of a number of factors associated with the development of mental health problems in children and young people. Looked after children face a significantly high risk, being five times more likely to develop mental health problems than the average child.

Children and young people in Haringey are affected by many of the same determinants of mental health as adults. Many are affected by deprivation – two fifths of primary and secondary school children in Haringey receive free school meals, and a significant proportion of children live in households affected by unemployment. In addition, many children in Haringey are exposed to the specific risk factors for mental health problems illustrated above.

In September 2004 in Haringey there were;

- 525 looked after children.
- 297 children on child protection registers.
- 501 children with a disability registered with the Council.
- 399 asylum seeking families with children assisted by the Council.
- 296 unaccompanied children seeking asylum.
- 4905 households living in temporary accommodation.

Mental health services for children and young people provide a variety of assessments, treatments and care. The Children's National Service Framework (NSF)⁵³ sets a standard that all children and young people, (from birth to eighteen), that have mental health problems and disorders should have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and

support for them and their families. This reflects the need for services to be organised around the child, with flexibly organised transition of care from child and adolescent mental health services (CAMHS) to adult services.

The Children's NSF⁵⁴ supports a tiered approach to CAMHS. This ranges from tier 1 services focused on mild emotional and behavioural difficulties, through to tier 4 services providing intensive and highly specialised care, usually for older children with severe disorders. Services in Haringey have adopted the tiered approach described above, and a strategy is in place to improve prevention and CAMHS across all tiers in Haringey.

The West Green and Chestnuts Sure Start programme has developed a parent-infant attachment strategy, recognising that the mental health of parents can affect their ability to identify and respond appropriately to their child's needs. Poor parental mental health, leading to problematic parent- infant interaction, can influence early brain activity and longer-term behavioural outcomes. The programme aims to support parents in responding to their child's needs, the main focus being on women at risk of or experiencing post-natal depression, or those facing socio-economic deprivation.

Substance misuse and individuals with a dual diagnosis

There are a number of disorders resulting from the misuse of substances such as alcohol, heroin, crack, cannabis, sedatives, cocaine, hallucinogens, tobacco and glue. The conditions include acute intoxication, dependence and psychosis. Substance misuse

itself can precipitate, worsen or aggravate mental illness in an individual. But it can also result in a social environment that is not conducive to good mental health.

A significant number of people with a mental illness in Haringey have a co-existing substance misuse problem, and are commonly described as having a 'dual diagnosis'. Many of these individuals are considered to be complex, chaotic, and difficult to manage within traditional service settings⁵⁵. Generally speaking, dual diagnosis services relate to individuals with a substance misuse problem who also have a severe mental illness, such as clinical depression, schizophrenia or bipolar disorders. Many of these service users also have physical health problems and so an active relationship with other health care services is also required.

Dual diagnosis clients face the double stigma of being labelled a 'drug user' and 'mentally ill'. Substance misuse clients are a marginalised group in society, as are individuals with mental health problems. This leaves dual diagnosis clients vulnerable and open to abuse.

Between April 2002 and March 2003, 272 individuals were admitted to St Ann's with a dual diagnosis, of whom three quarters were men. A few individuals were admitted up to three times in that period, indicating that their needs were not being met in community settings.

Nearly one fifth (17%) of patients in the census on 12th August 2004 had a dual diagnosis, of whom two-thirds were male and nearly half were under 35 years of age. Over one third were admitted with a diagnosis of schizophrenia (see Figure 9).

One recent report by service users at St Ann's Hospital suggests that 40% of mental health service users and at least 25% of substance misuse service users experience both mental health and substance misuse problems⁵⁶.

Individuals with a dual diagnosis can be difficult to engage and retain in treatment, due to the complexity of the issues that they need to address. A specialist dual diagnosis service (the Maple Unit) is available on the St Ann's site, which also aims to increase capacity to meet the needs of dual diagnosis patients in mental health services, and ensure that appropriate mental health inputs are made through substance misuse services. In addition to addressing substance misuse and mental health issues, clients may also require support in a range of other areas including risk assessment, housing, welfare rights, general health care, and the criminal justice system.

The National Treatment Agency (NTA) for substance misuse advocates the establishment of common screening and assessment protocols across all substance misuse services in an area⁵⁷. For dual diagnosis clients with problems accessing treatment, this will ensure that clients are assessed and directed to the appropriate treatment service promptly.

Refugees and asylum seekers

It is estimated that around a third of a million refugees live in London – about 1 in 20 of the city's residents⁵⁸. Asylum seekers apply for leave to remain in the UK, generally for fear of persecution due to race, religion, nationality, membership of a particular social group, sexuality, or political opinion. Refugees are those granted leave to remain outside their country of nationality, and are generally unable or unwilling to return to it because of such fear. In many cases, this fear may

be a direct result of experiences of war, imprisonment, violence, torture, intimidation or threats to their lives.

It is estimated that 25-30,000 refugees and asylum seekers live in Haringey, representing over 10% of the population. They originate from many countries, with diverse ethnic and cultural backgrounds. Some of the larger and more established communities are Turkish, Kurdish, Somalian, Ethiopian, Eritrean, and Zairean⁵⁹. Most recently there have been arrivals from Kosovo and Albania. In general, the majority of refugees are men (around 70%), and most are relatively young (80% being under the age of 40). Half of refugee men are likely to be single, and a third of women⁶⁰. Many refugees arrive without other family members, including an increasing number of unaccompanied children.

A significant proportion of asylum seekers arrive in the UK in a state of mental distress, traumatised by their experiences at home and their journey to the UK. In a survey of refugees in Haringey, over half reported that they had suffered imprisonment and/or torture before arrival in Britain, with particularly high levels amongst Kurdish, Ugandan and Eritrean interviewees. Besides the immediate physical effects, torture can bring long-term health problems and have severe psychological effects. Women are also vulnerable to physical assault, sexual harassment and rape, which can carry a heavy psychological burden.

Research suggests that two-thirds of refugees have experienced clinical anxiety and depression⁸. Many have poor sleep patterns or problems with memory and concentration, and studies suggest that between 25 to 50% of refugees have post traumatic stress

The range of health problems that may follow torture

Physical	Psychological
Persistent back or shoulder pain	Nightmares
Aches and arthritic pain	Hallucinations
Convulsions	Panic attacks
Inability to walk unaided	Sexual problems
Organ damage	Phobias
	Difficulty trusting people/making relationships
	Depressive illness/anxiety

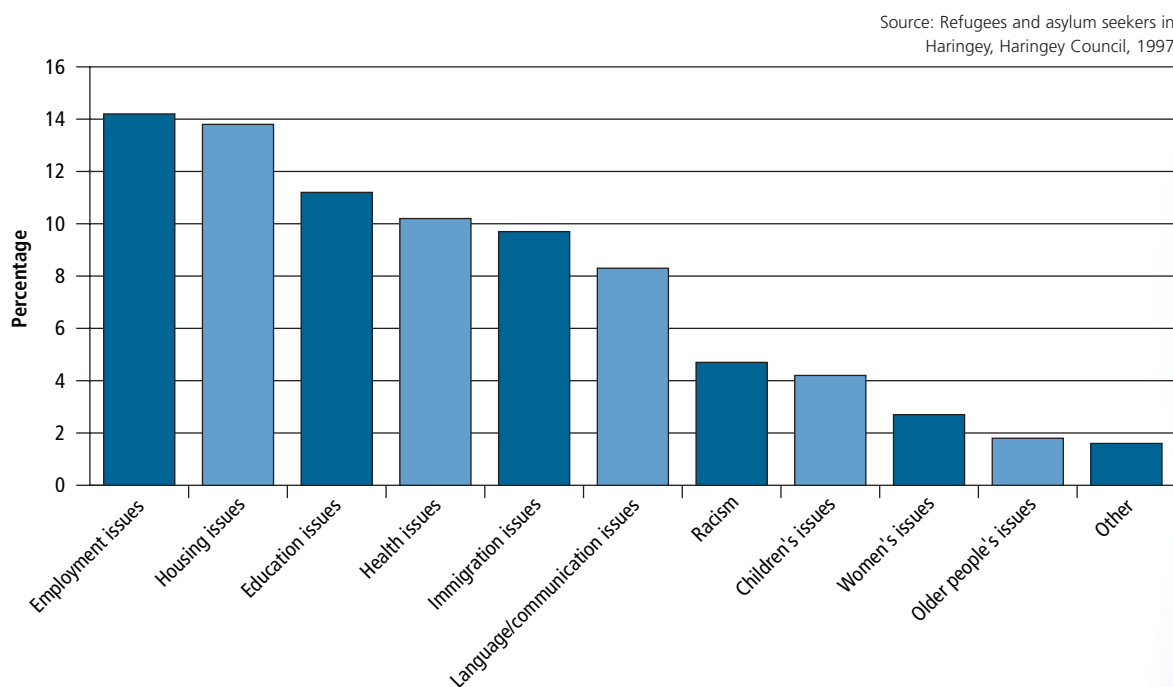
Source: Medical Foundation for the Care of Victims of Torture⁶¹

disorder (PTSD). The challenges faced by asylum seekers on arrival to Britain can also have a significant impact⁶⁰. Coping with immigration issues, finding accommodation and a job and unfamiliar language creates additional stress and pressure. Figure 15 illustrates the type of challenges that refugees and asylum seekers in Haringey face. The combination of problems can lead to a sense of isolation and desperation. Women and children are particularly vulnerable as women often take on new roles as heads of disrupted households.

A local study of unaccompanied Albanian and Kosovan adolescents⁶² suggested high levels of mental health problems amongst the young people, with nearly a quarter (23%) showing significant psychological distress. Those aged between 16-18 receive far less structured support than those aged under 16, and the study showed that those with the worst mental health were those unsure of the whereabouts of their parents, or living in a hostel or bed and breakfast accommodation.

Figure 15:

Problems identified by refugees and asylum seekers since arrival in the UK



Although effective treatment for the mental illnesses encountered by refugees and asylum seekers is available, many refugees experience difficulties accessing such services. In addition, clinical services will be insufficient for most individuals, given the complexity of issues affecting their mental health. Therefore rehabilitation programmes must address the determinants of mental health, including material and social support.

Information on health services utilisation by refugees is not routinely available, but the refugees who do present to local psychiatric services may represent the tip of the iceberg. Of the 4% of patients in the hospital census on 12th August 2004 who indicated they were refugees or asylum seekers, half were admitted for depression.

Approximately 15% of all referrals received by the Psychological Therapies Service from Haringey are for refugees and asylum seekers, many of whom require a combination of treatment and

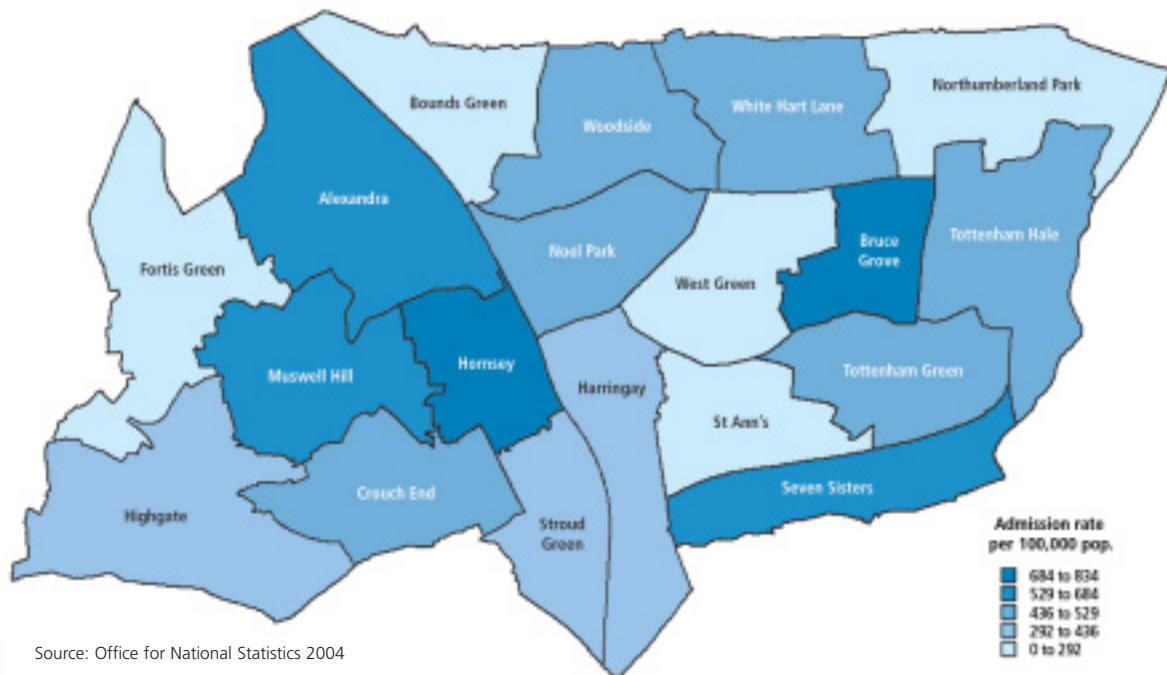
support that is not generally available within mainstream services. The Service has a small group of dedicated clinicians who provide a psychotherapeutic response to individuals by offering a number of sessions to consider what form of psychotherapy might be helpful and, to work out what other forms of support – social or otherwise – might be needed. It has also piloted and is now developing and evaluating a multi-agency project with other services and agencies for complex cases where legal and social support is required.

Older people

Mental well-being is a significant aspect of older people's health. Growing old does not automatically mean decline or loss of mental functions for older people. For many it is a time of opportunity, increased leisure, reduced worries and care responsibilities. However, all older people have to adjust to the physical and psychological changes of

Figure 16:

Mental health admission rates in those aged over 65 in Haringey 2002-2004



Source: Office for National Statistics 2004

later life, which can coincide with a loss of social role following retirement, children growing up or the loss of a partner. These factors may lead to isolation, loneliness and increased risk of physical and mental illness. They can also coincide with a loss of financial resources after retirement⁶³.

The rates of admission of older people to mental health services in Haringey vary considerably by ward, with the highest admission rates in Bruce Grove, Hornsey, Muswell Hill and Seven Sisters (see figure 16).

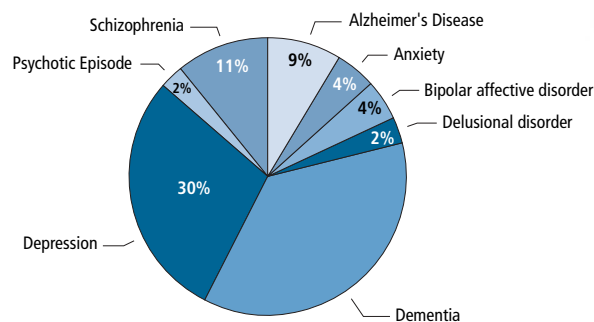
Further information on those admitted to hospital is available through the St Ann's census of patients on hospital wards conducted on 12 August 2004, of whom a fifth were aged over 65 years. The diagnoses of those admitted are shown in Figure 17, the most frequent being dementia followed by depression.

While many of these patients had been there for less than three months, almost half had been in hospital for more than 6 months, with a significant proportion having been in for more than 12 months.

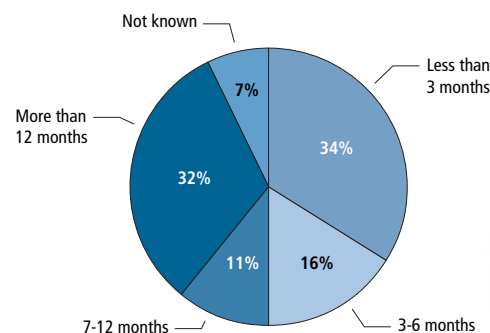
In Haringey a growing number of older people are from minority ethnic communities. This has an impact on the presentation of mental illness as cultural variations, historical factors, perceptions, beliefs, and values affect the level of suspicion or discomfort that the older person has with mental health services. Such factors can subsequently affect the course of overall mental health treatment, including the effectiveness of assessment of mental status, determination of causes, and the interventions used⁶⁴. In a borough such as Haringey culturally appropriate approaches to mental health in older people need to be considered.

Figure 17:
Inpatient census profiles of patients aged over 65 years, 12th August 2004

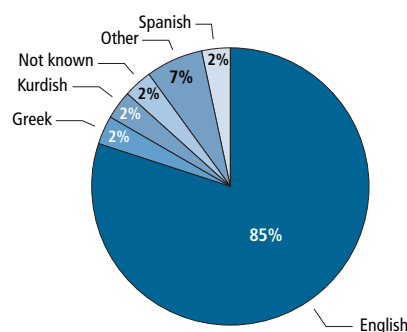
Diagnosis



Length of stay



First Language



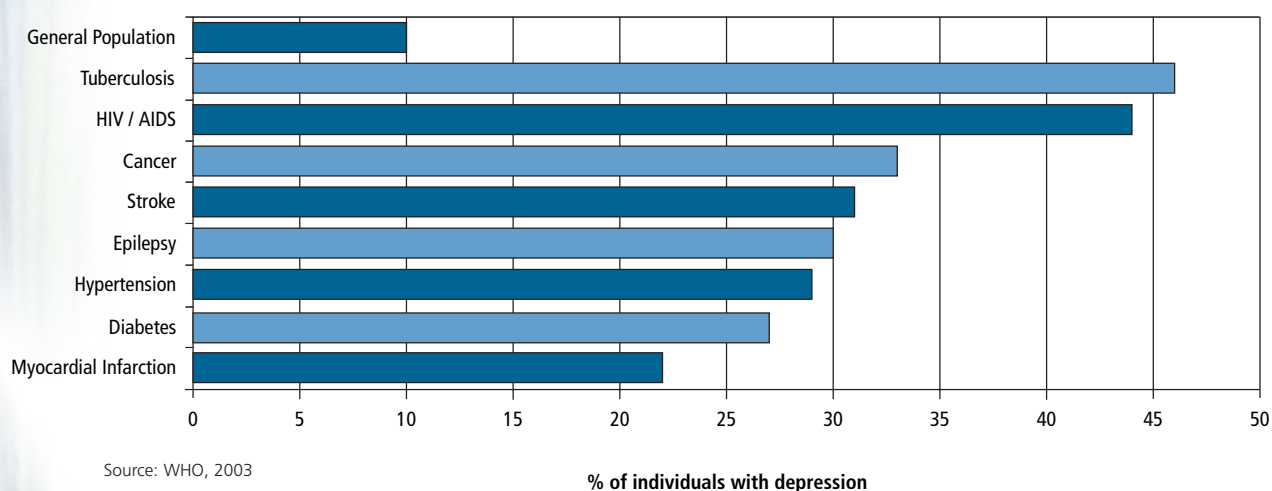
Source: Barnet, Enfield and Haringey Mental Health Trust 2004

Physical illness and mental illness in older age

Chronic illness, isolation and loneliness, loss of purpose in society or physical disability all increase the risk of mental illness in older people. Conversely mental illness such as

Figure 18:

Prevalence of major depression in individuals with physical illnesses



depression can have an adverse effect on the outcome of care for physical illnesses. Patients with depression are at greater risk of other illness, and treatment for depression can be effective in improving outcomes in a diverse range of diseases including Alzheimer's, Parkinson's and heart disease.⁶⁵

Clinically significant depression in later life is often under diagnosed. The consequences of depression in old age include suicide, alcohol dependence, cognitive impairment, and increased rates of healthcare utilisation and mortality as well as poorer outcomes of care for physical illnesses.⁶⁶ Figure 18 shows the prevalence of depression in people with a range of different physical illnesses, some of which are more prevalent amongst older people e.g. hypertension, stroke, and diabetes.

Alzheimer's disease and dementia

The prevalence of Alzheimer's disease and dementia increases with age. Dementia is a condition characterised by a decline in memory, thinking, comprehension, calculation, language, learning capacity and judgement. While Alzheimer's is a significant cause of dementia, there are a number of other causes including stroke. There is

currently no cure for dementia. However, good care can help to maintain the functioning of the individual, minimise symptoms such as depression, and provide support to families. Interventions, including education, support, counselling and respite care, are extremely important in Alzheimer's disease, both for patients and family care givers. Some medication can slow the progress of the disease and assist with daily functioning for a limited period.

Estimates suggest that there are approximately 1,700 people with dementia in Haringey, of whom an estimated 55% have Alzheimer's disease. The responsibility for caring for those with Alzheimer's disease and other forms of dementia usually rests with families. Over time this can become a 24 hour responsibility that can overwhelm other aspects of the carer's life.



Conclusions and key messages

Mental illness affects a significant number of people in Haringey. This report identifies areas where action can be taken to improve mental health and well-being. These include:

1 *Reducing stigma and discrimination*

The stigma, discrimination and prejudice that people with mental illness and their carers face perpetuates a vicious cycle of social exclusion. The NHS in Haringey and other partners have an important role in reducing the levels of stigma and discrimination associated with mental illness, and providing the necessary support for people to continue living in the community. Stigma should be challenged in all areas of public life, including the media and through local voluntary and community groups.

2 *Preventing mental illness*

A range of social and environmental factors impact on mental and physical health, and improvements in these can make a positive contribution to mental health and well-being and possibly prevent progression to mental illness. Efforts to regenerate local neighbourhoods and create a 'better Haringey' should consider how they can maximise their important contribution to mental health.

3 *Increasing the ability to cope with mental distress in life*

People seek support in times of crisis from a range of sources, including social networks

and a range of health and social services. There is some evidence of what works to support mental health in key settings, such as schools and workplaces, including employment policies that support employees with mental health problems. Provision of prompt and effective support is effective in reducing progression to more severe mental illness, and early intervention to support children with mental health problems can effectively prevent them developing mental illness as adults. Support for carers in maintaining their role is also important.

4 *Improving the quality of mental health services*

The delivery of a holistic model of mental health care is complex. Integrated, seamless care provision across hospital and community based services requires the development of good communication and planning mechanisms between different agencies to meet both the mental and physical health needs of individuals. Services must have the cultural competency to meet the needs of ethnically and culturally diverse communities, and to ensure that the complex needs of those with mental illness and substance misuse problems are met.

There has been a considerable amount of activity in the development of mental health services in Haringey in recent years. Primary

care services still support the majority of individuals with mental illness, and yet these services may be insufficient. Primary care services also have an important on-going role in supporting the physical health needs of those with mental illness.

Development and expansion of the range of community-based services will hopefully contribute to a reduction in the need for hospital admissions for mental illness. However, for those that are admitted to hospital, the St Ann's Hospital site is acknowledged as being out of date for the provision of modern care services for individuals with severe mental illnesses. It lacks adequate space to provide multi-disciplinary care and treatment while maintaining privacy and dignity for patients. Services will need to consider the appropriateness and adequacy of the site as they develop.

5 *Improving data and information systems*

Robust information to inform the future development of services is currently lacking. All of the above approaches should be underpinned by reliable information with which to plan mental health services for those with mental illness, and wider efforts to support mental health and well being. This will be particularly important if we are to develop our understanding of mental health and the extent and type of mental illness in Haringey as the ways of delivering mental health care services change and evolve.



Sources of further information, help and support

HARINGEY

Information on mental health services in Haringey can be found using the following web link:

www.beh.nhs.uk/communitygroups/mental_health_dbase.asp

Patient advice and liaison service (PALS) Barnet, Enfield and Haringey Mental Health Trust

Tel: 020 8375 1187

Camlet 2, North London Forensic Service,
Chase Farm Hospital Site
The Ridgeway, Enfield, Middlesex EN2 8JL

St Ann's Hospital Patients Council

Tel: 020 8442 6843

An independent service user group working to put forward the views of people using mental health services.

Haringey Mental Health Unit

St Ann's Hospital, St Ann's Road,
Tottenham, London N15 3TH
Main Switchboard: 020 8442 6000
Emergency Reception Centre: 020 8442 6706

TULIP Mental Health Group

Tel: 020 8889 6921

Tulip works with clients experiencing mental health needs ranging from emotional distress to severe and enduring mental health problems. The vulnerable groups served include women, refugees, Black and Minority Ethnic groups and clients with a dual diagnosis.

Rethink – Enfield and Haringey Group

Tel: 020 8886 6065

Rethink works to help everyone affected by severe mental illness, including schizophrenia, to recover a better quality of life.

Mental Health Carers Support Association

Tel: 020 8885 2006

Support for carers of people who are mentally ill.

MIND in Haringey

Tel: 020 8340 2474

73c Stapleton Hall Road, London N4 3QF
Black and Minority Ethnic counselling service, an activity centre, an advocacy service and an independent living scheme for those with mental health problems.

**Open Door – Young People
Consultation Service**

Tel: 020 8348 5947

www.opendooronline.org

12 Middle Lane, Crouch End, London N8 8PL

A free counselling service for young people aged 12-25 who are experiencing emotional or personal difficulties.

Age Concern Haringey

Tel: 020 8801 2444

www.ageconcernharingey.gov.uk

Tottenham Town Hall,

Town Hall Approach Road, London N15 4RY

Alzheimer's Society Haringey

Tel: 020 8808 9931

R18 William Rainbird House, Beaufoy Road,
London N17 8AY

Drug advisory service Haringey (DASH)

80 Stroud Green Road, Finsbury Park N4 3EN

Tel: 020 7272 2757

Antenna Outreach Service

The Antenna Outreach Service is a service for young black African and African-Caribbean people aged between 16-25 years, who suffer from mental ill health.

Excel House, 312 Tottenham High, London
N15 4BN

Tel: 020 8365 9537

Email: antenna@outreachservice.fsnet.co.uk

EMERGENCY CONTACTS (24 HOURS)

Samaritans

Tel: 08457 909090, www.samaritans.org

Confidential emotional support to those in crisis.

Haringey Crisis Unit

Tel: 020 8365 7287

Support for those in any crisis situation

Haringey Crisis Teams

East Haringey: 020 8442 5888

West Haringey: 020 8442 5889

NATIONAL ORGANISATIONS

MIND

Tel: 0845 766 0163

www.mind.org.uk

Rethink

Tel: 0845 456 0455

www.rethink.org

Saneline

Tel: 0845 767 8000 (helpline)

www.sane.org.uk

YoungMinds

Tel: 020 7336 8445

www.youngminds.org.uk

Mentality

Tel: 020 7716 6777

www.mentality.org.uk

**National Institute for Mental Health,
England**

Tel: 0113 254 3811

www.nimhe.org.uk

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For further information or copies contact:

Graeme Walsh, Health Information Analyst,

Haringey Teaching Primary Care Trust

Block A1, St Ann's Hospital, St Ann's Road, London N15 3TH

Tel: 020 8442 6783

Fax: 020 8442 6939

Email: graeme.walsh@haringey.nhs.uk

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Tel: 020 8584 5255

