NHS
Tower Hamlets
Clinical Commissioning Group

Mental Health
Joint Strategic Needs Assessment
for Tower Hamlets

Part One: Mental Health Needs

August 2013

Part One: Mental health needs

Contents

CHAPTER 1
INTRODUCTION: STRUCTURE OF DOCUMENT ..,,,,,,,,,……………………………………………….. 3

CHAPTER 2
NATIONAL CONTEXT AND LOCAL VISION ……………………………………………………………… 4

CHAPTER 3
DEMOGRAPHY AND SOCIAL AND ECONOMIC DETERMINANTS OF MENTAL HEALTH …… 14
APPENDIX …………………………………………………………………………………………………37

CHAPTER 4
RISK AND PROTECTIVE FACTORS FOR MENTAL HEALTH AND WELLBEING ………………..41

CHAPTER 5
PREVALENCE OF MENTAL ILLNESS …………………………………………………………………62
APPENDIX …………………………………………………………………………………………...101

CHAPTER 6
MENTAL HEALTH IN TOWER HAMLETS: A SERVICE USER AND CARER PERSPECTIVE ….104

1. Introduction: structure of document

The Mental Health Joint Strategic Needs Assessment (JSNA) for Tower Hamlets has been produced in order to inform the development of a new Mental Health Strategy and is published alongside the Strategy.

The Mental Health JSNA is an in-depth review published in three parts, with chapters numbered in sequence. Part One describes what is known about the mental health needs of the borough, and Part Two describes the funding and utilisation of current services. Each chapter from 3 onwards contains a summary of key points, to which those who do not wish to read the full document are directed. The recommendations are given in Part Three.

The structure is illustrated below:

Figure 1: Structure of Tower Hamlets Mental Health Joint Strategic Needs Assessment (JSNA)

Part One: Mental health needs

1 Introduction: structure of document

2. National context and local vision

3. Demography and social and economic determinants of mental health

4. Risk and protective factors for mental health and wellbeing

5. Prevalence of mental illness

6. Service user and carer perspective

Part Two: Facts and figures

7. Investment in mental health services

8. Service utilisation

Part Three: Recommendations

9 Recommendations of Mental Health JSNA

Together these chapters give a detailed picture of the mental health needs of the borough, and analysis of the facts and figures concerning investment and the current use of services. They provide essential information and a document of record for those stakeholders with an interest in mental health in Tower Hamlets.

In addition, a mental health JSNA Factsheet will be produced in the usual format, which is shorter and intended to be accessible for a wide range of stakeholders.

Chapter 2 – National context and local vision

1. What is a Joint Strategic Needs Assessment?

The duty to undertake Joint Strategic Needs Assessments (JSNA) is set out in Section 116 of the Local Government and Public Involvement in Health Act (2007). This duty commenced on 1st April 2008.

JSNAs are the means by which local leaders work together to understand and agree the needs of local people, with the joint health and wellbeing strategy setting the priorities for collective action. JSNAs establish local patterns of need and, in partnership with other stakeholders, make recommendations for local investment, service developments and, where necessary, decommissioning.

Tower Hamlets Health and Wellbeing Board has the responsibility to secure better health and wellbeing outcomes for local residents. The Board considers recommendations from the JSNA and then agrees priorities for health improvement and prevention. Through undertaking the JSNA, the Board will contribute to the local commissioning of health care, social care and public health and create a more effective and responsive local health and care system.

This JSNA focuses on mental health needs and services for people with mental health problems in the London Borough of Tower Hamlets. The document sets out information about the national and local context for mental health, including relevant policy and the wider context of public mental health. It describes the demography of the borough, some of the socio-economic determinants of mental health, the risks and protective factors for well-being, and their impact in Tower Hamlets.

The document also contains a detailed analysis of the prevalence of mental illness in the borough, the range of services available from the statutory sector, and the use of those services. It contains an account of feedback from service users and carers about their perspective on local services, specifically what works well and where things could be improved.

Finally, the JSNA makes recommendations to improve the ways the Tower Hamlets Partnership works to support those with existing mental health problems, including ways to address unmet needs, service gaps and inequalities in access to mental health services.

2. About mental health

Mental health is not just the absence of mental disorder. Positive mental health is defined as: *a state of well-being in which every individual realises his or her own potential, 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]. Mental wellbeing is 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[2] .

Emotional wellbeing is defined as: *"A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment*[3]*".*

Mental health is determined by a broad array of factors directly or indirectly related to the mental well-being component included in the World Health Organisation's (WHO) definition of health. It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders. Good mental health allows for cognitive and emotional flexibility, which are the basis for social skills and resilience in the face of stress. This mental capital is vitally important for the healthy functioning of families, communities and society.

A mental illness 'is a clinically recognisable set of symptoms or behaviour associated in most cases with considerable stress and substantial interference with personal functions[4]'.

There is no single cause of mental health problems and the reasons they develop are often complex. Mental health problems can affect anyone[5].

Although the exact cause of most mental illnesses is not known, it is becoming clear through research that many of these conditions are caused by a combination of biological, psychological, and environmental factors. There are many reasons why someone might develop a mental illness. They might inherit it from a family member, it may be linked to their lifestyle or it may be because of things that have happened to them in the past. Often it is a combination of all of these[6]. Without the correct support and treatment, mental health problems can have a serious effect on an individual and those around them.

3. Why mental health is important?

At least one in four people will experience a mental health problem at some point in their lifetime which can affect their daily life, relationships or physical health, and one in six adults

---

[1]World Health Organisation (2004) *Promoting Mental Health: Concepts; emerging evidence; practice* Geneva: WHO

[2]Project Foresight Mental Capital and Wellbeing. Final Project Report. London : The Government Office for Science, 2008

[3]As set out in two diagnostic manuals: a) World Health Organization (2007) *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines* Geneva: WHO. b) American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* Arlington: APA

[4]ICD-10 definition

[5]www.nhs.uk/conditions/Mental-health/

[6]http://www.rethink.org/about_mental_illness/what_causes_mental_illness/

have a mental health problem at any one time[7]. One in ten children aged between 5 and 16 years has a mental health problem, and many continue to have mental health problems into adulthood[8]. Among adults under 65, nearly half of all ill health is mental illness. In other words, for those of working age, nearly as much ill health is mental illness as all physical illnesses put together[9].

Every year in the UK, more than 250,000 people are admitted to psychiatric hospitals and over 4,000 people commit suicide[10]. Mental ill health represents up to 23% of the total burden of ill health in the UK – the largest single cause of disability[11]. Research shows that 2.3 million people with a mental health condition are receiving benefits or are out of work[12]. Estimates suggest that the cost of mental health problems in England are close to £105 billion per year, which includes costs of lost productivity and wider impacts on wellbeing and treatment costs. These are expected to double in the next 20 years[13] [14].

Improved mental health and wellbeing affects who people are, changes their lives and has a positive impact on relationships and families. It is also associated with a range of better outcomes including improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours, reduced risk of mental health problems and suicide, improved employment rates, reduced anti-social behaviour and higher levels of social interaction and participation[15] [16] [17] [18].

4 National strategy aims

The coalition government published a new mental health outcomes strategy in February 2011, *No Health Without Mental Health.* This clearly outlines that mental health is everyone's business and good mental health and resilience are fundamental throughout life to our physical health, our relationships, our education, our training, our work and to achieving our

---

[7]McManus s, Meltzer H, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey* Leeds: NHS Information centre for health and social care

[8]Green H, McGinnity A, Meltzer H et al. (2005) *Mental Health of Children and Young People in Great Britain, 2004* Basingstoke: Palgrave Macmillan

[9]The Centre for Economic Performance's Mental Health Policy Group (2012) *How Mental illness loses out in the NHS:* London School of Economics

[10]NHS Choices http://www.nhs.uk/conditions/Mental-health/Pages/Introduction-OLD.aspx

[11]WHO (2008) *The Global Burden of Disease: 2004 update*, available at: www.who.int/healthinfo/global_burden_disease

[12]HM Government (2009) *Work, recovery and inclusion*

[13]Department of Health (2011) *No Health without Mental Health: A Cross Government Mental Health Strategy for People of All Ages*, HMG/DH, p2 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

[14]Centre for Mental Health (2010) *The Economic and Social Costs of Mental Health Problems in 2009/10*

[15]Chevalier A and Feinstein l (2006) *Sheepskin or Prozac: The causal effect of education on mental health*. Discussion paper. London: Centre for Research on the Economics of Education, London School of Economics

[16]Meltzer H, Bebbington P, Brugha T et al. (2010) *Job insecurity, socio-economic circumstances and depression* Psychological Medicine 40(8): 1401–1407

[17]McManus s, Meltzer h, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey* NHS Information centre for health and social care

[18] Rees S (2009) *Mental Ill Health in the Adult Single Homeless Population: A review of the literature* London: Crisis and Public health Resource unit

potential[19]. The benefits of good mental health and wellbeing also have wider social and economic benefits which require a multi-agency approach to overcome the challenge of stigma and discrimination.

The strategy aims to:

- Improve the mental health and wellbeing of the population across the life course and keep people well
- Improve outcomes for people with mental health problems through the commissioning and provision of high-quality services that are equally accessible to all.

It sets out six outcomes:

- More people will have good mental health
- More people with mental health problems will recover or maximise their wellbeing, enabling them to live life as fully as possible with their condition
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination.

5. The costs of mental illness nationally

The costs to the NHS in England have been described in a report by the London School of Economics[20] :

- Total expenditure on healthcare for mental illness amounted to some £14 billion/year (2010/11). The largest expenditure is on people with schizophrenia, bipolar disorder and personality disorder. The next big expenditure is on elderly patients, mainly with dementia – who also attract large social care expenditure from local authorities

- However these costs give a very incomplete account of the costs which mental illness imposes on the NHS. Nearly a third of all people with long-term physical conditions have a co-morbid mental health problem like depression or anxiety disorders. These mental health conditions raise the costs of physical healthcare by at least 45%.

- Mental illness accounts for a massive share of the total burden of disease. Yet, despite the existence of cost-effective treatments, it receives only 13% of NHS health expenditure.

[19] Department for Health (2011) *No Health without Mental Health: A Cross Government Mental Health Strategy for People of All Ages*
20 Mental Health Policy Group, Centre for Economic Performance (2012) *How Mental Illness Loses out in the NHS*. London: LSE

The wider costs of mental illness to the government and to society are:

- The loss of output resulting from people being unable to work – or to work to their full capacity. The Centre for Mental Health estimates that mental illness reduces GDP by 4.1% or £52 billion a year.

- Non-employment costs the Exchequer £8 billion in benefits for the 1.3 million people on incapacity benefits. The total non-NHS cost of adult mental illness to the Exchequer may be around £28 billion.

- 30% of all crime is committed by people who had a clinically diagnosable conduct disorder in childhood or adolescence, the estimated cost related to criminal offenses is £20 billion a year.

According to the LSE report quoted, the national programme for Improving Access to Psychological Therapies (IAPT) has shown that the costs of psychological therapy are low and recovery rates are high – in fact sufficient to ensure that, as more people work, the costs of IAPT are more than recovered through savings in reduced benefits and additional taxes. Potential savings related to reduced healthcare costs are also important to the NHS. When the cost-effectiveness of mental health treatment was compared with physical health treatment as measured by cost per quality-adjusted life year (QALY); mental health treatments have been shown to be more cost-effective.

6. Resource constraints

The NHS and local authorities are facing significant financial challenges. Unless there is a change in how services are delivered, there will be a substantial gap in the NHS between the actual funding available and that required to improve the quality of patient care and to respond to demographic changes and other cost pressures.

An estimate in 2010 by The King's Fund[21] put the size of this gap at around £14 billion by 2013/14. If it is to be closed, the NHS will need to improve productivity consistently – doing more each year with the same or similar resources. The mental health sector will be expected to play a key part in responding to the financial challenge.

The requirement to commission the most clinically effective and cost effective services is therefore greatly intensified, for example through imperatives such as Quality Innovation Prevention and Productivity (QIPP) to deliver efficiencies and savings. New developments and existing service models are being scrutinised even more closely to ensure that they are evidence based, clinically effective and provide good value for money. Providers and commissioners must be able to clearly demonstrate that they are making the most effective use of public money to deliver quality care.

[21] Naylor C, Bell A (2010) *Mental Health and the Productivity Challenge*. London: King's Fund

There is also strong evidence that the prevalence of mental health problems can increase during periods of economic recession and high unemployment, putting the NHS and other public services under increasing pressure[22]. Across Europe, from 2006 to 2010 the gap in unemployment rates between individuals with and without mental health problems significantly widened, especially affecting men and individuals with lower levels of education.[23] . Mental health problems are intimately connected with many of the social issues that governments must respond to during times of economic austerity, and in England were estimated to have had economic and social costs of £105 billion in 2009/10, including £30 billion in lost economic output[24]. In this context, it is important to find ways to improve the delivery of mental health services within existing budgets.

The review by the King's Fund[25] suggested that from 2010 the immediate priorities were:

- Improve the assessment process so that service users gain fast access to effective care and that the need for repeat assessments is reduced
- Reconfigure community services and reduce unnecessary use of acute beds by strengthening crisis resolution and home treatment. Develop alternatives to admission and targeting high-risk groups
- Improve discharge and step-down arrangements
- Reduce out-of-area treatment.
- Respond effectively to substance misuse through more integrated treatment
- Improve secure services and reduce length of stay to realise savings.
- Build peer support
- Maximise workforce productivity related to direct care time and deploying specialist skills more effectively.

These priorities represent a continuing challenge and are likely to remain relevant in 2014 and beyond.

7. Key issues in the life course

The life course approach to tackle the unfair distribution of health and length of life was proposed by Sir Michael Marmot[26], since disadvantage starts before birth and accumulates

---

[22]Dorling D (2009) *'Unemployment and health' (*editorial). British Medical Journal, no 338, p b829. Available at: www.bmj.com/content/338/bmj.b829.full (accessed on 24 October 2010)

[23] Evans-Lacko S, Knapp M, McCrone P, Thornicroft G, Mojtabai R (2013) The Mental Health Consequences of the Recession: Economic Hardship and Employment of People with Mental Health Problems in 27 European Countries. PLoS ONE 8(7): e69792. doi:10.1371/journal.pone.0069792

[24]Centre for Mental Health (2010a). *The Economic and Social Costs of Mental Health Problems in 2009/10* London: Centre for Mental Health. Available at: www.centreformentalhealth.org.uk/pdfs/Economic_and_social_costs_2010.pdf

[25] Naylor C, Bell A (2010) *Mental Health and the Productivity Challenge.* London: King's Fund

[26] Marmott, M (2010) *Fair Society, Healthy Lives*

throughout life. Action to reduce health inequalities must start before birth and be followed through the life of the child so that the close links between early disadvantage and poor outcomes throughout life can be broken. Marmott also called for action to improve the lives and health of people who have already reached school, working age and beyond, and services that promote the health, well-being and independence of older people Such services can prevent or delay the need for more intensive or institutional care, and make a significant contribution to ameliorating health inequalities.

7.1 Pregnancy, birth and early years

The foundations of good mental health are laid during pregnancy, infancy and childhood. Abstaining from alcohol, substance misuse and smoking during pregnancy promotes a healthy start in life. Protection from childhood neglect and negative life events promotes mental health. Feeling respected, valued and supported, high quality parenting and a positive relationship with their care-giver promote positive mental health and resilience[27]. Mental health is promoted by holistic preparation for life in preschools and schools by providing social and emotional learning opportunities[28].

Early interventions, particularly with vulnerable children and young people, can improve lifetime health and wellbeing, prevent mental illness and reduce costs incurred by ill health, unemployment and crime.

Prevention of mental disorder in children and young people is thus an important public health measure to avoid the long term serious health and social related consequences and premature death. Both the public health white paper *Healthy Lives, Healthy People* (2010) and the mental health strategy *No Health Without Mental Health* (2011) put early intervention in particular at the heart of improving mental health outcomes for children and families.

7.2 Mental health service transitions for young people

Policy concerns about mental health service transitions for young people are longstanding. Evidence that young people often struggle to move between services, and in particular that they are poorly supported when they are referred by child and adolescent mental health services (CAMHS) to adult mental health services (AMHS), has been highlighted in a number of government reports and policy guidance[29, 30.] This also includes the need for good interagency working and arrangements to facilitate the transition of young people from CAMHS to AMHS[31].

---

[27]Werner EE. (2004) *Journeys from childhood to midlife: risk, resilience, and recovery* Pediatrics, 114:492
[28]Durlak JA, Wells AM. (1997) *Primary prevention mental health programs for children and adolescents: a meta-analytic review* American Journal of Community Psychology, 25:115–152
[29]Department of Health (DH) (2004) *Report on the implementation of Standard 9 of the National Service Framework for Children, Young People and Maternity Services*, London: DH
[30]National Advisory Council for Children's Mental Health and Psychological Wellbeing (2010) *One Year On*, London: DH/DCS
[31] National Mental Health Development Unit - National CAMHS Support Service Planning (March 2011). *Mental health services for young adults – improving transition - A resource for health and social care commissioners*

The move from CAMHS to AMHS is likely to coincide with other transitions during this period such as relationships and friendships, education and training, pregnancy and childbirth, employment, housing and money. This highlights the need for a co-ordinated, multiagency approach to support this critical transition. Adolescence is also the time when new mental health problems such as psychosis or eating disorders may first emerge, or existing difficulties may become more complex or severe.

7.3 Benefit changes for adults of working age

On 8 March 2012 the Welfare Reform Act received Royal Assent. The Act legislates for the biggest change to the welfare system for over 60 years. It introduces from September 2013 a wide range of reforms including the introduction of Universal Credit.

Other key changes to the benefits system:

- Introduces Personal Independence Payments to replace the current Disability Living Allowance
- Restricts Housing Benefit entitlement for social housing tenants whose accommodation is larger than they need
- Up-rates Local Housing Allowance rates by the Consumer Price Index
- Amends the forthcoming statutory child maintenance scheme
- Limits the payment of contributory Employment and Support Allowance to a 12-month period
- Caps the total amount of benefit that can be claimed.

People with mental health problems will be affected by these changes when they need to claim benefits, including difficulties understanding them, access to a computer to claim benefits on-line, and uncertainty about how the changes will affect their circumstances.

7.4 Older people

The national dementia strategy was published in 2009. Its aim was to ensure that significant improvements are made to dementia services across three key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care. The strategy identified 17 key objectives intended to result in significant improvements in the quality of services provided to people with dementia and to promote a greater understanding of the causes and consequences of dementia.

In 2012 the Prime Minister’s challenge on dementia set out renewed ambition to go further and faster, building on progress made through the National Dementia Strategy, so that people with dementia, their carers and families get the services and support they need. Three champion groups were set up to focus on the main areas for action:

- Driving improvements in health and care
- Creating dementia friendly communities
- Improving dementia research.

Housing plays a critical role in helping older people and disabled adults to live as independently as possible, and in helping carers and the wider health and social care system offer support more effectively.

The Care and Support Specialised Housing Fund was announced by the Department of Health in the white paper *Caring for our future: reforming care and support* published in July 2012. The main aim of the fund is to support and accelerate the development of the specialised housing market for older people and adults with disabilities.

8. Local Vision

Changes to the way that health services are commissioned (as introduced by the Health and Social Care Act, 2012) present the Tower Hamlets Partnership with an opportunity to review and develop its approach to promoting positive mental health and providing efficient and clinically effective support and treatment to people with mental health problems.

The Tower Hamlets Shadow Health and Wellbeing Board identified mental health as one of its four priority areas for 2012/13 and beyond. This priority has been carried forward by the Health and Wellbeing Board since it formally came into being on 1 April 2013. Its strategy will take a life course approach, through childhood, the transition to adulthood and on to older age. It will consider the whole spectrum of need within our mental health system: mental health promotion, primary, secondary and tertiary mental health care as well as wider service provision within the social care and the voluntary sector. Its vision is:

Developing a Partnership strategy that promotes emotional and mental health and wellbeing, supports the prevention of mental illness, and supports those with existing mental health problems and their carers.

The strategy will, through an understanding of need in the borough, inform commissioning priorities into the future. The first step in the development of a Tower Hamlets Mental Health Strategy is the development of a Mental Health Joint Strategic Needs Assessment (JSNA). This will consider need across the spectrum, and provide the evidence and information from which to develop local decisions for strategy development.

The objectives of the Mental Health Joint Strategic Needs Assessment are to:

- Understand where there might be areas of unmet need within the mental health system, to provide insight into effective interventions for the Mental Health Partnership's priority areas of focus, to identify gaps and to provide recommendations for the development of the strategy (chapter 9, Recommendations)
- Summarise the national context and local vision (this chapter)
- Describe the demography of Tower Hamlets, and the local social and economic determinants of mental health (chapter 3)
- Set out the risk and protective factors for mental well-being in the borough (chapter 4)

- Provide epidemiological information on the prevalence of mental illness (chapter 5)
- Give a picture of service user, carer and clinical perspective on the current mental health system (chapter 6)
- Understand the financial costs and their distribution within the mental health system in Tower Hamlets (chapter 7)
- Provide a picture of current service provision and utilisation data, considering equality strands (chapter 8)

Chapter 3: Demography and social and-economic determinants of mental health

Chapter summary

Population
Tower Hamlets population (254,100 in 2011) will continue to increase. The main population groups are white British and Bangladeshi origin, with high ethnic diversity.

- The London Borough of Tower Hamlets (LBTH) experienced the highest population growth rate (29.6% from 2001 census) seen across England and Wales
- Population is projected to rise by 8% to 2016, and by 26% to 2023
- Tower Hamlets has a young population in the age band 20 to 34 years compared with London as a whole.
- 7.2% of the total Tower Hamlets population is aged 65 and over, compared to 11.0% for London as a whole.
- People of Bangladeshi ethnic origin (hereinafter Bangladeshi) are the largest single population group (32%) in Tower Hamlets. 31% of the population is classified as white British, which is lower than London (45%) and England (80%).
- The third largest population category white 'other' (14%) has more than doubled in size between 2001 and 2011
- The ethnicity distribution varies substantially across different age groups: the population to age 17 is 57.5% Bangladeshi and 15% white British, whilst the older population (aged 65 plus) is 31% Bangladeshi and 61% white British
- Tower Hamlets has more males than females aged 30 to 54 (an average of 123 to 100) which differs from the England and Wales overall population, which has slightly more female than male in this age band
- Population churn equates to 19% of the population moving in or out of the borough each year.

Deprivation
There are high levels of deprivation in Tower Hamlets which will drive high levels of poor mental health and mental illness. Homelessness is an important local issue.

- High levels of deprivation are strongly linked to poor mental health. Tower Hamlets is the seventh most deprived local authority district in England out of 326 local authority districts, based on the average score of the Indices of Multiple Deprivation (IMD) 2010
- In 2011, over 69% of the residents of Tower Hamlets lived in 20% of the most deprived wards in England.
- Tower Hamlets has the highest rates of child poverty (as defined by the percentage of children living in low income households)
- As of June 2012, 39.5% of the Tower Hamlets working age population (16-64) were classed as unemployed and Tower Hamlets has the second highest rates of long-term unemployment in London. In Tower Hamlets during 2010/11 the rate of working age

adults that were unemployed (per 1,000) was 104.3 which was significantly worse than London (69.9) and England (59.4).

- The 2011 census showed that in Tower Hamlets there were almost 21,000 households with at least one occupant who had a long term health problem or disability. However, as a proportion of total households, the percentage of households in this category was lower than the equivalent figure for London and for England.
- The occupancy rating in relation to habitable rooms shows that Tower Hamlets has the second highest proportion of overcrowded households nationally. 34.8% of all households in the borough were classed as not having a suitable number of rooms for the occupants (35,235 households). The borough had the third highest proportion of households with insufficient bedrooms for the occupants at 16.8%.
- At 14.7% Tower Hamlets has the sixth highest proportion of working age people claiming key out-of-work benefits in London.
- Mental health and behavioural disorders accounted for 45.4% of all Incapacity benefit (IB) / Severe Disablement Allowance (SDA) claims and 44.7% of Employment Support Allowance (ESA) claims. Taken together, this accounted for 44.8% of all claims for a work limiting illness.
- 2011 Census figures based on authority boundaries (inclusive of water bodies) place LBTH as the fourth most densely populated area in England with 128.5 residents per hectare.

Geography

- Deprivation varies within the borough. In the three most deprived wards, East India & Lansbury, Mile End East and Bromley by Bow, most or all of the Lower Super Output Areas (LSOAs) are ranked in the bottom 20% nationally. The three least deprived wards St Katherine's & Wapping, Millwall and Blackwall & Cubitt Town also have the largest polarity of ranks (so that for example, Millwall, includes LSOAs in both the top and bottom 20% of LSOAs nationally).
- There are variances between ethnic makeup in different areas and also in rate of claims for work limiting illness and claims under mental health issues
- According to the 2011 census Tower Hamlets has the fourth highest population density in London (at 128.5 residents per hectare).

Population risk group

- Homelessness is an important issue in Tower Hamlets and the numbers appear to be increasing. The response of mental health services to the needs of homeless people, and to the challenges of partnership working to address those needs, will be important factors in improving mental health and wellbeing for this highly vulnerable group.

1. Population size and characteristics

This chapter summarises the demography of the Tower Hamlets population, highlighting the social and economic characteristics related to mental health. The commissioning process and development of strategy will draw upon the analysis of this information to inform future priorities for investment and service delivery.

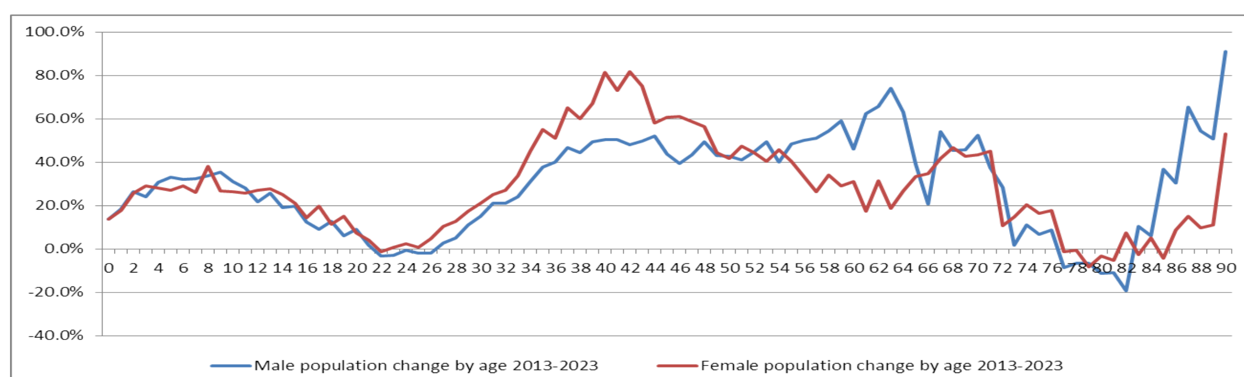
1.1 Overview

Population size and growth: The census estimate for the usually resident population in Tower Hamlets in 2011 was 254,100.

The London Borough of Tower Hamlets (LBTH) has experienced the highest population growth rate (29.6% from 2001 census) seen across all of England and Wales[32].

The population is projected to rise by 8% to 2016, and by 26% to 2023. The following figure shows a projection of expected male and female population change.

Figure 2: Male and female population: projected change (per cent) 2013-23



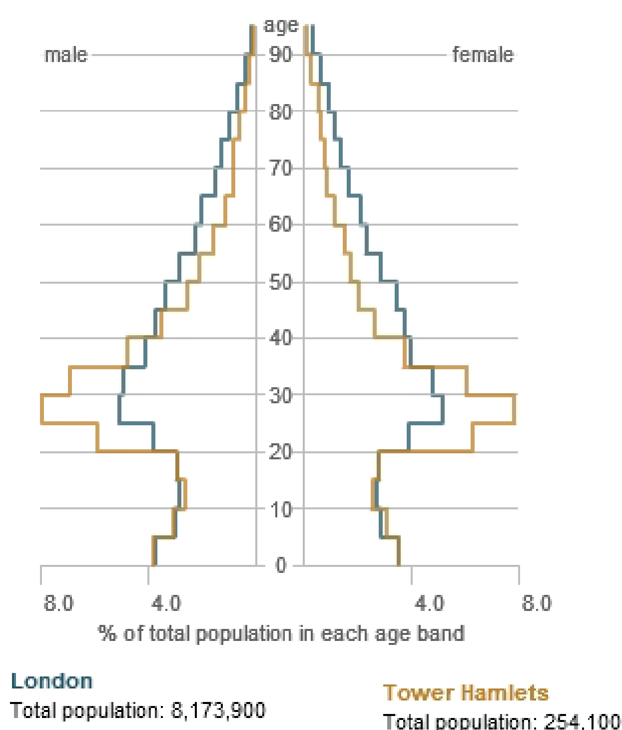
Source: GLA population projections, 2012

The population of Tower Hamlets is expected to grow in the next ten years, and the age groups 0-18, and 30-40 (particularly for women), and 55-60 (particularly for men) will see the highest growth.

Population age structure: Tower Hamlets has a young population. The following diagram shows the population in five year age bands by gender for Tower Hamlets and London.

[32] 2011 Census Results: Headline Analysis Research Briefing 2012-07 (July 2012)

Figure 3: Tower Hamlets population estimates (age profile by gender)



Source: Population estimates for Tower Hamlets and England and Wales, Census 2011

Tower Hamlets has a young population profile compared with London as a whole. Note that this no longer applies to children and young people (ages 0 to 19) but is instead a feature of the age band 20 to 34 (to 39 for males), with a correspondingly smaller than average proportion aged 40 and above compared with the rest of London.

People aged 65 and over make up a relatively small proportion of the Tower Hamlets population in comparison to London as a whole. In 2012 just 7.2% of the total Tower Hamlets population is thought to be aged 65 and over[33] compared to 11.0% for London as a whole.

In general, the inner London boroughs tend to have a younger age profile than those in outer London. For example the proportion of people aged 75 years and over ranges from only 2.9% in Tower Hamlets and 3.0% in Newham up to 8.5% in Bromley and 9.2% in Havering.

1.2 Proportion of residents by ethnicity compared to London and England

Ethnicity: 31% of the population of Tower Hamlets is classified as white British, which is lower than that of London (45%) and England (80%). People of Bangladeshi ethnic origin are the largest single population group, 32%. Tower Hamlets has the largest Bangladeshi community in the country. The following figure shows the ethnic breakdown of the population compared to London and England.

[33] GLA 2011 Round Ethnic Group Projections (2012) - SHLAA Standard Fertility

Figure 4: Ethnic breakdown of Tower Hamlets population (all ages)

Source: Census, 2011

The following table shows the population number and percentage by ethnic group, and the change between the census in 2011 and 2013.

Table 1: Population by ethnic group, 2001 and 2011 compared, Tower Hamlets

	2001 Census		2011 Census		Change between 2001-2011**	
	Number	% total	Number	% total	Number	% change
All residents	196,106	100.0	254,096	100.0	57,990	30
White ethnic groups	100,799	51.4	114,819	45.2	14,020	14
- White British	84,151	42.9	79,231	31.2	-4,920	-6
- Irish	3,823	1.9	3,863	1.5	40	1
- Gypsy or Irish Traveller (*)	n/a	n/a	175	0.1	n/a	
- Other White	12,825	6.5	31,550	12.4	18,725	146
Mixed/multiple ethnic groups	4,873	2.5	10,360	4.1	5,487	113
- White and Black Caribbean	1,568	0.8	2,837	1.1	1,269	81
- White and Black African	789	0.4	1,509	0.6	720	91
- White and Asian	1,348	0.7	2,961	1.2	1,613	120

- Other Mixed	1,168	0.6	3,053	1.2	1,885	161
Asian/Asian British	75,380	38.4	104,501	41.1	29,121	39
- Indian	3,001	1.5	6,787	2.7	3,786	126
- Pakistani	1,486	0.8	2,442	1.0	956	64
- Bangladeshi	65,553	33.4	81,377	32.0	15,824	24
- Chinese	3,573	1.8	8,109	3.2	4,536	127
- Other Asian	1,767	0.9	5,786	2.3	4,019	227
Black ethnic groups	12,742	6.5	18,629	7.3	5,887	46
- African	6,596	3.4	9,495	3.7	2,899	44
- Caribbean	5,225	2.7	5,341	2.1	116	2
- Other Black group	921	0.5	3,793	1.5	2,872	312
Other ethnic groups						
- Arab (*)	n/a	n/a	2,573	1.0	n/a	
- Any other ethnic group	2,312	1.2	3,214	1.3	902	39

Source: 2011 Census (Table KS201); 2001 Census (Table KS06).

This shows that the population groups with the highest numbers of residents are Bangladeshi (31.2%) and white British (32.0%), followed by white 'other' (14%) which has more than doubled in size between 2001 and 2011.

The ethnic profile of Tower Hamlets has changed significantly since the 2001 Census. Because of the overall population growth of 29.2%., some groups that have increased in actual numbers will show a decline as a percentage of the population (i.e. if they have grown by less than 29.2%). This is the case with the Bangladeshi population, which although increasing in size by 24% (to become the single largest ethnic group in the borough), has decreased as a proportion of residents from 33.4% in 2001 to 32% in 2011 (81,377 residents).

There have been significant increases in the number and proportions of some smaller groups in the borough, with the largest growth seen in the 'Other White' category. This group more than doubled in size between 2001 and 2011 from 12,825 residents to 31,550 (growth of 146%) and now accounts for 12.4% of residents in Tower Hamlets.

Other ethnic groups which saw significant growth included Chinese, which grew by 4,536 residents (127% growth) and now account for 3.2% of the population, and the 'Other Asian' category which grew by 227% (4,019 additional residents) to account for 2.3% of LBTH residents.

The only ethnic group to have shown a decline since 2001 is the white British group which has reduced in absolute numbers by almost 5,000 residents (a 6% fall), and has reduced as a proportion of the population from 43% in 2001 to 31% in 2011 (79,231 residents).

The Somali population, although not separately identified in census or GLA data, has been recently estimated to be between 2.3%[34] and 3%[35].

Ethnicity and age: the census data on the ethnicity break down by age bands is shown in the following table.

Table 2: Proportion of population by ethnic group and age.

Ethnic Group	**0 to 17**	**18 to 64**	**65 and over**	**All ages**
White	15.1%	35.7%	60.7%	32.8%
Other white	3.6%	15.8%	3.8%	12.4%
Mixed/multiple ethnic group	7.4%	3.3%	1.2%	4.1%
Asian/Asian British (excluding Bangladeshi)	5.1%	10.8%	4.0%	9.1%
Bangladeshi	57.5%	25.3%	21.3%	32.0%
Black/African/Caribbean/Black British	9.5%	6.6%	8.0%	7.3%
Other ethnic group	1.9%	2.5%	1.0%	2.3%
All categories: Ethnic group	**100%**	**100%**	**100%**	**100%**

Source: Tower Hamlets Council Corporate Research Unit from 2011 census. Note that the definition of white population here includes Irish and traveller groups as well as white British

The ethnicity distribution varies substantially across different age groups. In Tower Hamlets:

- The population for children and young people (to age 17) is 57.5% Bangladeshi and 15% white British
- The older population (aged 65 plus) is 31% Bangladeshi and 61% white British
- Of the smaller ethnic groups, 'Mixed and Black' have a higher proportion under 18 than in the 18 to 64 group (i.e. are younger), whereas the 'Other White' and 'Other Asian' have a higher proportion in the 18 to 64 age group.

The proportions of the Bangladeshi population using older people's services and CAMHS will therefore be markedly different, if they reflect the population.

1.3 Population inflow and outflow

Analysis conducted at London level suggests a population churn (combined inflow and outflow) in Tower Hamlets of 189 per 1,000 residents, equating to nearly 19% of the population. If movement within the Borough is added, this equates to 24% of the population (the 11th highest population movement of the 33 Boroughs[36]).

---

[34] NKM Population count, 2009 (Whilst the NKM data is an accurate method of counting the population, 13% of the population in this dataset do not have an identified ethnicity)

[35] Tower Hamlets Health and Lifestyle Survey, 2009 (note this survey was for adults)

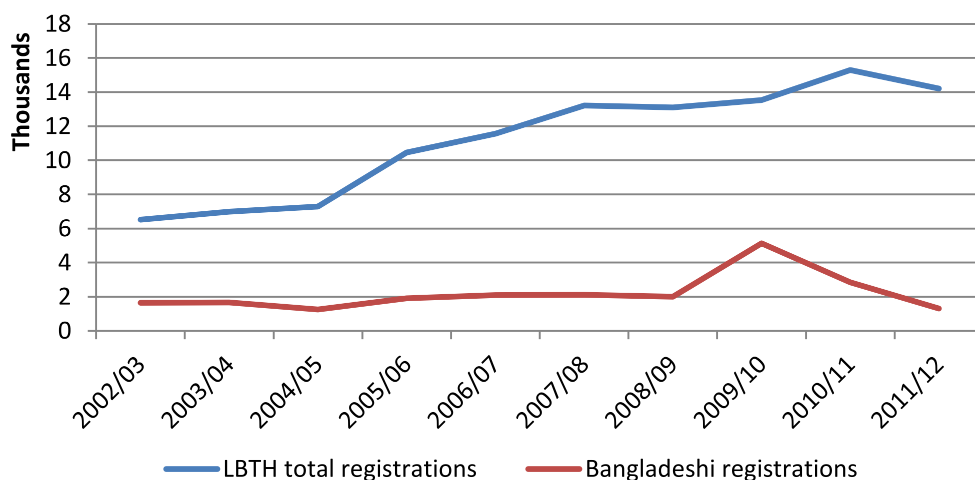
[36] JSNA Factsheet: Population 2011, Tower Hamlets Public Health **[NB the source does not include a date]**

Data on new national insurance registrations to non-UK born residents from the DWP is an indicator of the initial destination of economic migrants once within the UK. (These figures, however, will only relate to migrants who register and captures only their initial arrival point. Domestic migration once registered is not shown.)

In the financial year 2011/12, Tower Hamlets had the third highest number of new national insurance registrations to non-UK born residents of all local authorities in England and Wales. At 14,200 new registrations, the figure for LBTH was lower only than Brent, (which had 15,170 registrations) and Newham (with 20,480).

Figure 4 shows the increase in registrations and the declining proportion of registrations to Bangladeshi nationals, reflecting increasing levels of economic migration from a wider variety of countries. (These figures, as stated, will only relate to migrants who register and captures only their initial arrival point. Domestic migration once registered is not shown and also those entering the country as asylum seekers, or those with 'no recourse to public funds' status.)

Figure 5: New National Insurance Registrations to Non-UK Nationals



Source: DWP

Registrations in Tower Hamlets have been increasing over the last 10 years. Bangladeshi nationals have accounted for 19.6% of all new registrations in the borough over this period. However, more recently the picture has been changing, and in 2011/12 the greatest numbers of new registrations were to Italian (1,790 or 12.6%) and Spanish (1,730 or 12.2%) nationals. This compares with Bangladeshi nationals who accounted for 1,310 (9.2%) of all registrations in 2011/12.

When asked the main reasons for being in Tower Hamlets in a local study, new migrants cited: long term aims to live with or be near friends and family, to be near work and cheaper accommodation.

Many migrants experience barriers to accessing healthcare services. This may be due to failure to understand what services are available and how to use them, confusion around entitlement to NHS care, and language and cultural barriers. This can lead to both failure in seeking care and treatment appropriately or at all.

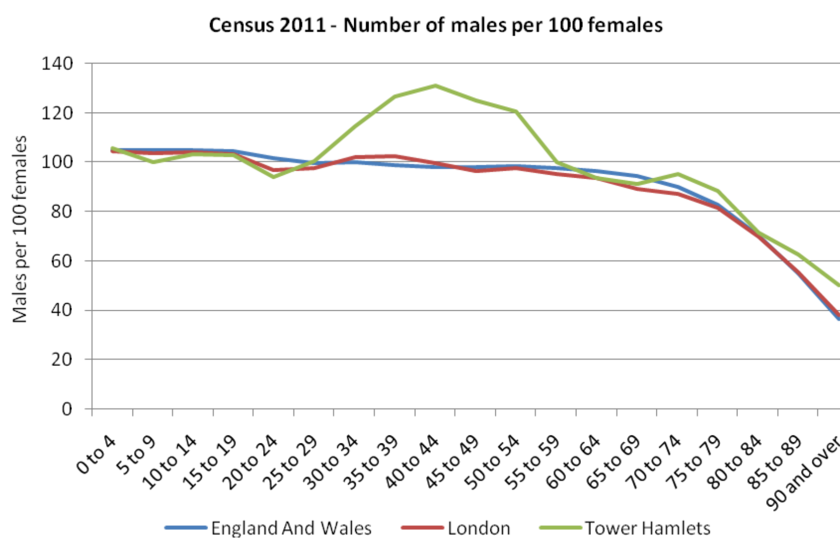
As a result of the recent reforms in welfare, London might expect to see significant migration within and between different boroughs as more areas become unaffordable – including the likely polarisation of disadvantage – and/or an increase in homelessness, repossessions and overcrowding. This may have wider impacts on services provision, community cohesion and physical and mental health, plus a worsening of a range of social and health conditions and widening inequalities[37].

Mental health service monitoring shows that a high proportion (84%)of those on the Care Programme Approach (who have the most complex needs of those using secondary mental health services) live in settled accommodation. There is no clear explanation why this should be the case, given the high population movement in the borough. It may be an issue of data recording, or it may indicate that the transient population do not have the most severe mental health needs, or do not remain in contact with services long enough for their needs to be established.

1.4 Proportion of men and women in the population

Tower Hamlets diverges from the national and London averages for the population aged 30 to 54. In this age group there was an average of 123 males per 100 females which differed markedly from the national and London figures, as shown in the following figure.

Figure 6: Number of males per 100 females (Tower Hamlets, London and England by age band)



[37]Bloomer E, Allen J, Donkin A (2012) *The impact of the economic downturn and policy changes on health inequalities in London* UCL Institute of Health Equity

Source: 2011 Census Results: Headline Analysis Research Briefing 2012-07 (July 2012)

In the 40-44 age range there are 132 males for every 100 females. In the older age groups (over 65) the borough followed the national and London trends in having more women than men (with women outnumbering men by 2:1 for those aged 90+ compared with 2.6 to 1 for London), reflecting gender differences in average life expectancy.

2. Deprivation and socio-economic factors

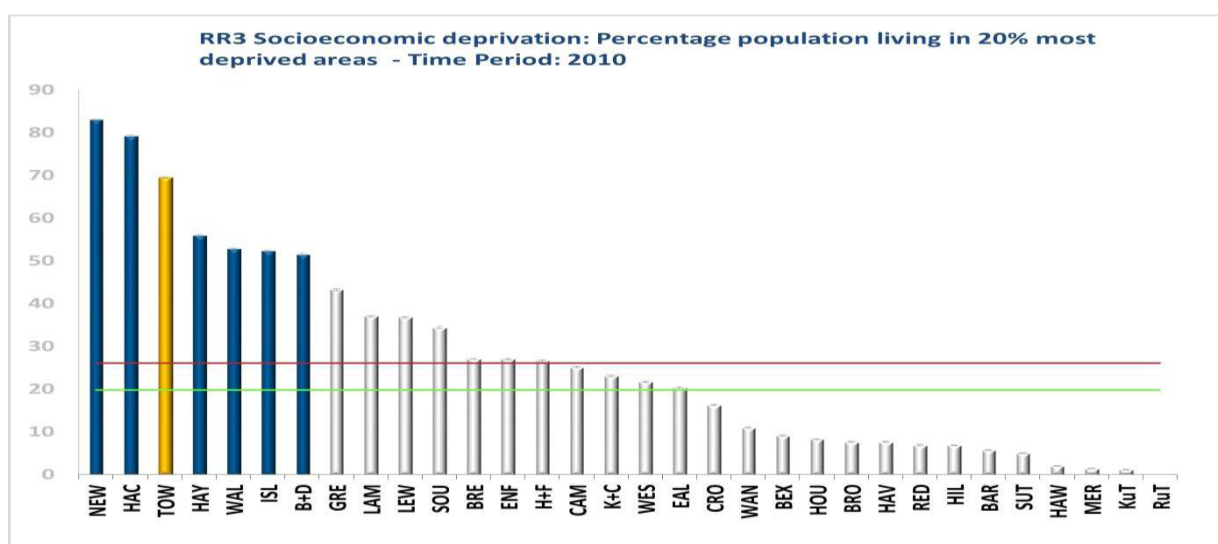
Material deprivation resulting from unemployment or low-paid work, and feelings of unfair pay (such as high levels of wage disparities within organisations) contribute to physical and mental ill health [38.] Tower Hamlets is the seventh most deprived local authority district in England out of 326 local authority districts, based on the average score of the Indices of Multiple Deprivation (IMD) 2010. There are high levels of deprivation in Tower Hamlets which will drive high levels of poor mental health and mental illness.

2.1 Indices of Multiple Deprivation (IMD), 2010

These indices identify areas with substantial levels of multiple deprivation, and can measure and identify health inequalities across England. Any increase in inequalities in deprivation is likely to result in widening inequalities in mental and physical health.

Deprivation is widespread in Tower Hamlets and the majority (72%) of Lower Super Output Areas (LSOAs) in the borough are in the most deprived 20% of all LSOAs nationally on the IMD. The following figure shows the percentage of the population living in the most deprived areas.

Figure 7: Percentage of population living in 20% most deprived areas, London, 2010



[38] Marmot M. et al (2012) WHO European review of social determinants of health and the health divide. *Lancet*; 380: 1011–29.

Tower Hamlets ranks third in London. The other boroughs highlighted are those forming the cluster of boroughs with similar needs to Tower Hamlets. .

The wards with the lowest median rankings (more deprived) are East India & Lansbury, Mile End East and Bromley by Bow. In these wards, most or all of the LSOAs are ranked in the bottom 20% nationally. At the other end of the scale, the three wards with the highest median LSOA rankings (less deprived) are St Katherine's and Wapping, Millwall and Blackwall & Cubitt Town. More information in the geographical distribution of deprivation within the borough is given in section 2.7.

It is important to highlight that the causal pathway may work both ways. Deprivation describes high levels of many risk factors for poor mental health, including unemployment, poverty and poor education. Conversely, people with mental health problems are less likely to be employed, for example, and therefore might only be able to afford to live in an area of deprivation[39].

2.2 Child Poverty

The connections between childhood poverty and mental health have been recognised for a number of years[40] and include

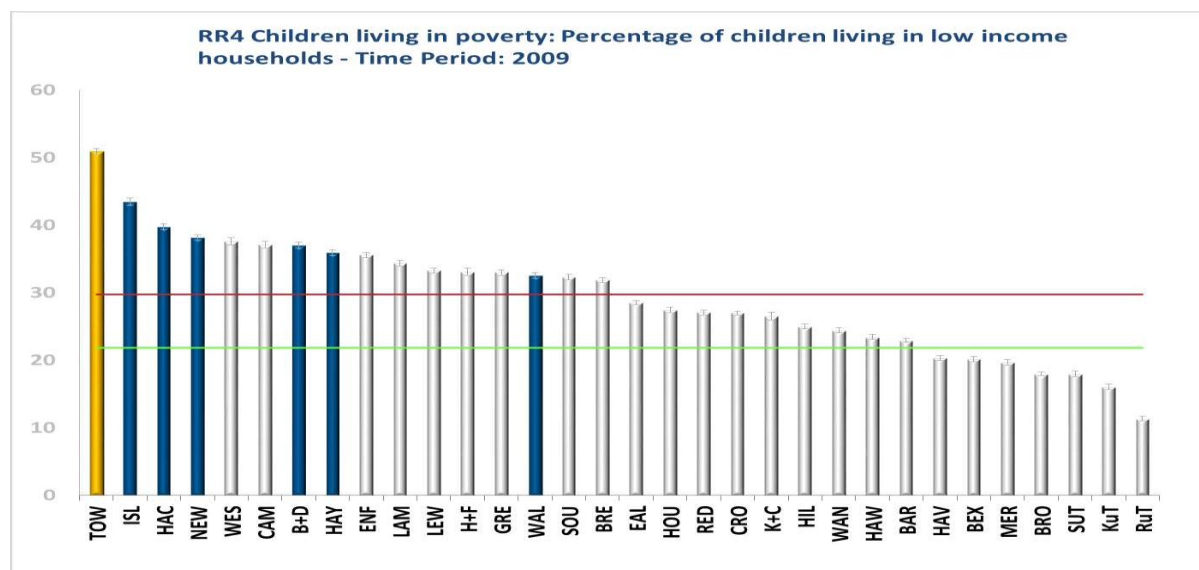
- Children in the poorest households are three times more likely to have a mental illness than children in the best-off households
- Conduct disorder is three to four times more common in children who live in socio-economically deprived families with low income
- Conduct disorder and attention-deficit hyperactivity disorder (ADHD) show links with family poverty, and this is most marked for children in families facing persistent economic stress. The relationship between poverty and childhood disorder appears to be more marked for boys than for girls, and seems to be stronger in childhood than in adolescence.

[39] Tower Hamlets Whole Systems Review, 2010

[40] Murali V and Oyebode F (2004) *Poverty, social inequality and mental health*. Advances in Psychiatric Treatment 10: 216-224 doi: 10.1192/apt.10.3.216

The following figure shows the proportion of children living in poverty in London Boroughs.

Figure 8: Children living in poverty: percentage of children living in low income households[41]



Source: NHS London Mental health tool indicator (RR4)

Tower Hamlets has the highest proportion of children living in low income households in London.

2.3 Unemployment

In Tower Hamlets during 2010/11 the rate of working age adults that were unemployed was 104.3 per 1,000. This is significantly worse than London (69.9) and England (59.4). In 2009/10 the Tower Hamlets figure was 101.20 which was significantly worse than London (71.06) and England averages (64.24)[42]. Interestingly, as the London and England rate improved, the Tower Hamlets rate fell. As of June 2012, 39.5% of the Tower Hamlets working age population (16-64) were classed as unemployed by the London Skills and Employment Observatory.

Unemployed individuals, particularly the long-term unemployed, have a higher risk of poor physical and mental health compared with those in employment, and unemployment is associated with unhealthy behaviours such as increased smoking, alcohol consumption and decreased physical activity. The health and social effects resulting from a long period of unemployment can last for years. Those more vulnerable to unemployment generally may

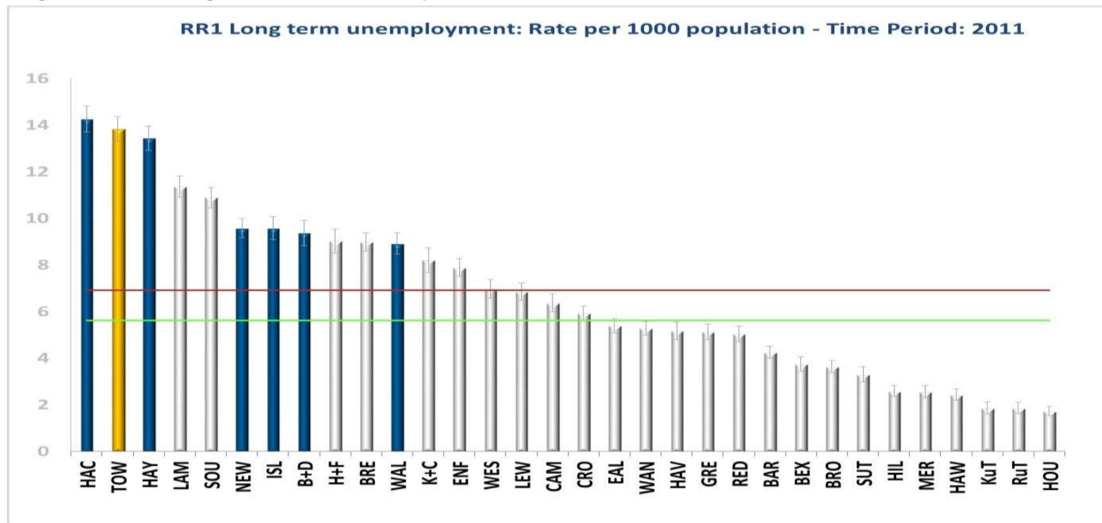
[41] The proportion of children living in families in receipt of out of work benefits or in receipt of tax credits where their reported income is less than 60 per cent of median income. Growing up in poverty affects children's health and well-being and evidence links adverse childhood circumstances to future adult health

[42] Department for Work and Pensions, 2006 www.dwp.gov.uk/docs/hwwb-is-work-good-for-you.pdf (ONS data)

be at greater risk, including people with fewer skills, lone parents, those with mental health problems and chronically ill or disabled people[43].

Tower Hamlets has the second highest rates of long term unemployed in London, as shown in the following figure.

Figure 9: Long term unemployment rate per 1,000 population, 2011[44]



Source: NOMIS http://www.nomisweb.co.uk/ NHS London Mental health tool indicator RR1)

There are high levels of unemployment and poor living conditions in Tower Hamlets. Consequently, there is an increased risk of both developing and also exacerbating existing mental health problems.

2.4 Physical health and disability

There is a sound body of evidence that suggests that the presence of limiting long term conditions and/or an inability to partake in physical activity can be risk factors for mental health problems[45]. For older people, it is recognised that a reduction in physical mobility can exacerbate this risk. Poor quality of life through physical illness is known to be closely related to mental health problems.

The 2011 census showed that in Tower Hamlets there were almost 21,000 households with at least one occupant who had a long term health problem or disability. However, as a

[43]Bloomer E, Allen J, Donkin A (2012) *The impact of the economic downturn and policy changes on health inequalities in London* UCL Institute of Health Equity
[44]This is the number of people claiming jobseekers allowance for over 12 months, expressed as a crude rate per 1,000 population

[45] Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M, Galea A. (2012) *Long-term conditions and mental health. The cost of comorbidities*, London: The Kings Fund and Centre for Mental Health.

proportion of total households, the percentage of households in Tower Hamlets in this category (20.6%) was lower than that for London (22.4%) and England (25.7%).

The census also included questions on the degree to which long term health problems and/or disability limited an individual's day to day activities and how they rated their own health. Tower Hamlets had a proportion of residents similar to that for London who stated that their day to day activities were 'limited a lot'. However this was however significantly below the figure for England. The proportion of those whose day to day activities were 'limited a little' was below that of both comparators. (Further information is given in the Appendix to this chapter.)

The Tower Hamlets Health and Lifestyle Survey conducted in 2009[46] highlighted the significantly higher prevalence of behavioural risk factors for poor physical health in people with worse mental health e.g. higher smoking, poorer diet and lower physical activity. Regular physical activity is also associated with a reduced risk of many conditions and improved mental health. In older adults physical activity is associated with increased functional capacities.

2.5 Housing

Good housing is crucial for good mental health and primary and secondary prevention of mental illness. People with mental health problems are far less likely to be homeowners and far more likely to live in unstable environments[47].

Ensuring service users have a suitable and settled place to live can aid recovery from mental health problems. When it is part of an effective recovery pathway, housing provides the basis for individuals to build a more independent life, in many cases returning to work or education, whilst still receiving the support and help they need[48]. Support with housing can improve the health of individuals and help reduce overall demand for health and social care services[49].

The 2011 census provides derived statistics on the *extent* of overcrowding in the borough (households that the Office of National Statistics (ONS) has classified as having an occupancy rating of -1 or less in relation to either rooms or bedrooms). It does not describe the *degree* to which households are overcrowded.

The following figure refers to households that the Office of National Statistics (ONS) has classified as having an occupancy rating of -1 or less in relation to either rooms or bedrooms, which implies that they have at least one room or bedroom fewer than required for the occupants of the household.

---

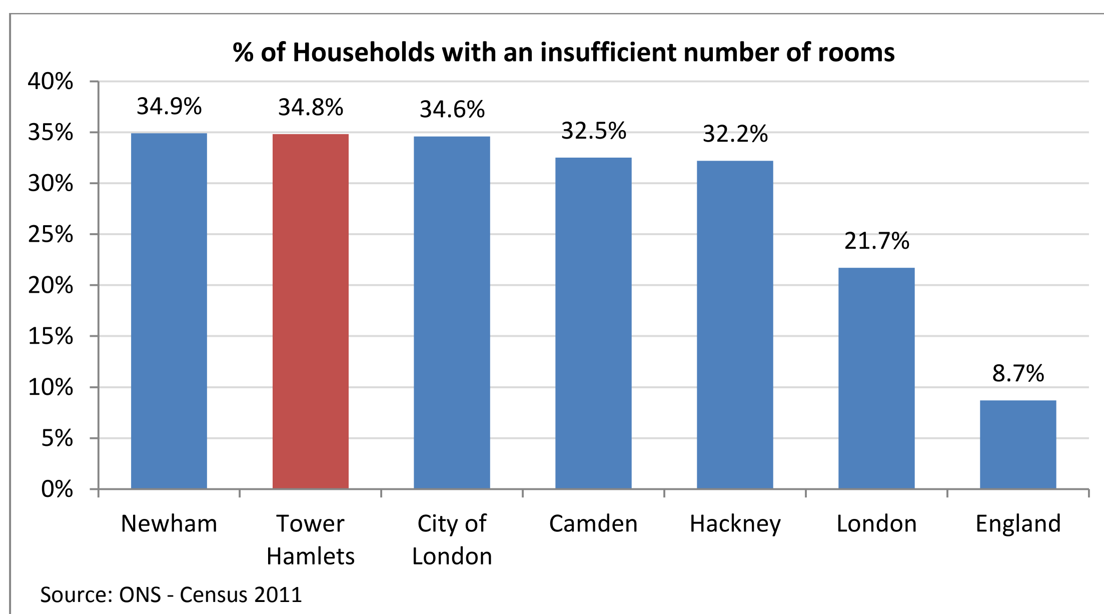
[46] Tower Hamlets Health and Lifestyle Survey, 2009

[47] Johnson R, Griffiths C, Nottingham T (2006) *At home? Mental health issues arising in social housing* National Institute for Mental Health in England

[48] http://www.nhsconfed.org/Publications/Documents/Housing_MH_021211.pdf

[49] Bolton J (2009) *The use of resources in adult social care: a guide for local authorities* Department of Health

Figure 10: Percentage of households with an insufficient number of rooms



Source: ONS - Census 2011

On the occupancy rating in relation to habitable rooms, Tower Hamlets has the second highest proportion of overcrowded households nationally. 34.8% of all households in the borough were classed as not having a suitable number of rooms for the occupants (35,235 households), which was significantly above the London figure and second only to Newham.

For the occupancy rating in relation to bedrooms, Tower Hamlets had the third highest proportion of households with insufficient bedrooms for the occupants at 16.8%. This equates to 16,964 households in the borough.

Further figures are given in the Appendix to this chapter.

2.6 Out of work benefits

For all out of work benefit claims (including Job Seekers Allowance and other out of work benefits), Tower Hamlets had the sixth highest rate within London at 14.7% of the working age population (February 2012). The London average was 12% and the rates for individual boroughs in London ranged from 5.3% to 17.7%. The England average was 12%. For Tower Hamlets, London and England the rates increased from 2008-2010 inclusive, dropped in 2011 and slightly increased again in 2012

As highlighted earlier in the chapter, changes in the economic climate and welfare reforms are likely to have detrimental impacts on the mental health and wellbeing of residents in Tower Hamlets, by increasing risk factors and potentially weakening key protective factors.

As of February 2012, there were 12,335 benefit claims for work limiting illness in Tower Hamlets (57.8 per 1,000 working age residents). This compares with averages for work limiting illness claims of 51.06 per 1,000 in London and 56.35 in England. Of these, in Tower Hamlets, 5,530 claims were for mental illness (25.99 per 1,000 working age residents). This compares with the for London average for mental health claims of 22.95 per 1,000 and the England average of 24.41.

Mental health issues and behavioural disorders accounted for 45.4% of all IB[50]/SDA[51] claims and 44.7% of ESA claims. Taken together, this accounted for 44.8% of all claims for a work limiting illness.

(Further information is given in the Appendix to this JSNA.)

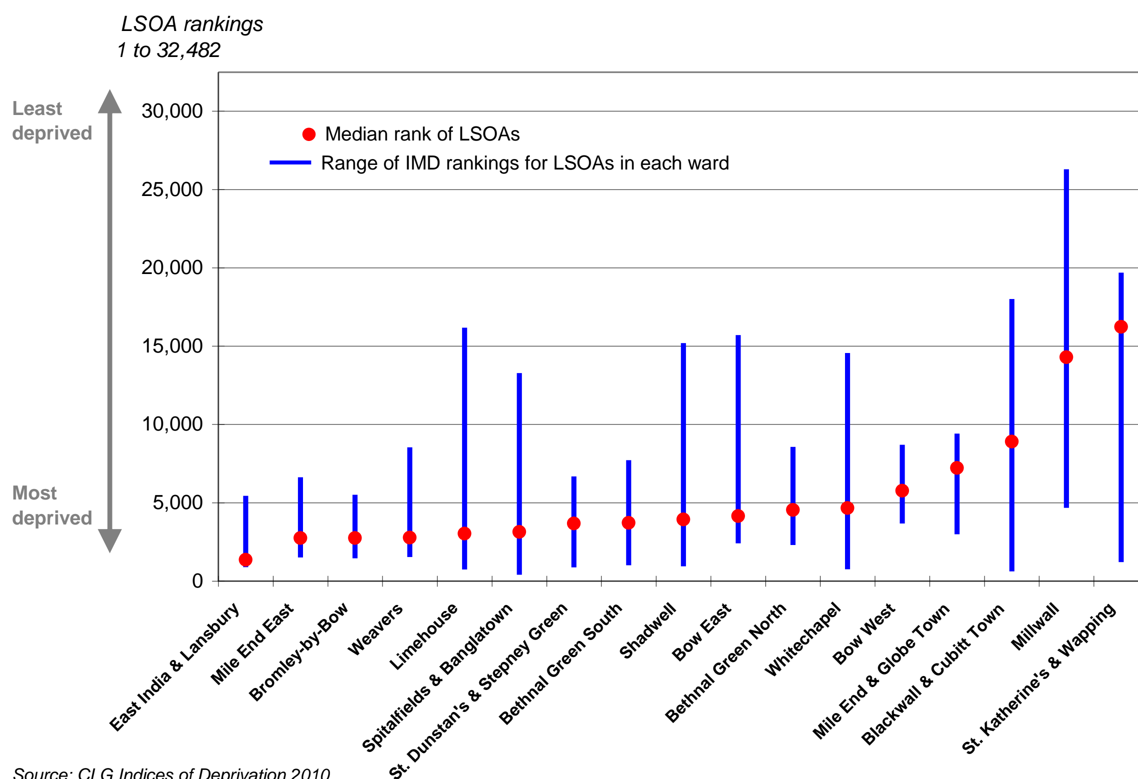
2.7 Geographic difference in socio-economic indicators

GP practices in the borough are divided into with networks which are coterminous with four localities. These networks correspond with current ward boundaries although this is likely to change with the implementation of Boundary commission recommendations.

Deprivation

While the IMD is produced at Lower Layer Super Output Area (LSOA) level, it is possible to produce some basic ward level analysis by comparing the deprivation rankings for LSOAs within each ward. Tower Hamlets has 17 wards, and there are between five and nine LSOAs in each ward[52]. Figure 1 below shows the range of LSOA rankings within each ward. The wards are ranked from lowest to highest on the basis of the median LSOA rank[53].

Figure 11: Rank of LSOAs in Tower Hamlets Wards, 2010



Source: Department for Communities and Local Government, 2010

---

[50]Incapacity benefit

[51]Severe Disablement Allowance

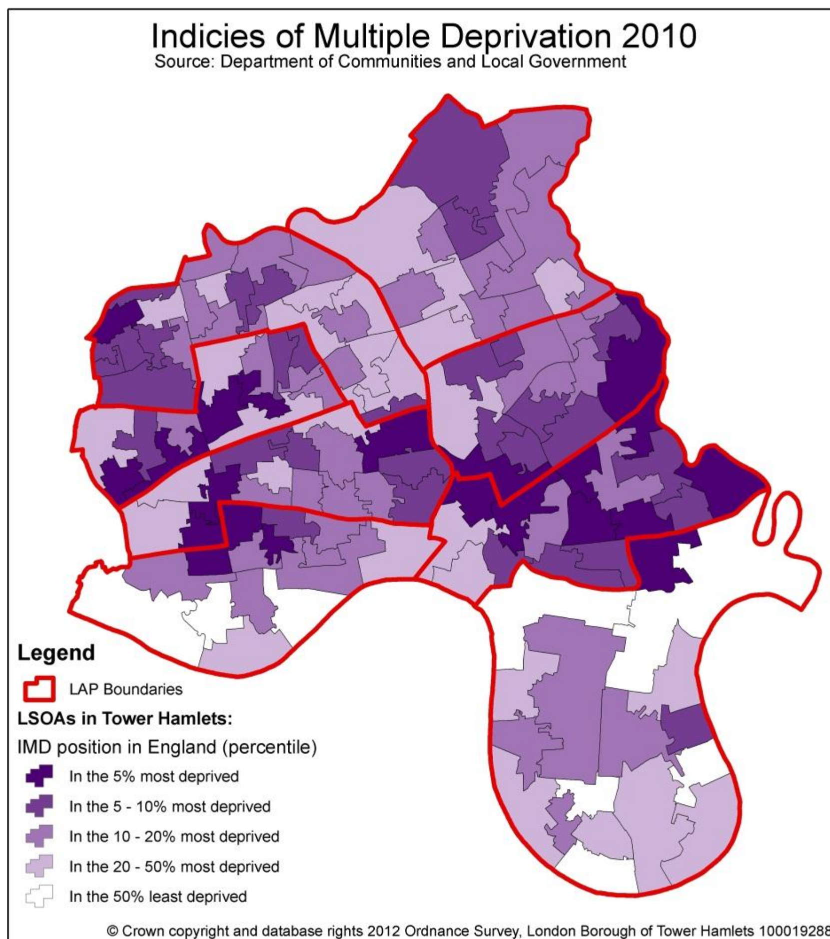
[52]The analysis does not take account of the difference in population size between LSOAs in the borough, so only provides indicative data on ward level deprivation

[53] That is the 'middle' LSOA with half the LSOAs ranked above and below

The wards with the lowest median rankings (more deprived) are East India & Lansbury, Mile End East and Bromley by Bow. In these wards, most or all of the LSOAs are ranked in the bottom 20% nationally. At the other end of the scale, the three wards with the highest median LSOA rankings (less deprived) are St Katherine's & Wapping, Millwall and Blackwall & Cubitt Town. These three wards also have the largest polarity of ranks. For example, in Millwall, where there are 9 LSOAs, the rankings range from 4,678 up to 26,281, so this area includes LSOAs in both the top and bottom 20% of LSOAs nationally.

The following figure presents the data differently (in quintiles) on a map of Tower Hamlets.

Figure 12: IMD 2010 at LSOA level with former LAP[54] boundaries

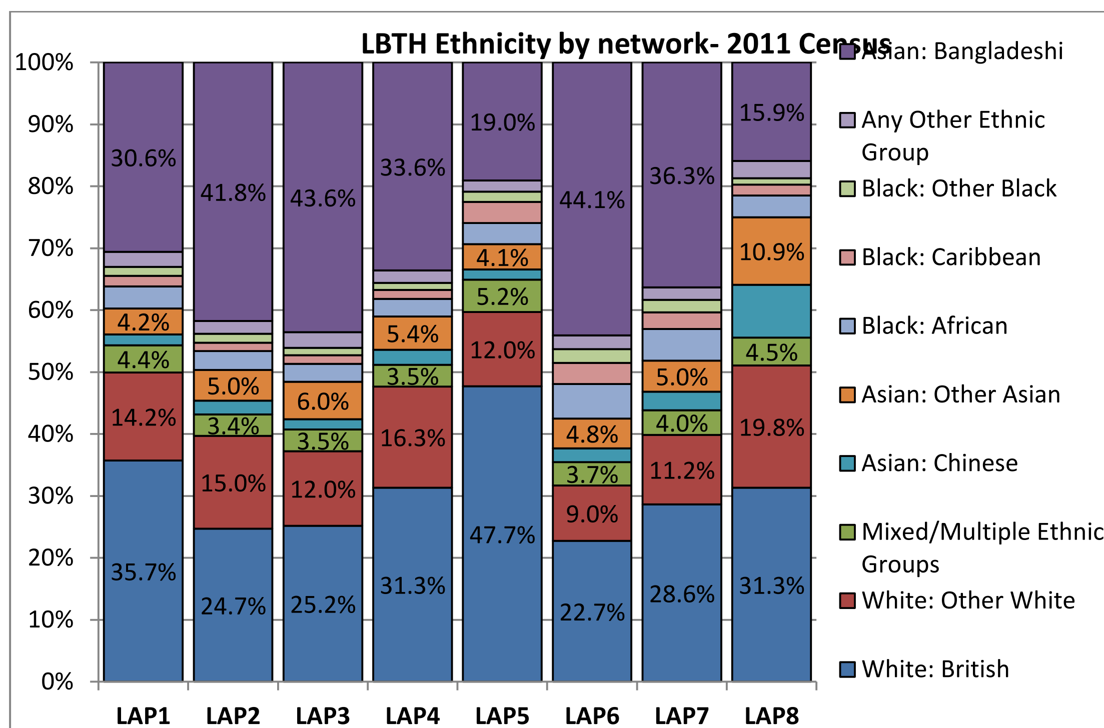


Ethnicity

The following figure shows the percentage of the main ethnic groups in the different parts of Tower Hamlets, at the 2011 census. Please note that these geographical areas broadly correspond to GP networks in the borough, but that the term LAP is no longer used.

[54]For LAP areas covered see Appendix B

Figure 13: Total Tower Hamlets population (all ages): Distribution of ethnicity by network



Source: Census, 2011. The eight GP networks correspond to the former Local Area Partnerships (LAPs) which were still in existence at the time the chart was prepared

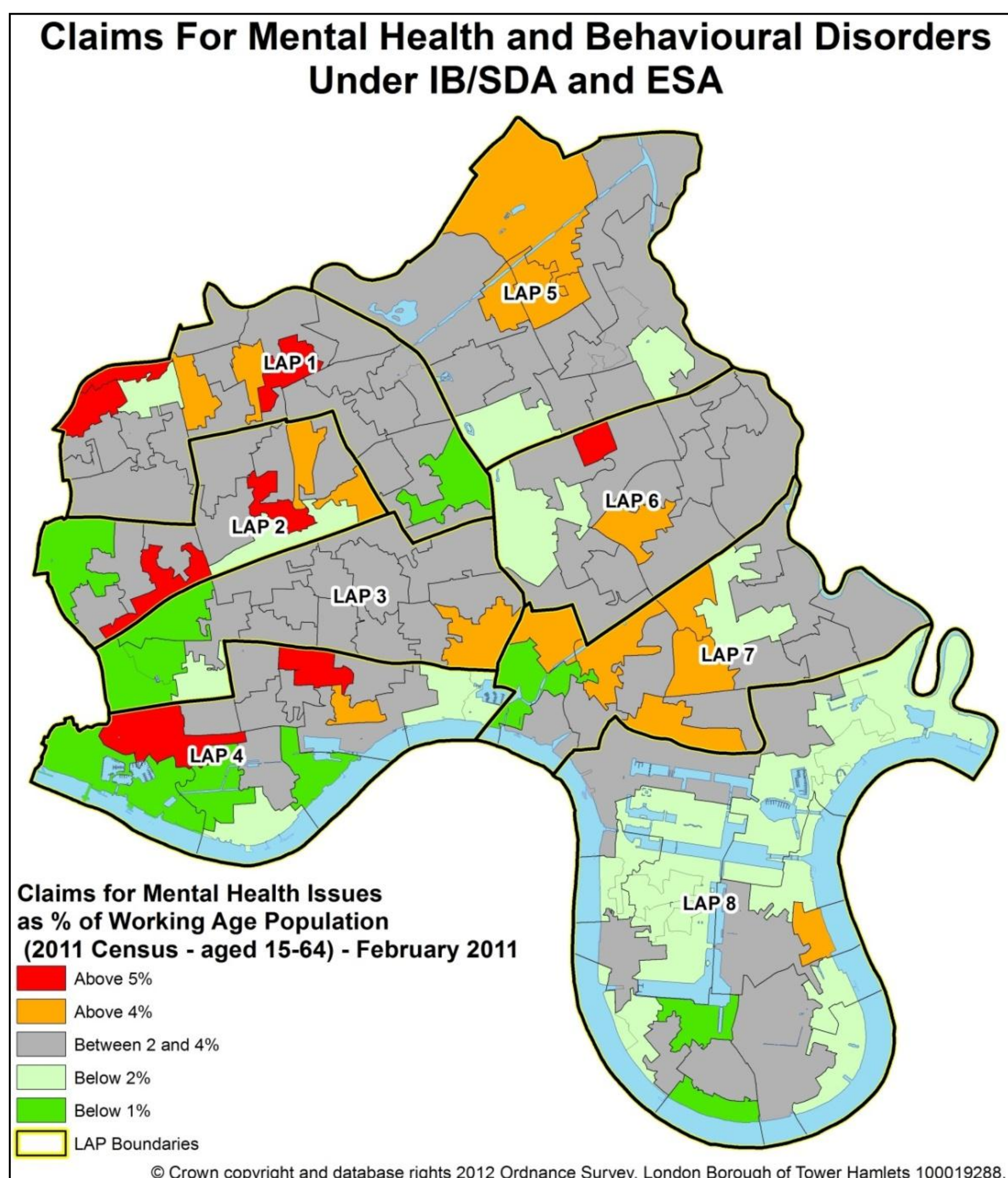
This shows that there are variances between ethnic makeup in different areas, with networks 1 and 5 (in the north of the borough – respectively Weavers, Bethnal Green North, Mile End and Globe Town; Bow West and East) having the largest numbers of White British, and networks 3 and 6 (in the centre of the borough – respectively, Whitechapel, St Dunstan's and Stepney Green; Mile End East, Bromley by Bow) having the largest numbers of Bangladeshi residents. Network 8 (Millwall, Blackwall and Cubitt Town) has the largest number of White other and Asian other population groups.

Geographic distribution of mental health related claims

The maps below shows the distribution of benefit claims for work limiting illness (for mental health and behavioural disorders) by census output area[55]. It also shows the former LAP boundaries (in GP terms now similar to networks).

[55]In each area, the DWP counts of claimants in February 2011 are shown as a percentage of the working age population[55] taken from the (March) 2011 Census

Figure 14: IB/SDA and ESA claims under mental health and behavioural disorders



The networks located in the north and east of the borough all have rates of claims for mental health issues which are above 3% of the working age population and also above the borough wide average of 2.8%.

Network (Limehouse, East India, Lansbury) has the highest rate of claims for a work limiting illness at 8.1% of the working age population, and also one of the highest rates of claims under mental health issues at 3.3% of working age residents. Network 2 (Spitalfields and Banglatown, Bethnal Green South) also has rate of claims for mental health issues of 3.3% of the working age population, but a lower rate of 7% for claims of work limiting illness.

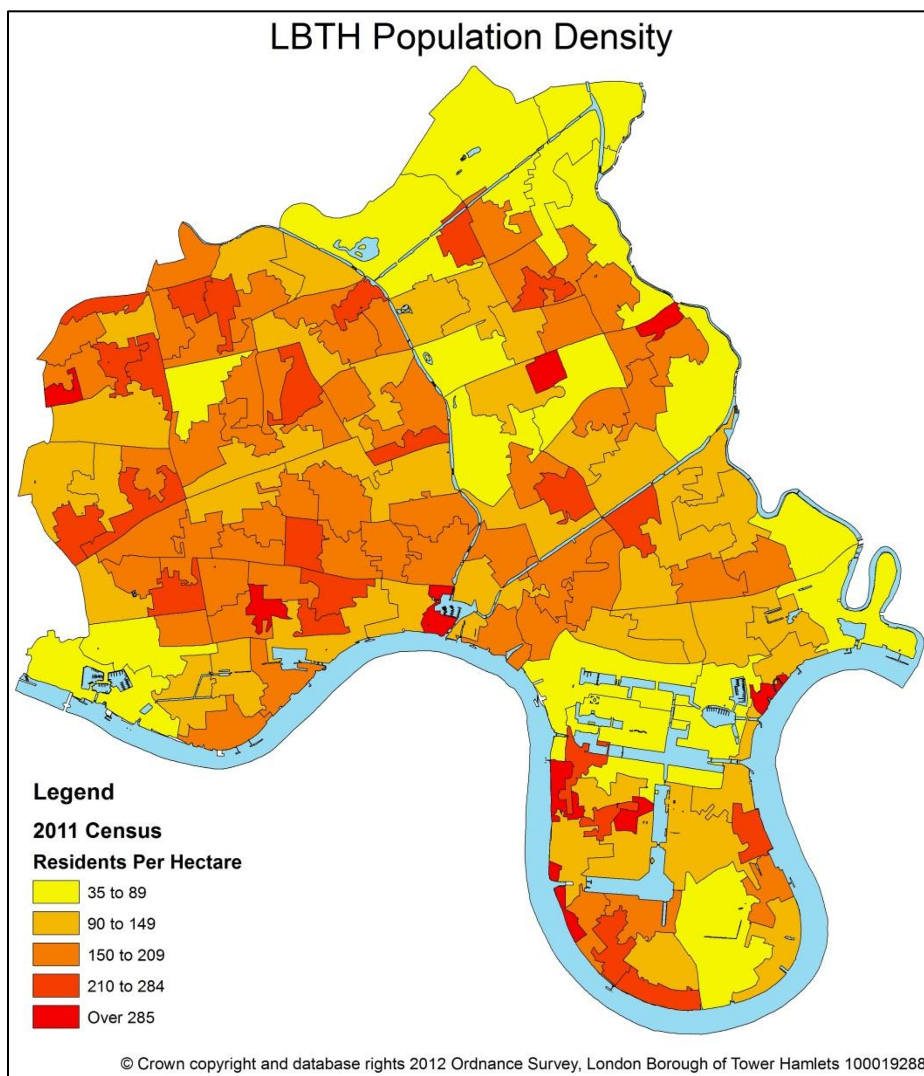
Networks 3, 4 and 8 (which are in the south or west of the borough - respectively Whitechapel, St Duncan's and Stepney Green; St Katherine's and Wapping, Shadwell; Millwall, Blackwall and Cubitt Town) all have rates of claims for mental health issues which are under 2.6% of working age residents (compared to the 2.8% borough average). Network

8 also has the lowest proportion of work limiting illness claims in the borough at 3.9% of working age residents and the lowest proportion of mental health claims at 1.8%.

Population density

According to the 2011 census Tower Hamlets has the fourth highest population density in London (at 128.5 residents per hectare behind Islington – the highest at 138.7 – Kensington and Chelsea and Hackney**).** The map below shows residents per hectare calculated using landmass only, excluding bodies of water and the part of the river Thames within the borough boundary.

Figure 15: Population density in Tower Hamlets, 2011



This map shows the areas of high density in the borough but does not distinguish between executive flats on the river Thames and other areas of high density with older blocks of flats in council estates.

Summary

Tower Hamlets like many London boroughs has areas of polarity, with high and low deprivation close together. Population density is not always related to deprivation. The whole borough is characterised by ethnic diversity but there are differences between the networks shown. The 2009 older people's needs assessment stated that Network 5 (Bow) has the highest concentration of older people whilst network 1 (Weavers, Bethnal Green North, Mile End and Globe Town) had the highest number.

Each neighbourhood may have distinct needs. Information on local areas can help commissioners plan for improved access and stronger community engagement, and help monitor delivery of services.

2.8 Homelessness, hostels and mental health

The socio-economic indicators described above are appropriate to every local authority area. However, homelessness is a significant aspect of local mental health need in Tower Hamlets, and has historically been an issue in the borough. It is therefore covered in this separate section.

Homelessness is associated with severe poverty and is a social determinant of health and mental health. Homeless populations are a vulnerable 'marker' group in several respects; they have poorer physical and mental health status making it imperative to ensure that integration between housing and other services is made, including mental health and substance misuse services. Tower Hamlets rates (5.77) are significantly worse than England (2.03) when looking at statutory homeless households per 1,000 population[56]. This indicator highlights a group that are amongst the most vulnerable in society.

As of 31st March 2012 there were 1,796 households in LBTH accommodated under the homeless provisions of the Housing Acts, a rate of 19.31 households per 1,000[57]. Of this figure, 404 were newly assessed cases in 2010/11 (on flow) and deemed to be unintentionally homeless and in priority need (a rate of 4.37 households per 1,000)[58]. Very limited statistics on rough sleepers are collected by the Department for Communities and Local Government and a snapshot captured on a single night in the autumn of 2011 found 9 rough sleepers in the borough[59]. However, a report produced by the Combined Homeless and Information Network (CHAIN) found that there had been 394 rough sleepers in the borough in 2011/12[60]. This was an increase from the 354 found in 2010/11, and was a

---

[56] APHO, Health Profiles, Indicator Guide, 2011.
www.apho.org.uk/resource/view.aspx?RID=105702

[57] Department for Communities and Local government - Rough Sleeping Statistics England 2011

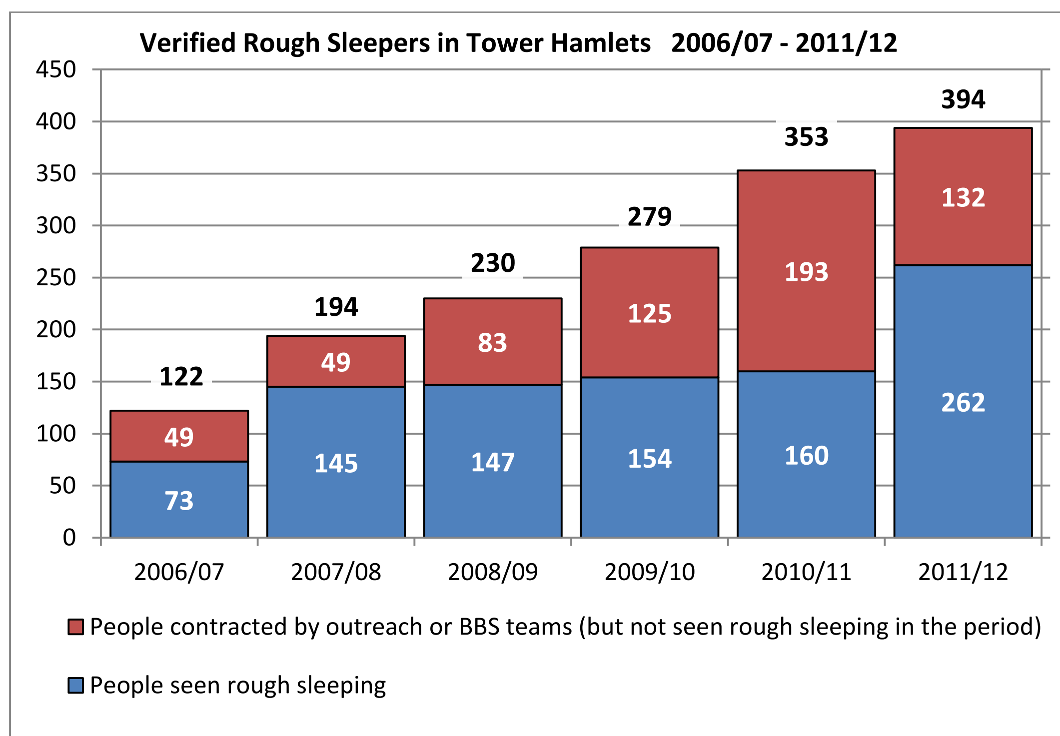
[58] These numbers will only include statutory homeless households assessed as having priority need and would normally exclude those without dependants and those who are assessed as falling outside of the statutory definition of vulnerable. The individuals who fall outside of the definition of statutory homelessness may end up rough sleeping becoming part of the 'hidden homeless', finding temporary solutions with family or friends, or living in squats and other places that are inaccessible to outreach workers.

[59] Ibid

[60] CHAIN Annual Report for Tower Hamlets 2011/12

continuation of consistent increases over the last 5 years[61] (see Figure 16 below). The CHAIN report also found that 46% of these people (176 individuals) were assessed by outreach teams to have mental health support needs, often in association with alcohol and/or drug misuse issues.

Figure 16: People seen by outreach or building based service (BBS) teams in the year - rough sleeping or contacted either on the streets or in services



Source: Chain Annual Reports for Tower Hamlets 2006/07 - 2011/12

As well as those recognised as homeless, it is important to note the 'hidden homeless' , such the people staying with extended family in overcrowded conditions or undocumented migrants with insecure accommodation.

There is recognition that the hostel sector is managing some of the most complex individuals in society, who have a multitude of complex social and health needs. People's support needs often include issues linked to substance misuse, mental health, challenging behaviour and personal care, often co-existing in one person. Tower Hamlets has recently carried out a Hostel Needs Assessment with a view to reconfiguring hostel provision within the borough. This is in order to try to manage and address client needs in a more systematic way within hostels but also together with, for example, mainstream social care, substance misuse and health agencies.

A revised range of hostel service types is being proposed. These service types include:

- Drug & alcohol recovery, including offenders
- Dual diagnosis (substance misuse & mental health)
- Women only services

[61] These were individuals who had spent at least one night sleeping on the street during the financial year

- Mental health & multiple needs linked to homelessness
- Multiple needs homelessness hostels

It is also proposed that in the future pattern of services, far greater specific emphasis should be placed on multi-agency assessment, at the shorter term, more generic type hostels which generally house people before they move onto longer term or more specialist hostels e.g. input will be delivered by professionals with a background in mental health, substance misuse, social services etc.[62].

Homelessness is an important issue in Tower hamlets and the numbers appear to be increasing. The response of mental health services in Tower Hamlets to the needs of homeless people in the borough, and to the challenges of partnership working to address those needs, will be an important factor in improving mental health and wellbeing for this highly vulnerable group.

[62]Tower Hamlets Draft Hostels Commissioning Plan (September 2012)

Appendix - Tower Hamlets demography data

The following data directly supplements what is in the main text.

Physical health and disability

Poor quality of life through physical illness is known to be closely related to mental health problems. Equally, people living with a serious mental illness are at higher risk of experiencing a wide range of chronic physical conditions.

Table 3: Number of households with at least one resident who has a long-term health problem or disability

2011 Census: Table KS106EW	Tower Hamlets		London	England
All Households	101,257	-	-	-
Households with at least one resident who has a long-term health problem or disability	20,840	20.6%	22.4%	25.7%
Households with at least one resident who has a long-term health problem or disability: With dependent children	5,742	5.7%	5.0%	4.6%
Households with at least one resident who has a long-term health problem or disability: No dependent children	15,098	14.9%	17.4%	21.0%

Source: 2011 Census

Table 4: Degree to which long term health problems and/or disability limited an individual's day to day activities

2011 Census: Table KS301EW	Tower Hamlets		London	England
Total Population	254,096	-	-	-
Day-to-day activities limited a lot	17,258	6.8%	6.7%	8.3%
Day-to-day activities limited a little	17,045	6.7%	7.4%	9.3%
Day-to-day activities not limited	219,793	86.5%	85.8%	82.4%

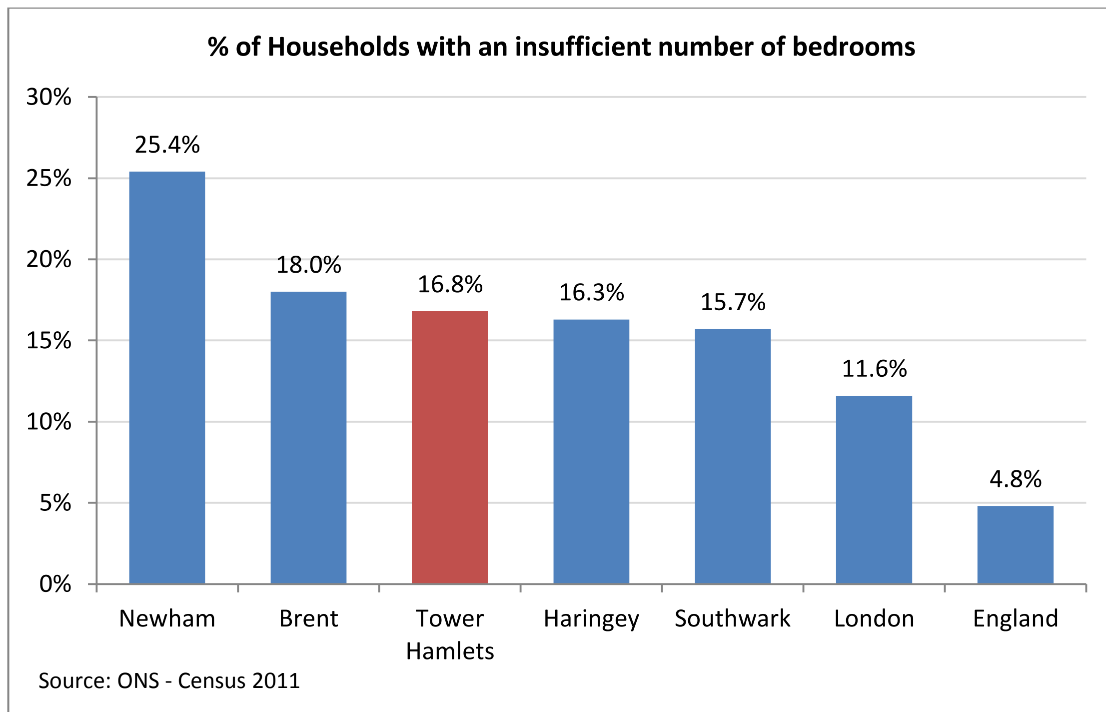
Source: 2011 Census

Housing

The 2011 Census provides derived statistics which provides information on the extent of overcrowding in the borough, but not the degree to which households are overcrowded.

For the occupancy rating in relation to bedrooms, Tower Hamlets had the third highest proportion of households with insufficient bedrooms for the occupants at 16.8%. This equates to 16,964 households in the borough.

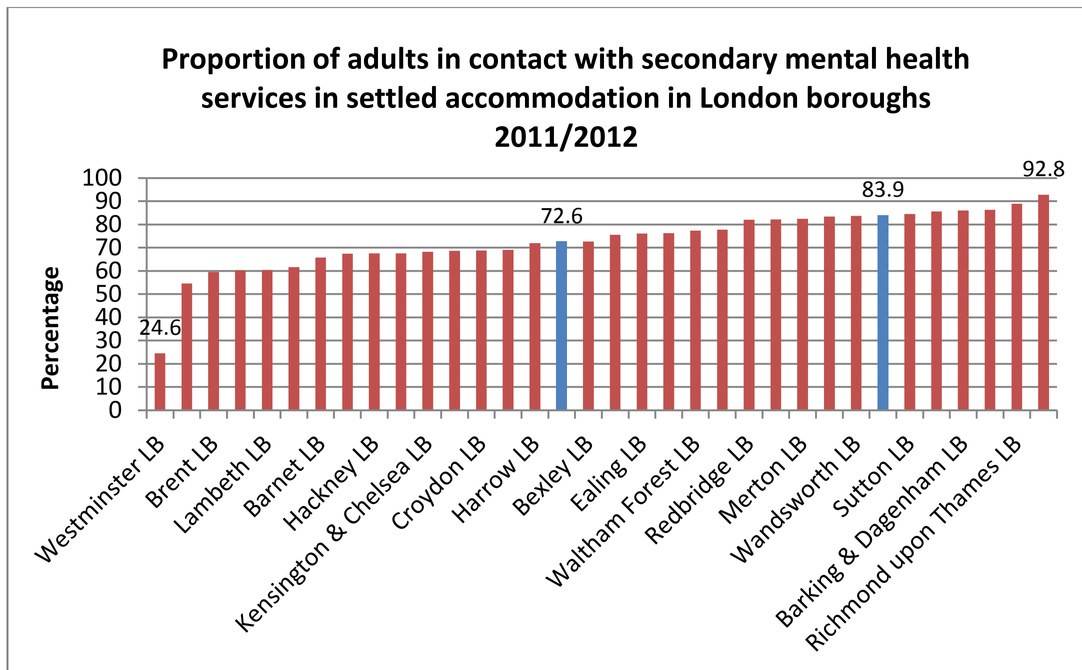
Figure 17: % of Households with an insufficient number of bedrooms



Source: ONS - Census 2011

Interestingly, Tower Hamlets performs better than the London average for those in contact with secondary care services being in settled accommodation (Figure 6) – 83.9% (Tower Hamlets) versus 72.6% (London). However, it is important to note that the figures were lower in previous years 71.3% in 2009/2010 and 39% in 2008/2009, and there appears to have been a significant improvement in numbers in settled accommodation (although there are very likely to be data quality issues here, which make it difficult to ascertain the true level of need that has been met).

Figure 18: Proportion of adults in contact with secondary mental health services in settled accommodation in London boroughs and England 2010/2011



Source: Communities and Local Government, NASCIS

Welfare benefits

Table 4 below shows the percentage of the working age population claiming out of work benefits in LBTH set against the figures for London and England.

Table 5: Percentage of the working age population claiming out of work benefits

Snapshot Date	Tower Hamlets	London	England
February 2008	15.7%	11.7%	10.7%
February 2009	16.0%	12.6%	12.3%
February 2010	16.3%	12.9%	12.4%
February 2011	14.4%	11.8%	11.7%
February 2012	14.7%	12.0%	12.0%

Source: DWP Benefit Caseload Data

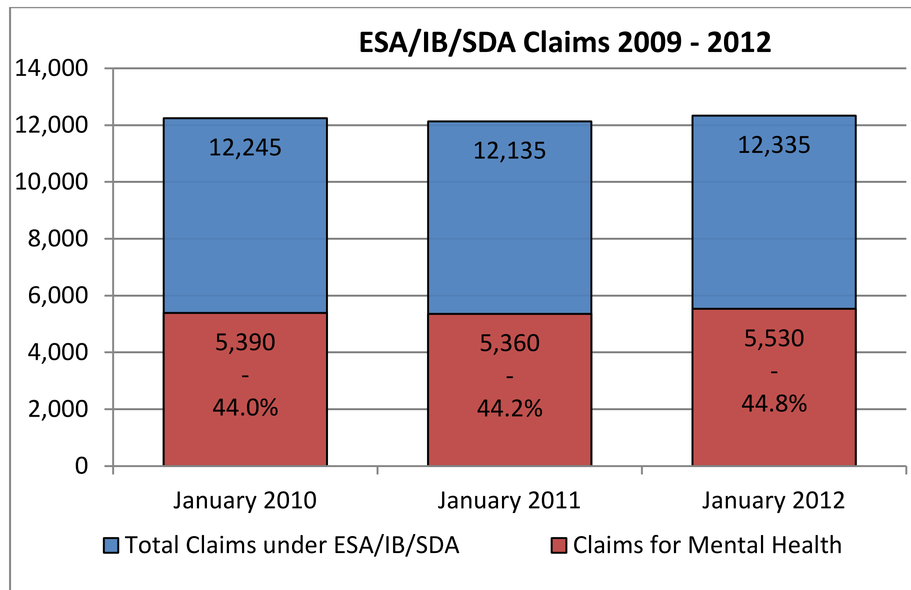
Claimants

As of February 2012, there were 12,335 benefit claims for work limiting illness in Tower Hamlets (57.8 per 1,000 working age residents) and of these, 5530 claims were for mental illness (25.99 per 1,000 working age residents). This compares with averages for work

limiting illness claims of 51.06 per 1,000 in London and 56.35 in England. For mental health claims the average for London is 22.95 per 1,000 and 24.41 for England.

Mental health issues and behavioural disorders accounted for 45.4% of all IB[63]/SDA[64] claims and 44.7% of ESA claims. Taken together, this accounted for 44.8% of all claims for a work limiting illness.

Figure 19: ESA/IB/SDA Claims 2009-2012



Source: DWP Out of Work Benefits Count – Nomis

However, when taken as a proportion of the working age population, benefit claims for work limiting illness have been in decline over the previous three years while claims under mental health and behavioural disorders have remained relatively stable at just over 2.8%-2.9% of all working age residents.

[63]Incapacity benefit
[64]Severe Disablement Allowance

Chapter 4: Risk and protective factors for mental wellbeing

Chapter summary

Background

National strategy is to reduce risk factors for mental health and wellbeing and strengthen protective factors.

- There is an emerging understanding of the borough's risk and protective factors, based on population surveys
- The cumulative effect of risk factors for poor health, including poor mental health, are dominant at various points in the life course
- The Tower Hamlets Health and Wellbeing Board made mental health and wellbeing one of its priorities when it was formally established in 2013
- Tower Hamlets Public Health undertakes a range of interventions to improve population health and well-being, including mental wellbeing, and is further developing initiatives specifically to address mental health.

Risk factors

The high levels of deprivation exacerbate the risk factors for mental health in the borough.

- What happens during the early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status
- Poor mental health is strongly related to other health conditions and development outcomes in young people, including lower educational achievements, substance abuse, violence, and poor reproductive and sexual health
- Looked After Children (LAC) exhibit higher levels of mental health need (particularly those in residential care). As of 31 March 2012 the London Borough of Tower Hamlets was the 'corporate parent' for 295 children, a reduction on the previous two years
- A higher proportion of the population provides unpaid care in Tower Hamlets (in both the classifications 20-49 hours and 50 hours or more) than the London or England average. Female carers have a higher risk of common mental disorders than other women.
- In the 12 months to September 2012, Tower Hamlets had a rate of 30.17 episodes of violent crime per 1,000 residents, significantly worse than the average for London (24.88) and England (15.99)
- Some people misuse alcohol and substances to help cope with the symptoms of mental illness. Others may experience mental health issues as a result of their substance abuse. Tower Hamlets is one of the areas with the highest levels of complexity of drug misuse in England. The directly standardised rate of hospital admissions for alcohol attributable conditions was significantly worse than the England average (2010/11)
- People with dual diagnosis of mental health problems and substance misuse have worse physical health, higher levels of personality disorder, greater levels of

disability, greater risk profiles and lower quality of life than those who are not identified as having a dual diagnosis

- Offenders are a vulnerable group with high needs for access to physical and mental health services
- The raised levels of mental health problems among people with long term physical conditions, and the priority given in national strategies, mean that this is an important issue for Tower Hamlets.
- The LGTB population of Tower Hamlets (as elsewhere) is at higher risk of poor mental health
- A local survey of adults living in Tower Hamlets demonstrated that older people have poorer reported mental wellbeing compared to younger adults
- The borough has the highest percentage of people over 60 living in income-deprived households.

Potential protective factors

The picture of potential protective factors for Tower Hamlets residents is mixed, and in several respects unfavourable.

- Employment can bring benefits for mental health and wellbeing, yet in addition to the high unemployment rate in the borough, only 6.1% of people in contact with secondary mental health services were in employment in 2010/11
- Participation in physical activity can be taken as a measure for mental health protective factors. In this respect, Tower Hamlets has significantly worse rates than the England average, for both pupils (5-16 year olds) and adults (aged 16 years and over) participating in physical activity
- The opportunities to benefit from green space in Tower Hamlets, and to gain the mental health and wellbeing advantages, are less than in other boroughs
- Nearly one-fifth of households do not use English as their main language, up to half the population may have a first language other than English, and although nearly four-fifths of those who have English as an additional language rate their proficiency as good, this still leaves one-fifth below average or poor
- One in eight residents (regardless of first language) rate their reading or understanding English as below average or poor, and the Bangladeshi population reports higher rates of poor literacy (one in four, with women having poorer literacy than men) and lower internet usage
- Religion can be a protective factor against mental ill health. The 2011 Census showed that Tower Hamlets had the highest proportion of Muslim residents of any local authority in England (34.5% of all residents), and conversely had the smallest proportion of Christian residents (27.1% of residents).

4.1 Background

This chapter provides an overview of risk factors and the current approaches to address them, followed by discussion of the main risk and protective factors in Tower Hamlets.

Overview of risk and protective factors

Mental health is affected by a range of factors. By understanding these determinants it is possible to address them and thereby promote good mental health and prevent the onset or deteriorations in mental illness. As discussed above, mental health problems are related to deprivation, inequality and other social and economic determinants of health. Economic crises therefore are times of high risk to the mental wellbeing of the population and of the people affected and their families[65]. They can work to weaken protective factors and strengthen risk factors.

Table 6: Determinants of population mental health

Protective factors	Risk factors
Social capital including religion and literacy and welfare protection	Poverty, poor education, deprivation, high debt
Healthy prenatal and childhood environment	Poor prenatal nutrition, abuse, harsh upbringing, poor relationship to parents, intergenerational transmission of mental health problems, learning disabilities/special needs
Healthy workplace and living	Unemployment, job security, job stress, social isolation
Healthy lifestyles	Alcohol and/or drug use

Source: Adapted from World Health Organisation, 2011

Evidence from previous economic downturns suggests that across the population there will be short term and long term health effects, including an increase in mental health problems such as depression, and possibly lower levels of wellbeing[66].

For various reasons, as discussed above, mental health problems are more common in certain groups, such as:

- People with poor living conditions
- People from ethnic minority groups
- People living with chronic physical illness/people with disability
- Homeless people
- Offenders
- Refugees & new migrants[67].

[65] World Health Organisation (2011) *Impact of economic crisis on mental health* Geneva: WHO
[66] Bloomer E, Allen J, Donkin A (2012) *The impact of the economic downturn and policy changes on health inequalities in London* UCL Institute of Health Equity
[67] NHS Choices http://www.nhs.uk/conditions/Mental-health/Pages/Introduction-OLD.aspx

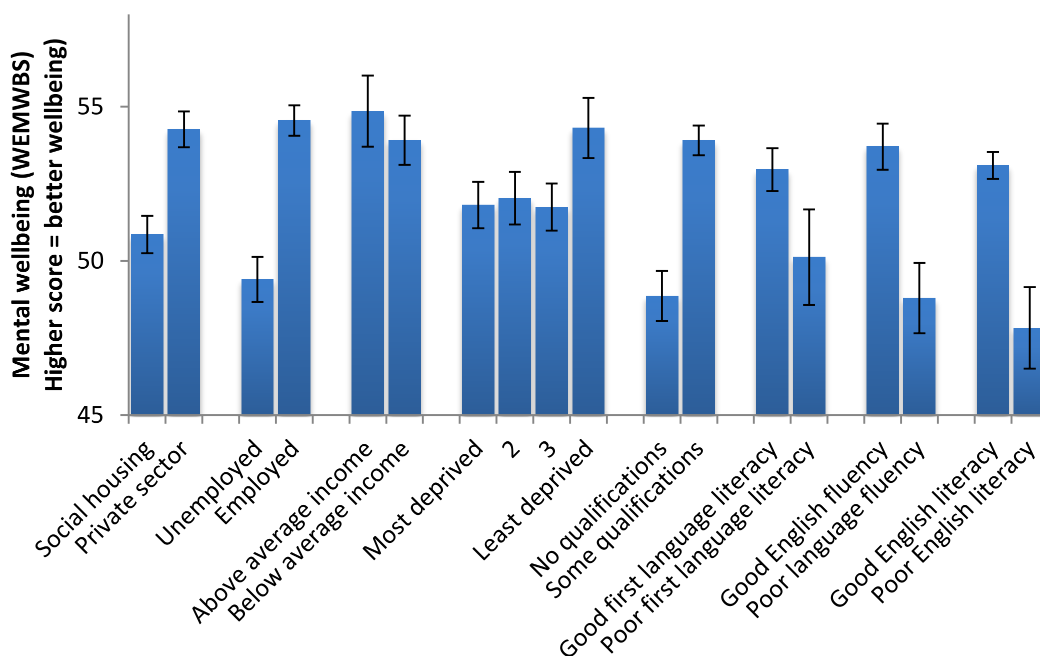
- People with long term physical health conditions.

As shown in preceding sections, Tower Hamlets is characterised by high numbers of people in several of these groups. These risks and protective factors are discussed in more detail below.

Residents' view of wellbeing

The figure below demonstrates the differences that can be seen owing to socioeconomic factors, as scored by local residents themselves in a local survey.

Figure 20: Mental wellbeing by socioeconomic factors in Tower Hamlets



Source: Health and lifestyle survey, 2009

To summarise, this shows that mental wellbeing is very crudely associated with:

- Living in private sector housing
- Being employed
- Living in a more affluent area
- Having educational qualifications
- Being literate in one's first language
- Good English literacy and fluency, when English is not a first language.

The results of the survey for older people are shown in section 4.2

Interventions to improve health and wellbeing in the borough

LB Tower Hamlets Public Health commission a range of interventions to improve health and wellbeing in the borough, taking a life course approach to address the determinants of health and to promote healthier lives. The overall commissioning budget for these interventions (over and above specific programmes for sexual health and substance misuse, which also come within Public Health's remit) is £9.5m.

The main programme areas are:

- Healthy community/environment
- Maternity, early years and childhood
- Oral health
- Tobacco cessation
- Long term conditions
- Mental health

All these interventions have an impact - to a great or lesser degree - on mental health and well-being. There is a dedicated post for mental health and one budget (determined each year) is dedicated to mental health promotion.

The four health trainer teams in the borough localities each include one mental health trainer who supports and signposts people with mental health problems to become more active, manage their weight and reduce or give up smoking.

In line with the commitment in the borough Health and Wellbeing Strategy, Public Health will develop a partnership and life course approach to improving mental wellbeing, and will clarify which outcomes will most improve public mental health.

Public Health has worked with Faith in Health and the Alzheimer's Society to produce a sermon pack for imams on mental health and dementia, followed by information giving at local mosques.

The overall Public Health strategy recognises the pivotal role of early life experience and parenting on lifelong mental health. Current interventions include:

- Family Nurse Partnership for teenage mothers
- Healthy Families Programme, where local delivery of parenting programmes has emphasised health messages
- Early Years accreditation involving children's centres, nurseries and child-minders.

Improved antenatal care also fits this priority, although this is the responsibility of commissioners in line with NICE guidance, rather than a Public Health programme.

Good mental health in childhood (where there is some concern that conduct disorders are becoming more prevalent[68]) is recognised by:

- Support for the Healthy Schools Programme, including grants for pupil-led projects

[68] *No Health Without Mental Health* (DH 2011)

- Work for children with disabilities
- Initiatives to improve the health of looked after children and young offenders.

In adulthood, mental health and wellbeing is promoted by:

- Healthy Weight, Healthy Lives strategy involves community grants panels in deciding on suitable activities such as food growing. These can promote social networks and community cohesion, which are especially relevant to people who are isolated or experiencing mental illness.
- Integrated care pathway initiatives and improved pathways for people with long term conditions such as chronic obstructive pulmonary disease and stroke
- The Well London programme, a capacity-building initiative since 2007 and now in its second phase, based in the most deprived Lower Super Output Areas (LSOAs), currently the Aberfeldy estate in Blackwall. The key themes are physical activity, healthy eating, mental wellbeing and employment. Local community-generated initiatives have included DIY Happiness projects and Changing Minds mental health awareness sessions (led by people with lived experience of mental distress). Well London projects have attracted substantial funding from The Big Lottery Project and the Greater London Authority, as well as backing from local partners such as University of East London.

In all these programmes, Public Health commissioning enables a focus on the evidence base, safe practice and measurement of outcomes.

4.2 Risk factors by life course

The importance of early years in the development of ill health was illustrated in the recent Marmot Review (2012). Its life course perspective demonstrated the cumulative effect of risk factors for poor health, including poor mental health, that are dominant at various points in the life course. The implication for this is that there are opportunities across the life course where people are susceptible to different interventions and therefore a range of targeted interventions are required throughout the life course to have maximal impact in improving (mental and physical) health.

Maternity and early years

Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being– from obesity, heart disease and mental health, to educational achievement and economic status[69]. There are some areas on in particular that may be identified as key risk factors for mental health and wellbeing at this time in the life course including lone parent families,

[69] Waldfogel J (2004) Social mobility, life chances, and the early years, CASE Paper 88, London: London School of Economics

family size (included related issues of overcrowding) and social isolation of young mothers.

Children and young people

Adolescents are generally perceived as a healthy age group, and yet an estimated 10% of them experience a mental health problem.[70] Depression is the main cause of worldwide disability among adolescents, and suicide is the second most common cause of death among young people. Poor mental health is strongly related to other health conditions and development outcomes in young people, including lower educational achievements, substance abuse, violence, and poor reproductive and sexual health[71].

Bad housing conditions, including homelessness, temporary accommodation, overcrowding, insecurity, and housing in poor physical condition, constitute a risk to health. A study carried out by Shelter in 2006 suggested that children in bad housing conditions are more likely to have mental health problems, such as anxiety and depression[72].

Any child can experience mental health problems, but some children are more vulnerable than others. These include those children who have one or more risk factors in the domains below[73] [74]:

Figure 21: Children and young people who may be more vulnerable to mental health problems

- low-income households
- parents unemployed or where parents have low educational attainment
- looked after by the local authority
- with disabilities (including learning disabilities)
- from BME groups
- are lesbian, gay, bisexual or transgender (LGBT)
- in the criminal justice system
- have a parent with a mental health problem
- misusing substances
- refugees or asylum seekers

- gypsy and traveller communities
- who are being abused
- experiencing stressful life events e.g. bereavement, divorce or serious illness
- physical illness (linked to onset of emotional disorders)
- family structure - those in single-parent households more likely to develop disorders
- household tenure - those in rented accommodation more likely to have emotional disorder than those who do not
- family conflict, domestic violence and bullying

Whilst children and young people in these groups may be at higher risk, this does not mean that they are equally vulnerable to mental health problems. A range of protective factors in the individual, family and community influence whether a child or young person will either not

[70] **Green**, H., McGinnity, A., Meltzer, H., et al. (2005). Mental health of children and young people in Great Britain 2004. London: Palgrave.
[71] World Health Organisation (2012) *Adolescent mental health* WHO: Geneva
[72] Harker L (2006) *Chance of a lifetime: The impact of housing on children's lives* London: Shelter. http://england.shelter.org.
[73] HM Government (2010) *Healthy Lives, Healthy People: Our strategy for public health in England* London: TSO
[74] Office National Statistics (2008) *Three Years On: Survey of development and emotional wellbeing of children and young people*

experience problems or will not be significantly affected by them, particularly if receiving consistent support from an adult whom they trust[75].

Young people aged 16-18 years old who are not in education, training or employment (NEETS) are more likely to have poor health and die an early death. They are also more likely to have a poor diet, smoke, drink alcohol and suffer from mental health problems[76]. There is also evidence that education from a young age around resilience can promote positive emotional and mental wellbeing in children and young people.

Looked After Children (LAC)

LAC exhibit higher levels of mental health need (particularly those in residential care). In one study 45% of looked after children were assessed as having a mental health disorder, rising to 72% of those in residential care. Among 5-10 year olds, 50% of boys and 33% of girls had an identifiable mental disorder. Among 11-15 year olds, the rates were higher at 55% for boys and 43% for girls. This compares to around 10% of the general population aged 5 to 15[77]. LAC are particularly vulnerable when leaving care and more likely than their peers to be teenage parents, almost twice as likely to have problems with drugs or alcohol (increased from 18% to 32%) and to report mental health problems (12% to 24%)[78] [79]. It is important to consider that the high levels of mental health needs in LAC may be exacerbated as a result of experiences of being in care and the relationship in not always clear.

As of March 31st 2012 the London Borough of Tower Hamlets was the 'corporate parent' for 295 children. This is a reduction on the previous two years where there were 325 children in Local Authority Care as of March 2011, and 350 in 2010. Although numerically there has been no significant trend since 2007 (355 children) the rate per 10,000 children under 18 years has fallen from 72/10,000 in 2007 to 63/10,000 in 2011[80]. The Tower Hamlets rate equates to 325 children (and when applying the ONS prevalence figures to Tower Hamlets) suggests that approximately 146 of these children would have experience of some form of mental disorder.

Carers

The mental and physical healthcare needs of carers (across the life course) are also very important for consideration. The health of family carers may affect not only their own lives

---

[75] JSNA Factsheet: Child and adolescent mental illness, mental health and emotional wellbeing – 2012 Tower Hamlets Public Health

[76] Local Government Improvement and Development, Oct 2009 http://www.idea.gov.uk/idk/core/page.do?pageId=13919780

[77] Meltzer H., Corbin T., Gatward R., Goodman R. and Ford T. (2003) *The mental health of young people looked after by local authorities in England* London: The Stationery Office

[78] 5 Biehal N. Clayden J. Stein M. Wade J. (1995) *Moving On: Young people and leaving care schemes* Barkingside, Essex: Barnardos

[79] Dixon, J. (2008) *'Young people leaving care: health, well-being and outcomes'* Child and Family Social Work 13, 207-217

[80] JSNA factsheet: Health of looked after children

but also the lives of the people for whom they provide care81. In particular young carers who care for parents who have mental health can have more complex emotional support needs of their own82.

A national survey of carers in 200183 found that 21% of female carers were on or above the threshold for common mental disorders, and 23% more likely to experience them than women in general (the proportion was not significantly different for male carers.) Over 91 per cent of carers were not receiving any medication, counselling or therapy for mental nervous or emotional problems, although 13 per cent had consulted a doctor.

Nationally the 2011 census found that:

- There were approximately 5.8 million people providing unpaid care in England and Wales in 2011, representing just over one tenth of the population
- 2.1% of children aged 5 to 17 provided unpaid care for family members, friends, neighbours or others because of long-term physical or mental ill-health, disability, or problems relating to old age –
- The numbers of carers and young carers had increased since 2001
- Care provision has a detrimental impact on general health for young carers.

According to a needs assessment conducted in the borough in 2010, the proportion of the Tower Hamlets population providing unpaid care does not differ substantially from the London or England average, but a higher proportion of the population provides 20-49 hours or 50 hours or more of unpaid care in Tower Hamlets than the London or England average. Tower Hamlets has a higher proportion of the population providing 50 hours or more of unpaid care per week than any other Inner London borough. At least 3.7% of the Tower Hamlets population (all ages) provide 20 hours or more unpaid care per week.

Support for carers is also highlighted as a current issue from a user and carer perspective in chapter 6 of this document.

Violence and violent crime

Crime levels are associated with both illness and poverty, increasing the burden of ill health on those communities least able to cope. Violent crime can result directly in psychological distress and subsequent mental health problems.

In the 12 months to September 2012, Tower Hamlets had a rate of 30.17 episodes of violent crime per 1,000 residents, significantly worse than the average for London (24.88) and England (15.99)[84]. See table 7 below.

---

[81]http://apt.rcpsych.org/content/12/3/162.full
[82]http://www.rcpsych.ac.uk
83 Singleton, N et al, (2002) Mental Health of Carers, ONS
[84]Office for National Statistics

Table 7: Rates per 1,000 of violent crime in Tower Hamlets, 2012

12 Months to September 2012 - Rates per 1,000 of population	Tower Hamlets	London	England
Violence against the person only (with or without injury)	22.90	18.87	13.63
Violence against the person, Sexual offences and Robbery	30.17	24.88	15.99

Source: ONS - Recorded crime data at local authority level

This indicates an environment within which mental health problems are more likely to manifest as a consequence of violence rates in the borough. However, it is also important to recognise that it is the perception of crime and danger issues in Tower Hamlets that causes further mental anxiety and distress, which may limit daily activities, having a subsequent impact on mental wellbeing.

Further work is needed to draw together information on the extent and effects of violence and abuse in Tower Hamlets, and the implications for mental health: for example, the adverse consequence of experiencing or witnessing domestic violence and abuse.

Drug misuse

There is an association between mental health problems and drug misuse. Some people misuse substances to help cope with the symptoms of mental illness. Others may experience mental health issues as a result of their substance abuse.[85].

According to the National Treatment Agency, Tower Hamlets is in the cluster of areas with the highest levels of complexity of drug misuse in England[86].

Alcohol misuse

Alcohol misuse leads to a range of public health problems and the long term effects of excessive alcohol consumption are a major cause of avoidable hospital admissions. Alcohol affects all of society, from the burden on the NHS in terms of hospital admission and treatment in primary care, the economic burden due to loss of employment and reduced capacity to work, through to other negative effects of alcohol on the social and behavioural welfare of communities.

---

[85] Social Care Institute for Excellence, Jan 2009 http://www.scie.org.uk/publications/briefings/briefing30/

[86] To be assigned to a cluster, complexity is assigned to clients individually using a scoring system initially developed for use in the Payment by Results pilots. A score is assigned based on presenting characteristics in the Treatment Outcomes Profile (TOP) and the National Drug Treatment Monitoring System (NDTMS) (looking at areas such as drug use, crime, employment, injecting status and health scores). The resulting scores are then grouped into the five complexity groups, from very low through to very high. Opiate use is a factor in this calculation and for this reason data is only provided for all clients and not broken down by opiate/non-opiate86. Partnerships are then grouped into the complexity of their clients; Cluster E which was assigned to Tower Hamlets is the cluster with the clients with the highest complexities. Tower Hamlets is benchmarked by the NTA against similar boroughs that have similar client profiles, Cluster E has 28 partnerships within it (including Manchester, Bristol and Birmingham). The other London Boroughs in this cluster are Camden, Lambeth, Islington, Westminster, Southwark, Newham and Hackney.

For the 2009/10 period Tower Hamlets had a directly standardised rate of hospital admissions for alcohol attributable conditions of 1841/100,000 versus 1743/100,000 (significantly worse) than the England average (London = 1684/100,000[87]). Most recent alcohol related admissions data from 2010/11 suggests that the directly standardised rate of hospital admissions (directly or indirectly) attributable to alcohol was 2289.6 (less than neighbouring Newham at 2760.2 but higher than Hackney at 2158.4 admissions per 100,000 population). The Tower Hamlets admission rate also remains higher than the London (1911.7) and England (1,895) figures[88].

Dual diagnosis of mental health problems and substance misuse

A large proportion of people in England with mental health problems have co-occurring problems with drug or alcohol misuse. Likewise poor mental health is commonplace in people who are dependent on or have problems with drugs and alcohol.

People with dual diagnosis were found to have had worse physical health, higher levels of personality disorder, greater levels of disability, greater risk profiles and lower quality of life than those who were not identified as having a dual diagnosis. [89] Estimates of numbers are given in chapter 5.

The need for integrated support for people with concurrent mental health and drug or alcohol problems is widely understood, according to the national charities, Drugscope and the Centre for Mental Health. However, Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system concluded that 'despite the recognised high prevalence of dual diagnosis among offenders with mental health problems, services are not well organised to meet this need. In fact, services are currently organised in such a way as to positively disadvantage those needing to access services for both mental health and substance misuse/alcohol problems.'[90]

---

[87]Local Alcohol Profiles for England and the Office for National Statistics

[88]This total includes alcohol-specific conditions (i.e. those that are wholly attributable to alcohol e.g. alcoholic liver cancer) plus conditions that are caused by alcohol in some, but not all, cases (e.g. stomach cancer and unintentional injury). For these latter conditions, different (nationally derived) attributable fractions are used to determine the proportion related to alcohol for males and females. A list of alcohol-attributable conditions with their ICD-10 codes can be found at: http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf - Tower Hamlets sees a significant rate of hospital admissions for conditions including diabetes or coronary heart disease which, in Tower Hamlets at least, are less likely to be alcohol related, given the consumption profile, and are more likely to be explained by poor diet or a sedentary lifestyle. The reliability of such nationally derived fractions as applied to the Tower Hamlets population, is thus questionable. However, this is the only currently nationally recognized technique used to provide a more complete picture of the true scale of alcohol related harm and no other more reliable indicator exists currently.

[89] Strathdee et al (2002), Dual diagnosis in a primary care group – a step-by-step epidemiological needs assessment and design of a training and service response model, DH/National Treatment Agency

90 Baron Bradley of Withington (Keith Bradley) (2009) Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system .Department of Health

Summary of substance misuse issues

The complexity of substance misuse, the higher than average admission rate for alcohol attributable hospital admissions, and the recognised deficits in pathways for people with dual diagnosis of substance misuse and mental illness together mean that the risks in Tower Hamlets are a significant concern for mental health and wellbeing.

Offenders [91]

Offenders are individuals who have committed a criminal offence or suspected of committing an illegal act. They have been through the Criminal Justice System following the legal process from the moment of arrest by the Police leading onto Courts, Prison or Community Orders, and Probation Service. The term 'offender' refers to an individual who is convicted in a court of law as having committed a crime, violated a law or transgressed a code of conduct.

Offenders experience disproportionate levels of poor physical and mental health. Many factors increase the risk of starting offending, and often contribute to the continued cycle of re-offending. These factors also contribute to poor health, and include homelessness; stress, domestic violence; substance misuse; and low educational attainment. Women offenders face disproportionately high needs. The level of severe mental illness in offenders is particularly high.[92]

Offenders in the community represent a wider group than offenders in prison, with a broad range of health needs and offending behaviour. Many of the health problems experienced by offenders are those that are prevalent in lower socio-economic groups. The health needs and offending behaviour of offenders not only reflect the offender's personal needs, but also those of their partners and families.

The main challenge for local health and wellbeing partners is reducing the risk and cycle of offending by addressing offenders health needs. Action is required to:

- Promote offenders as a vulnerable group among health services as a whole
- Include ex-offenders in developing health services
- Ensure access to mental health services
- Promote access to drug and alcohol treatment services;
- increase diversion of offenders with mental health problems and/or learning disabilities away from the criminal justice system
- Develop a criminal justice liaison team for offenders with mental health issues in line with Lord Bradley's recommendations
- Address family needs.

[91] Communication from London Probation Service

[92] See for example Survey of Psychiatric Morbidity Among Prisoners in England and Wales (Singleton et al., HMSO 1998)

In summary, offenders are a vulnerable group with high needs for access to physical and mental health services.

Long-term physical health conditions

The national strategy *No Health Without Mental Health* (2011) highlighted the extent of common mental disorders for people with long term physical health conditions. It noted that having both physical and mental health problems delays recovery from both, and that people with one long-term condition are two to three times more likely to develop depression than the rest of the population. Adults with both physical and mental health problems are much less likely to be in employment.

One of the key areas proposed for action in the national strategy was to ensure that fewer people with physical ill health, including those with long-term conditions and medically unexplained symptoms, should experience mental health problems.

The evidence for particular conditions has been summarised in a joint publication by the King's Fund and the Centre for Mental Health[93] as follows:

- Cardiovascular diseases: depression is two to three times more common in a range of cardiovascular diseases including cardiac disease, coronary artery disease, stroke, angina, congestive heart failure, or following a heart. Prevalence estimates vary between around 20 per cent and 50 per cent depending on the conditions studied and the assessment approach used, but the two- to threefold increase compared with controls is consistent across studies. Anxiety problems are also common in cardiovascular disease
- Diabetes: people living with diabetes are two to three times more likely to have depression than the general population .As observed for cardiovascular disease, prevalence estimates vary but the proportionate increase is consistent. There is also an independent association with anxiety.
- Chronic obstructive pulmonary disease: mental health problems are around three times more prevalent among people with chronic obstructive pulmonary disease than in the general population. Anxiety disorders are particularly common; for example panic disorder is up to 10 times more prevalent than in the general population.

Many other long term conditions such as chronic musculo-skeletal problems and irritable bowel syndrome are also associated with psychological difficulties, although the examples highlighted above perhaps account for the highest healthcare utilisation.

[93] Naylor C et al (2012) Long term Conditions and Mental Health. London: King's Fund and Centre for Mental Health

The raised levels of mental health problems among people with long term physical conditions, and the priority given in national strategies, mean that this is an important issue for Tower Hamlets.

Lesbian, Gay, Bisexual and Trans (LGTB) people

Although the majority of lesbian, gay and bisexual (LGB) people do not experience poor mental health, research suggests that some LGB people are at higher risk of mental disorder, suicidal behaviour and substance misuse. For example.[94]:

- LGB people demonstrate higher rates of anxiety and depression than heterosexuals; lesbians and bisexual women may be at more risk of substance dependency than other women.
- In comparison with their heterosexual counterparts gay and bisexual men are five and a half times, and lesbian and bisexual women are two times, more likely to have deliberately self-harmed;
- Gay and bisexual young men under the age of 25 appear to be particularly vulnerable to thoughts about suicide and suicide attempts in comparison with heterosexual young men

Transgender people are more likely to experience mental distress due to the social disapproval and discrimination that they encounter and are at greater risk of depression, self-harm and suicide. A 2007 survey of 872 trans people found that 34% of respondents had considered suicide. This is considerably higher than the general population.[95]

A 2012 survey similarly found 35% had attempted suicide at least once and 25% had attempt suicide more than once. In that on-line survey, 53% of the participants had self-harmed at some point, and 55% reported depression at some time. 66% of trans respondents reported that they had used mental health services for reasons other than access to gender reassignment medical assistance. Approximately equal numbers were satisfied as were unsatisfied, but nearly two thirds reported negative interactions with the services.[96]

Overall, the LGTB population of Tower Hamlets is at higher risk of poor mental health, and this should be recognised by services.

---

94 Mental health issues within lesbian, gay and bisexual (LGB) communities Briefing 7 for Health and Social Care Staff DH 2007

[95] http://www.nhs.uk/Livewell/Transhealth/Pages/Transmentalhealth.aspx

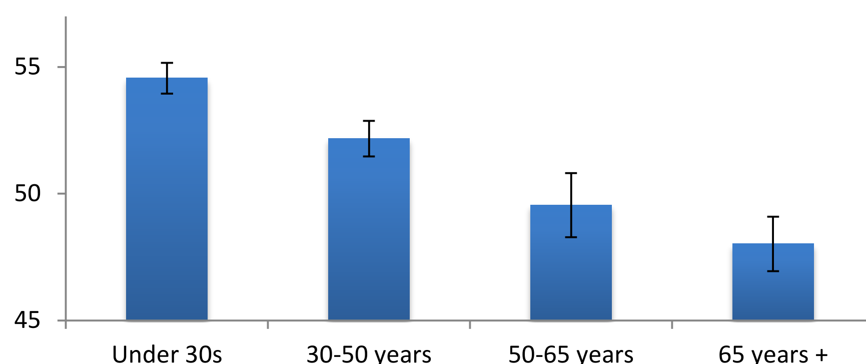
96 McNeil, J et al Trans Mental Health Study 2012 Scottish Transgender Alliance info@scottishtrans.org. (Survey in 2012 with dataset of 889 people on-line, recruited by word of mouth.)

Older people

A local survey of adults living in Tower Hamlets demonstrated that older people have poorer reported mental health compared to younger adults according to the Warwick Edinburgh Mental Wellbeing Scale (WEMBWS, a validated questionnaire). (Figure 22 below).

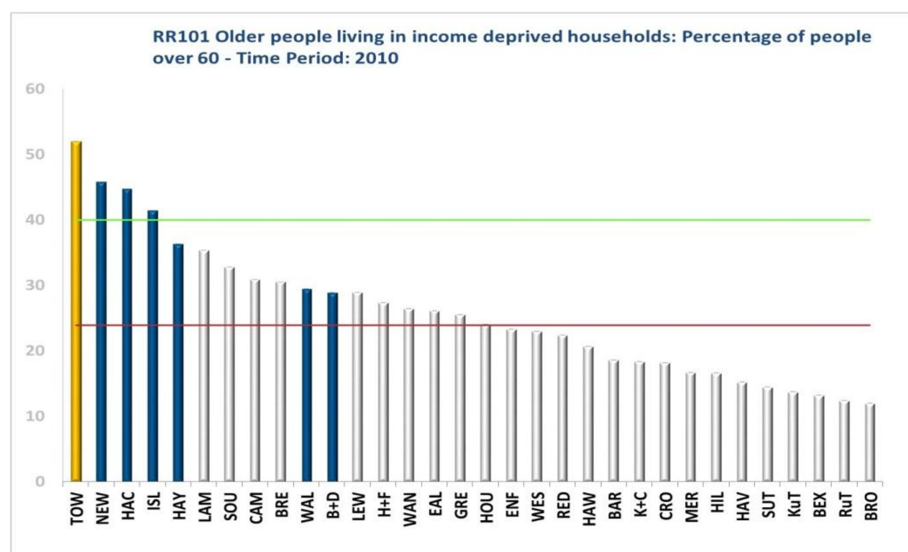
Figure 22: Levels of mental wellbeing in Tower Hamlets by age group (WEMWBS score)

Source: Health and Lifestyle Survey 2009 (WEMWBS score – higher score = better mental wellbeing)



Older people in Tower Hamlets are affected by poverty. The following figure shows that the borough has the highest percentage of people over 60 living in income-deprived households.

Figure 23: Percentage of people aged over 60 living in income deprived households. London 2010



There is a lot of evidence to suggest that isolation and loneliness can be extremely problematic for those transitioning into older age, this can be a particularly an issue for those

who are living alone/housebound. One study found that over half (51%) of all people aged 75 and over live alone[97]. It is estimated that nationally about 20% of the older population is mildly lonely and another 8–10% is intensely lonely,[98] and 17% of older people are in contact with family, friends and neighbours less than once a week, and 11% are in contact less than once a month[99]. Although these figures may be lower in Tower Hamlets due to differences in cultural factors and family structures, it nevertheless highlights a specific area of need moving into the future.

4.3 Protective factors

Employment

It is widely recognised that employment is good for mental health, and that good employment practices can improve employee satisfaction and enhance productivity. NICE has issued guidance on workplace support.

There is strong evidence to suggest that work is generally good for physical and mental health and wellbeing, taking into account the nature and quality of work and its social context. Long term worklessness is associated with poorer physical and mental health and employment is recognised to be an integral part of recovery from mental ill health. Both research and practice has shown that, given the right support, the vast majority of people can take up and sustain employment[100].

Yet attitudes towards employing those with a mental health condition are poor - just four in ten employers would hire someone with a mental health condition, compared to 62% of employers who would hire someone with a physical health condition[101]. Problems of stigma were amongst those highlighted by services users, carers and other stakeholders in the borough in chapter 6.

The high level of unemployment in Tower Hamlets has already been noted. Further challenges to achieving the protective benefits employment can bring to mental well-being are:

It is even harder to bring the benefits of employment to those who have a serious mental illness

---

[97]Cann P and Joplin K. Safeguarding the Convoy – a call to action from the Campaign to End Loneliness, Age UK Oxfordshire (2011) http://campaigntoendloneliness.org.uk/wp-content/uploads/downloads/2011/07/safeguarding-the-convey _-_a-call-to-action-from-the-campaign-to-end-loneliness.pdf

[98]De Jong Gierveld J, Fokkema T, Van Tilberg T. Alleviating loneliness among older adults: possibilities and constraints of interventions. Safeguarding the Convoy: a call to action from the Campaign to End Loneliness, Oxfordshire: Age UK Oxfordshire (2011)

[99]Cann P and Joplin K. Safeguarding the Convoy – a call to action from the Campaign to End Loneliness, Age UK Oxfordshire (2011) http://campaigntoendloneliness.org.uk/wp-content/uploads/downloads/2011/07/safeguarding-the-convey _-_a-call-to-action-from-the-campaign-to-end-loneliness.pdf

[100]http://www.centreformentalhealth.org.uk/employment/issue_overview.aspx

[101]Mental Health Network NHS Confederation, 2011

- Only 7.9% of adults in England with mental health conditions in contact with secondary care services are known to be employed.
- Only 6.1% of people in contact with secondary mental health services were in employment in 2010/11, (although it is suspected that there are issues with the quality of the data submitted for this indicator).

Nevertheless there is a body of research [102]which shows that independent placement and support (finding people in real work) can achieve positive results.

Participation in physical exercise

Participation in physical activity can be taken as a measure for mental health protective factors. In this respect, Tower Hamlets has significantly worse rates than the England average, for both pupils (5-16 year olds) and adults (aged 16 and over) participating in physical activity:

- The percentage of pupils participating is 77.22% compared to an England average of 86.36% (the London percentage is 83.61%[103]). The target is for 85% of 5-16 year olds to take part in a minimum of two hours of high quality sporting activities each week.
- The percentage of adults is just 8.6% in Tower Hamlets compared to an England average of 11.2% (London is 9.9%[104]).

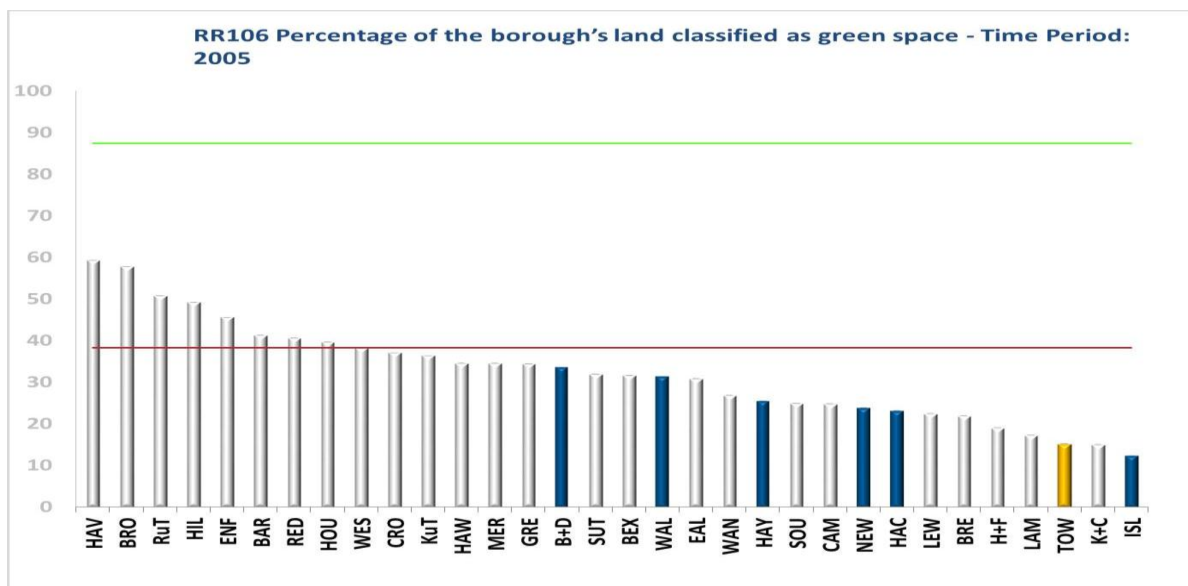
Promotion of physical activity is one of a number of interventions which promote public health, as noted earlier in this chapter.

Green space

The mental health benefits of access to green space in urban environment are widely claimed, although difficult to evaluate. Proponents link the benefits both to access or proximity to natural areas, and to eco-therapy activities such as gardening, conservation and exercise[105]. The following figure shows the proportion of land classified as green space in London boroughs.

[102] See the range of publications by the Centre for Mental Health http://www.centreformentalhealth.org.uk/publications/employment_publications.aspx
[103]PE and Sports Survey, Department for Education 2009-2010
[104]Active people survey, Sports England 2009/2010-2011/12
[105] MIND (2007) *Ecotherapy: the green agenda for mental health* (contains references)

Figure 24: Percentage of the borough's land classified as green space



Source: NHS London Mental health tool indicator (RR106)

It has already been noted that the population density in the borough is the fourth highest in inner London. The opportunities to benefit from green space in Tower Hamlets, and to gain the mental health and wellbeing advantages, are clearly less than in other boroughs.

Language and literacy

The 2011 census included questions about the main household language and showed that 19% of households in Tower Hamlets did not contain any occupants whose main language was English. This was a higher proportion than for London (13%) and Inner London (15%). A further 15% of households also reported that at least one, but not all occupants had English as a main language. Again, this was higher than for both London (10%) and Inner London (12%).

Questions on proficiency in English were included in the Tower Hamlets 2008/09 Health and Lifestyle Survey, which found that 50% of individuals had a first language other than English.

The survey asked respondents who reported having English as an additional language (EAL) to rate their ability to speak or understand English when they needed to in daily life. 79% of those with English as a second language rated their ability as 'very' or 'fairly' good, with the remaining 21% stating their understanding of English was 'below average' or 'poor'.

Amongst the Bangladeshi EAL population, 28% rated their proficiency in spoken English as 'poor'; this rose to 38 per cent for women compared with 18 per cent for men.

The survey also asked residents how good they were at reading and understanding English in daily life. This question was put to all respondents, regardless of their first language. Around one in eight (12%) residents said they were not good ('below average' or' poor') at reading or understanding English. This rose to 26% among Bangladeshi residents. Again, within the Bangladeshi population, there was a considerable gender differential: women were twice as likely as men to report poor literacy (34% vs. 18%).

In LBTH it is estimated that 16.5% of the population do not regularly access the internet[106] (around 33,000 residents). This is higher than the equivalent estimate for London (13.9%), but below that of the UK (17.4%). The regional breakdown shows that Inner London – East has a significantly higher estimate for non-usage of the internet than Inner London – West (15.2 % and 10.6% respectively), but the LBTH still exceeds both of these.

A London wide breakdown of these estimates show that non-usage of the internet is correlated with age, with non–usage increasing steadily with age group. It is estimated from the survey that 43.6% of those aged 65 to 74 do not use the internet, rising to 78% of those aged 75 and over. These estimates show that non-usage rates are highest amongst the Pakistani 19.7% and Bangladeshi (22.3%) communities, whilst Indian, White and Black ethnic groups are 13-14%.

In summary:

- Nearly one-fifth of households do not use English as their main language
- Up to half the population may have a first language other than English
- Although nearly four-fifths of those who have English as an additional language rate their proficiency as good, this still leaves one-fifth below average or poor
- One in eight residents (regardless of first language) rate their reading or understanding English as below average or poor
- The Bangladeshi population reports higher rates of poor literacy (one in four), with women having poorer literacy than men
- The local population makes less use of the internet than elsewhere in London, with the Bangladeshi and Pakistani communities making less use than others.

Religion

According to Indications of Public Health in the English Regions 7: Mental Health (Association of Public Health Observatories 2007), there is some evidence (quoted in that publication) which suggests that involvement in religion or 'spirituality' may be an important factor for mental wellbeing [107]. Some studies have shown that religious involvement is

---

[106]Labour Force Survey 2011 Q2: Borough level breakdown produced under special licence by GLA

[107] Ellison CG and Levin JS (1998). *The Religion-Health Connection: Evidence Theory and Future Direction*. Health Education & Behaviour; 25(6):700-720

associated with positive mental health outcomes and religious commitment. [108] More specifically, some studies have shown that involvement in religion can lower the incidence and prevalence of depression, and there is a negative correlation between religiosity, spirituality, mental ill health and drug and alcohol abuse. Other factors with a direct influence on social capital such as social inclusion, strong social networks, and a more positive lifestyle are intimately intertwined with most religious movements.

The 2011 Census showed that Tower Hamlets had the highest proportion of Muslim residents of any local authority in England (34.5% of all residents), and conversely had the smallest proportion of Christian residents (27.1% of residents). The borough was also ranked third nationally for the proportion of residents opting not to answer the question on faith, with 15.4% of residents not stating a preference. The third largest group after Muslim and Christian residents were those who stated that they had no religious beliefs who accounted for 19.1% of residents.

The high proportion of Muslim residents means that there may be stronger protective factors for mental health in Tower Hamlets, if these arguments are accepted. Conversely, there may be higher risks given that nearly one fifth of residents have no religious belief.

4.4 Summary of risks and preventive factors for mental wellbeing

The overall national policy aim for mental wellbeing is to mitigate risks and strengthen protective factors.

There are recognised risk factors to mental wellbeing which contribute to worse outcomes. The key issues are:

- Maternity
- Children
- Looked after children
- Carers
- People with long term conditions
- Drug misuse
- Alcohol misuse
- Dual diagnosis of substance misuse and mental health problems
- Offenders
- LGTB
- Older people.

On some measures Tower Hamlets has been shown to face a greater challenge than the rest of London (carers, older people, drug and alcohol misuse) but all need attention because of the specific risks they pose to mental health (maternity, children, looked after children long term conditions, LGBT) or because all are linked to the high levels of deprivation which exist in the borough.

---

[108] Aukst-Margetic B and Margetic B. (2005). *Religiosity and Health Outcomes: Review of Literature*. Collegium Anthropologicum 29(1):365-371.)

A number of protective factors have been identified for mental wellbeing. However, several start from a low base in the borough:

- Employment
- Poor levels of physical activity
- Limited green space
- Limitations on language and literacy
- Religion can be a protective factor and the Muslim population means Tower Hamlets is well served in this respect; however, the one-fifth of the population with no religion cannot benefit.

These severe challenges to mental health and wellbeing in Tower Hamlets have been recognised by the:

- Priority in borough Health and Wellbeing Strategy
- Emergent programme of public mental health commissioning.

Further work is needed to share information, develop measures, and design and implement appropriate programmes of public mental health interventions[109].

109 Joint Commissioning Panel on Mental Health (2013) Guidance on Public Mental Health Services http://www.rcpsych.ac.uk/pdf/jcpmh-publicmentalhealth-guide[1].pdf

Chapter 5: Prevalence of mental illness

Chapter summary

- Data on post-natal depression is limited, but the national prevalence is estimated to be at least 13%. This equates to approximately 580 women in 2010/2011 in Tower Hamlets (based on 4,468 births). Approximately 900 women will be affected by common mental health problems during pregnancy
- Based on national prevalence of 10%, there are about 3,400 children and young people aged 5 to 16 with a mental disorder in the borough
- Prevalence of mental disorders among children and adolescents aged 15 years and under is 9.1% in Tower Hamlets, compared to 9.6% for the national prevalence rate. The reason for the difference from national rates is not known
- National estimates of prevalence and numbers among children and adolescents aged 5 to 16 are available and produce estimates for Tower Hamlets as follows: conduct disorders 1,100, emotional disorders 830, ADHD 230 and (based on a study in a London borough) Autistic Spectrum Conditions 360
- In a national survey, parents of children with mental disorders were seven to twelve times more likely than other parents to report that their child had harmed themselves
- A recent Tower Hamlets study shows the overall clinical incidence rate for Attention Deficit Hyperactivity Disorder (ADHD) corresponds to 0.22% of the school population and appears to indicate that the condition is under-diagnosed In Tower Hamlets, in relation to the research data.
- One in six adults in Great Britain has some form of common mental disorder at any one time. Applying this to the projected Tower Hamlets adult population (aged 18 and over: 200,617) would estimate approximately 35,300 adults to have a common mental disorder at any one time.
- In Tower Hamlets in 2011/12, a lower percentage of adults aged 18 and over (9.51% - 19,552 people) are on depression registers than the national average of 11.68%, but a higher percentage than the London average of 8.07%. In 2011/12 there were 15,906 people on the register.
- As of 1 April 2012, a total of 2,422 people were diagnosed with SMI (i.e. psychosis) according to local registers, of whom 1,409 (58%) are male and 1,013 are female (42%). This works out as an age standardised prevalence of 1.03%. On this measure, Tower Hamlets has a significantly higher prevalence (1.03%) than Newham (0.78%) and City and Hackney (0.90%)
- The prevalence of ten long-term conditions (and also of smoking) was higher among people with a serious mental illness in Tower Hamlets than in the rest of the population, illustrating the risks to physical health
- In a local audit in East London, serious mental illness was more prevalent in the black than the white population, but least prevalent in the Asian population
- It is estimated that 1,100 people in the borough have dementia; however just over half were on dementia registers (575) in 2012
- More needs to be done to understand the number of older people (aged 65 and over) with depression (estimated in the range 1,500 to 2,250) and the severity of their

depression, and also to understand the needs of the 275 older people identified with severe mental illness (i.e. psychosis) in the borough.

- Suicide rates are a high level indicator of mental health and wellbeing in a population. 61 suicides took place between 2008 to 2011 in Tower Hamlets. This does not amount to a rate statistically different to the national rate, which is falling overall. However, suicide reduction is an established public health target and remains a national and local priority
- Public Health estimate the following numbers of people with long term conditions in the borough: 2,900 people in the borough have COPD, 4,700 are diagnosed with coronary heart disease, 11,800 have diabetes and 2,000 people who have had a stroke. All have a higher risk of depression
- Based on population data of 16-74 year olds (183,724), the prediction is that that there should be approximately 735 adults suffering from antisocial personality disorder (ASPD) in Tower Hamlets and 918 with borderline personality disorder (BPD)
- The national Psychiatric Morbidity Survey showed higher rates of post-traumatic stress disorder among black men, but no local data on prevalence is known
- No local prevalence data on eating disorders is readily available, so further work is necessary to understand the needs of this group for services
- One in five users of community mental health services had drug or alcohol problems (780 of 3,900 unique patient seen by CMHTs in 2012/13)), and one in three users of inpatient mental health services. However, there is no authoritative way of identifying the number of people using substance misuse services who also have mental health problems(dual diagnosis), and no way of knowing whether they are the same people captured by the recording in mental health services
- There are 643 people on the learning disabilities register (aged 18 and over) in Tower Hamlets. This equates to a significantly lower percentage of all registered patients than the English average (0.3% versus 0.42%) and the same as the London average.
- There are an estimated 20,000 carers in Tower Hamlets. If an estimated one-third of the carers providing 50 unpaid care hours a week (5,700) experience depression, that gives 1,900 carers
- Nearly 1,100 offenders adhering to statutory conditions are managed by London Probation Service, of whom about 650 are living in the community (the rest are in custody). (NB Many offenders are not managed by probation, e.g. those with sentences less than 12 months, released without conditions, fined or cautioned.) Nearly a quarter (257) are described as having emotional or wellbeing issues linked to their offending, but this cannot be assumed to be a mental health need which necessarily requires treatment.

Table 7: Summary of estimated prevalence of mental disorders Tower Hamlets

Condition	Basis of calculation	No. in Tower Hamlets	Note
Antenatal depression/ anxiety	20% of births are to women with depression or anxiety	900 pa	NICE (8% may require referral for psychological therapies)
Postnatal depression/ anxiety	13% of births (included in above)	580 pa	Research
All childhood mental disorders	10% aged 5 to 16	3,400	2004 ONS survey
Conduct disorder (included in all childhood estimate)	6.6% aged 5 to 16	1,100	All children 2004 ONS (rates for boys and girls differ)
Emotional disorder (included in all childhood estimate)	5% aged 5 to 16	830	All children 2004 ONS (rates for boys and girls differ)
ADHD (included in all childhood estimate)	3 to 9% aged 5 to 16	230	All children 2004 ONS (rates for boys and girls differ)
Autistic Spectrum disorder (included in all childhood estimate)	0.4%	360	All children 2004 ONS (rates for boys and girls differ)
Common mental disorders (CMD)	Nationally calculated	35,300	As part of IAPT programme
Depression (included in CMD)	Observed	15,906	GP registers
Serious mental illness (psychosis)	Observed	2,422	Clinical Effectiveness Group
Dementia	Nationally calculated	1,100	To support dementia strategy
Dementia (included in nationally calculated)	Observed	575	GP registers

Note: ONS - Office for National Statistics. ADHD Attention Deficit Hyperactivity Disorder

1. Introduction: national and local prevalence of mental disorders

As described in chapter 3, Tower Hamlets has high levels of deprivation and associated socio economic characteristics that can increase the risk of mental health problems and reduce mental well-being in the population. This chapter examines the national and local prevalence data for different mental health conditions across the life course:

- Depression in pregnant women and mothers
- Mental disorders in children and adolescents
- Common mental disorders in adults
- Serious mental illness (SMI)
- Older people's mental health.

The following are relevant to residents at any age:

- Suicide
- Self harm and suicide attempts

- Long-term physical health conditions
- Personality disorder (adults)
- Post-traumatic stress
- Eating disorders.

Finally, information is given on the numbers of people in groups of the population who have a higher risk of mental health problems:

- Carers
- Dual diagnosis with learning disabilities and substance misuse
- Dual diagnosis of mental health problems and substance misuse
- Offenders.

Where possible, high level benchmarking data has been included to allow comparison with London and England.

2. Mental health of mothers in pregnancy and the year after childbirth

Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status[110].

It is also important to note the impact that parental mental health problems can have, and the potential impact to children born in families with pre-existing mental health problems. It is important to address the parents' mental state as there is considerable evidence that untreated postnatal depression in parents has a negative impact on the infant's emotional and psychological development[111].

Research has shown that some children of parents with a severe and enduring mental illness experience greater levels of emotional, psychological and behavioural problems than children and young people in the rest of the population. Problems can be long term, and both behavioural problems and impaired cognitive outcomes in children up to 7 years old have been reported[112].

National estimates suggest there are about 175,000 young carers in the UK who are caring for a parent or other family member with mental health problems[113].

[110]Waldfogel J (2004) Social mobility, life chances, and the early years, CASE Paper 88, London: London School of Economics
[111]Murray and Cooper, 1997, Postpartum Depression and Child Development, New York
[112]Huizink et al. 2003: O'Conner et al, 2003
[113]Mental health foundation http://www.mentalhealth.org.uk/help-information/mental-health-a-z/P/parents/

Background and national prevalence of antenatal and postnatal depression

The NICE commissioning guide (2008) for antenatal and post natal mental health services estimates that 20% of deliveries are to women with common mental disorders (mainly anxiety and depression). Of these, around 4% of will be to women who have severe and/or complex mental disorders and about half the remainder, or 8%, are to women who will require and take up the offer of psychological therapies.[114]

Postnatal depression (PND) can be defined as any non-psychotic depressive illness of mild to moderate severity occurring during the first postnatal year. It is common, and the prevalence of depression in the first month after childbirth is three times the average monthly prevalence in non-childbearing women[115]. There is a threefold increase in depression in the five weeks after delivery[116]. Risk factors include past history of mental illness, low social support, poor marital relationship, and potentially unplanned pregnancy, unemployment and antenatal parental stress.

A meta-analysis of studies mainly based in the developed world found the prevalence of PND to be at least 12-13%, with higher incidence in developed countries such as England[117] [118]. Some studies have estimated 12.7% as the rate of depression during pregnancy and 21.9% at 12 months[119].

Local prevalence

It has not been possible to obtain local data on postnatal depression, but since many of the risk factors listed above apply to a significant number of women in Tower Hamlets, it can be assumed that the prevalence of PND is at least 13% if not more.

In 2009, PND would have affected approximately 570 women (based on 4,358 births), and approximately 580 women in 2010/2011 (based on 4,468 births[120]). The estimate given by NICE, which estimates the number with common mental disorders during pregnancy at 20%, would give the numbers potentially requiring support as 871 and 893 respectively.

3. Prevalence of mental health problems in childhood and adolescence [121]

Prevalence estimates for mental health disorders in children aged 5 to 16 years were estimated in a report by the Office of National Statistics published in 2005[122] Prevalence

---

114 http://www.nice.org.uk/usingguidance/commissioningguides/antenatalpostnatalmentalhealth/assumptionsusedestimatingpopulationbenchmark.jsp

115 http://www.babycentre.co.uk/a1041792/postnatal-depression-research-brief

116 Cox et al 1993, British Journal of Psychiatry 163:27-31, A controlled study of onset, duration and prevalence of postnatal depression

117 NICE Clinical Guideline CG45 Antenatal and postnatal mental health

118 Mental Health in East London and the City. A Sector-Level Health Needs Assessment. 2011; Tower Hamlets JSNA Core Dataset/ONS

119 Gavin et al., (2005) Obstetrics and Gynaecology 106

120 Mental Health in East London and the City. A Sector-Level Health Needs Assessment. 2011; Tower Hamlets JSNA Core Dataset/ONS

121 For more information please see Child and adolescent mental illness, mental health and emotional wellbeing factsheet http://www.towerhamlets.gov.uk/lgsl/701-750/732_jsna.aspx

122 Green et al (2005). Mental Health of Children and Young People in Great Britain 2004, Office for National Statistics).

rates were based on the ICD-10 Classification of Mental and Behavioural Disorders with strict impairment criteria – the disorder causing distress to the child or having a considerable impact on the child's day to day life. The report found that in 2004, one in ten children and young people (10 per cent) aged 5 to 16 had a clinically diagnosed mental disorder: 4 per cent had an emotional disorder (anxiety or depression), 6 per cent had a conduct disorder, 2 per cent had a hyperkinetic disorder, and 1 per cent had a less common disorder (including autism, tics, eating disorders and selective mutism). Some children (2 per cent) had more than one type of disorder.

Prevalence varies by age and gender, with boys more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%). Children aged 11 to 16 years olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems. 40% of young people who have a learning disability may also have a mental health disorder[123].

Some available estimates indicate that the prevalence of mental disorders among children and adolescents aged 15 years and under is 9.1% in Tower Hamlets, compared to 9.6% for the national prevalence rate[124] [125].

The accuracy of such estimates when applied to Tower Hamlets is under debate. The scale of deprivation across the borough may suggest an underestimation to the actual need in Tower Hamlets; conversely, the existence of protective factors such as family and social cohesion and connectedness may serve to reduce the prevalence of mental ill-health and wellbeing. In this strategic needs assessment, the national estimate has been retained.

Unfortunately, very little local data is available on which to base estimates of expressed need (unmet) or unexpressed need.

If the higher 10% rate is applied to Tower Hamlets population aged 5 to 15 (31,393 at the 2011 census), this would give 3,139. (The 16 year olds are not included - resulting in an under-estimate - since the census data on population by year of age is not yet available.)The 9.6% rate used in local prevalence studies would give 3,013.

A publication from 1996 (shortly after the tiered modeled was adopted) provides an estimate[126] of the number of children/young people who may experience mental health problems appropriate to a response from child and adolescent mental health services (including universal services) at each of Tiers 1 (universal), 2 (targeted), 3 (specialist) and 4 (inpatient). Table 8 below shows these estimates when applied to the 2011 Tower Hamlets population aged up to 17 and estimated at 58,737 before the detailed release of age band data in the 2011 census).

[123]Foundation for People with Learning Disabilities, 2002

[124]The Office of National Statistics (2001) small area estimate for childhood mental disorder in England at ward level is based on variables that are significantly associated with an increase in the rate of mental disorders such as age, gender, household composition/tenure, economic status, social class, and household income

[125]Meltzer (2003*) Model-based small area estimation series No. 1. Childhood Mental Disorder in England: Ward Estimates* Office for National Statistics

[126]Kurtz Z. *Treating Children Well* London: Mental Health Foundation, 1996

Table 8: Estimated number of children/young people aged 17 years and under who may experience mental health problems appropriate to a response from child and adolescent mental health services (2011 population estimate)

CAMHS Tier	Tower Hamlets
Tier 1[127] (15%)	8,810
Tier 2 (7%)	4,111
Tier 3 (1.85%)	1,086
Tier 4 (0.075%)	44

Applying Psychiatric Morbidity Survey (Office for National Statistics) prevalence estimates[128] to the population estimates for 2011 and 2016 in Tower Hamlets suggests the following prevalence of mental disorders (NB they are not totalled since some children have more than one disorder):

Table 9: Estimated number of children aged 5 to 16 years with mental disorders (ONS prevalence)[129]

Disorder Type	Tower Hamlets	
	2011	2016
Conduct disorders (5.8%)	2,090	2,351
Emotional disorders (3.7%)	1,333	1,500
Being hyperactive (1.5%)	540	608
Less common disorders (1.3%)	468	527

Approximately 2% of children are estimated to have more than one type of disorder (equating to approximately 720 individuals in Tower Hamlets)

Source: GLA population estimates; prevalence rates from Mental Health of Children and Young People in Great Britain 2004.
Less common disorders: Autistic Spectrum Disorder (ASD), tic disorders, eating disorders, mutism)

In contrast to the previous table, these estimates adopt a higher threshold and apply to the population aged 5 to 16 than the previous table and are more likely to reflect numbers requiring services at tiers 2 and 3.

National evidence suggests that between the ages of 11 and 16 the rates for both boys and girls are higher[130].The estimated number of residents aged 11-16 years in Tower Hamlets is 16,600.

[127]Tier 1: provision at this level is provided by practitioners who are not mental health specialists working in universal services; this includes GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies. Tiers are explained more fully on the link below:
http://webarchive.nationalarchives.gov.uk/20100202100434/http://dcsf.gov.uk/everychildmatters/healthandwellbeing/mentalhealthissues/camhs/fourtierstrategicframework/fourtierstrategicframework/
[128]Mental Health of Children and Young People in Great Britain (2004); Office for National Statistics
[129]Based on GLA 2011 Round Ethnic projections
[130]Mental Health of Children and Young People in Great Britain (2004); Office for National Statistics

The estimated number of children aged 11-16 years with the following disorders according to the same ONS estimates is shown in the following table.

Table 10: Estimated number of disorders by sex for children aged 11-16 years in Tower Hamlets (ONS prevalence)

Disorder Type	**Estimated numbers affected**		
	Males	**Females**	**Total**
Conduct disorders	672 (8.1%)	428 (5.1%)	1096 (6.6%)
Emotional disorders	332 (4%)	512 (6.1%)	830 (5%)
Hyperactive disorders	199 (2.4%)	34 (0.4%)	233 (1.4%)
Less common disorders	133 (1.6%)	92 (1.1%)	233 (1.4%)

Source: GLA population estimates; prevalence rates from Mental Health of Children and Young People in Great Britain 2004
Note: Less common disorders: Autistic Spectrum Disorder (ASD), eating disorders, mutism)

Reliable prevalence estimates by ethnicity are unfortunately unavailable.

3.1 Conduct and emotional disorders

Conduct disorder is a disorder of childhood and adolescence that involves long-term (chronic) behaviour problems, such as defiant or impulsive behaviour, drug use or criminal activity. Emotional disorder is described as any mental disorder not caused by detectable organic abnormalities of the brain and in which a major disturbance of emotions is predominant.

The national estimate of prevalence (as used in the above table) is 8.1% in boys aged 11-16 and 5.1% in girls.

3.2 Autistic Spectrum Disorders (ASD)

Background and national prevalence

ASD is diagnosed according to guidelines listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition - Text Revision* (DSM-IV-TR). The manual currently defines five disorders, sometimes called pervasive developmental disorders (PDDs), as ASD:

- Autistic disorder (classic autism)
- Asperger's disorder (Asperger syndrome)
- Pervasive developmental disorder not otherwise specified (PDD-NOS)
- Rett's disorder (Rett syndrome)
- Childhood disintegrative disorder (CDD).

A study in South East London in 2006[131], estimated the prevalence of childhood autism at 38.9 per 10,000 and that of other Autistic Spectrum Disorders (ASD) at 77.2 per 10,000, making the total prevalence of all ASDs 116.1 per 10,000 or approximately 1%[132]. The European Union Commission highlights the problems associated with establishing prevalence rates for ASD e.g. the absence of a long-term study of psychiatric case registers and inconsistencies of definition over time and between locations.

Local prevalence

If the prevalence rate found by the South London study were applied to the population aged 5 to 16 years of Tower Hamlets this would estimate approximately 360 cases. In 2010/11 there were 205 children aged 18 and under in Tower Hamlets with an Autistic Spectrum Disorder alone, and a further 65 children with an ASD in combination with another disability. There are thought to be around 1,910 adults with ASD in Tower Hamlets in 2011, approximately 765 of whom do not also have a learning disability[133].

3.3 Attention Deficit Hyperactivity Disorder (ADHD)

Background and national prevalence

Attention deficit hyperactivity disorder (ADHD) is a widely recognised complex developmental disorder in childhood. It is best understood as a group of behavioural symptoms that reflect excessive impulsivity, hyperactivity and/or inattention. Extensive research evidence points to a neurobiological basis for AD/HD[134].
Prevalence estimates for childhood ADHD are thought to be in the region of 3% to 9%[135]. There are very considerable discrepancies in reported clinical incidence rates with up to 11% of American children being diagnosed as ADHD in certain regions of the USA compared to only 0.4% in the UK.

Local Prevalence

A recent Tower Hamlets study[136] shows the overall clinical incidence rate for ADHD corresponds to 0.22% of the school population and appears to indicate that the condition is significantly under diagnosed in relation to the research data concerning its prevalence in the population (i.e. the range of 3 – 9%quoted in the previous paragraph). Caution however must be exercised in interpreting the prevalence rates reported.

---

[131]Baird et al., (2006) *Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP)* The Lancet; 368:210-215
[132]This study supersedes the Medial Research Council study which estimated the prevalence of ASD at 60 per 10,000 population aged less than 8 years
[133]Tower Hamlets JSNA Autistic Spectrum Disorder: Factsheet
[134]Nigg, J.T. (2006) *What causes AD/HD?* New York: Guilford Press
[135]For further information see: http://www.nice.org.uk/guidance/index.jsp?action=download&o=39062
[136]Henryk Holowenko (2012) *Is AD/HD Overdiagnosed? A survey of clinical incidence across schools within an Inner London local authority*

The issue of differential diagnosis highlighted in the context of the surprising variation in numbers between ADHD and autistic spectrum condition (ASC) seems to be particularly pertinent. While the number of pupils with a clinical diagnosis of ASC within the locality stood at 0.9% of the population this was in stark contrast to the identified numbers of pupils with ADHD at 0.2%. The clinical incidence for ASC figures compare well to the reported NICE prevalence rates of 1%[137] in contrast to the ADHD figures which appear to be substantially below the reported NICE prevalence rates of 3.62% of boys and 0.85% of girls[138].

3.4 Self-harm in children and adolescents

Background and national prevalence

A conservative estimate is that there are 24,000 cases of attempted suicide by adolescents (of 10-19 years) each year in England and Wales, which is one attempt every 20 minutes[139]. Self-harming in young people is not uncommon (a separate study suggests that 10%–13% of 15–16-year-olds have self-harmed)[140]. A Samaritans study found that four times more adolescent females self-harmed than adolescent males[141]. It is important to note that a lot of self-harm incidents do not come to medical attention.

The ONS survey of mental health of in childhood reported that parents of children with mental disorders were much more likely to report that their child had harmed themselves. The following figures apply to children of all ages:

- Emotional disorders 14 %
- Conduct disorders 16 %
- Hyperkinetic disorders 14 %
- Autistic spectrum disorder 25 %

Among parents of children without a mental disorder the rate was 2%.

As many as 30% of adolescents who self-harm report previous episodes and at least 10% repeat self-harm during the following year, with repeats being especially likely in the first two or three months. The risk of suicide after deliberate self-harm varies between 0.24% and 4.30%. Knowledge of risk factors is limited and can be used only as an adjunct to careful clinical assessment when making decisions about after care. However, the following factors seem to indicate a risk: being an older teenage male; violent method of self-harm; multiple previous episodes of self-harm; apathy, hopelessness, and insomnia; social isolation, substance misuse, comorbid mental health problems and previous admission to a psychiatric hospital[142].

---

[137] National Institute of Clinical Excellence, 2011
[138] National Institute of Clinical Excellence, 2009
[139] Hawton, K, Simkin, S, Harriss, L, Bale, E and Bond, A, (unpublished), (1999b), *Deliberate Self-harm in Oxford 1999*, enquiries to Professor Hawton, University Dept of Psychiatry, Warneford Hospital, Oxford OX3 7JX
[140] Hawton K, Rodham K, Evans E and Weatherall R (2002) *Deliberate self-harm in adolescents: self-report survey in schools in England* British Medical Journal 325: 1207–1211
[141] Samaritans, (2003), *Youth and self-harm: Perspectives – A report* www.samaritans.org
[142] Ibid

4. Common Mental Disorders (CMD) in adults of working age

Background and national prevalence

Common mental disorders (CMDs) are mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder, and may affect up to 15% of the population at any one time. Reducing the prevalence of common mental disorders such as depression and anxiety is a major public health challenge[143]. CMDs can result in physical impairment and problems with social functioning, and are a significant source of distress to individuals and those around them. Both anxiety and depression often remain undiagnosed[144] and often individuals do not seek treatment. If left untreated, CMDs are more likely to lead to long term disability and premature mortality[145]. People with long term physical health conditions have a higher risk of depression.

Depression and anxiety disorders can have a lifelong course of relapse and remission. There is considerable variation in the severity of common mental health disorders, but all can be associated with significant long-term disability[146].

The most recent National Psychiatric Morbidity Survey among adults living in private households[147] showed that depression with anxiety is experienced by 9.7% of people in England, and depression without anxiety by 2.6%[148]. (A table showing prevalence for each separate disorder is given in the Appendix.) Women have a higher prevalence of mixed anxiety and depressive disorder than men. The figure for women is 11.8 % of the population in England and for men 7.6 %[149]. Although the overall prevalence of common mental disorders did not increase between the psychiatric morbidity surveys of 2000 and 2007, the prevalence among women aged 16-64 did increase.

People on low incomes are more likely to experience common mental disorders. The National Psychiatric Morbidity Survey showed that people in the lowest quintile of equivalised household income are more likely to have CMDs than those in the highest quintile, with a linear trend through the income quintiles. The pattern is more marked in men than women.

---

[143]Goldberg DP, Huxley P. (1992) *Common mental disorders: a bio-social model.* London; New York: Tavistock/Routledge

[144]Kessler D, Bennewith O, Lewis G, Sharp D. (2002) *Detection of depression and anxiety in primary care:*
follow up study BMJ, 325(7371) 10: 16-1017

[145]Cassano P, Fava M. (2002) *Depression and public health: an overview* J Psychosom Res, 53: 849-57

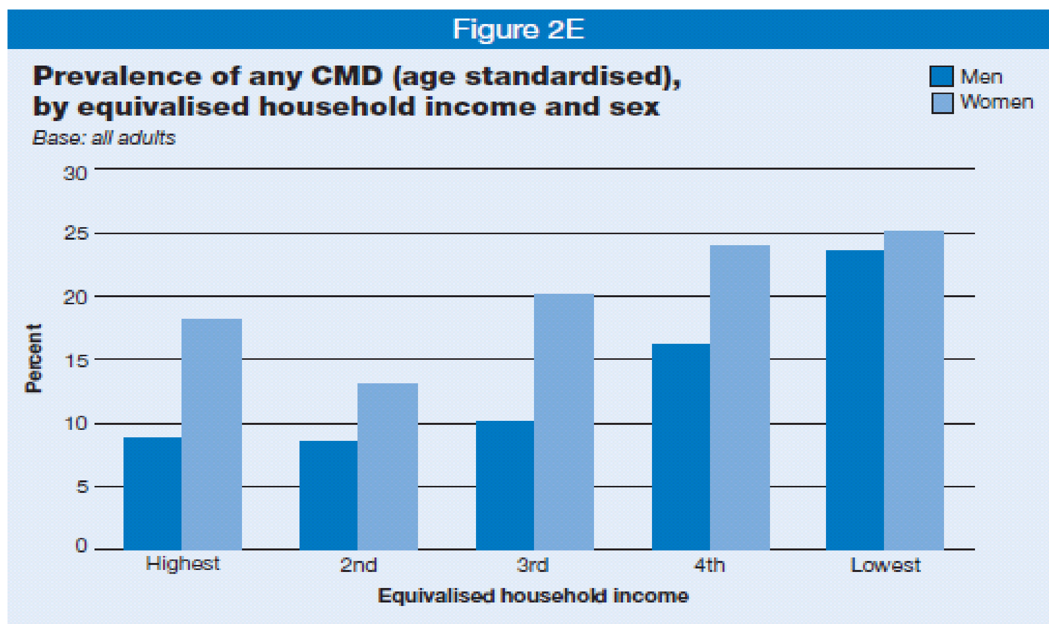
[146]NICE (May 2011) Common mental health disorders: Identification and pathways to care

[147]Singleton N, Bumpstead R, O'Brien M et al., (2001) *Psychiatric morbidity among adults living in private households, 2000*

[148]McManus S, Meltzer H, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey* NHS Information centre for health and social care

[149]Ibid

Figure 25: Prevalence of any CMD (age standardised), by equivalised household income and sex



Source: National Psychiatric Morbidity Survey 2007

According to one study (using national data from the 1990s and covering common mental disorders) 'the poor among the Bangladeshi, Pakistani and African Caribbean groups clearly suffered both from low income and a greater burden of mental health morbidity than the [Irish, White and Indian] groups.' [150] -

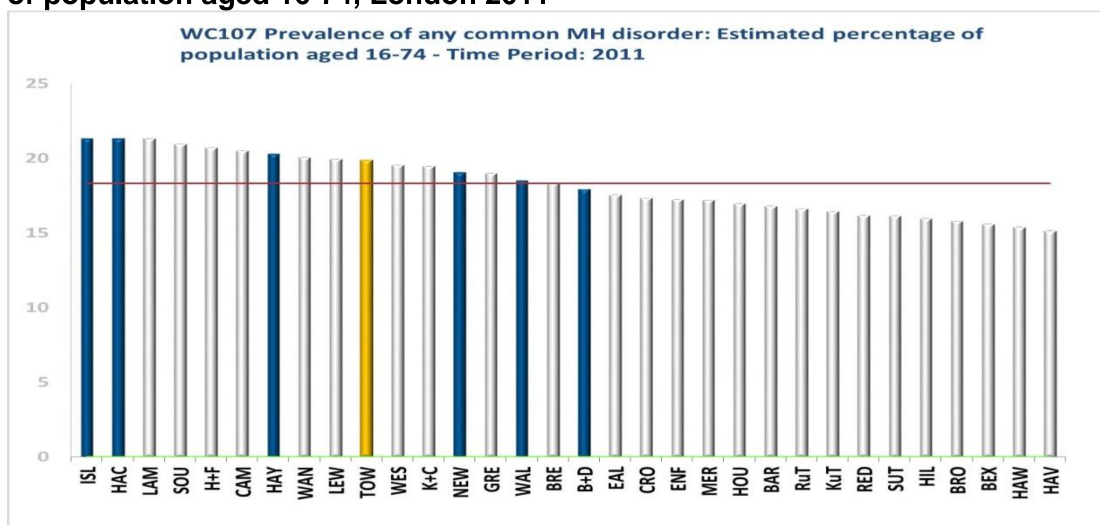
Detailed prevalence rates for common mental disorder are given in the Appendix to this chapter.

Local prevalence

Applying the Psychiatric Morbidity Survey results to the Tower Hamlets adult population (16-64) (190,038[151]) we would expect approximately 33,500 adults to have a common mental disorder at any one time. The expected prevalence for Tower Hamlets (as a percentage of population aged 16-74) is highlighted in the figure below:

[150] Mangalore R & Knapp M (2012) Income related Inequalities in Common Mental Disorders among ethnic minorities in England *Soc Psychiatry and Psychiatric Epidemiology* 47, 351-9
[151] Census, 2011

Figure 26: Prevalence of any common mental health disorder: estimated percentage of population aged 16-74, London 2011



Source: North East Public Health Observatory estimates based on the National Psychiatric Morbidity Survey, updated with 2011 population data (MH tool indicator WC107)

This shows that Tower Hamlets ranks 10th in London boroughs in the estimated population of people with common mental disorders, and in the middle of its comparator group of boroughs with similar needs (shaded columns).

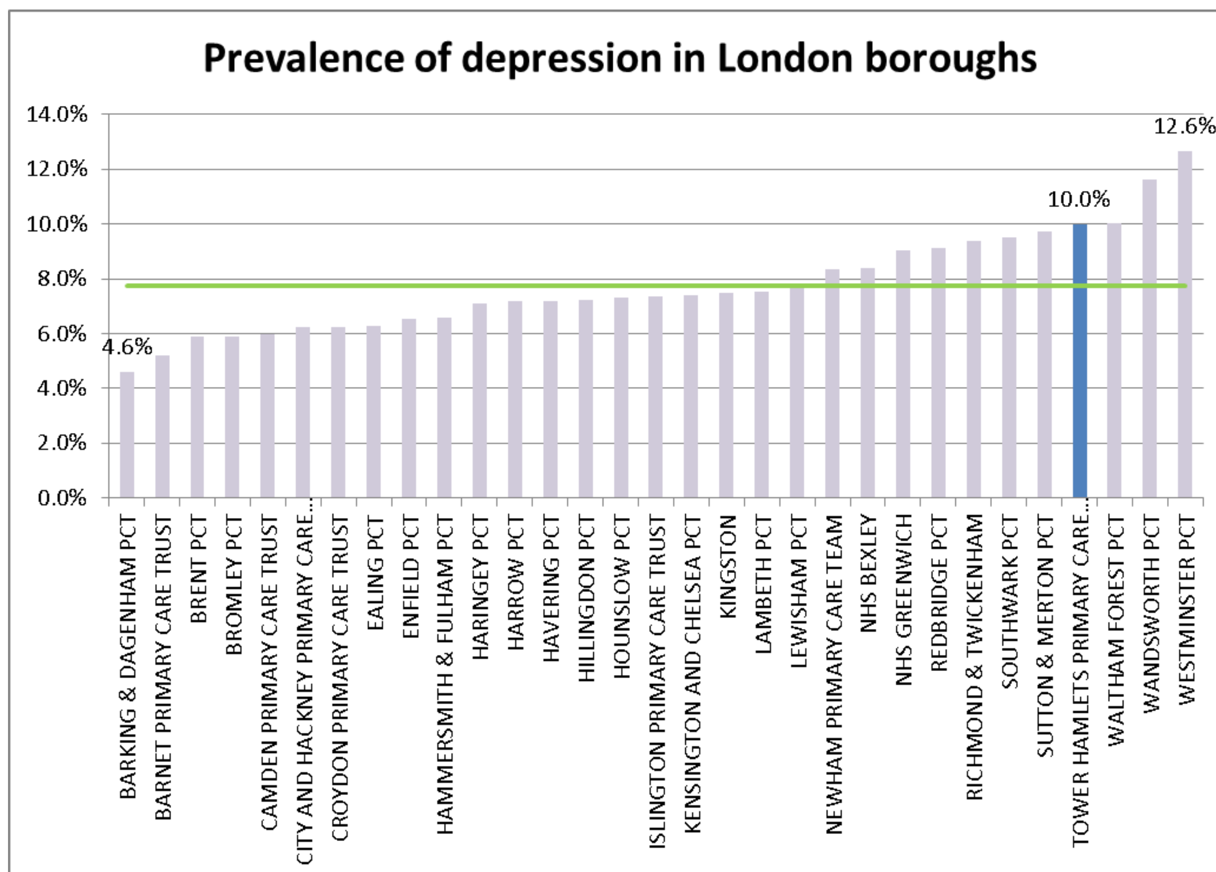
It is important to note that not everyone will seek treatment or even need it, and some will have already received treatment. It is estimated that at a given point in time around a fifth of those with the conditions set out above would benefit from psychological therapies (around 7,000 people)[152]. It is worth noting that a great deal of these disorders are dealt with in primary care. This therefore has implications for GPs and their everyday practice.

GP practices hold a register of people diagnosed with depression (as noted this figure is lower than estimated prevalence since some people are not diagnosed). In 2011/12 there were 15,906 people on the register. The following chart shows the raw prevalence of depression (i.e. the number on the practice register divided by the total list size) for London.

---

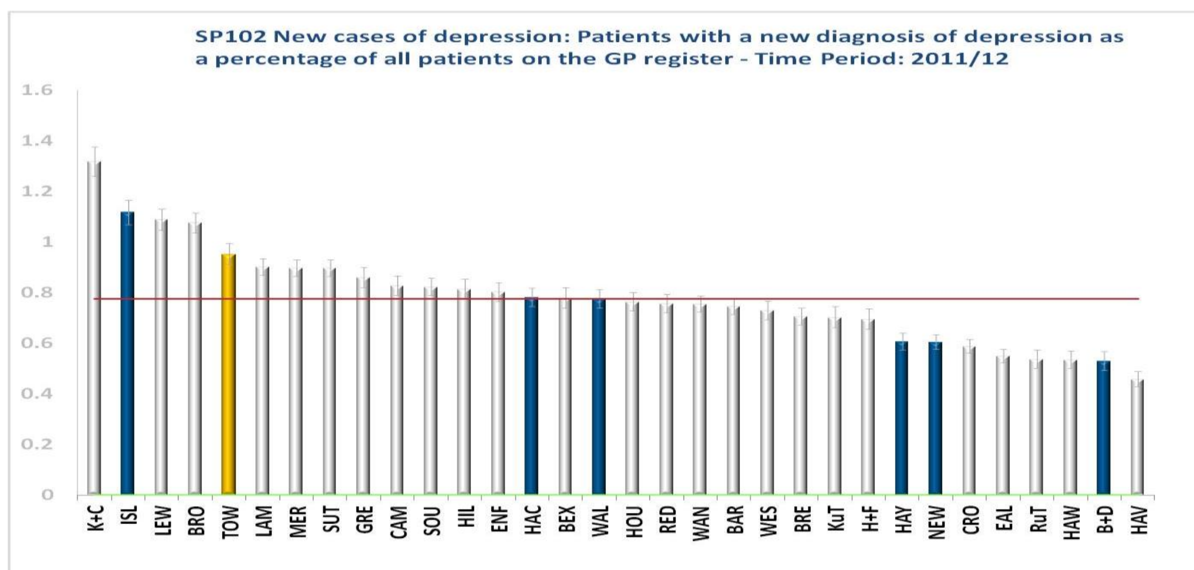
[152] Ibid

Figure 25: Prevalence of observed depression in Tower Hamlets and London boroughs



This shows that in 2010/2011 Tower Hamlets had one of the highest rates of observed prevalence of depression in London (at 10.0%) when looking at GP registers. The following table shows the percentage of patients with a new diagnosis of depression.

Figure 26: Patients with a new diagnosis of depression as percentage of all patients on GP register, 2011/12



Source: Quality Outcomes Framework 2010/2011[153]

This is further confirmation of the high prevalence of depression in Tower Hamlets. The following table shows the prevalence of depression in four localities (North East (GP networks 1 & 2), North West (networks 5 & 6), South East (networks 3 & 4) and South West (networks 7 & 8).

Table 11: Numbers on depression register (CEG) and age standardised prevalence by locality

Locality	Depression register average	Age Standardised Prevalence
North East locality	115.3	1.77%
North West locality	187.3	2.45%
South East locality	201.3	2.40%
South West locality	109.75	1.48%

Source: CEG

Within Tower Hamlets, using locally collected CEG data[154], the North West locality has the highest age standardised prevalence rate.

[153]This indicator estimates the prevalence of depression from General Practice records (QOF, The NHS Information Centre for health and social care)
[154]QOF inclusion criteria are much broader than CEG. CEG is the Clinical Effectiveness Group, a partnership between GPs and the Centre for Primary Care and Public Health at the Blizard Institute, Queen Mary University of London

Summary

- The commonest mental illnesses are those conditions referred to as common mental disorders – mainly depression and anxiety, experienced by just over 16 per cent of adults aged 16-74
- Based on national estimates, about 33,500 people experience common mental disorders at any one time – this is in the top third in London
- People on low incomes are more likely to experience common mental disorders
- There were 15,906 people on GP depression registers in 2011/12
- Figures from GP practice data show that Tower Hamlets has the fourth highest prevalence of depression recorded by GPs (cases on the depression register) and the fourth highest for new diagnoses
- Within Tower Hamlets, the North West and the South East localities have the highest rates of depression.
- One national study indicated that people of Bangladeshi origin suffer more from both low income and a greater burden of mental health morbidity for common mental disorders, than the white ethnic group.

5. Serious Mental Illness (SMI) in adults of working age

Background and national prevalence

Serious Mental Illness (SMI) is a term used to refer to mental illnesses such as schizophrenia and bipolar disorder. When estimating prevalence, these two conditions are called 'psychoses'. This JSNA uses the term and abbreviation SMI, but also recognises that other mental health conditions are 'serious' to the person that is affected by them and their families/carers.

Despite being relatively uncommon (generally estimated at about 1% of the population), psychotic illness results in high service and societal costs[155] and to people and those around them. The World Health Organisation (WHO) calculates that the burden and human suffering associated with psychosis at the family level is exceeded only by dementia and quadriplegia[156]. People with a psychotic illness and living in the community are known to have low rates of employment[157], and when employed are often in poorly paid and less secure jobs[158].

The National Psychiatric Morbidity Survey 2007 found that there was no change in the overall prevalence of probable psychosis[159] between the 2000 and 2007 surveys: the rate was 0.5% of 16-74 year olds in both years (asking about the previous year in terms of symptoms, diagnosis and hospital admission). In both surveys the highest prevalence was observed among those aged 35 to 44 years (1.0% in 2000, 0.8% in 2007)[160]. Nationally according to the Psychiatry Morbidity Survey, the prevalence of psychotic disorder is particularly high in mid-adulthood. When compared to the local population age structures, we can see that this is likely to contribute to a higher prevalence of psychotic disorder overall, due to a disproportionately large number of young-middle age adults (and growing) in Tower Hamlets[161].

Comparison in London.

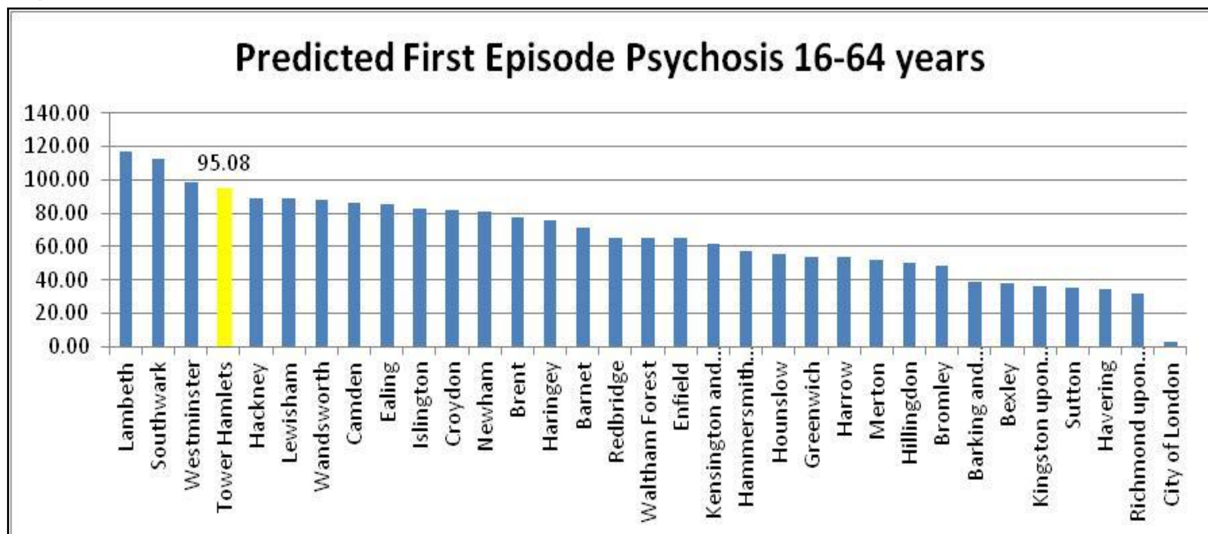
The number of first episodes of psychosis in London boroughs has been predicted by Psymaptic, a model built on epidemiological study in East London which forecasts the

---

[155] Knapp M (2003) *Costs of schizophrenia* British Journal of Psychiatry; 171:509-518.
[156] World Health Organisation (2001) *The World Health Report: Mental health: new understanding, new hope* World Health Organisation: Geneva
[157] Forster K, Meltzer H, Gill B, Hinds K (1996) *Adults with a Psychotic Disorder living in the Community:*
OPCS Surveys of Psychiatric Morbidity in Great Britain, Report 8 Office for National Statistics: London
[158] Marwaha S and Johnson S. (2004) *Schizophrenia and employment* Soc Psychiatry Psychiatr Epidemiol,39: 337-349
[159] It is defined as 'probably psychotic disorder' due to the survey methods – the survey was administered to people who may not have been diagnosed with a mental illness and therefore the survey was not able to formally make this diagnosis
[160] McManus S, Meltzer H, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey* NHS Information centre for health and social care
[161] Mental Health in East London and the City, A Sector-Level Health Needs Assessment (2011)

expected incidence of clinically-relevant first episode psychoses. The following figure shows the expected incidence for London borough.

Figure: 27: Predicted incidence of first episode psychosis per year



Source: Psymaptic

This shows that Tower Hamlets has the fourth highest incidence in London. This is likely to be related to the young age structure of the population. Actual demand for psychosis services, including EIS, may be significantly higher, given a proportion of people who will present to services with some level of mental health need, but who may not be in their first episode of a psychotic disorder.

Local prevalence

In Tower Hamlets SMI conditions are routinely measured by the Quality and Outcomes Framework (QOF) and are also recorded locally by the Clinical Effectiveness Group or CEG (see note on definitions in Appendix to this chapter)

Higher numbers of recorded cases in Tower Hamlets are to be expected due to higher risk factors such as a young (working age) population, deprivation, homelessness and substance misuse,

CEG data is permits analysis of SMI population by available demographic information. It uses a narrower definition than QOF and is collected in the three boroughs covered by East London Foundation Trust, and results in a considerably smaller number. The information is therefore thought to be reliable. However, it cannot be used in wider London or national comparisons.

As of 1st April 2012, a total of 2,422 people were diagnosed with SMI of which:

- 1,409 (58%) are male and 1,013 are female (42%).
- 69 (2.8%) had learning disabilities

- 49 are recorded as housebound (2%)[162].

Seventy-two per cent of the recorded SMI patients reside in areas in the lowest two deprivation quintiles (range of 1-5).

CEG figures show an age standardised prevalence of 1.03% for Tower Hamlets - a higher prevalence than Newham (0.78%) and City and Hackney (0.90%). Differences could be explained by differences in detection rates or in recording.

Table 11 and Figure 26 below show that ethnicity of those currently with SMI known to general practice, showing both CEG and QOF data.

Table 12: Ethnicity breakdown of SMI register (CEG and GOF comparison)

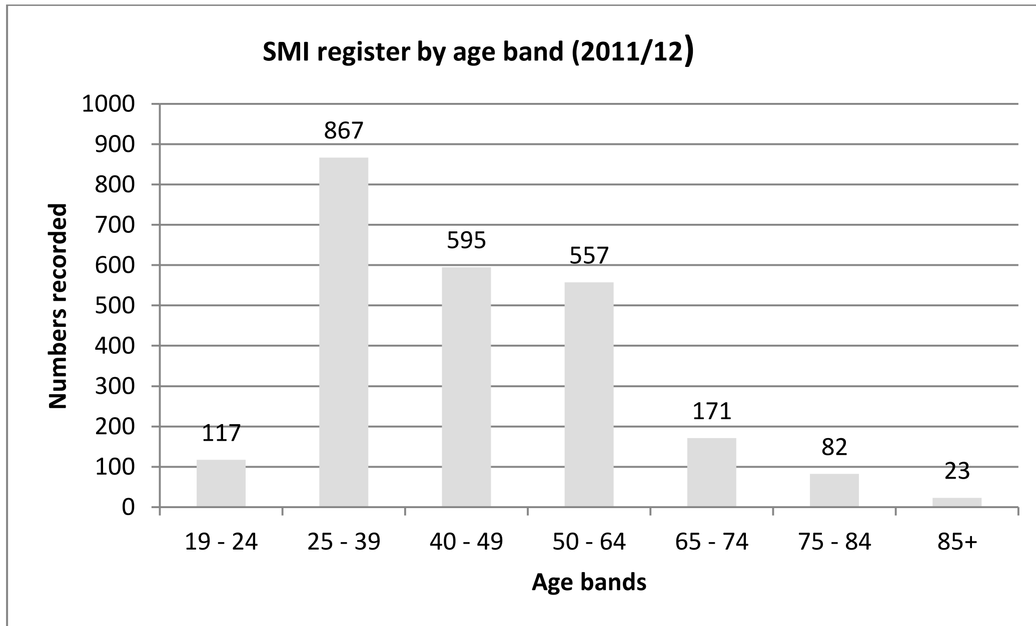
Ethnicity	Proportion of SMI register (CEG)	Proportion of QOF register
White	38.9%	42.9%
South Asian	37.0%	33.9%
Black	18.3%	16.7%
Other ethnic group	3.0%	3.2%
Not stated	1.2%	1.4%
Not recorded	1.2%	1.8%

Source: Clinical Effectiveness Group and QOF, 2012

[162] For the same timescales, QOF figures indicated numbers on the SMI register at 3,556 with a breakdown of 55% male and 45% female

This shows that the greatest number of people with SMI are white, followed by Bangladeshi (with some differences between the sizes of the two groups) and then black. The following table shows the age-band of people with psychosis as recorded by CEG.

Figure 28: Tower Hamlets SMI cases (numbers) by age band

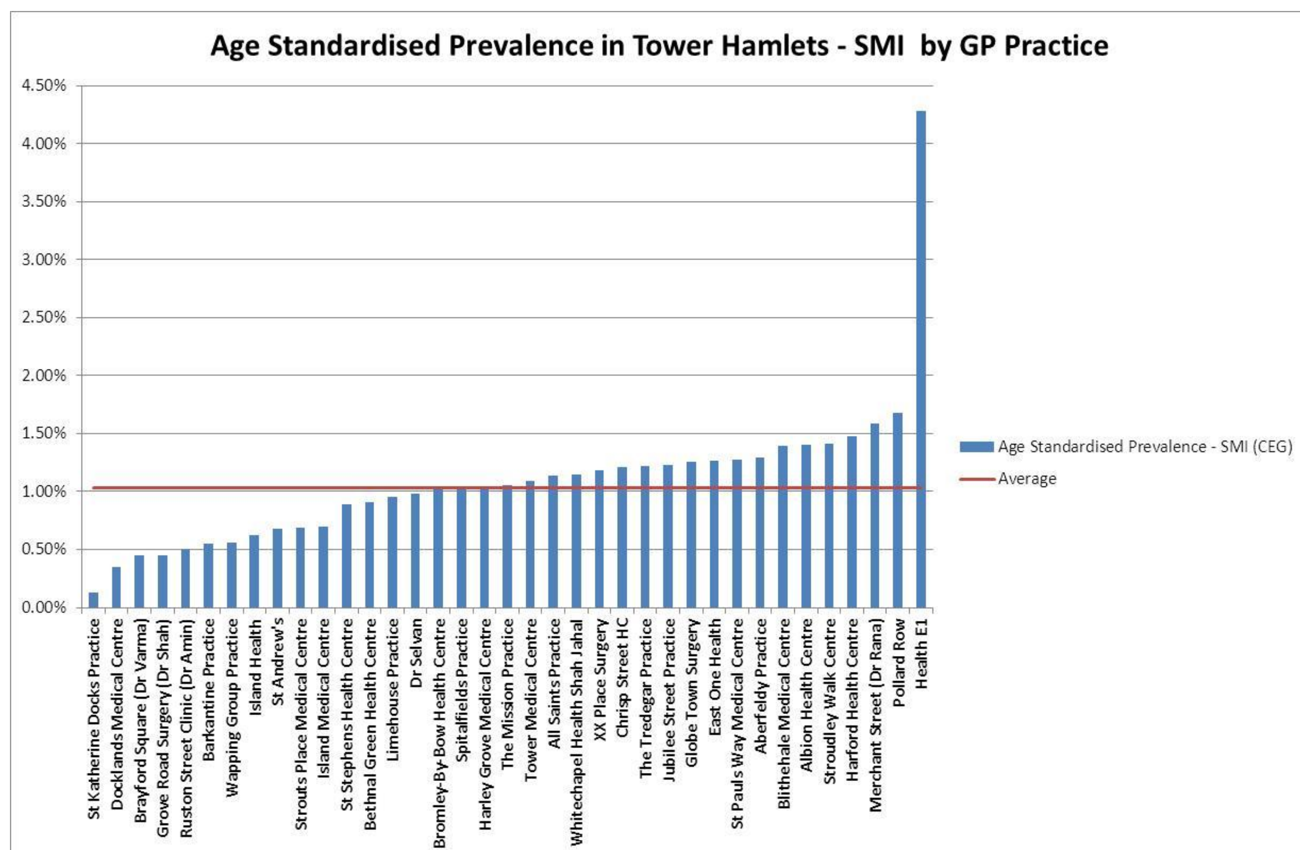


Source: Clinical Effectiveness Group, 2012

This shows the high prevalence in the 25-39 age band, although it should be noted that this band covers 15 years.

The following figure shows the prevalence of serious mental illness by GP practice.

Figure 29: Age standardised prevalence for SMI in Tower Hamlets by GP practice



Source: Clinical Effectiveness Group, 2012

This shows there is considerable variation in the prevalence recorded by GPs. The Health E1 practice has highest prevalence because it was set up to meet the needs of street homeless people, hostel

Table 13 shows age standardised prevalence and average numbers on psychosis register by Tower Hamlets locality and GP practice.

Table 13: Age standardised prevalence of SMI in Tower Hamlets by locality

Locality	SMI register average	Age Standardised Prevalence
North East locality	49.8	1.01%
North West locality	85.3	1.49%
South East locality	60.8	0.87%
South West locality	65.4	0.92%

Source: Clinical Effectiveness Group, 2012

The North West is higher as Health E1 practice[163] is included in this locality and as they serve a higher risk population group. The South East locality, which had the second highest prevalence of depression, has the lowest SMI prevalence.

The following table shows the prevalence of physical ill health amongst people with serious mental illness.

Table 14: Crude disease prevalence per 1,000 population for people with serious mental illness in Tower Hamlets compared to all residents

Long term condition/disease	All	Serious Mental Illness
Asthma	44.4	67.7
Cancer	11.2	20.1
Chronic Obstructive Pulmonary Disease	10.4	30.2
Coronary Heart Disease	17.0	23.8
Diabetes	44.4	153.3
Hypertension	75.9	151.9
Learning Disabilities	2.8	26.5
Obesity (BMI>30)	104.0	307.1
Morbid Obesity (BMI>40)	12.1	42.6
Serious Mental Illness	8.3	n/a
Smoking	201.4	471.4
Stroke	5.3	13.7

Source: Health Equity in Primary Care in East London and the City, 2012

This table demonstrates how the prevalence of the majority of chronic diseases investigated is higher in people with serious mental illness. The physical health of people with severe mental illness is very important, since it is estimated that people with severe mental illness die on average 20 years younger than the general population[164].

A very high proportion of people with SMI (48%) are also recorded smokers (compared to borough average of 27%[165]), putting them at significantly higher risk of most cancers, heart disease, stroke, CPOD and a range of other smoking related conditions. This reaffirms the importance of the links identified in the national strategy *No Health Without Mental Health* around mental and physical health.

[163]It is worth noting here that the Health E1 practice does not issue temporary registrations. It also worth noting that there is currently a Royal London pathways project which is a model of integrated healthcare for single homeless people. It puts the patient at the centre of their own care pathway and works to transform health outcomes for some of the most vulnerable groups in society.

[164]Rethink mental health

[165]It is important to note that this is weighted differently in subpopulation groups within the given percentage e.g. more than 40% Bangladeshi men

Prevalence by gender and ethnicity

In 2011 a primary care equity audit conducted[166] highlighted that the SMI prevalence in Tower Hamlets was 0.82% or a rate of 8.2 per 1,000, higher (or 'worse' than the sector average of 7.2 per 1,000.

Red indicates where prevalence is statistically significantly[167] 'worse' than the total population, statistically significantly 'better' than the total population prevalence (green), or not statistically significantly different from the total population prevalence (grey).

Table 15: crude prevalence per 1,000 populations by gender in Tower Hamlets

Disease	All	Male	Female
Serious Mental Illness	**8.3**	**9.9**	**6.8**

Source: Health Equity in Primary Care in East London and the City, 2012

This shows that is higher prevalence of SMI in men and table 16 below shows the prevalence by ethnicity from the same study.

Table16: crude prevalence per 1,000 population by ethnicity in Tower Hamlets

Disease	All	White	Asian	Black	Other
Serious Mental Illness	**8.9**	**8.7**	**6.9**	**15.4**	**8.3**

Source: Health Equity in Primary Care in East London and the City, 2012

In this audit, serious mental illness was more prevalent in the black population, but least prevalent in the Asian population.

6. Older people's mental health

There is an assumption that mental health problems are a 'normal' aspect of ageing. This is not true. Most older people do not develop mental health problems, and they can be helped if they do. However, many older people may experience psychological or emotional distress associated with factors linked to old age, including isolation, loss of independence, loneliness and losses of many kinds, including bereavements[168].

6.1.1 Dementia

Background and national prevalence

Nationally, the number of older people in the population is growing, with a corresponding increase in the number of those at risk of dementia and depression.

[166] Six months of data was analysed (October 2011-March 2012)
[167] Results are reported as being 'statistically significantly different' where 95% confidence intervals do not overlap.
[168] Mental Health Foundation

Dementia is the most common mental health disorder in the over 65s. It also affects in those under 65 (an estimated prevalence of 85 per 100,000 aged 45- 64, and very rare under 45) and improvements in diagnosis may identify more people in future**.**

Local prevalence

In 2009, the Tower Hamlets Older People's Mental Health Strategy, based on a locally developed model, calculated that there were 1,532 people with dementia in Tower Hamlets.

The following sets out the prevalence estimates given in *Dementia UK: the full report* (Alzheimer's Society, 2007) and applies them to the 2011 census population.

Table 17: Population of Tower Hamlets over 65, with estimated number of people with dementia, by gender

Tower Hamlets population 2011			
Age	**Male**	**Female**	**Total**
65-69	1,952	2,188	4,140
70 -74	1,955	2,074	4,029
75-79	1,518	1,686	3,204
80-84	1,047	1,360	2,407
85 plus	635	1,155	1,790
All over 65	**7,107**	**8,463**	**15,570**

Estimated people with dementia			
Age	**Male**	**Female**	**Total**
65-69	29	22	51
70 -74	61	50	110
75-79	77	110	187
80-84	107	181	288
85 plus	141	193	334
Total	**415**	**555**	**970**

Note: This table applies the rates for 85-90 years to all the over 85 population (since the population by year of age is not yet available from the census data) and therefore underestimates the total.

The estimated number (970) does not include people with young onset dementia (i.e. under 65 years of age). However, the estimate is less than that used in the Tower Hamlets 2009 strategy.

The Dementia Prevalence Calculator published by NHS England [169]is based on GP lists and gives a total of 1,076 people with dementia in Tower Hamlets CCG, of whom 190 are said to be living in residential care. Taking these latter estimates, around 1,100 people in the borough may have dementia. (The higher figure of 1,076 is used in this JSNA since the prevalence tool is recommended in NICE commissioning guidance.)

In March 2012 dementia registers recorded 575[170] patients, at best still less than 60% of the estimated population with dementia.

Many people with dementia go undiagnosed, and may not have the access to care that could be available to them. One way to investigate the variation of diagnosed to underdiagnosed patients is to look at numbers of observed to expected prevalence of

[169] http://www.dementiapartnerships.org.uk/diagnosis/dementia-prevalence-calculator/
[170]As of March 2012: QMAS.

dementia. However, Tower Hamlets is not significantly different to London or England in the ratio of observed to expected prevalence[171].

6.2 Depression in older people

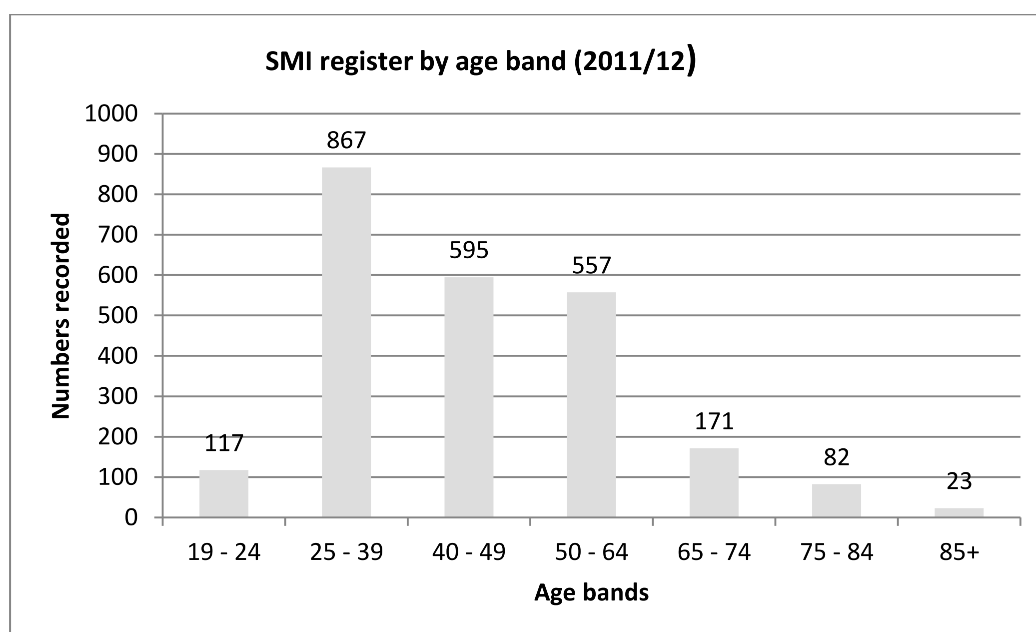
The 2009 Tower Hamlets Older People's Mental Health Strategy estimated the number of older people with depression as between 10 and 15%. This provides a reasonable range since no single figure can be derived from the Psychiatric Morbidity survey since it covered the ages 16 to 74. The strategy also estimated the prevalence of severe depression as 3%. Accepting these estimates and applying them to the census population of 15,570 gives the following estimates:

- All depression: 1,550 -2,230 people
- Severe depression: 470 people.

6.3 Serious mental illness in older people

The following figures shows the age of people with serious mental illness based on CEG data, which is reckoned to be robust.

Figure 30: Tower Hamlets SMI cases (numbers) by age band



Source: Clinical Effectiveness Group, 2012

This shows that 276 of the total number of people on SMI registers were aged 65 and over out of a total of 2,422 (11.4%). However, very little is known about the uptake of services by older people with psychosis, since they have traditionally been counted either with all users of older people's mental health services (i.e. including dementia), or with people of all ages with functional (i.e. non-organic) mental illness.

However, the proportion of older people with serious mental illness according to CEG data is lower in Tower Hamlets than in City and Hackney (15.2%) and Newham (12.9%).

---

[171] THE NHS Information Centre (QOF) v POPPI &PANSI (Projecting older people information)

Overall, more work is needed to understand the prevalence of mental illness in Tower Hamlets at a practice or locality level, and in terms of service use and ethnicity.

8. Suicide (all ages)

Background and national prevalence

Suicides rates are a high level indicator of mental health and wellbeing in a population[172]. It is estimated that around one million people will die by suicide worldwide each year.

In the national Psychiatric Morbidity Survey in 2007, 16.7% of people reported having ever had suicidal thoughts, 5.6% have made a suicide attempt and 4.9% had self-harmed[173].

The most recent data from the Office for National Statistics indicate that in 2005 there were 125 deaths of 15 to 19 year olds from suicide or undetermined injury in England and Wales. This is a rate of 3.6 deaths per 100,000 population aged 15 to 19 years[174].

According to the Public Health Mortality file, deaths among young people aged 19 years and under from Tower Hamlets numbered less than 5 in 2010/11 and to prevent compromising anonymity, the details of these are not reported here. In the preceding 5 years across the Inner North East London sector, 11 suicides were reported in this age group.

The National Suicide Prevention Strategy (2012) highlights that the strategies deployed to prevent or reduce suicide are not exclusive to one service or sector of society, and need to have a considered partnership approach.

Local prevalence

For 2010/11 the indirectly standardised mortality rate for suicide and undermined injury Tower Hamlets rate (102.57) was not statistically different to England average (100.0), but higher than the London rate of 89.68 per 100,000[175].

Between 2008 and 2011 there were 61 recorded suicides in Tower Hamlets[176]. Male suicide was highest amongst all age groups except for 0-19 year olds. Male suicide amongst age group 20-29 was threefold higher than female. Interestingly there were no recorded deaths among women aged 30-39 or 65 plus. This may be because of missing data, women seeking help before reaching crisis point or deaths being misattributed to a physical illness, especially in elderly women. From the 61 suicides that have taken place between 2008 to

[172]The Public Health Outcomes Framework 2013-2016 retains an indicator on suicide while the NHS Outcomes Framework 2012/13 proposes a new indicator to reduce premature death in people with serious mental illness.

[173]McManus S, Meltzer H, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey* NHS Information centre for health and social care

[174]ONS Vital Statistics and 2005 ONS Mid-Year Population Estimate

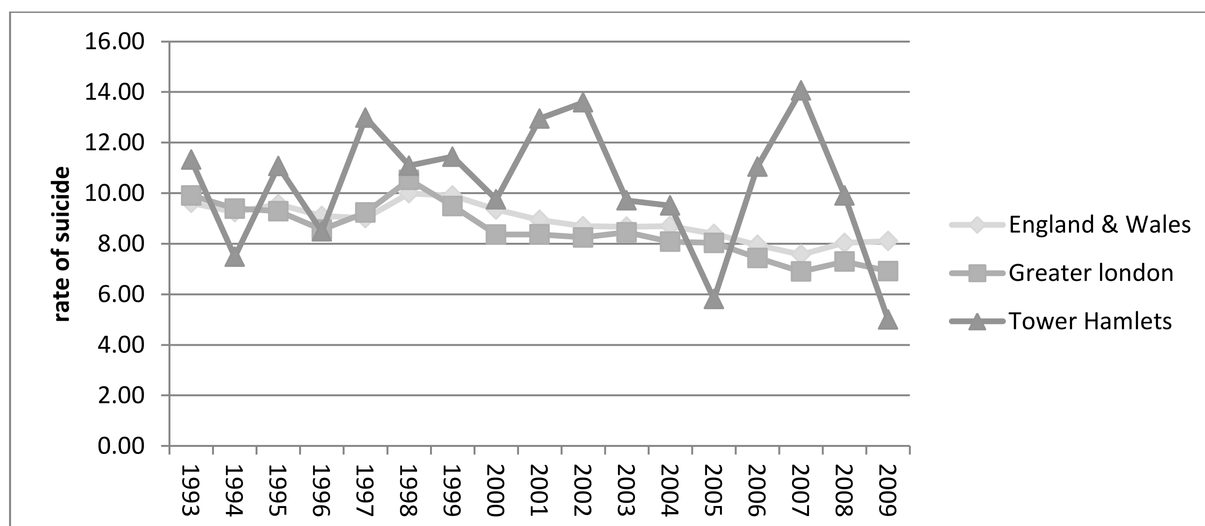
[175]Compendium of Population Health Indicators, The NHS Information Centre for Health and Social Care, and the Office for National Statistics

[176]The Public Health Mortality File Note: sometimes a coroner verdict can affect recording of suicide

2011 in Tower Hamlets, only 8 cases have been recorded to have some kind of mental disorder at time of death.

Figure 30 shows trends in suicide in Tower Hamlets from 1993 to 2009. There is an overall decline in the rates of suicide nationally and in London. Although the figures for Tower Hamlets are generally higher in comparison to regional and national figures the rates for 2009 are lowest. It will be important to see if this trend is sustained into the future.

Figure 31: Suicide trends for England, London and Tower Hamlets



Source: Public Health Mortality File

Overall, these charts appear to show that Tower Hamlets' suicide rate is slightly higher than other areas, but that, because of the small numbers, firm conclusions cannot be drawn.

9 Self-harm and suicide attempts

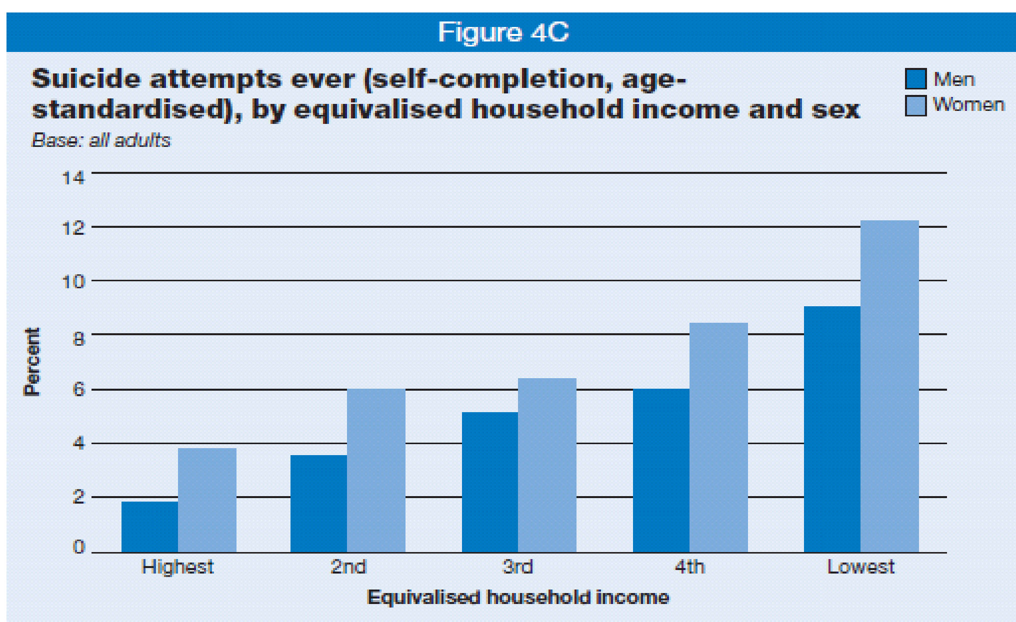
Self-harm is an expression of personal distress. It can result from a wide range of psychiatric, psychological, social and physical problems and self-harm can be a risk for subsequent suicide. The directly standardised rate for emergency hospital admissions for self-harm in Tower Hamlets is 52 per 100,000 which is significantly better than the England average of 207 per 100,000[177]. There could be many reasons for this including coding and recording issues in secondary care, nevertheless it is important to note that nearly the whole of London fairs significantly better than the England rate, the London rate is 112 per 100,000 for emergency hospital admissions for self-harm.

The pattern of association with household income is pronounced for suicide attempts (Figure 8). 9.0% of men and 12.2% of women from the lowest income quintile report having attempted suicide, compared with 1.8% of men and 3.8% of women from the highest quintile. Similarly, self-harm is more common among those in the lowest equivalised

[177]Hospital Episode Statistics, The NHS Information Centre for health and social care, and the Office for National Statistics

household income quintile (9.0% of men, 8.2% of women) than those in the highest (2.8% men, 3.3% women respectively)[178].

Figure 32: Suicide attempts ever by equivalised household income and sex



Source: National Psychiatric Morbidity Survey 2007

10. Long term physical health conditions

Local prevalence

The following information is taken from the JSNA factsheets produced by Public Health in Tower Hamlets.

Chronic Obstructive Pulmonary Disease (COPD): about 2900 people have COPD in Tower Hamlets. The age-standardised prevalence (1.9%) is higher than the London average. Data from 2009/10 shows Tower Hamlets has the highest emergency admission rate for COPD in the country. Readmission rates and COPD mortality are also high.

The burden of COPD is predominately amongst the white population, although Bangladeshi males are expected to share an increase burden in coming decades due to very high smoking levels in this group. COPD cases are slightly higher amongst men, again reflecting a higher proportion of male smokers.

Coronary Heart Disease (CHD) and Cardiovascular disease (CVD): there are 4,769 people who have CHD in Tower Hamlets. This represents an age-standardised prevalence of 3.1%, (March 2010). There are an estimated additional 2,800 cases of CHD that are not

[178] Ibid

currently diagnosed. There is a high correlation between unemployment and CHD, which is strongest in the Bangladeshi population. Men account for two thirds of CVD cases locally, and there is a higher rate of the Bangladeshi population that other ethnic group. Mental health issues, cancer or money worries were of greater concern than CVD in a survey of white low income men aged 30 to 50 who form the highest risk group.

Diabetes: diabetes is a long term condition that affects 11,859 people in Tower Hamlets, as a result of high levels of glucose in their blood. Prevalence is higher in Tower Hamlets than the nationally average, in part due to the large Bangladeshi community

Stroke: there are approximately 2000 people living in Tower Hamlets who have had a stroke. (In March 2010, there were 2044 residents on GP stroke registers which means that over 2000 people living in Tower Hamlets have previously suffered one or more strokes) and each year there are approximately 350 incidences of stroke admissions to secondary care each year. Incidence of stroke amongst the African or Caribbean population is twice as high as for the white population. Stroke is more common in men compared with women by the age of 75 but the latter have a higher mortality rate.

In future, information on the full range of long term physical health conditions and the mental health needs of people who live with them, should be collected as part of the on-going public mental health work in the borough.

11 Prevalence of other mental disorders

11.1 Personality disorder

Background and national prevalence

Personality disorders are longstanding, entrenched difficulties of personality that interfere with the ability to make and sustain relationships. Antisocial personality disorder and borderline personality disorder are two types with particular public and mental health policy relevance[179]. They are associated with substantial burden on affected individuals, their families and wider society, both in their own right and because of their substantial co-morbidity with mood and anxiety disorders, substance use, suicidal behaviour and other personality disorders[180].

The prevalence of antisocial personality disorder in adults aged 16-74 and living in England was similar in 2000 (0.6%) and 2007 (0.4%). Prevalence is highest amongst men aged 18 to 34 (1.7%), four times higher than women aged 16 to 34 (where the rate was 0.4%).

---

[179]Coid J, Yang M, Tyrer P, Roberts A, and Ullrich S. (2006) Prevalence and correlates of personality disorder in Great Britain *British Journal of Psychiatry*, 188: 423-431.
[180]Grant BF, Hasin DS, Stinson FS, *et al.* (2005) Co-occurrence of 12-month mood and anxiety disorders and personality disorders in the U.S.: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *J Psychiatric Res*, 46:1-5.

Likewise, the rate of borderline personality disorder in those aged 16-74 and living in England did not change significantly between the 2000 (0.8%) and 2007 (0.5%). A considerable proportion of people with BPD are known to have experienced some form of physical, emotional or sexual abuse or neglect in childhood.[181]. While the association with sex was non-significant, the observed pattern fits with the expected profile (0.3%of men, 0.6%of women). Younger women were more likely to have BPD than older women, but no association with age was observed in men.

Local Prevalence

Based on population data of 16-74 (183,724) then the expectation from national prevalence rates is that that there should be around 735 adults suffering from antisocial personality disorder in Tower Hamlets and 918 with borderline personality disorder. However, not all of these would require access to mental health services.

11.2 Posttraumatic stress disorder

Background and national prevalence

Many people will experience one or more major traumatic event[182] in their lifetime, such as a personal assault or a car crash, or witnessing a violent death. While most of these people will feel symptoms such as distress, insomnia, anxiety or unhappiness, only a minority will develop a mental health problem such as post traumatic stress disorder (PTSD) as a result. Where PTSD does occur, it usually onsets within three months of the event and may persist for months or even years[183]. It is a disabling condition characterised by flashbacks and nightmares, avoidance and numbing, and hyper-vigilance. In a small proportion of cases the disorder can follow a chronic course over many years, with eventual transition to an enduring personality change[184].

A third (33.3%) of people reported having experienced a traumatic event since the age of 16. Experience of trauma in adulthood was higher in men (35.2%) than women (31.5%).The age-standardised rate of trauma in adulthood is highest among black men (45.7%, compared with 36.0% of white men and 29.3% of South Asian men). Black men are also more likely to screen positive for current PTSD[185]. Their age-standardised rate (7.4%) is twice that of South Asian men (3.1%) and three times that of white men (2.5%). Their conditional probability of current PTSD is 16.3%, compared with 7.5% of men overall[186].

---

[181]Mental Health Network NHS Confederation, , 2011

[182] A traumatic event is where an individual experiences, witnesses, or is confronted with life endangerment, death or serious injury or threat to self or close others.

[183]Royal College of Psychiatrists. http://www.rcpsych.ac.uk/mentalhealthinfo/problems/posttraumaticstressdisorder/posttraumaticstressdisorder.aspx

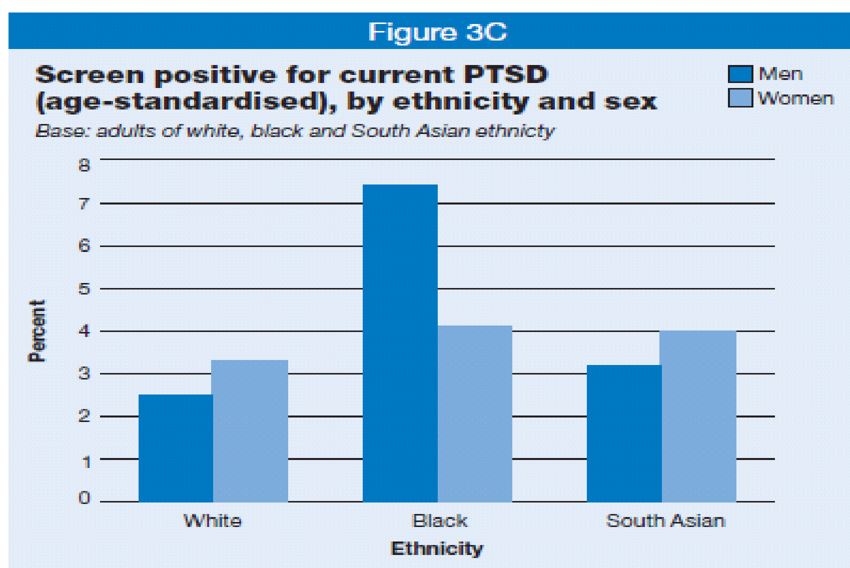
[184]McManus S, Meltzer H, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey* NHS Information centre for health and social care

[185]Using The Trauma Screening Questionnaire (TSQ)

[186]McManus S, Meltzer H, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey* NHS Information centre for health and social care

After age-standardisation, South Asian women appeared to be more likely than other women to have experienced a trauma (43.9%, compared with 31.4% of both white and black women). Despite this apparent increased trauma rate among South Asian women, the rate of screening positive for current PTSD did not vary in women by ethnicity[187].

Figure 33: screen positive for current PTSD (age-standardised) by ethnicity and sex



Source: National Psychiatric Morbidity Survey 2007

Local prevalence

No local prevalence data is readily available.

11.3 Eating disorders

Background and national prevalence

Eating disorders are syndromes characterised by a persistent and severe disturbance in eating attitudes and behaviour, to an extent that significantly interferes with everyday functioning[188]. The National Psychiatric Morbidity Survey 2007 found that:

- Overall, 6.4% of adults screened positive for a possible eating disorder in the past year.
- At 9.2%, women were more likely than men (3.5%) to screen positive for an eating disorder.
- The prevalence of screening positive for an eating disorder decreases with age and the pattern is particularly pronounced for women. One woman in five (20.3%) aged 16-24 screened positive compared with one woman in a hundred (0.9%) aged 75 and over.

[187] It should be noted here that age-standardised rates can be unreliable when base sizes are small, and they should be considered alongside the observed rates.
[188] Parliamentary Office of Science and Technology (2007) Postnote: Eating Disorders, p.1 www.parliamentuk/parliamentary_offices/post/pubs2007.dfm

Ethnicity and equivalised household income were not significantly associated with screening positive for an eating disorder[189].

Local prevalence

No local prevalence data is readily available. However, if the very high prevalence found by the national psychiatric morbidity survey were applied to the local population (approximately 204,000 over 16 years of age), then 13,000 people in the borough would screen positive for a possible eating disorder. No reports exist of such a number contacting services, so further work is necessary to understand local prevalence and needs for service.

11 Risk groups

11.1 Carers

'Commissioning for Carers' was published in 2013 by the Royal College of General Practitioners. It provides the following statements about mental health needs:

- 40% of carers experience psychological distress or depression, with those caring for people with behavioural problems experiencing the highest levels of distress.
- 33% of those providing more than 50 hours of care a week report depression and disturbed sleep.
- Those providing more than 20 hours of care a week over an extended period have double the risk of psychological distress over a two year period compared to non-carers. Risk increases progressively as the time spent caring each week increases
- Caring can also limit carers' ability to take time out to exercise. Reduced income and lack of cooking skills may contribute to excess weight gain or loss. As many as 20% of adult carers increase their alcohol consumption as a coping strategy.

It also notes that emotional impacts such as worry, depression and self-harm have been identified in young carers.

Carers in Tower Hamlets were the subject of a Joint Strategic Needs Assessment in 2010. At that time the number of carers was estimated as follows (using rates derived from the 2001 census.):

- All carers in the population: 20,700 (8.57% of the population)
- Providing 20 – 49 hours or more of unpaid care per week:3,200 (1.32% of the population)
- Providing 50 hours or more of unpaid care per week: 5,700 (2.38% of the population)

[189]McManus s, Meltzer h, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey* NHS Information centre for health and social care

The JSNA for carers also includes an analysis of needs, ethnicity, gender and contact with services.

Taking the estimate of one-third of carers providing more than 50 hours care per week suffering depression and applying it to the 2010 population estimate, produces 1,900 people in Tower Hamlets at risk. This does not include other carers, amongst whom women are at a higher risk of depression, as mentioned in chapter 2.

11.2 Substance misuse

Background and national prevalence

Nationally, according to the Psychiatric Morbidity Survey, 14% of alcohol dependent adults are currently receiving treatment for a mental or emotional problem. Dependent women (26%) were more likely than dependent men (9%) to be in receipt of such treatment[190].

Adults who were dependent on drugs were more likely than other adults to be receiving treatment for mental or emotional problems. 14% of adults who were dependent on cannabis and 36% of those dependent on other drugs were receiving counselling or medication, compared with 7% of those reporting no signs of drug dependence[191] [192].

Dual diagnosis of mental health problems and substance misuse

Dual diagnosis is a term commonly used to describe people who have a combination of mental health problems, such as schizophrenia, bipolar disorder, personality disorder as well as drug and / or alcohol problems (a known as substance misuse)[193]. The term is used rather inconsistently and sometimes includes people with common mental health problems such as depression and anxiety, which are very common in those who are substance misusers.

Two research studies in the last decade found that:

- 75 per cent of users of drug services and 85 per cent of users of alcohol services were experiencing mental health problems;
- 30 per cent of the drug treatment population and over 50 per cent of those in treatment for alcohol problems had ‘multiple morbidity’;
- 38 per cent of drug users with a psychiatric disorder were receiving no treatment for their mental health problem;

---

[190]McManus s, Meltzer h, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey* NHS Information centre for health and social care

[191]McManus s, Meltzer h, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey* NHS Information centre for health and social care

[192]Estimates should be treated with caution as the sample of drug-dependent adults was small, in particular for those dependent on drugs other than cannabis.

[193]http://www.rethink.org/about_mental_illness/dual_diagnosis/

- 44 per cent of mental health service users either reported drug use or were assessed to have used alcohol at hazardous or harmful levels in the past year.[194]
- Dual diagnosis was present in 20 per cent of community mental health clients; 43 per cent of psychiatric in-patients[195];

Local prevalence: drug misuse

According to the draft 2012/13 Substance Misuse Needs Assessment, the estimated number of drug users in Tower Hamlets was 2,683 in 2009/10. Between April 2011 and March 2012 there were 1,851 over 18 year old individuals in drug treatment in Tower Hamlets. It can reasonably be expected that those drug users who are not in drug treatment also have mental health needs.

The proportion of those estimated to need treatment who are receiving treatment is the highest in London. However, as in all areas, there is a gap between the estimated number need (calculated using formulas set out by the National Treatment Agency) and the numbers in service.

Ninety-five per cent of Tower Hamlets drug treatment service users are opiate and/or crack users. This is the highest proportion in London and indicates that Tower Hamlets drug service users have unusually complex needs. Correspondingly, Tower Hamlets has lower proportion receiving treatment for use of other drugs than other areas.
Service users in Tower Hamlets have unusually complex needs -the highest percentage of users who identified crack use in their last treatment journey. Tower Hamlets has a higher than average percentage of clients with very high complexities (26% in comparison to 14% for the national average).

Data shows that 32% of the treatment population in 2011-12 were parents who had their children living with them and 19% were parents, but did not have their children living with them.

Local prevalence: alcohol

Ninety-six per cent of new presentations to Tower Hamlets Community Alcohol Team (THCAT) in 2011/12 had a dual diagnosis, which equates to 99 individuals. There were a total of 346 clients in treatment in 2011/12. This information is obtained from the assessment at the drug service so is essentially a self-report; unfortunately there is no way of knowing whether these clients are accessing support or treatment for their mental health needs.

---

[194] Weaver T et al (2002), Co-morbidity of substance misuse and mental illness collaborative study (COSMIC), Department of Health/National Treatment Agency
195 Strathdee et al (2002), Dual diagnosis in a primary care group – a step-by-step epidemiological needs assessment and design of a training and service response model, DH/National Treatment Agency

Local prevalence: dual diagnosis of mental health problems and substance misuse

Specialist Addiction Unit (SAU) clients are included within the figures for clients with dual diagnosis. SAU clients represent 150 of the 835 new treatment presentations during 11/12[196] with 70 recorded as having a dual diagnosis (47%). However, the true figure with dual diagnosis is thought to be much higher and therefore this denotes a potential recording issue.

In Tower Hamlets, 34-37% of mental health inpatients were recorded as having a dual diagnosis, and 21% of community patients. (ELFT performance report 2013)

Summary of need

Tower Hamlets is a borough with high needs for substance misuse

- Is in the high need cluster (with seven other London boroughs), as reported in Chapter 5
- Has the highest proportion of those in need receiving treatment
- Has a high complex opiate/crack using population with complex needs and risk of poor outcomes
- One in five users of community mental health services has a dual diagnosis of mental illness and drug and/or alcohol misuse, and one in three users of inpatient services.

Residents of Tower Hamlets who have a dual diagnosis of mental illness and substance misuse are a vulnerable group who are likely to have poor health outcomes. However, the data systems to provide accurate estimates of numbers are very limited. There is no authoritative way of identifying the number of people using substance misuse services who have mental health problems, or knowing whether they are the same people captured by the recording of the mental health service.

11.4 Dual diagnosis mental health and learning disability

Background and national prevalence

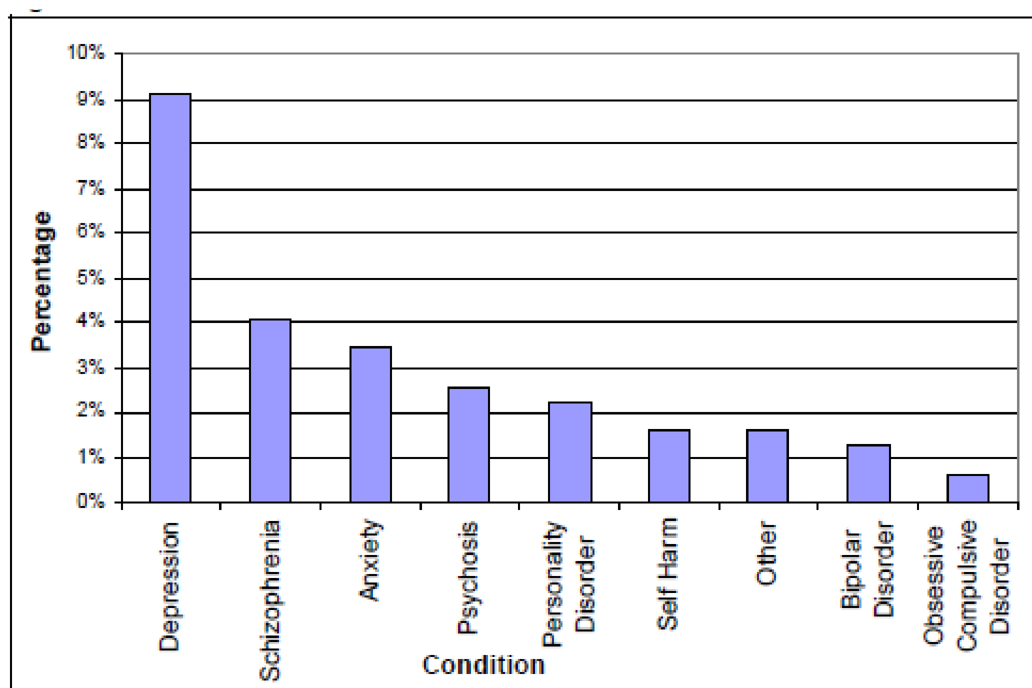
There are approximately one million people with learning disabilities in England and estimates of the prevalence of mental health problems in this population vary from 25-40%. Prevalence of anxiety and depression in people with learning disabilities is the same as the general population, although risks may be higher, yet for children and young people with a learning disability, the prevalence rate of a diagnosable psychiatric disorder is 36%, compared with 8% of those who do not have a learning disability[197].

[196] The vast majority of other presentations would have been managed in primary care
[197] The Mental Health Foundation, Mental Health in People with Learning Disabilities, June 2011

Local prevalence

The percentage of patients on the Tower Hamlets learning disabilities register (aged 18+) is lower than the England average (0.32% versus 0.45%) and similar to the London average (according to QOF). This equates to an observed number of approximately 643 people. The percentage of patients on the learning disabilities register may be lower in Tower Hamlets due to under-detection: the learning disabilities JSNA estimated prevalence of moderate or severe learning disabilities at 1,049 people (aged 15 years and over). Nevertheless, the importance of the mental health needs of these individuals is very important, particularly in children and young people. Figure 13 below shows the range of mental health conditions of those on the Tower Hamlets Community Learning Disabilities Service (CLDS) caseload:

Figure 34: Prevalence rates of mental health conditions in CLDS clients, February 2010



Source: CLDS Case File Audit

Areas of unmet need identified through a health needs assessment for Learning Disabilities included accommodation, employment, transport, access to continence services, access to mental health services, and assessment of children with Attention Deficit Hyperactivity Disorder (ADHD) and with Autistic Spectrum Disorder (ASD).

11.5 Offenders

Offenders can be categorised in a basic manner, using two groups as follows:

- Offenders who must adhere to statutory conditions and are subject to community supervision. Probation data gives a comprehensive assessment of need for these ‘statutory offenders’

- Offenders who, whilst in the community, have no conditions to which they must comply, such as those individuals released from short term prison sentences (less than 12 months), those individuals who have served their entire prison sentence and are released without being on licence, or those individuals who have been found guilty or have admitted guilt, but who have not received a custodial sentence or an order managed by probation (i.e., individuals receiving a Conditional Caution, Court Fines, etc.). Probation data excludes information on this large non statutory offender population

The following table shows the number of offenders managed by London Probation Service in Tower Hamlets who must adhere to statutory conditions.

Table 18: Tower Hamlets Probation Caseload

Gender	Offenders on Licence	Custody	Community and Suspended Sentence Orders	Grand Total
Male	251	411	358	1296
Female	8	14	39	135
Grand Total	**259**	**425**	**397**	**1081**

Source: London probation Service. Data produced February 2013.

This shows that there are nearly 1,100 offenders 'on the books' adhering to statutory conditions, of whom 656 are in living in the community. However, as pointed out above, there are an unknown number of offenders living on the community who are not managed by Probation.

The following table shows the ethnicity of those reported on the Tower Hamlets Probation caseload in February 2013.

Table 19: Ethnic origin of Probation caseload in Tower Hamlets

Ethnicity	Count	%
Asian or Asian British - Bangladeshi	382	35.34%
Asian or Asian British - Chinese	9	0.83%
Asian or Asian British - Indian	21	1.94%
Asian or Asian British - Other	17	1.57%
Asian or Asian British - Pakistani	14	1.30%
Black or Black British - African	66	6.11%

Black or Black British - Caribbean	95	8.79%
Black or Black British - Other	13	1.20%
Mixed - Other	9	0.83%
Mixed - White & Asian	4	0.37%
Mixed - White & Black African	7	0.65%
Mixed - White & Black Caribbean	44	4.07%
Not known	2	0.19%
Other Ethnic Group	15	1.39%
Refusal	61	5.64%
White - British/English/Welsh/Scot/NI	261	24.14%
White - Gypsy or Irish Traveller	1	0.09%
White - Irish	16	1.48%
White - Other	44	4.07%
Grand Total	**1081**	**100.0%**

Source: London Probation Service. Data produced February 2013.

This shows that the largest ethnic groups were 'Asian/Asian British - Bangladeshi)' and white British. The following table shows the age of the probation caseload in Tower Hamlets.

Table 20: Age of Probation caseload in Tower Hamlets

Age Group	Total Population	%	Male %	Female %
18 - 24	325	30.06%	28.86%	1.20%
25 - 30	211	19.52%	18.78%	0.74%
31 - 40	293	27.10%	25.25%	1.85%
41 - 50	161	14.89%	13.78%	1.11%
51+	89	8.23%	7.49%	0.74%
Not known	2	0.19%	0.19%	1.20%
Grand Total	**1081**	**100.0%**	**94.36%**	**5.64%**

Source: London Probation Service. Data produced February 2013.

This shows that four out of five male offenders are under 41 years old. Over 94% of all offenders supervised by the Probation Service in Tower Hamlets are male.

The Probation Service's Offender Assessment System (OASys) records comprehensive information about offenders' needs. However, it does not use a common terminology so it is difficult to draw conclusions. Of note, formal health treatment conditions were recorded in only a very small percentage of cases:

- 2.8% had mental health conditions
- 2.5% on an alcohol treatment requirement (ATR)
- 4.4% on a drug treatment requirement (DTR).

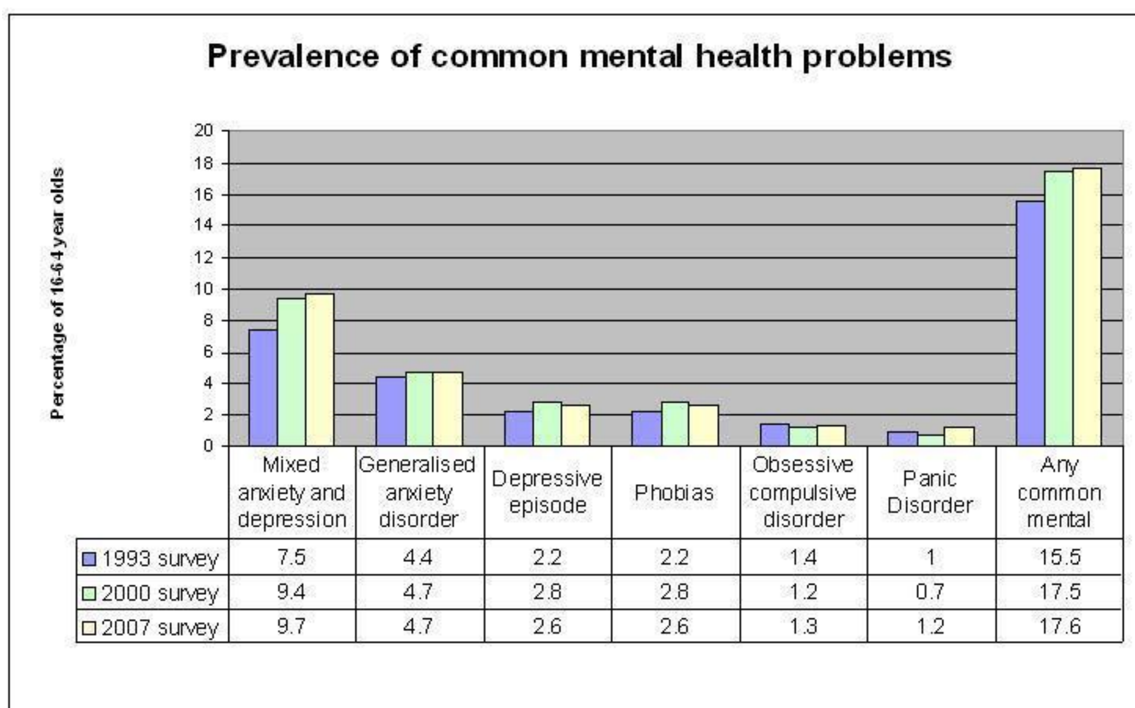
By contrast, high proportions were recorded as having alcohol issues linked to their offending (27.6%), drug issues linked to their offending (31.9%), or emotional well-being issues linked to their offending (23.8%). (NB individuals may be counted in more than one category if they have more than one need.)

Appendix

Common Mental Disorders

The estimated prevalence of major depression among 16-65 year olds in the UK is 21/1,000 (males 17, females 25)[198].

Figure 35: Changes in national prevalence of common mental health problems



	Mixed anxiety and depression	Generalised anxiety disorder	Depressive episode	Phobias	Obsessive compulsive disorder	Panic Disorder	Any common mental
1993 survey	7.5	4.4	2.2	2.2	1.4	1	15.5
2000 survey	9.4	4.7	2.8	2.8	1.2	0.7	17.5
2007 survey	9.7	4.7	2.6	2.6	1.3	1.2	17.6

Source: Psychiatric morbidity among adults living in private households, 2007

Applying the Psychiatric Morbidity Survey results to the Tower Hamlets adult population (16-64) (190,038[199]) we would expect approximately 33,500 adults to have a common mental disorder at any one time. This would be estimated to break down into the following subcategories (numbers add to more than the overall figure above as many people may have more than one diagnosis):

Table 21: Estimated numbers and rates per 1,000 of common mental disorders

Condition	Estimated numbers for Tower Hamlets	Tower Hamlets rate per 1000
Depressive episode	4,940	25.9
Generalised anxiety	8.900	46.8

[198]British Medical Association, May 2008 http://www.bma.org.uk/employmentandcontracts/independent_contractors/quality_outcomes_framework/qof06.jsp?page=20
[199]Census, 2011

disorder		
Mixed anxiety with depression	18,400	96.8
Obsessive compulsive disorder	2,500	13.2
Panic disorders	2,300	12.1

In Tower Hamlets depressive conditions are routinely measured by the Quality and Outcomes Framework (QOF) and are also recorded locally by the Clinical Effectiveness Group (CEG). However, caution should be used in directly comparing figures obtained from these two sources as each use a different definition. In broad terms, the QOF definition contains more conditions than CEG definitions; this means that the estimated prevalence of SMI using CEG data will be lower than using QOF data.

In Tower Hamlets in 2011/12, 9.51% (19,552) of adults (18+) are on depression registers compared to the national average of 11.68%, this is a significantly lower percentage, but higher than the London average of 8.07%.

At the time of writing this JSNA, CEG data shows that 5,716 were on depression registers and that age standardised prevalence in Tower Hamlets is 2.20% higher than compared to City and Hackney (2.17%) and Newham (0.93%).

Table 22: Projected estimated prevalence of common mental health disorders in London, 2016 and 2021

Number of people in London with:	2011	2016	2021	Percentage increase 2011 to 2021
Mixed anxiety and depressive disorder	522,190	555,630	580,030	11.1%
Generalised anxiety disorder	326,440	353,250	376,170	15.2%
Depressive episode	216,830	233,400	247,480	14.1%
All phobias	134,590	143,850	150,750	12.0%
Obsessive compulsive disorder	95,850	101,650	106,610	11.2%
Panic disorder	52,400	56,830	59,770	14.1%
Any common mental health disorder	1,124,600	1,203,150	1,263,640	12.4%

Source: NEPHO estimates based on the National Psychiatric Morbidity Survey, projected with 2011-based population projections for 2016 and 202 (MH tool indicators WF101 to WF114 inclusive)

The projections suggest that there will be an additional 140,000 people with a common mental health disorder in London by the year 2021. This will bring significant additional demand for not only mental health services but for services dealing with the physical health

effects of mental illness. In looking at their own position, local boroughs will find it helpful to apply sensitivity analysis, calculating 'high' and 'low' figures according to different scenarios.

Note on psychosis registers

Caution should be used in directly comparing figures obtained from QOF and CEG as each use a different definition. In broad terms, the QOF definition contains more conditions than CEG definition as CEG defines SMI as schizophrenia and bipolar disorder only. This means that the estimated prevalence of SMI using CEG data will be lower than using QOF data[200].

Most QOF indicators state 'Patients with schizophrenia, bipolar affective disorder and other psychoses'.

Chapter 6: Mental health in Tower Hamlets: a service user and carer perspective

Chapter Summary

Approach

- In order to fully understand the needs of Tower Hamlets in relation to mental health, it is crucial to listen to and engage with those using the services and their carers, so as to understand what's working and what could be improved
- A number of approaches have been used to engage with service users and carers from the start of the strategy, including visioning workshops, surveys, reference group meetings and consultation events

Overview

- Community groups and the public support mental health as a borough priority- the Health and Wellbeing Strategy consultation identified that 67% of respondents agreed that mental health should be one of the strategy's priorities
- Key findings of the Health and Wellbeing Strategy consultation, the mental health visioning workshops and other consultation and engagement exercises were broadly similar and included: reducing stigma, ensuring an appropriately funded service across the life course, support and information for service users and their carers, early diagnosis and intervention, and improved recognition and support for children's mental health
- Carers of service users highlighted the importance of looking at the wider picture of a family, for example their housing situation, and how this could impact on both the service user's mental health condition, but also how different situations could affect the mental health of carers themselves

Children and young people

- When listening to children and young people and their carers, some key suggestions for improvement included being able to see the same mental health practitioner through childhood, and having staged and gradual transition processes in place into adulthood
- Children and young people with mental health conditions are keen to have more accessible and appropriate information at the right stages, including better awareness and information in schools
- Young people are keen to be treated as such - not as children. They identified a good mental health service as one which does not patronise young people, and many (though not all) are also keen to have more involvement and control over the services they receive.
- There is continued confusion stigma amongst children and young people about what a mental health problem is which universal awareness raising services or projects could help to rectify
- They wanted to see non-judgmental and non-patronising services

Adults

- For adults with mental health problems responding to the annual social care Service User Experience survey, 71.4% agreed that the support they receive helps them to stay as independent as possible, compared to 91% last year.
- Adults with mental health problems are more likely to have difficulties managing their finances. The impact of the current welfare reforms could make this more difficult still.
- Adults with mental health problems in long-term social care reported high satisfaction rates with the care they receive
- However, adults with mental health problems have made clear they want better information and the right time, and that more should be done to raise awareness of mental health amongst adults in the boroughs
- They wanted more choice and control, although there were mixed views on personal budgets
- There was substantial dissatisfaction with adult inpatient services: only 61% rated their care positively in a satisfaction survey, with concerns about the welcome given and the activities available
- Priorities emerging from a visioning workshop held with adults of working age with mental health problems included service integration, taking an innovative approach to tackling stigma, embedding recovery therapies across the mental health system, and community and service user involvement at all levels of the mental health system

Older adults

- Older adult service users said they were generally satisfied with the care received for their mental health conditions, although there were worries about funding and possible cuts to services
- At a visioning workshop held with older adult mental health service users, strengths of the current system included the wide networks across health and social care, and the Dementia Liaison team at the Royal London Hospital
- At a consultation event with the Older People's Reference Group, priorities identified included the need to reduce stigma and discrimination, and to integrate services across the mental health system.
- There were also concerns about the levels of support and acknowledgement for carers
- The event suggested more group therapy sessions could help overcome isolation and could be used to complement or reduce medication
- Another priority was to ensure GPs are trained and able to spend more time talking with older people with mental health issues prior to prescribing medication
- Activities which promote community resilience and enable people to look out for each other and maintain independence were also suggested

Other groups

- On-going discussions with carers highlighted the need for better recognition from

GPs, and support to enable them to carry out daily activities and have a break from caring
- LGBT people in Tower Hamlets are recognised as being vulnerable in terms of mental illness for a number of reasons including where a heterosexual marriage has been entered in order to prevent discrimination, and, amongst LGBT older people who may be isolated from their families
- New residents and refugees can be vulnerable to becoming mentally ill due to isolation, language barriers and lack of access to provision

Cross-cutting themes and priorities for all service
Patients and carers in services for all ages wanted to see:
- Recovery and holistic care
- Information and communication
- Better access to services
- Combat stigma and discrimination
- Service integration and connectedness across a wider range of services
- Community and service users involvement
- Support for carers and families
- Early interventions and better transitions.

1. Introduction

1.1 About this chapter

An important part of understanding need in Tower Hamlets is listening and responding to what service users, carers and residents have to say about their experience of services in the borough. This chapter of the JSNA provides information collected from a range of engagement activities that provide insight into resident, service user and carer perspectives. It is structured using the life course approach and:

- Outlines the different approaches that the Tower Hamlets Partnership uses to engage and consult with service users and their carers.
- Highlights wider issues which can impact on mental health
- Sets out some of the key themes arising from consultation with mental health service users across the life course, including strengths and weaknesses of current service provision, information from surveys and suggestions for improvements
- Sets out some of the key themes arising from consultation with carers of children, young people, working age adults and older people of mental health service users
- Identifies issues that affect particular groups.

1.2 Approaches to engage and consult with service users, carers, local people and stakeholders

The Tower Hamlets Partnership uses a range of approaches to engage with local people; from specific consultation events about particular pieces of work, to regular forums that give service users and carers an opportunity to meet and feedback to service managers. This chapter makes use of information collected through a series of engagement events, which include:

- Mental health strategy visioning workshops (three workshops held - covering the life course stages).
- Mental health strategy customer reference group meetings.
- 2011 NHS East London Foundation Trust: in-patient survey results for Tower Hamlets.
- 2012 NHS East London Foundation Trust: user-led standards audit results.
- 'Your Say, Your Day' events.
- Older People's Reference Group meeting minutes.
- Adult Social Care User Experience Survey 2010-11 and 2011-12.
- East London Foundation Trust focus groups with children, young people and parents.
- Feedback from the health and wellbeing strategy consultation.

The visioning workshops with children, young people, carers, parents, working aged adults and older people aimed to identify what is working, what needs to change and what the priorities should be for the new mental health strategy. Workshops were also held with clinicians, local authority and voluntary and community sector representatives.
Some workshops were convened by ELFT staff, to whom thanks are due. The Tower Hamlets Partnership also recognises the input to many discussions from Healthwatch Tower Hamlets, which formally came into being on 1 April 2013, during this period of engagement.

1.2 Overview

Overall, improving mental health and emotional health were seen as a priority among community groups, residents and staff. Other agencies such as, The Carers Forum, The Tower Hamlets Housing Forum, The Tower Hamlets Inter Faith Forum, The Older People's Partnership Board, The Great Place to Live Community Plan Delivery Group and the Community Voluntary Sector Health and Wellbeing Forum and the police also raised mental health as a priority for improving health and wellbeing.

From the Tower Hamlets health and wellbeing strategy consultation, 67% of respondents strongly agreed that 'mental health and wellbeing – no health without mental health' should be a partnership priority and 31% agreed, leaving just 2% who disagreed. In addition to this, the six outcomes[201] stated in the outline strategy were strongly supported, 89% to 96% of respondents rated them either 'very important' or 'important'.

---

[201]More people will have good mental health
More people with mental health problems will recover

Other outcomes that were suggested through the consultation included:

- More evidence of early diagnosis and intervention.
- Improved recognition and support for children's mental health.

Many of the findings from the Health and Wellbeing Strategy consultation concur with findings from other community discussions that aim to understand what is needed to improve mental health and wellbeing, which include:

- Respectful staff and a stigma free community.
- A community that understands what mental health problems are and how to access support.
- Sufficient and appropriate access to services, particularly in primary care (i.e. counseling, cognitive behavioral therapy and informal talking therapy).
- An appropriately funded system.
- A system that focuses on the whole family and wider relationships in someone's life.
- A system that focuses on each stage across the life course.

2. Being Born

2.1 Services for pregnant women and new mothers

Currently, the Partnership has very little feedback/engagement with new parents who have mental health problems. The need to improve this area has been identified and as part of the strategy implementation the Partnership seeks opportunities to strengthen its engagement with this target group.

Work is taking place through the Maternity Early Years and Childhood Partnership group to enhance health education for young people and women of child bearing age including building on the Maternity Mates programme to provide peer support for vulnerable women during pregnancy and in the first six weeks after birth, and reviewing and strengthening the ante and post natal depression pathway, raising awareness of the importance and links to safeguarding.

From the Health and Wellbeing Strategy consultation, emphasis on education of parents, promoting resilience within children was identified as an area of focus, one respondent stated:

> *"So many people are just not aware of how their interaction with children impacts on their emotional well-being."*

More people with mental health problems will have good physical health
More people will have a positive experience of care and support
Fewer people will suffer avoidable harm
Fewer people will experience stigma and discrimination

2.2 Child and Adolescent Mental Health Services (CAMHS)

The majority of engagement with children and young people with mental health problems and their carers was facilitated by CAMHS (ELFT) on behalf of the Partnership.
East London Foundation Trust (ELFT) held a focus group[202] with young people who are in contact with CAMHS. At this session, young people discussed the importance of being aware of what CAMHS is and the type of support or plans they offer. Some young people felt it was important for them to be involved in planning their support. This suggests that young people may value a choice about how services communicate with them, such as having letters addressed to them and being involved in discussions about their support. Having the same worker throughout their support from CAMHS was raised as an important issue and where this was not possible taking steps towards a seamless transition between workers was seen as essential.

Some quotes from the young people focus group are noted below:

"I expect to be given some ideas of what kind of help I will be given in the first appointment."
"I would like to have an idea of what CAMHS were planning to do with me."

"It is important to get some information about CAMHS before an appointment."
"It is important to know what CAMHS do before we come. We did get some information on CAMHS, but it was addressed to our Mum and she opened it and told us we had an appointment."

"I want to see copies of letters about me?" This view gives us insight into how services are currently balancing between judging whether young people have the capacity to make decisions/hold information and parental responsibility. This point more broadly links with the implementation of the mental capacity act and the social and public health models of disability.
"We would prefer to have an individual letter addressed to us. I think when you are 12 or 13 we should get our own letters. Yes when you start secondary school."
"When I was referred the teacher talked to my Mum about it. I was in the room, but she did not talk to me about it, just my Mum."
"I would want to see what was written about me, because then I would have a chance to agree or disagree."
However, not all young people feel the same illustrating the value of choice:
"I don't want to see them I would prefer the information to be kept between professionals just in case it upsets me."

"It is important to see the same person from start to finish even if I have to wait longer for a service - if this is not possible it's better to have a cross over period between old and new worker."
"It just means you have to start all over again if you change worker."

[202] ELFT Focus Group, September 2012

"With me, when my last worker was leaving, the new worker joined the previous worker for a few sessions with me first, so I got used to her. That was much better."
"Even if it was a different type of therapist I still think they should join the sessions with the previous worker so they are introduced to you slowly so you get used to them."

When asked the question: "If I was in charge of CAMHS for the day I would…?"
"Make them do things as a family."
"Make things lively."
"Keep things the way they are but make sure the hour is not all about depressing and crying."

ELFT also held a focus group with parents of young people in contact with CAMHS[203]. Parents raised how their own mental wellbeing and in some cases mental health problems can impact on their family. A specific example was that nonattendance at appointments can be interpreted as a sign of lack of commitment to the process; however, this may be a manifestation of managing stress. When appointments are missed the problems between them and their children often worsened which highlights the importance of keeping appointments. Two parents said that when they kept appointments family relations improved but that this could be difficult to sustain between sessions.

Parents also raised the importance of continuity of staff:

> *"She talked about having to see a series of doctors who stay for 6 months to a year and the difficulty of people leaving just as they had got to know them."*

The importance of long-term relationships with clinicians was raised as being important to families with multi-faceted problems and several diagnoses over a lengthy period. Thinking about and responding to issues that are wider than the presenting mental health condition were also raised as being important to parents, this includes issues like housing and cultural issues:

> *"One parent spoke about the impact of a dire housing situation on the health of her family. It had been helpful that CAMHS had referred her to a housing advice and support service who had taken on the burden of liaising with the housing department, advocating on her behalf."*
> *"an ELFT member of staff spoke about how having bi-lingual co-workers within the CAMHS service meant that we could work with two different belief systems, e.g. working with a belief in spirit possession (often held by Bangladeshi families) alongside Western interpretation and treatment of mental health difficulties."*

The issue about whether young people should be seen on their own or with family members was discussed and generally people said that in their experience there had been a combination of both, and one parent said that the family sessions had been more helpful because there was a mediator so they were able to have calmer conversations.

[203] ELFT Focus Group, September 2012

2.3 Attitudes of young people towards mental health

In November 2012, a study was conducted with young people living in Tower Hamlets to determine their attitudes towards mental health. The report highlighted support for "a mental health educational campaign/programme for young people"[204]. There is evidence that some families consider mental health to be "more important than issues such as alcohol and drugs on the basis that if mental illness was an issue then a young person may well be more likely to succumb to such temptations." [205]

A teacher who was interviewed highlighted that:

> *"Everything depends on mental health. One of the most important issues for our society...and for our kids.'" (Teacher)* [206]

The research involving young people, parents and teachers concluded that "there was a lot of confusion around what was meant by the term mental health. Although depression was the most frequently recognised mental health problem, special needs was identified by many." [207] Self-harm was not recognised as being a mental health problem. The research conducted provides a good evidence base for the development of an education programme to raise awareness and tackle stigma amongst young people in Tower Hamlets.

2.4 Visioning workshops: services for children and young people

To inform the development of the mental health strategy a series of workshops were held to better understand the needs of young people with mental health problems and their carers. There were 3 workshops held: (1) children & young people (2) parents (3) clinicians and professionals supporting young people and their families.
Young people, parents and carers outlined some common key concerns which include:

- Lack of universal awareness-raising of support services.
- Need for improved transition from young people to adult mental health services.
- Concerns related to stigma and mental health among young people and how this can affect service access and support.

Parents and carers

This session highlighted that peer to peer support can be gained from parents and carers getting together, sharing experiences and supporting each other. Family therapy was also noted as working well for parents and carers, as well as, the child and/or young person. One individual told the group that she had been in family therapy for two years and had learnt a lot of useful information as well as how to be more confident in her relationship with her daughter.

---

[204] Millbank Social Marketing, 2012, Determining the Attitudes of Young People Towards Mental Health and their Reponses to Challenging Stigmatising Perspectives – A Service Improvement Project
[205] Ibid
[206] Ibid
[207] Ibid

Parents and carers raised the issue of delays in getting support for children/young people and noted that the referral process was a barrier to young people accessing support. They also identified the need for improved clarity for who children/young people could talk to. Some specific examples included the need for:

- Speech and language support.
- Applied behaviour therapy (not currently available in Tower Hamlets).
- Extra support at school.
- Housing and wider services support to reduce further impact on mental health and wellbeing.

Young people

Discussions with young people were carried out in two groups: male and female.
Both groups identified some common concerns about the mental health services which included (mainly emerging from the discussion with males):

- Services need to run on time.
- Practitioners provide more support for young people, family members and/or carers.
- Non- judgemental and non-patronising services.

The male group also highlighted that a barrier for young people in accessing mental health services was feeling fearful about opening up about personal things. It was also suggested that some young people might self-medicate with drugs and get involved with gangs rather than talk about how they feel and seek help.

The female group discussed the different ways that they had accessed services; one young girl said that she had been offered counselling support at school but worried about people finding out and gossiping. Other young girls mentioned that there was a fear to use a school service as other pupils and teachers would become aware of their concerns and access for help. This needs to be considered when developing mental health services/support in schools, despite much of the literature which highlights the important role of schools, young people's concerns about 'being identified' need to be taken on board.

How clinicians should contact and involve young people was also discussed, overall it was felt that clinicians should individually discuss with young people how they preferred to be contacted instead of using a universal approach.

Young people also suggested that there should be a CAMHS drop-in for service users in the event a young person felt they were going through a crisis. Some young people said they do not access universal youth services, as they preferred not to be around young people who would not understand their situation. Many young people said they enjoyed meeting other CAMHS service users, as it was felt they can better understand their situation.

Clinicians, local authority and voluntary and community sector representatives

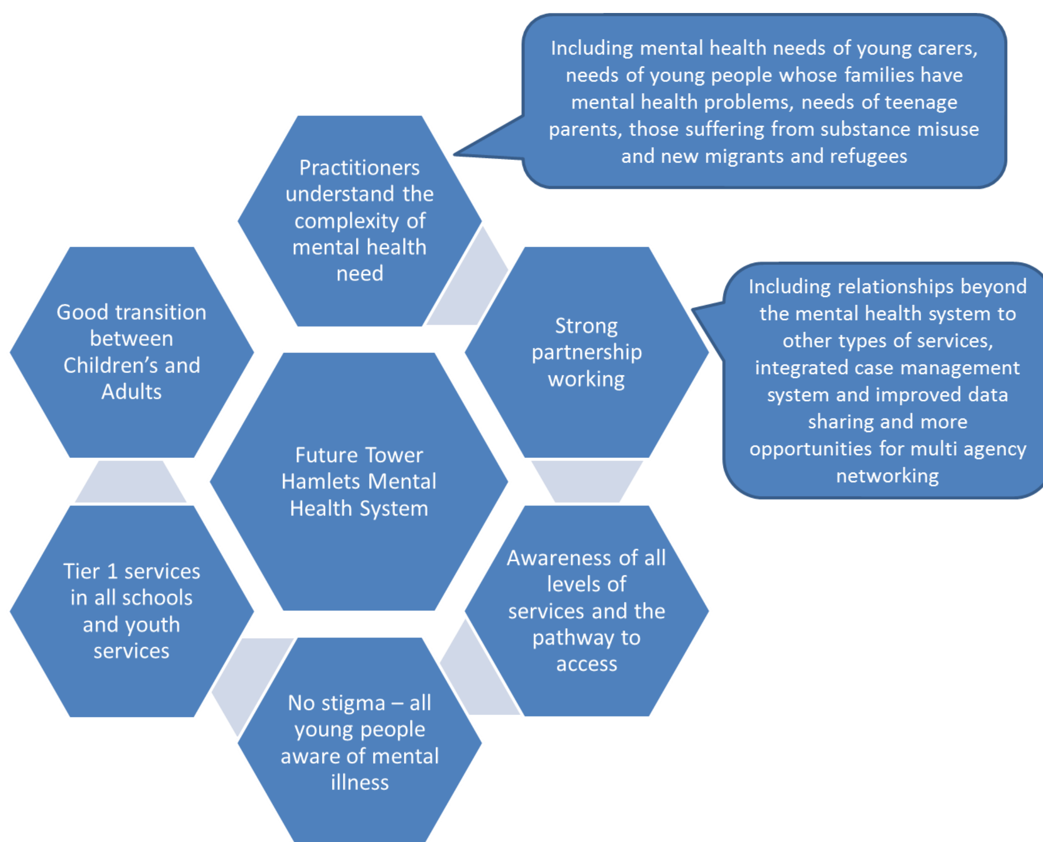
The visioning workshop with clinicians, local authority and voluntary and community sector representatives discussed the strengths and weaknesses of the current mental health system which are outlined below:

Table 23: Strengths and weaknesses of current mental health system local authority, voluntary and community sector representatives

Strengths	Weaknesses
• There are good examples of collaborative working across agencies and organisations. • CAMHS is family focused. • Focus on other issues related to mental health i.e. social inclusion panel and the view that conduct disorder is well managed. • Training courses including those for parents.	• Pathways between children's and adult's services need to be improved – including the period of transition as well as the approach i.e. adult service focus on the individual rather than the family. • The mental health system needs to be more holistic in its approach. • Awareness and understanding of early intervention and low level services need to be improved. • Mobility between tiers in the family wellbeing model needs to be less variable and smoother. • The borough needs to be more mental health friendly. • Support for carers needs to be strengthened.

The groups of clinicians, local authority and the community and voluntary sector representatives then discussed what the future mental health system in Tower Hamlets should look like, the illustration below highlights some of the key words, phrases that were captured:

Figure 36: Diagrammatic presentation of views concerning future components of a mental health system in Tower Hamlets (children and young people)



The priorities for the mental health system in Tower Hamlets identified through the workshop included:

- Improved transition between children and adults mental health services.
- Stronger interagency links across health and social services.
- Build the capacity of universal services and voluntary sector to identify and respond to emotional health and wellbeing needs of children and young people.
- Improved support for the mental health needs of young carers.
- Clear and structured care pathways.
- Focus on family support.
- Early identification of mental health needs of vulnerable groups.
- Continuity of care.

3. Being an adult

3.1 Quality of life

The service user experience survey is sent to all people accessing social care in Tower Hamlets. The 2011/12 survey highlighted that people who had mental health problems, 64.7% of people receiving long-term social care services reported a good quality of life, compared to 67% last year; 18.4% reported a bad quality of life[208]. For those people with mental health problems 71.4% agreed that the support they receive helps them to stay as

[208] User Experience Survey 2011-12

independent as possible, compared to 91% last year. People in mental health services are less likely to agree when compared to the response from all “eligible” social care service users.

64.6% of people with mental health problems in long-term social care are positive about the amount of control they have over their lives. People with mental health problems in long-term social care are more likely to feel in control when compared to the response from all “eligible” social care service users. 92.2% of people with mental health problems in long-term social care told us that care and support services help them to have control over daily life. These comparisons are interesting, seemingly people with mental health problems in contact with social care feel less independent but have more control over daily life than all social care users.

The results of the social care experience survey also show that people with mental health problems in long-term social care require support to manage their finances. The implications of the welfare reform may well mean that this need increases overtime whilst people are re-assessed for their benefits:

- 22.6% of people with mental health problems in long-term support say that they do not have their own bank account
- 71.5% of people with mental health problems say they cannot deal with finances and paperwork by themselves.

Attendees of the THINk 2012 AGM talked about what can be done to improve the health and wellbeing of people living in Tower Hamlets, raising awareness of the symptoms of mental ill-health was raised as an important area for adults living in the borough. GP patients reported that they want to feel like they are being treated as a whole person and that their emotional and mental wellbeing is being looked after as well as their physical wellbeing.

3.1. Being involved in my care and support

Being involved in my care and support is central to personalising services and implementing the full meaning of the Mental Capacity Act. In the 2011 ELFT in-patient survey 31% of respondents said that they were not involved as much as they wanted in decisions about care and treatment. In the ELFT user-led standards review people gave a “fair” rating to “service users are involved in important decisions about care planning and discharge”. As we have seen with young people there is a need and a want for people with mental health problems to be better involved in their care and support planning, arrangements and decisions.

3.2. Experience and views on social care

87.6% of people with mental health problems in long-term social care are extremely, very or quite satisfied with their care and support, compared to 81% last year. 3.1% reported as being dissatisfied which is a similar result to last year[209]. In the last year there has been an improvement in the number of people with mental health problems who responded to say that getting support undermines how they feel: 4.8 % compared to 12% last year.

[209] User Experience Survey 2011-12

In terms of choice, 62% of people with mental health problems in long-term social care agreed that they can choose the support they receive, and 54.8% agree that they can choose how and when they get support. With the policy agenda focussed around person-centred support and personal budgets this is arguably lower than would have been expected. The survey also asked people's views on personal budgets, 31.2% of people with mental health problems in long-term social care are interested in managing a cash personal budget, 26.2 % of people are interested if someone else can manage the money. Only 8.2% said that cash personal budgets would involve too much paperwork, although 11.5% said that they have other concerns. Interestingly, 23% of people with mental health problems in long-term social care said that they don't know enough about them to say. This is supported through discussions at the Your Say, Your Day sessions; questions about personal budgets raised at a service user event indicated that not everyone knows about personal budgets, and that people have concerns about services closing or being privatised, and it being difficult for people to get through any bureaucracy associated with personal budgets. Some people were concerned about the potential and consequences of people misusing their personal budget People noted that staff as well as service users can be institutionalised.[210]

24.2% of people with mental health problems in long-term social care found it difficult to find information and advice about support, services or benefits. 79.1% of people with mental health problems in long-term social care were satisfied with the information, advice and support they initially received from social care. People in mental health services are more likely to have found it easy to find information and advice, and are more likely to be satisfied with the information and advice they were initially given from social care, when compared with the average response from "FACS eligible[211]" adult social care users[212].

3.3. Experience and views on mental health inpatient services

Locked hospital wards have raised discussion at service user events and suggestions have been made that a combination of open and lock wards based on needs are needed[213].
In the ELFT inpatient survey 61% of respondents rated the care they received during their stay in hospital as either "excellent", "very good" or "good". 39% of people said it was "fair or poor" with 5% stating "poor". 100% of people found talking therapy useful. 38% felt there were not enough activities to do during the day, and 51% felt there were not enough on evenings and weekends. 15% felt that not enough care was taken of their physical health problems. 84% received some or all of the help needed. From the ELFT user-led standards audit, service users gave a "fair" rating for "service users have regular access to therapeutic groups and activities that enhance their wellbeing".

When asked about the help from and experience of staff results included: 63% said that when they arrived on the ward staff made them feel welcome. 56% felt that when they arrived on the ward, staff definitely or to some extent knew about them and any previous

[210]"Your Say Your Day" event, November 2011.
[211]Fair Access to Care Services - FACS is a national eligibility framework for allocating social care resources fairly, transparently and consistently
[212]User Experience Survey 2011-12
[213]Your Say, Your Day event, February 2011

care received. 69% said the hospital helped them to keep in touch with family or friends. These results indicate that things could be improved.
Positive feedback was captured from the ELFT inpatient survey when asked about their experience of hospital psychiatrist and hospital nurses:

- Hospital psychiatrist: 87% said the hospital psychiatrist(s) always or sometimes listened carefully to them. 81% said they always or sometimes had enough time to discuss their condition and treatment with the psychiatrist. 76% always or sometimes have confidence in the psychiatrist. 86% feel they are always or sometimes treated with respect and dignity by the psychiatrist.
- Hospital nurses: 90% said the nurses always or sometimes listen to them. 77% said they always or sometimes had enough time to discuss their condition and treatment with the nurse.

However, in the user-led standard audit service users gave a 'poor' rating for 'service users receive regular, quality one to one time with their allocated nurse'.

Areas that have been highlighted for improvement include, being kept informed within a ward, patients being aware of their rights, making a complaint, explaining medication and who to contact in a crisis:

- 21% of respondents said staff did not tell them about the daily routine of the ward, such as times of meals and visitors times, when they first arrived. A "poor" rating was also given for "on admission, service users receive a Welcome Pack containing useful information".
- 22% said their rights were not explained in a way that could be understood. Service users gave a "poor" rating in relation to "service users are informed of their rights in regard to the Mental Health Act 1983 and accessing clinical notes".
- 52% were not aware of how to make a complaint.
- 20% said staff did not explain the purpose of their medication in a way they could understand. 31% said staff did not explain the possible side effects of medication in a way they could understand.
- 38% were not given information about how to get help in a crisis, or when urgent help is needed.

3.4. Mental health visioning workshop: services for adults of working age

In August 2012 the Partnership hosted a mental health visioning workshop about the mental health system for adults of working age, this included people with mental health problems, carers, clinicians and those working to support people with mental health problems.
From the session the main strengths of the mental health system were:

- High level of service user involvement and focus on recovery and long term care across community and voluntary sector services.
- Primary care provided good quality of care and introduction of networks help to better integrate services.

- Wide range of community services that promote the recovery process in their delivery.
- Person-centred and supportive community services.
- Major improvement for in-patient services such as availability and choice of therapeutic services, service user involvement and listening to patient's needs, improved staff training and knowledge, facility and aesthetic improvements.

The main weaknesses identified across the system included:

- Lack of communication and service integration.
- Sustainability and funding issues faced by community based services.
- Lack of understanding and knowledge across clinical care about mental health – provision of care is medically focused.

The key priorities that emerged from the session included the need for:

- Embedding recovery therapies across the mental health system – shift towards holistic person centred approaches that applies both medical and social care.
- Community and service user involvement at all levels - for service improvement, identifying unmet needs, support for families and carers, commissioning and other areas.
- Service integration and communication to improve the individual's journey along the mental health care pathway.
- Innovative and bespoke approaches to tackle stigma and discrimination across a range sectors.

4. Growing older

4.1 Overview

From the discussions with older people about mental health and related services, there was overall satisfaction with the approach and support provided for older people in their own homes. However, there were concerns raised about cuts to services given the current financial context:

> *Older people generally thought it was a good idea to release under-used beds in dementia services to pay for care in the home. One person praised the Diagnostic Memory Clinic. Some people are uncertain about the future in the light of NHS cuts.*[214]

The issue of older people being isolated was captured explicitly or implicitly through feedback, although older people in long-term social care report being less socially isolated than younger adults (74.5% of people aged over 65 have enough social contact, compared to 67.4% of people aged 55-64). In the health and wellbeing strategy consultation there is a

[214] 5th October 2011, Older People's Reference Group

general message from residents and staff about the impact of isolation on people's emotional health and wellbeing.

4.2 Mental health visioning workshop: services for older adults

In August 2012 the Partnership hosted a mental health visioning workshop about the mental health system for older adults.

Some of the main strengths identified across the system included:
- Availability of a wide range of services in the community and voluntary sector.
- Provision of a supportive network of health and social care from CMHTs - which improves diagnosis and early intervention.
- Support provided by the Dementia Liaison team at the Royal London Hospital.

The main weaknesses identified across the system included:
- Lack of integration and service awareness among providers.
- GPs to provide a more balanced approach to care (clinical and wider services).
- Not enough value and recognition given to carers.

The key priorities that emerged from the session were:
- Improved service integration across the system and provision of holistic care.
- Promotion of service awareness and communication across all stakeholder and sectors.
- A strengthened and more cohesive approach to address stigma and discrimination in the community.
- Enhanced support and value for carers throughout the care pathway.
- Awareness raising and promotion of prevention, early diagnosis and issues faced by older people.

The mental health strategy was also discussed with the Older People's Reference Group and some of the concerns raised included the need for:

- Further support around housing issues and transfers.
- Opportunities for older people to be listened to about their feelings rather than relying on medication, as isolation and other life events can lead to depression.
- Training for GPs to better understand and discuss mental health concerns with their patients.
- Alternatives to medication for older people such as group therapy sessions and counselling services.
- Seamless access to mental health services across the life course, as older people feel they experience poorer access to services compared to when they were younger.
- Activities and peer projects that strengthen the community resilience so people can watch-out, help and listen to each other.

- Information about relevant projects and activities is widely disseminated to include vulnerable older people who are not on benefits and/or live in owner-occupier housing.

5. Issues raised that affect particular groups

5.1. New residents and refugees

A concern has been raised by the New Resident and Refugee Forum about the mental health is the lack of care and access to services which could potentially lead to delinquency and drug or alcohol dependency impacting their long term health and wellbeing[215].

5.2. Carers

Through on-going discussions with carers for people with mental health problems as well as for people with other needs (e.g. physical disability, learning disability and older person), it was highlighted that the role of caring can impact on their own mental health and wellbeing. The need to address this in development of the mental health strategy was a priority concern for this group.

The most important needs identified by carers included:

- Support from services to improve time spent on other activities such as work, daily activities, caring for other family members, socialising, personal health and wellbeing.
- Support to assist with personal activities such as food shopping and household maintenance.
- Recognition of the role of carers by GPs and other health professionals, as there is a high demand on a carer's time, emotional health and wellbeing when caring for individuals.
- Peer support, counselling and mental health provision for carers to cope with stress and anxiety.

The strengths and weaknesses of carers' services in Tower Hamlets are outlined below:

Table 24: Strengths and weaknesses of carer's services in Tower Hamlets

Strengths	Weaknesses
Family action and carers centre provide a high level of supportive care.	Lack of awareness of available carer services.
Carer forums and groups are useful for sharing information.	Some services have long waiting times for access.
	The role of a carer is not well recognised by health and social services.
	Some carer services need to improve their signposting to other supportive

[215]New Resident and Refugee Forum 3rd August 2011

	services.
	Time of service is not always convenient for the carer.
	Traveling expenses can be a barrier to service access.
	Lack of carers to provide cover. Where coverage is provided there are other issues to consider such as safeguarding and patient confidentially.
	Some services lack recognition for young carers and secondary carers.

The key priorities identified to improve services for carers in Tower Hamlets include:

- Respite care and child day-care.
- A holistic approach towards support for carers.
- Improved engagement with carers for service development.
- Raised awareness of the important role of carers throughout the mental health system and wider services.
- Improved navigation and pathways through the mental health system to reduce the amount of time carers spend attending appointments and undergoing multiple registrations.

5.3. Lesbian, Gay, Bisexual and Transgender (LGBT)

Rainbow Hamlets and other stakeholders highlighted some of the key concerns surrounding mental health in the LGBT community[216] which include:

- The need for tailored mental health approaches and treatments for young people in the LGBT community.
- The reluctance of LGBT people to disclose their sexuality and how this can lead to feelings of isolation which can negatively impact mental health and wellbeing.
- Emotional health and wellbeing issues arising from a person who is either lesbian or gay enters a heterosexual marriage due to fear of stigma and discrimination by their social circles.
- Social exclusion of older people in the LGBT community which can lead to them being overlooked by services.
- The expectation that siblings who are LGBT would care for older family members, as they are less likely to have children or a family of their own. This can be an isolating experience and not all LGBT carers feel comfortable to access available carer support.

6. Key points and common themes

6.1 Outcomes from public consultation on Health and Wellbeing Strategy

[216] Rainbow Hamlets Health Consultation 11th July 2012

67% of respondents strongly agreed, and 31% agreed, that “mental health and wellbeing – no health without mental health” should be a partnership priority. Respondents wanted to see:

- More evidence of early diagnosis and intervention
- Improved recognition and support for children’s mental health

6.2 Views from engagement events and surveys across the life course:

- Specific feedback on CAMHS: young people and parents want to see
    - Practitioners should offer continuity and understand the complexity of mental health need, including families, migrants and substance misuse
    - Awareness and information and services in schools and youth services
    - Non- judgemental and non-patronising services
    - Better awareness of access and pathways at all levels of service
    - No stigma
    - Good transition between children and adult services
- Specific feedback: Adult services
    - Service users wanted more choice and control
    - Mixed views on personal budget but high satisfaction amongst social care users
    - Substantial dissatisfaction with inpatient services
    - More involvement for service users in their own care; the recovery approach; and better service integration
- Specific feedback: Older people’s services
    - Concern about isolation due to lack of social networks
    - More GP support wanted – being treated as a whole person (also adult services)
    - Importance of carers emphasised
    - Integration and prevention should characterise services

6.3 Cross-cutting themes and priorities for all services:

Patients and carers in services for all ages wanted to see:

- Recovery and holistic care
- Information and communication
- Better access to services
- Combat stigma and discrimination
- Service integration and connectedness across a wider range of services
- Community and service users involvement
- Support for carers and families
- Early interventions and better transitions.