Mental Health in East London and the City

A Sector-Level Health Needs Assessment

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Sector-level Health Needs Assessment of Mental Health Services

Tower Hamlets, Newham and City & Hackney PCTs

January-February 2010

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Foreword

To be completed

Introduction

Positive mental health is essential for the maximization of the wellbeing of individuals, families and broader society. Mental health is an essential component of overall health, and it is intertwined with physical health, such that a complete separation of the two is impossible.

There are substantial potential gains for improving mental health, including increased self-esteem, productivity, relationships, economic benefits and a reduction in the burden on health services.

The coalition government has recently published its national mental health strategy, “No Health without Mental Health” which aims to shift the mental health paradigm towards the promotion of mental health, prevention of mental illness and early identification and intervention as soon as mental illnesses arises.

Mental health is affected by a broad range of determinants, reaching far further than the scope of health services alone. The socioeconomic conditions, the build environment, education and housing all affect a person’s mental wellbeing. Therefore, to improve the mental health of a population, a broad perspective that encompasses all of these determinants is required.

This Health Needs Assessment is one component in the process of improving mental health. It provides a start, or a check-up on progress, and asks how services can better meet the needs of population.

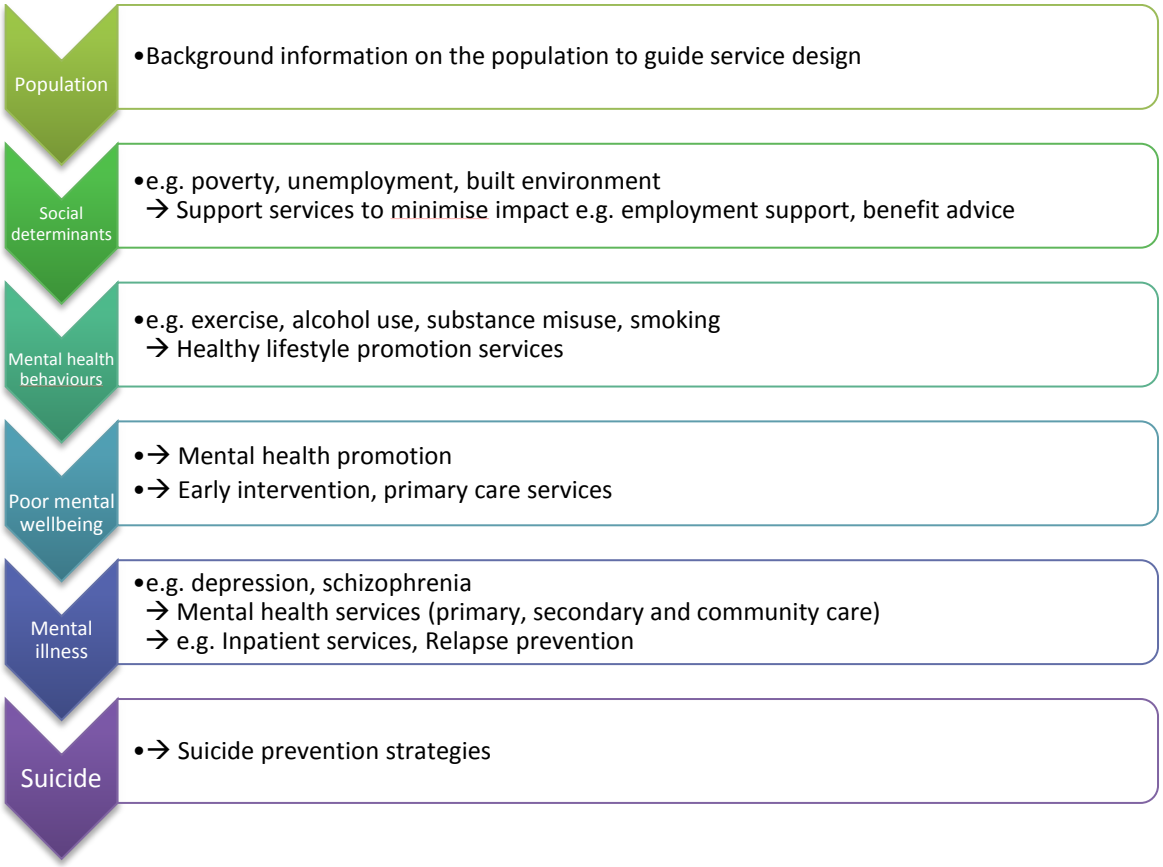
What is a Health Needs Assessment?

> **'Health needs assessment is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities.'**
>
> **- Health Development Agency, 2005**

A mental health needs assessment is a tool that is used to assess the mental health needs of a population. The term 'mental health need', which is used frequently throughout this report, is defined as 'the capacity of an individual to benefit from mental health services'. Mental health services are, for this health needs assessment (HNA), broad and encompass all types of services commissioned by East London and the City Alliance (ELCA) for mental health.

An HNA facilitates the identification of health service needs within a population. These needs may exist through the causal pathway of mental ill health, as shown in Figure 1.

Figure 1: Examples of mental health needs – the capacity to benefit from mental health services



This HNA will use available data to quantify the extent of mental health need in Inner North East London (INEL) by working through determinants of mental health and assessing where the extent of the capacity to benefit from health services at each level.

The report also has a few sections that focus on particular areas of mental health, for example, employment. These have been chosen for variety of reasons, for example, relevance to national

policies, concerns raised by stakeholders, or simply because there is good data available to enable a fuller exploration of the issue.

Local context of the HNA

This Health Needs Assessment (HNA) is a component of a Whole Systems Review (WSR) of mental health services within East London and the City Alliance, which covers the City of London and the London Boroughs of Hackney, Newham and Tower Hamlets. The WSR has the following components:

- Productivity analysis: An analysis of cost and activity by service line
- Health Needs Assessment
- Review of Best Practice: shared care, secondary prevention, carers, physical health
- Stakeholder Analysis including users perspectives
- Quality analysis
- Thematic review of Serious Untoward Incidents
- Gap analysis and synthesis of all components

Stand-alone HNAs typically contains some of the above elements, for example, stakeholder analyses and evidence reviews. Given that these are being conducted separately as part of the WSR, this HNA will not repeat these components.

We always welcome comments and feedback. Please contact Marie-Carmen Burrough, Senior Strategist, NHS Tower Hamlets for further information: marie-carmen.burrough@thpct.nhs.uk

Scope

The following scope was agreed:

	INSIDE SCOPE	**OUTSIDE** SCOPE
Population	All adults aged over 18 years	Children (under 18 years)
Diagnoses	Severe mental illness (SMI) Suicide and suicidal ideation Self-harm Common mental disorders Dual diagnosis Dementia Personality disorder Perinatal mental health Eating disorders	Alcohol and drug misuse only Head injuries Learning difficulties Autistic spectrum disorder
Settings	Tower Hamlets, Newham, City and Hackney	
Timeframe	2010-2015	
Comparator areas	London, England, London PCTs	

Background: The population of Inner North East London

This section describes the population within City and Hackney, Newham and Tower Hamlets. It asks:

- How many people do our mental health services cover?
- How will this change in the future?
- What are the wider determinants of mental health in this population?

Based on the most recent GLA estimates, the total estimated resident population for East London and City Alliance in 2010 was 746,350.

Table 1: Population size of ELCA boroughs[1]

Borough	2010 Estimate
City	9,500
Hackney	229,040
Newham	265,690
Tower Hamlets	242,130
Total	746,350

Age: What does the age profile mean for mental health services?

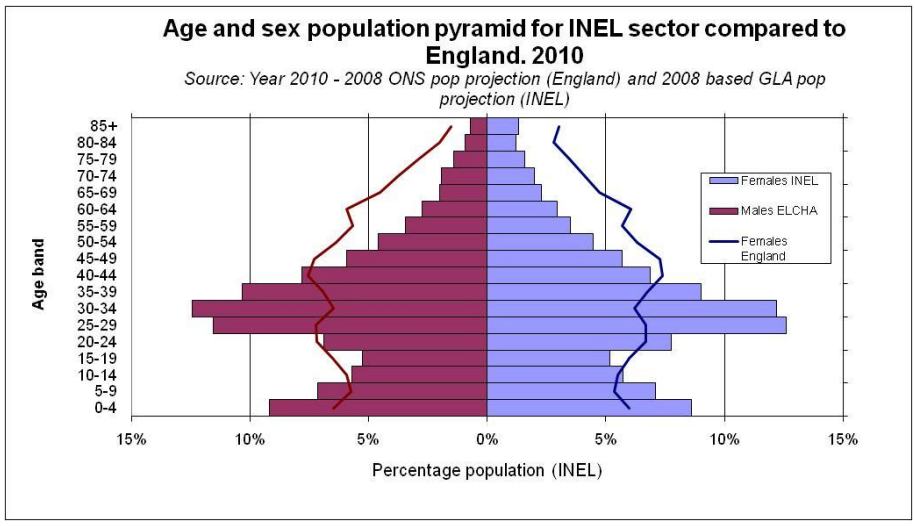
Summary:

- INEL sector has a very young population, particularly 25-45 year olds.
- This may lead to more new diagnoses of severe mental illnesses, such as schizophrenia and bipolar disorder, which demand significant health service resources.
- The smaller older population are at risk of being overlooked in health care provision

Figure 2 shows the population pyramid for INEL. The population pyramids for the three separate boroughs are very similar, so are not included here. It shows that INEL has a very young population, with substantially more adults aged 25-45 years than the England average. The proportion of older people is therefore much smaller than the national average.

[1] GLA population estimates

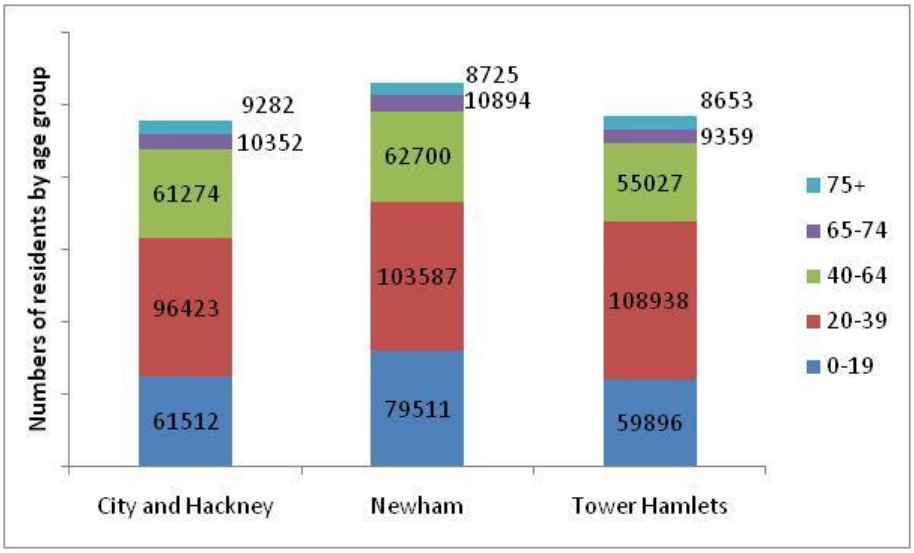
Figure 2: Age and sex breakdown of the INEL population



Both males and females have a similar age distribution, apart from in older age, which reflects the longer life expectancy of females.

Figure 3 shows the number of people within each age group, showing that older people are a minority group within the sector.

Figure 3: Numbers of residents by age group



There are a number of implications for mental health services. Many of the severe mental illnesses such as schizophrenia and bipolar disorder first present in early adulthood. There will therefore be a disproportionately higher number of new diagnoses of these conditions, which will require significant service input to establish treatment. The large working age population offer a substantial opportunity to improve mental health through the work-place, and similarly to prevent poor mental health that is triggered through workplace factors, such as stress.

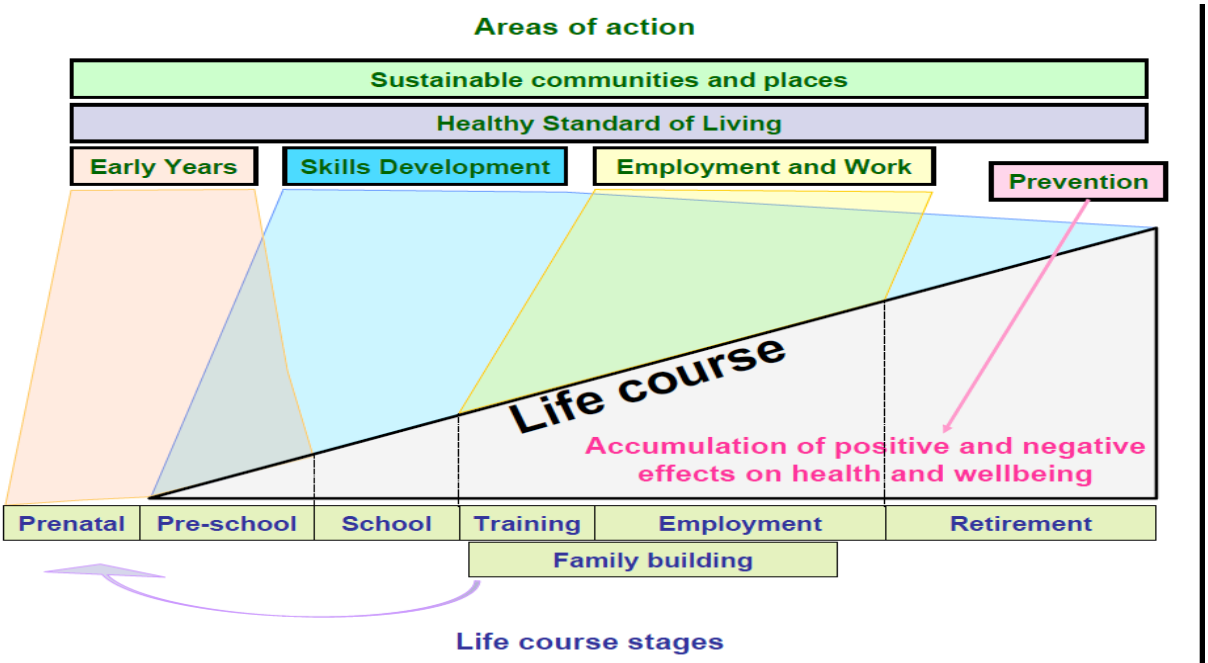
However, amongst the working age population, levels of economic inactivity vary markedly across the sector, with particularly high levels in Tower Hamlets. Consequently, there is a high proportion of children born into poverty. The sector has some of the highest child poverty levels in the country.

The importance of early years in the development of ill health was illustrated in the recent Marmot Review. Its lifecourse 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, as shown in Figure 4. The implication for this is that there are similarly different opportunities in the life course where people are most susceptible to different interventions and therefore a range of targeted interventions are required throughout the life course to have maximal impact in improving (mental) health.

The wider determinants of health are explored in more detail in a later chapter.

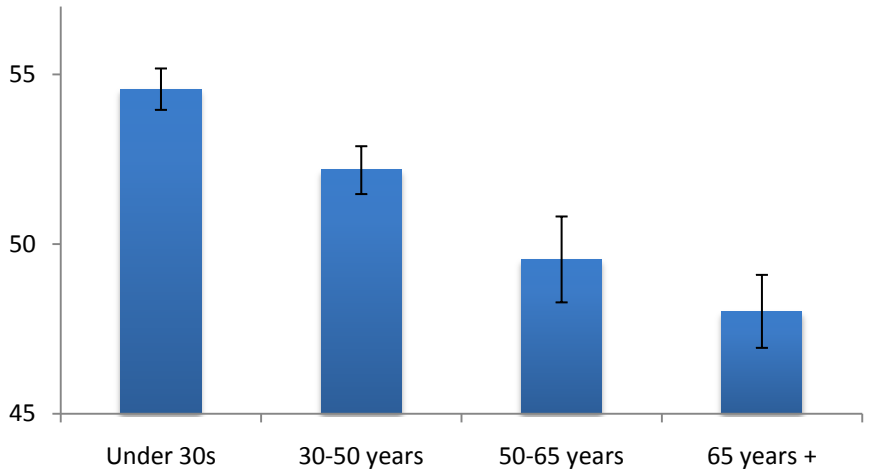
Figure 4: Marmot Review conceptual framework - The Life course Perspective



The relatively small population of older people are at risk of being overlooked in mental health service planning, despite carrying a high burden of mental health problems as service may be more orientated to the larger young population. Up to 25% of older people nationally are thought to have symptoms of depression that may require intervention[2]. Furthermore, a local survey of adults living in Tower Hamlets demonstrated that older people have poorer mental health compared to younger adults (Figure 5).

[2] No health without mental health: a cross- government mental health outcomes strategy for people of all ages. Department of Health. 2011

Figure 5: Levels of mental wellbeing in Tower Hamlets by age group (WEMEBS score) (WEMWBS score – higher score = better mental wellbeing)



How will the population change in the future? What does this mean for mental health services?

Summary:

- The population of INEL is anticipated to grow considerably
- All other factors remaining equal, this will increase demand for mental health services
- Most of this growth (and therefore demand for mental health services) will be in the 25-49 year and 50-64 year age groups
- Tower Hamlets will see the largest growth out of the three boroughs and therefore face the greatest increase in demand for mental health services
- The area will become more ethnically diverse, with the white population predicted to reduce from 50% to 45%

The overall population of East London and City is anticipated to grow from 746,350 in 2010 to 791,720 in 2014 (an increase of 6.1%) and to 866,440 by 2021 (an increase of 16.1%). The rate of estimated population growth varies across the Boroughs. Based on the most recent GLA estimates, 8% growth is predicted between 2010 and 2014 in Tower Hamlets, 6% in Newham, 3% in Hackney and 8% in City.

Figure 6: Population growth in INEL areas

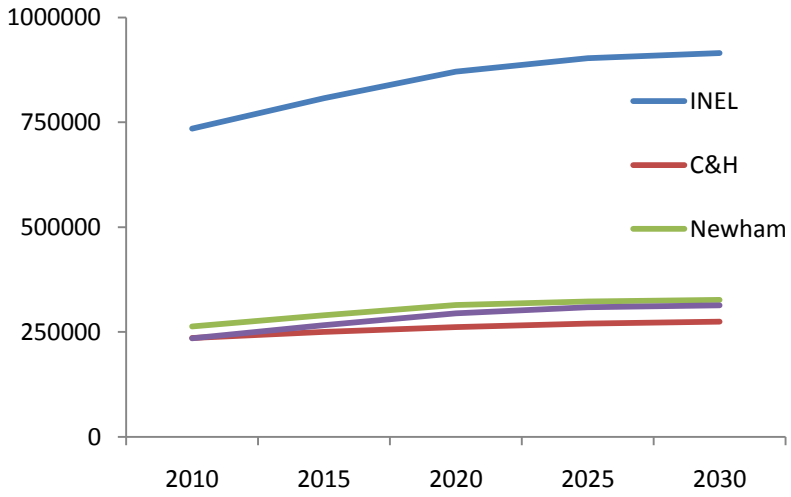


Figure 7: Population change by age group in INEL areas

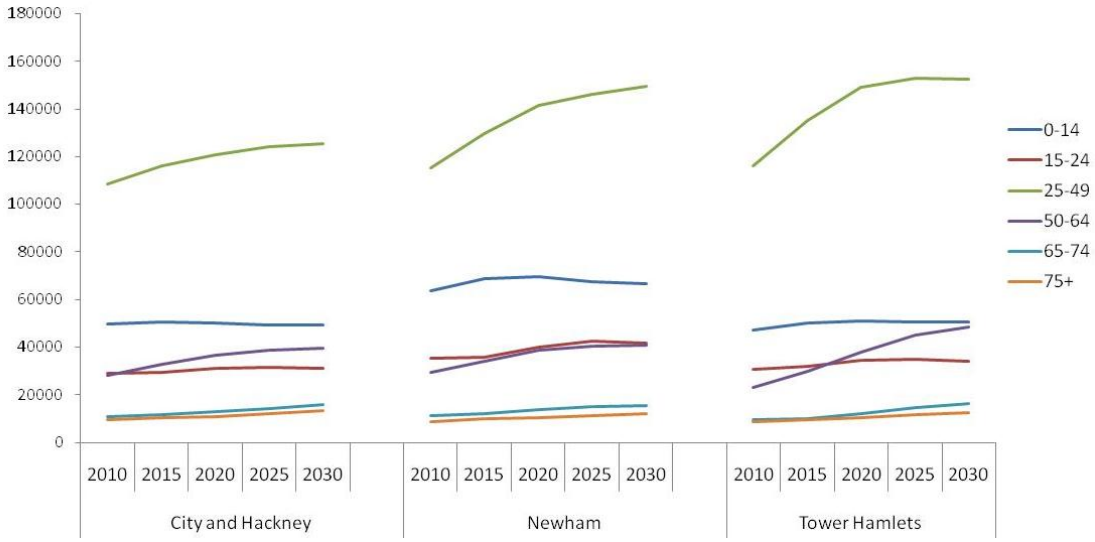
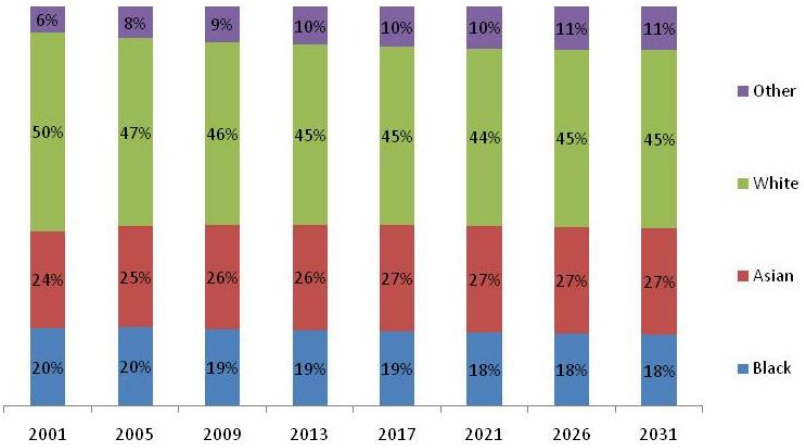


Figure 8: Projected ethnic composition of INEL population[3]



[3] Source: GLA 2009 Ethnic group projections

Ethnic diversity

Summary:

- INEL is ethnically diverse, with different profiles in each borough
- Ethnicity is a protected characteristic
- The relationship between ethnicity and mental health is complex with well-documented inequalities at a national and local level with respect to mental health

Figure 9 shows the ethnic breakdown of the INEL boroughs and compares this to London and England. The City has a similar profile to England as a whole. The other boroughs are much more ethnically diverse, with BME communities making up 61% of the population of Newham. Hackney has a large Black population and Tower Hamlets and Newham have large Asian populations. Figure 10 shows that the Asian population is heterogeneous and has a different composition in each of the boroughs.

Figure 9: Ethnic composition of INEL boroughs, compared to London and England

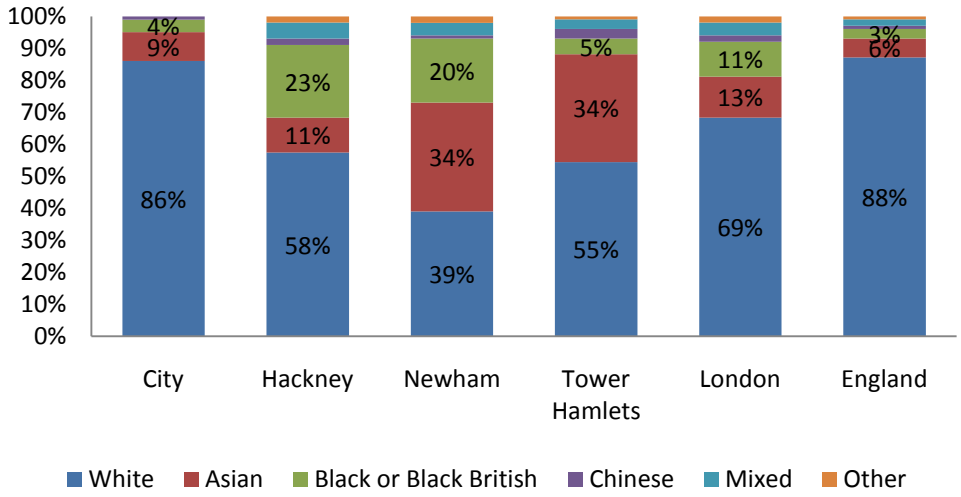
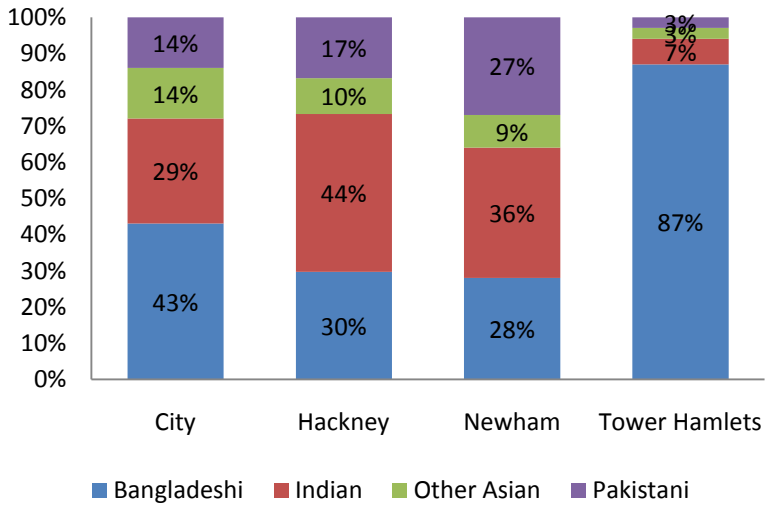


Figure 10: Breakdown of ethnic background amongst Asian people living in INEL



Religion: How does religion diversity affect mental health need?

Summary:

- Religion can affect a person's beliefs about personal responsibility for mental health and about the aetiology of mental health problems.
- It is closely related to the constructs of ethnicity and culture
- Information about the religious profile of an area can be compared to service use data to assess whether there are inequalities in access and utilisation of health service between different ethnic groups.

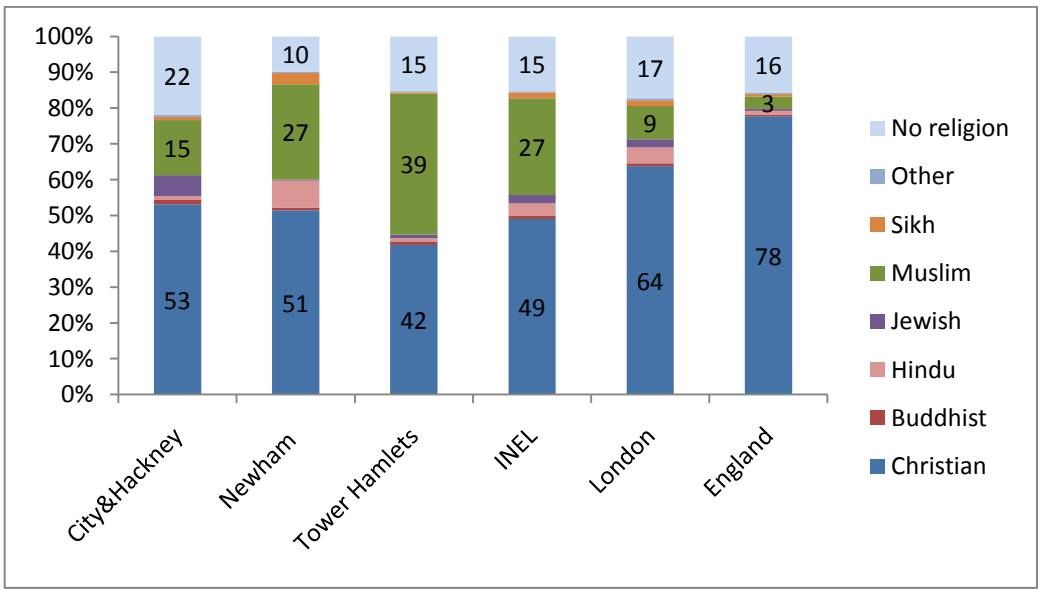
As much as the INEL sector is an ethnically diverse area, it is also a religiously diverse area, with the breakdown differing between boroughs, as shown in Figure 11.

Globally, there are a wide number of different paradigms relating to mental health, which are tied into cultural and religious beliefs about the origins of mental health and individuals' capacity to determine the course of a mental health problem. These beliefs can affect help-seeking behaviour and make it difficult to engage with services delivered with a Western mental health paradigm. This is based on the concept that many determinants of health are modifiable and that individuals have the capacity to both prevent and aid their recovery from mental health issues. It is therefore important to understand the beliefs of local residents to ensure that health services are commensurate with their beliefs but also deliver the best possible outcomes for all people's mental health, regardless of their religion.

People with religions beliefs that focus on fatalism may be less motivated to engage in activities to prevent mental illness, such as exercising or gaining employment, which may lead to higher levels of mental health issues. However, other cultural and social factors that are associated with these religions may compensate for this.

After Christians, Muslims make up the second largest religious group in INEL, particularly in Newham and Tower Hamlets.

Figure 11: Religious profile of the INEL area, compared to London and England



Information on religion is not routinely collected in primary or secondary care, despite being a protected characteristic. It is important to measure this and use data to ensure that there is no discrimination in health services, so that services are able to meet the needs of all members of the community regardless of their religious belief.

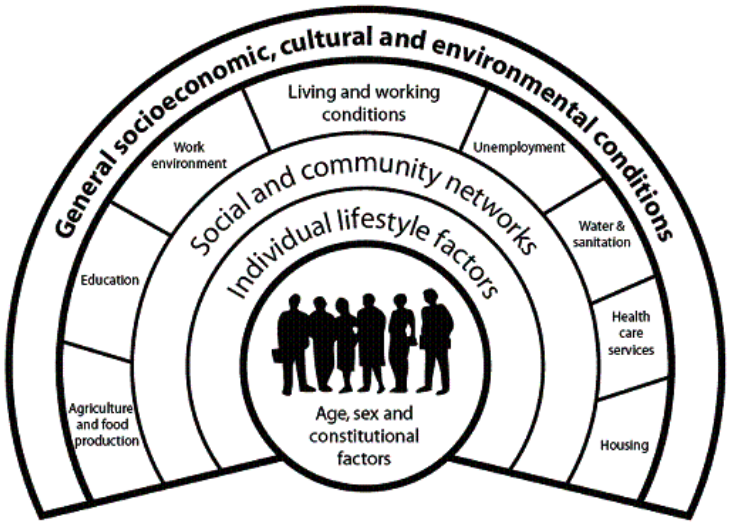
Wider determinants of mental health: What is the mental health service need?

Summary:

- There are high levels of deprivation, unemployment, poor living conditions and poor educational achievement in INEL
- Consequently, there is an increased risk of both developing and also exacerbating existing mental health problems.
- These risks can in part be mitigated by providing support services, such as employment support and benefits advice

Mental health is affected by a range of factors, which are summarised and structured in the Health Policy Rainbow, by Dahlgren and Whitehead (Figure 12). By understanding these determinants, we can then effectively address them to promote good mental health and prevent the onset or deteriorations in mental illness, through the delivery of services such as employment support or benefits advice.

Figure 12: Dahlgren and Whitehead model of the determinants of health



Deprivation

Summary:

- There are high levels of deprivation across the INEL sector which will drive high levels of poor mental health and mental illness.

High levels of deprivation are strongly linked to poor mental health. The relationship is bidirectional: Deprivation describes high levels of many risk factors for poor mental health, including unemployment, poverty, poor education, high crime etc. Conversely, people with mental health problems also are less likely to be employed, for example, and therefore might only be able to afford to live in a deprived area.

There are high levels of deprivation across the INEL sector. Table 2 shows how deprivation levels the INEL boroughs compare to all national local authorities – INEL is the most deprived area in the country.

In the context of mental health, there are therefore high levels of risk factors for mental health and one would expect therefore a high burden of mental high. This will be explored in latter sections.

Table 2: Deprivation– rank of the INEL boroughs by IMD (Index of Multiple Deprivation) score[4] out of all boroughs/local authorities in the country

	IMD 2007
City	253rd
Hackney	1st
Newham	2nd
Tower Hamlets	3rd

Figure 13 shows that in comparison to other London wards, the vast majority of wards in INEL are the most deprived in London, with only a few 'pockets of affluence' or areas with comparatively less deprivation.

Figure 13: Deprivation across the INEL PCTs in comparison to London

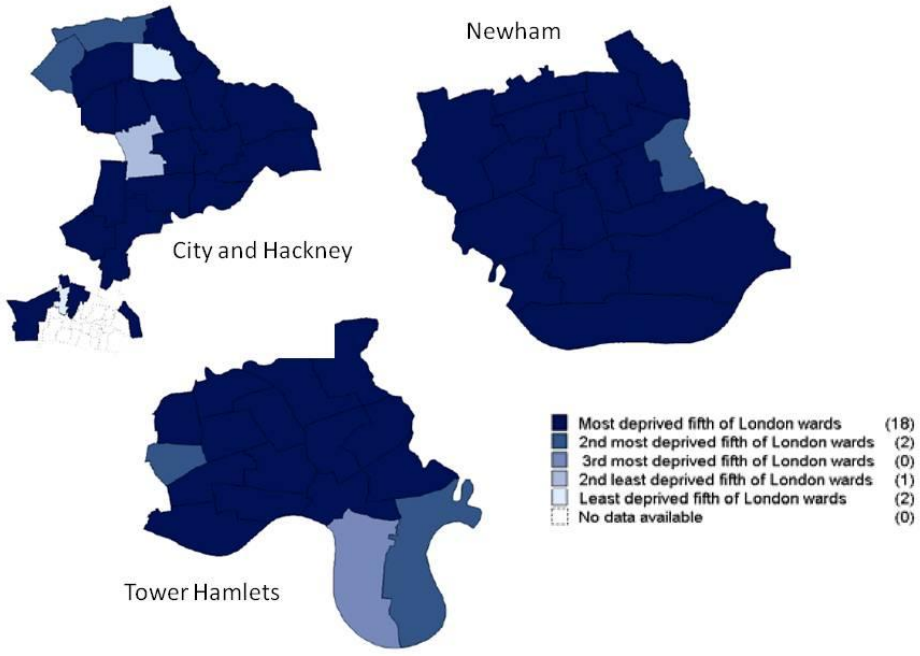
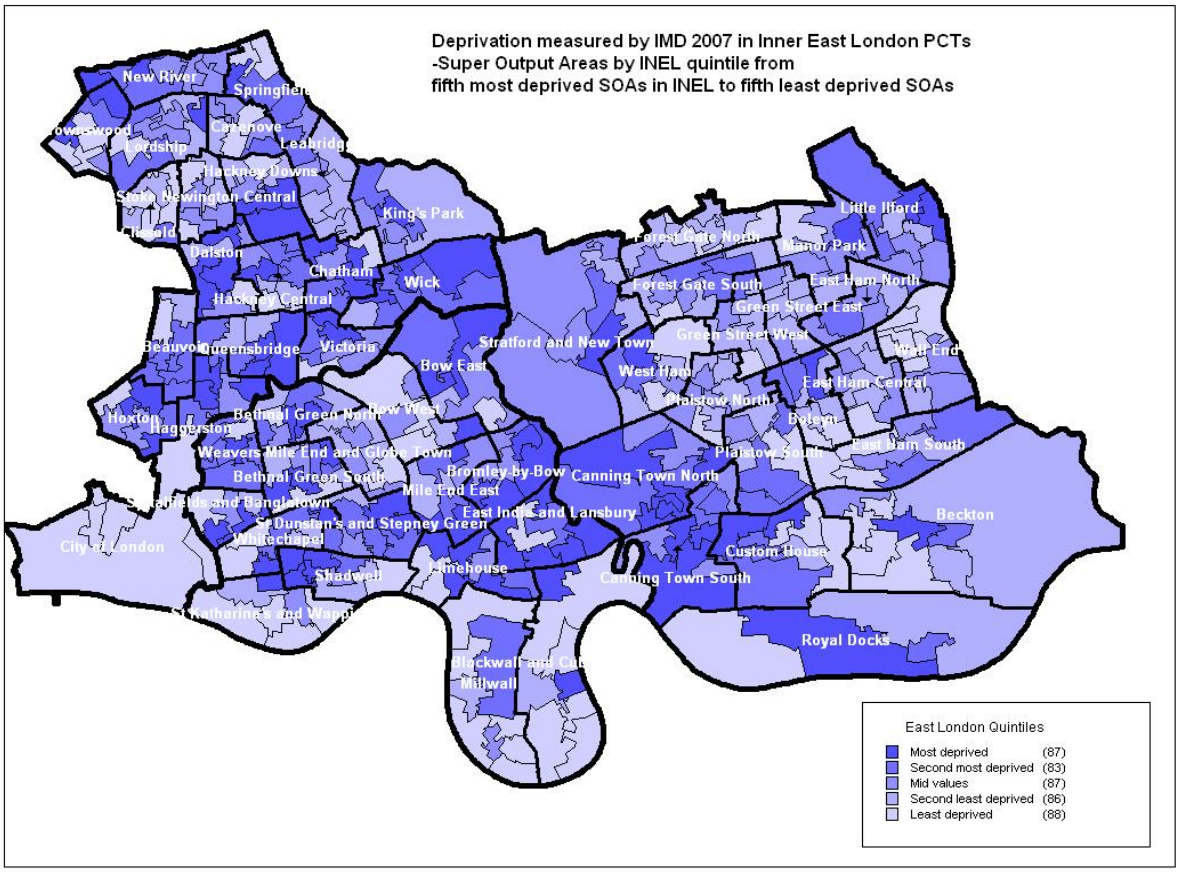


Figure 14 shows a map of comparative deprivation within the sector. Areas of relative affluence exist in the City of London and along the riverside, however, even within these, there are pockets of deprivation.

[4] Tulloch S, Priebe S. Population-based indices for the funding of mental health care: a review and implications. J Publ Mental Health. 2010: 9;15-22. Link

Figure 14: Levels of deprivation by Super Output Area (SOA) in the INEL sector



Other socioeconomic determinants of mental health

Summary:

The INEL sector has high levels of socioeconomic risk factors for poor mental health, including:

- High unemployment and economic inactivity
- Poor educational achievement
- Relatively higher proportion of residents who have poor English fluency and literacy
- High levels of deprivation
- High proportion of social housing

There have been several attempts to create a combined measure of mental health need, as shown in Table 3. These use socioeconomic variables alone, such as IMD 2007, or in combination with data on health service use. For more information on these, Tulloch and Priebe have discussed the relative merits of each score. However, regardless of the measure used, it is clear that there are very high levels of mental health need in INEL.

Table 3: Ranked scores of needs and deprivation in the sector (1 being the most deprived)

	UPA	York Index	PNI	MINI	IMD	LIN
City	33	-3	2	21	253	*1
Hackney	2	-3	2	8	1	*1
Newham	4	-3	4	12	2	4
Tower Hamlets	1	-3	1	5	3	8

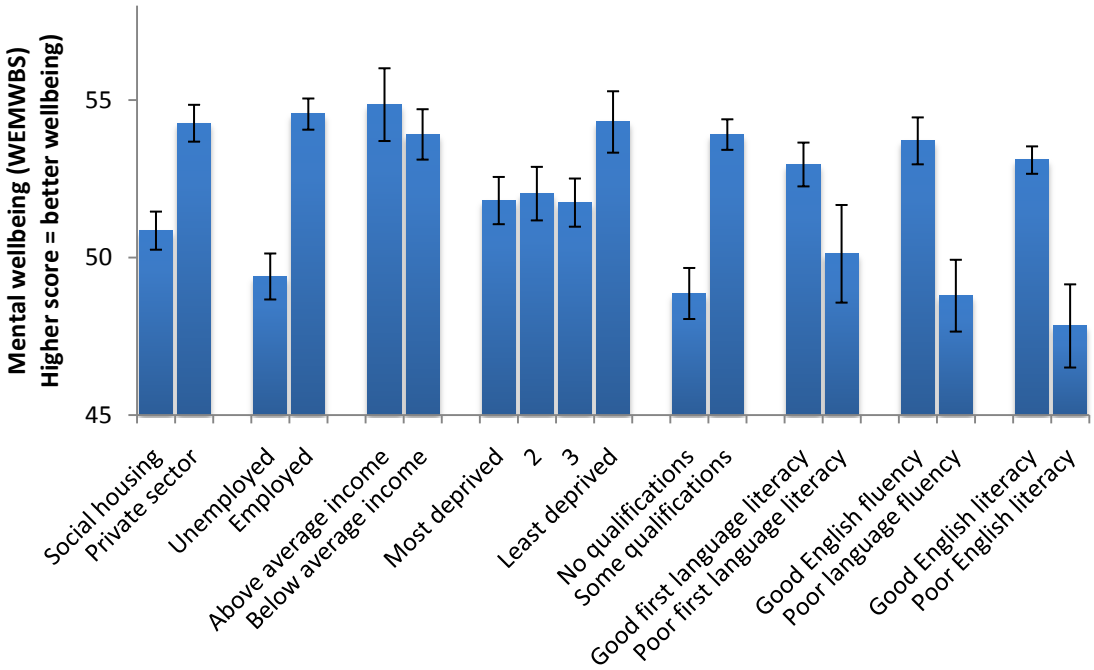
*** Data are combined for City and Hackney**
Table adapted from Tulloch and Priebe 2009[5]

Figure 15 shows how mental wellbeing is related to a range of socioeconomic variables within the borough of Tower Hamlets, taken from a bespoke Health and Lifestyles Survey (2008/2009) commissioned by NHS Tower Hamlets. It does not show independent variables as a multivariable analysis has not been conducted.

To summarise, mental wellbeing is 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

Figure 15: Mental wellbeing by socioeconomic factors in Tower Hamlets



[5] Tulloch S, Priebe S. Population-based indices for the funding of mental health care: a review and implications. J Publ Mental Health. 2010: 9;15-22. Link

Confidence Intervals

A number of charts in this document use confidence intervals. These allow us to take into account the uncertainty that accompanies using data with small numbers.

The I-shaped bar over top datapoint indicates that the true value (e.g. prevalence) is likely to lie in that range with a 95% level of confidence.

Broadly speaking, if two confidence intervals overlap, there is no statistical evidence of a difference between the two values in question.

Housing

Summary:

- Housing provision across the sector is poor, which increases the risk of poor mental health at a population level.
- There is some evidence that housing provision for people with mental health problems is inadequate, which may risk worsening mental health and increased health service use

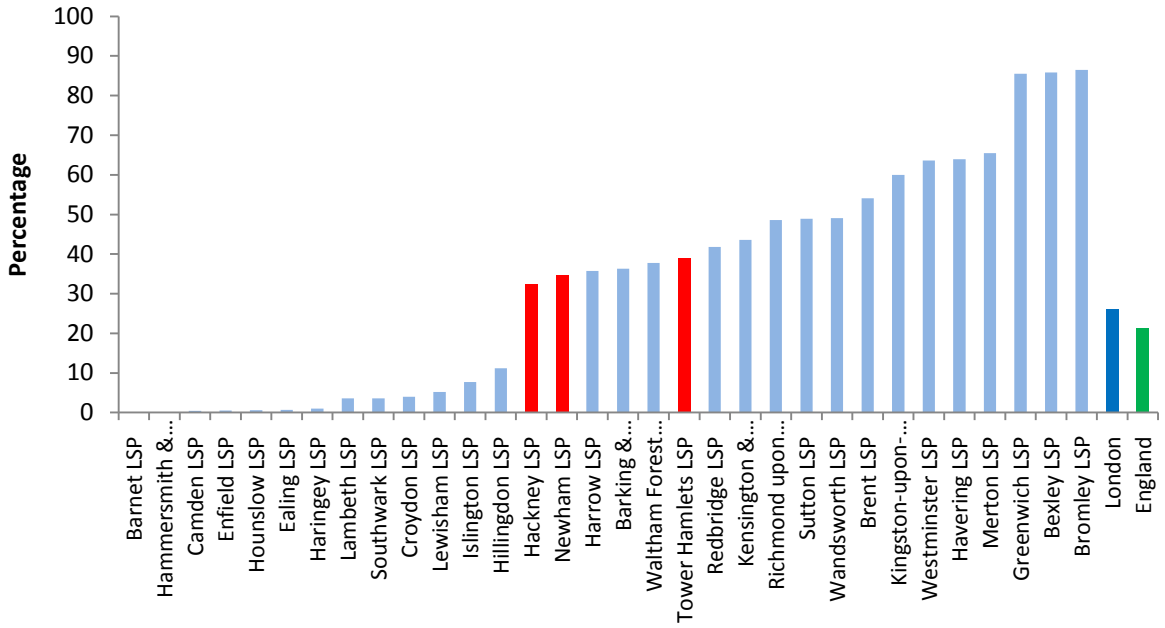
Good quality housing is important for mental health, both for primary and secondary prevention. Figure 16 shows the proportion of adults in contact with secondary mental health services in settled accommodation in London. There is clearly an issue with data quality, and it is difficult to ascertain whether the data submitted for INEL is complete. However, there are two alternative explanations for this pattern:

- Data collection on housing needs to be more rigorous
- The data submitted shows that the sector has amongst the highest levels of unmet need relating to housing in London

It is likely that both explanations contribute to the pattern seen, as inadequate housing is a well-documented problem within INEL (see, for example, recent JSNAs).

Whilst housing is generally within the remit of the local authority, mental health services have an important role to play in the identification of housing needs and signposting to appropriate housing services.

Figure 16: Proportion of adults in contact with secondary mental health services in settled accommodation in London boroughs and England. 2008/2009
Source: NASCIS



Employment

Summary:

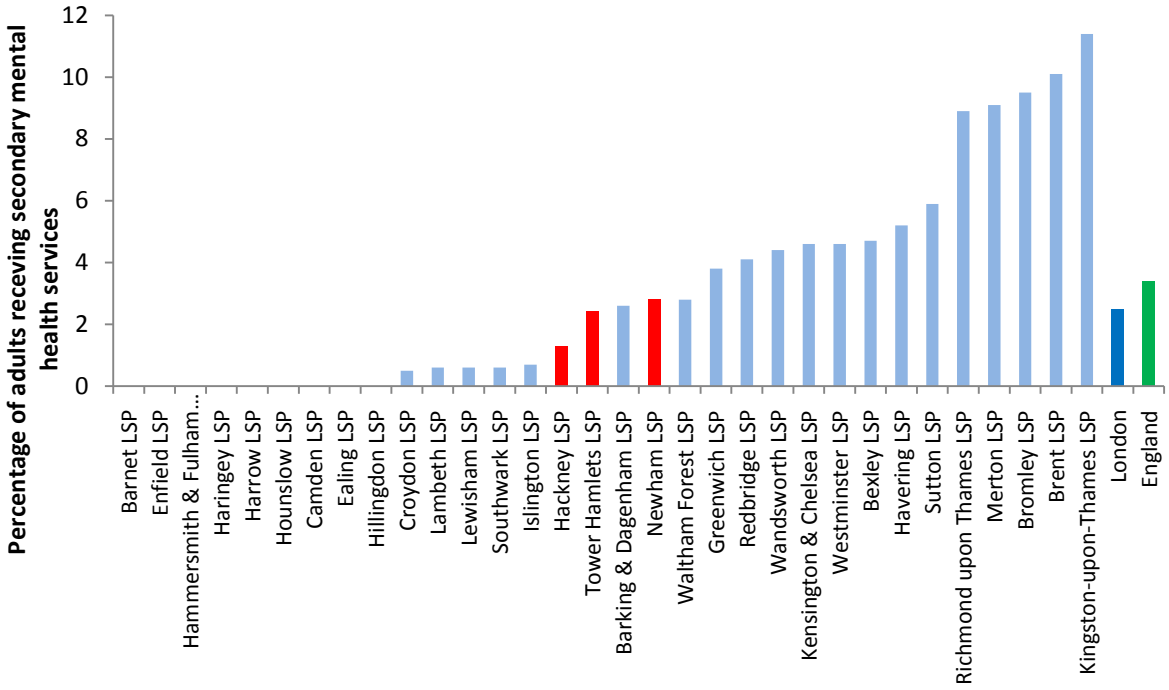
- There are high levels of unemployment and economic inactivity in the sector, which increases the risk of poor mental health
- Unemployment rates in people with existing mental health problems are very high
- The considerable stigma around mental illness increases barriers to gaining employment for those suffering with mental health problems.
- The need for employment support services is likely to increase in the face of change to the benefit system
- Current employment support services are limited in their capacity and are unlikely to meet needs in the near future.
- Employment support services should be expanded to meet these expected needs
- Programmes to tackle stigma in the workplace should also be implemented

As mentioned above, there are high levels of unemployment in INEL, which is associated with poor mental health. Employment support services can help prevent the onset of poor mental health in a well but at-risk population and help prevent a deterioration and maintain quality of life in patients with existing mental health problems.

Figure 17 shows the employment level of adults receiving secondary mental health services in London boroughs. It is clear that the data quality here is very poor and should be interpreted with caution. Therefore, two possible alternative explanations can be made:

- Data collection on employment needs to be more rigorous
- The data submitted shows that the sector has amongst the lowest employment levels in London (discounting those without data)

Figure 17: Percentage adults receiving secondary mental health services in employment in London boroughs and England. 2008/2009
Source: CSL



Data on incapacity benefits shows that there are higher than average proportion of people claiming incapacity benefit for mental illness in City & Hackney and Tower Hamlets, but a similar proportion to the national average in Newham.

There are a number of Employment Support services in INEL those with existing mental health problems. The main service is community-based Employment Support. This differs between boroughs but is delivered by occupational therapists within community teams. In addition, ELFT is aiming to become an exemplar employer, with work experience placements being developed. Also, there is a user-led website, Florid, which provides volunteering and work placement for service users.

Employment targets were set from 1st January 2010 which report on the number of service users in paid employment (full or part time), into work related training, or into self employment. The target is 13 service users per specialist per year. Caseloads of employment specialists have been capped at 25 individuals to enable intense and sustained effort through all the stages of job search, transition to work, initial stages of work and ongoing support in work.

Table 1 shows full year figures are only available for Tower Hamlets due to changes in personnel in the other two boroughs. The statistics are for the period January – December 2010.

Table 4: Evidence of effectiveness of employment services

	Q1	Q2	Q3	Q4	Total
16 hours + paid employment	4	16	13	1	**34**
Less than 16 hours paid employment	4	8	5	2	**19**
Self employment	1	6	3	0	
Education/training (work related)	34	34	39	39	**14**
					184

Migration: How does migration affect the need for health services?

Summary:

- Tower Hamlets and Newham have higher than average inward international migration
- Migration can have positive and negative effects on mental health, which affect the need for mental health services
- Access to mental health services is restricted before people register with GPs
- Certain migrant groups have particular health needs, such as asylum seekers and refugees, that require specialist mental health services

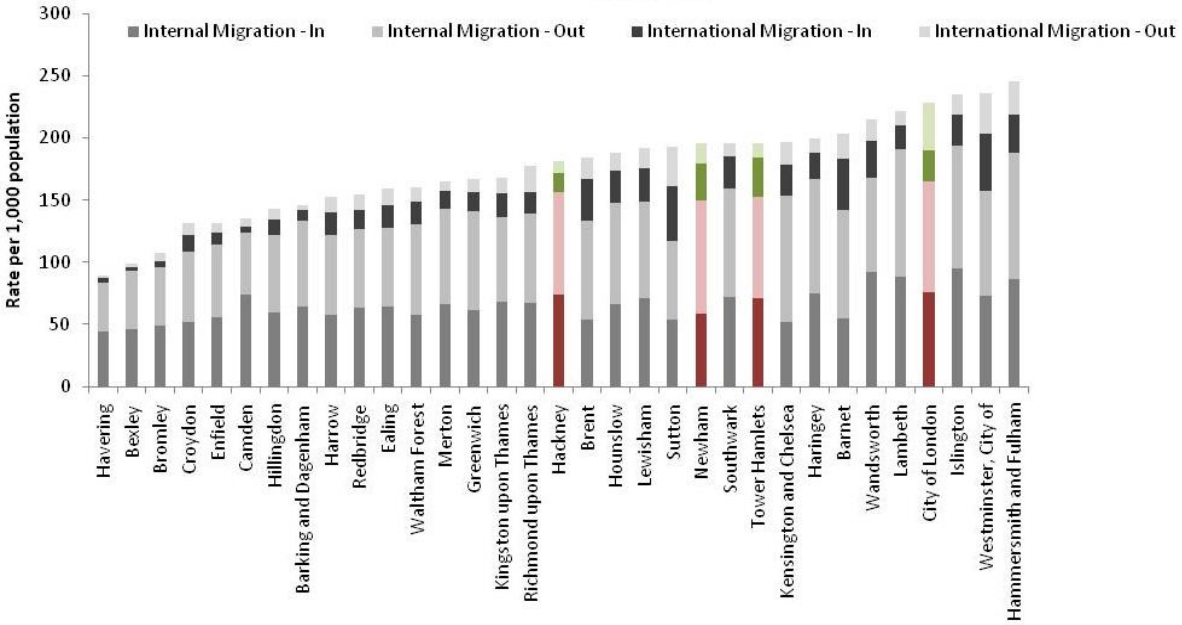
Migration has positive and negative effects on mental health. At an individual level, the arrival of family members can improve mental health and overall wellbeing, through a variety of methods, such as economic or social support. Reducing isolation is a key mental health promotion strategy.

At a population level, migration can pose difficulties to the delivery of health care. Patients known to a service may have their care disrupted if them move out of area. Those moving into the area may find it difficult to access healthcare promptly before they are settled and registered with a GP.

The rates of mental health problems in particular migrant groups, and subsequent generations, are also sometimes higher. This was highlighted in the national mental health strategy, "No Health without Mental Health" which stated that migrant groups and their children are at two to eight times greater risk of psychosis. It also highlighted that recent arrivals, such as asylum seekers and refugees, may also require mental health support following their experience in their home countries.

Figure 18 shows migration rates across the London boroughs. The overall migration rate is similar to the London average. However, Tower Hamlets and Newham inward international migration rates that are higher than average.

Figure 18: International and internal migration rates in London boroughs (2007/08)[6]



A recent study was performed to assess the scale of population churn in the INEL sector. It included 20,654 Flag 4 patients who registered with GPs in the INEL sector were followed for two years to see whether they moved out of the borough or the sector. Flag 4 patients are those that are newly arrived to the UK i.e. whose previous residence was overseas. The table below shows that 77% of these patients remained in the sector after one year and 67% remained after two years.

These findings further underline the importance of encouraging residents who have recently arrived in the UK to register with GPs, as the majority of these patients will stay in the area for at least two years. The stress arising from moving home, starting a new job, living into a new culture etc., will increase the risk of poor mental health. By registering with a GP as soon as possible, they will be able to access the mental health service, should it be required.

Figure 19: Destinations of Flag 4 patients one and two years after registration

	Jun-08	Jun-09						Jun-10					
		Same Borough		Other E.London		Total E.London		Same Borough		Other E.London		Total E.London	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
City	41	25	61%	2	8%	27	66%	21	51%	2	5%	23	56%
Hackney	3,811	2,812	74%	48	2%	2,860	75%	2,440	64%	73	2%	2,513	66%
Newham	10,432	7,837	75%	80	1%	7,917	76%	6,918	66%	131	1%	7,049	68%
Tower Hamlets	6,370	4,996	78%	100	2%	5,096	80%	4,212	66%	191	3%	4,403	69%
East London	20,654	15,670	76%	230	2%	15,900	77%	13,591	66%	397	2%	13,988	68%

[6] Source: ONS

Physical Health

Summary:

- Physical and mental health are intricately related, with poor mental health increasing the risk of poor physical health, and vice versa.
- People with long-term conditions and who don't exercise are more likely to have lower mental wellbeing
- Smoking prevalence amongst people with SMI in INEL is 44% - this is extremely high.

Mental health and physical health are intricately related. The national mental health strategy, 'No Health without mental health' states that having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50% and doubles the risk of coronary health disease in adults[7]. Similarly, people with long-term conditions, such as COPD or heart failure are at greater risk of mental health problems, particularly depression.

Therefore, the physical health and mental health are inseparable and demand a holistic approach to the care of all patients with health problems.

The third objective of the national strategy, 'No Health without Mental Health' states:

More people with mental health problems will have good physical health. Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health.

The key areas for action were:

- That fewer people with mental health problems should have poor physical health
- That fewer people with mental health problems should die prematurely
- That fewer people with physical ill health, including those with long-term conditions and medically unexplained symptoms, should have mental health problems.

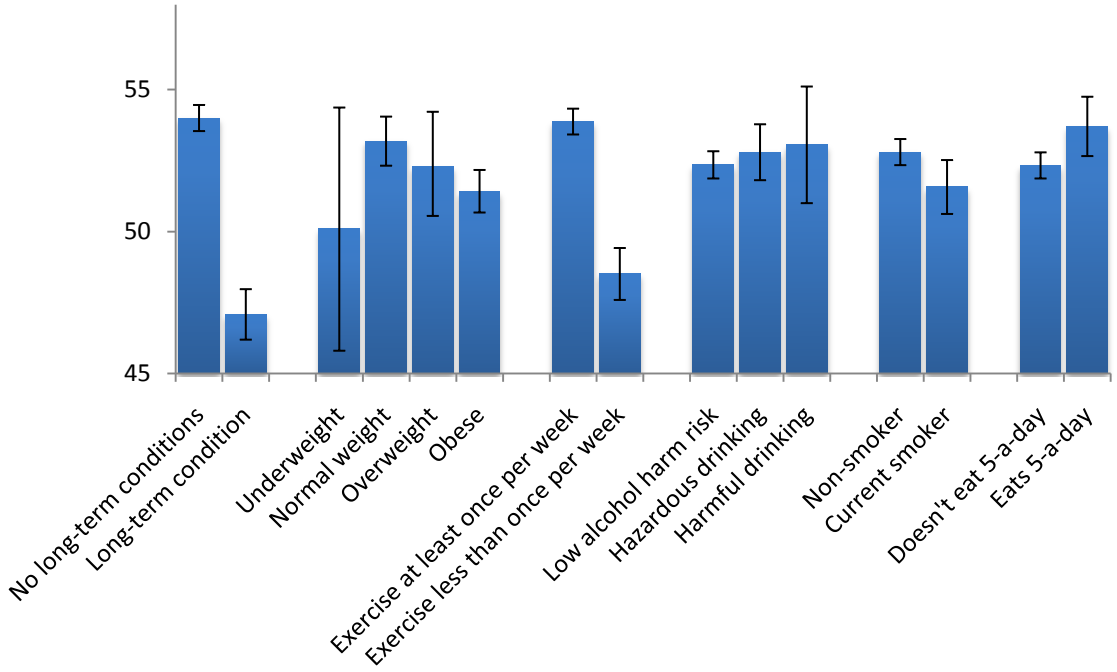
Physical health is being explored in the depth as part of the best practice evidence review also within this WSR.

Mental wellbeing and physical health

Locally, we have information about the relationship between mental and physical health from the NHS Tower Hamlets Health and Lifestyles survey, as shown in Figure 20. This was commissioned by NHS Tower Hamlets and so the information unfortunately is not available for City and Hackney and Newham.

[7] No health without mental health: a cross- government mental health outcomes strategy for people of all ages. Department of Health. 2011

Figure 20: Mental wellbeing, physical health and healthy behaviours in Tower Hamlets[8]



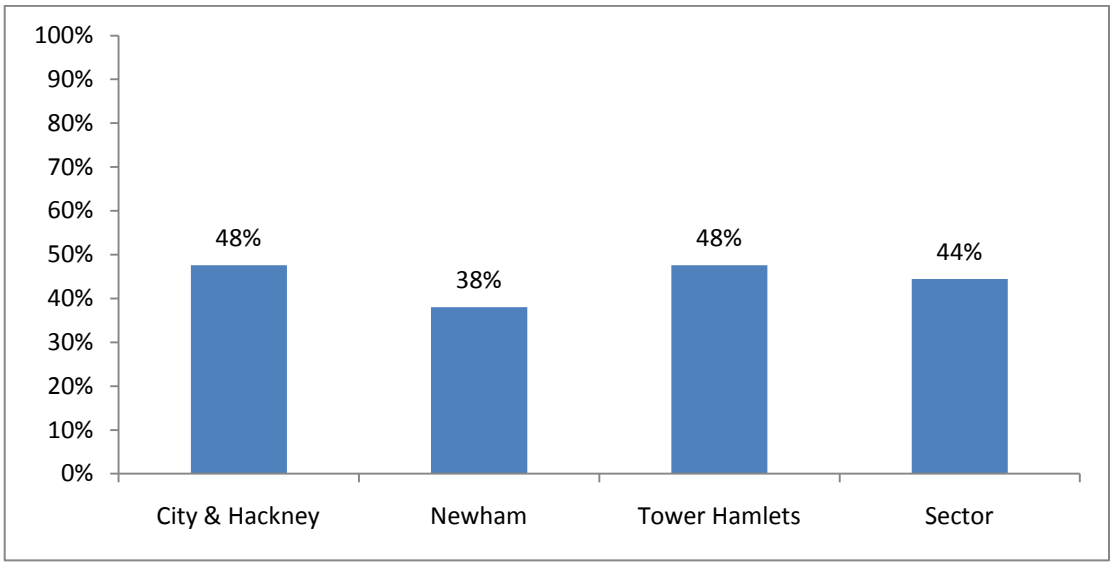
It shows that people who reported having a long-term condition, infirmity or disability had significantly lower mental wellbeing that those who didn't. Similarly people who rarely exercised and smokers also reported having poorer mental wellbeing. There was no difference seen in mental wellbeing by BMI, alcohol consumption and fruit-and-vegetable consumption. The BMI data however was self-reported with large amounts of missing data.

This demonstrates the substantial needs to improve mental wellbeing through adopting healthy lifestyle behaviours, which also will improve physical health and can prevent the onset and deterioration of long-term conditions.

Figure 21 shows smoking prevalence amongst people with SMI (i.e. the proportion of people with SMI who are recorded as smoking). 99% of people on the CEG SMI register had their smoking status recorded.

[8] Tower Hamlets Health and Lifestyles Survey 08/09

Figure 21: Smoking prevalence amongst people with SMI



This shows very high levels of smoking in this group - the national self-reported smoking prevalence in 2005 was 24%[9]. This represents a major health inequality. People with SMI in the sector are at significantly higher risk of most cancers, heart disease, stroke, COPD and a range of other smoking-related conditions. By reducing smoking rates, these risks will decrease.

This issue is recognised in the government's new mental health strategy, "No Health without Mental Health", which states,

"Increased smoking is responsible for most of the excess mortality of people with severe mental health problems. Adults with mental health problems, including those who misuse alcohol or drugs, smoke 42% of all the tobacco used in England. Many wish to stop smoking, and can do so with appropriate support. Over 40% of children who smoke have conduct and emotional disorders. This is particularly important as most smoking starts before adulthood. People with mental health problems need good access to services aimed at improving health (for example, stop smoking services)."

Furthermore, smoking rates in people with SMI is proposed as a national target measure in the new Public Health Outcomes Framework.

The physical health of people with SMI

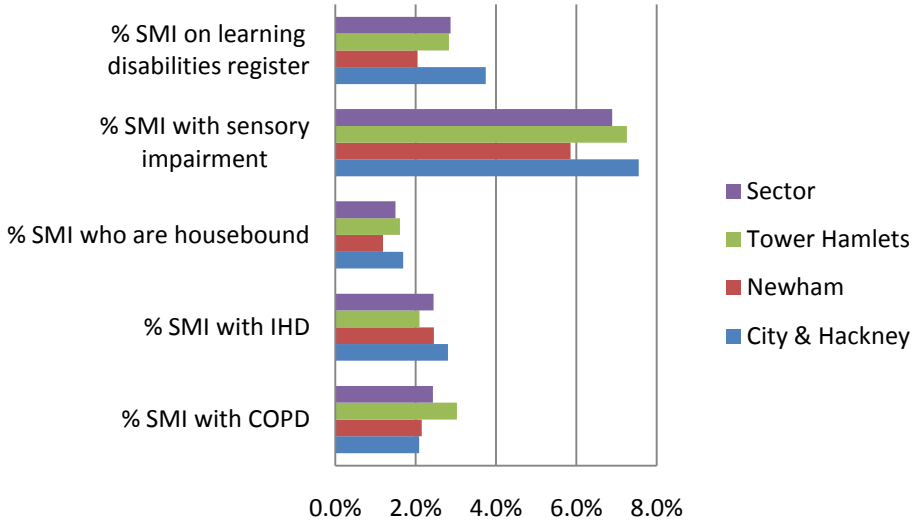
Summary:

- There was no relationship seen between physical and mental health from a small analysis of local data.

Figure 22 shows the data obtained from CEG relating to disability amongst those with SMI in INEL. It shows that relatively small proportions (about 2%) of those with SMI have a learning disability, are housebound or have IHD or COPD. A larger proportion have a recorded sensory impairment.

[9] http://www.statistics.gov.uk/cci/nugget.asp?id=866

Figure 22: Disability amongst those with SMI in INEL



A separate data request from COPD in December 2010 for Tower Hamlets only (request made by Tower Hamlets PCT) found that there was no difference in the prevalence of COPD amongst those with depression, and similarly, no difference in the prevalence of COPD amongst those with depression, as shown in Figure 23 and Figure 24.

Figure 23: Prevalence of COPD in those with and without depression in Tower Hamlets

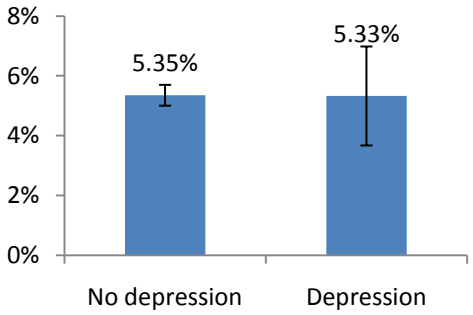
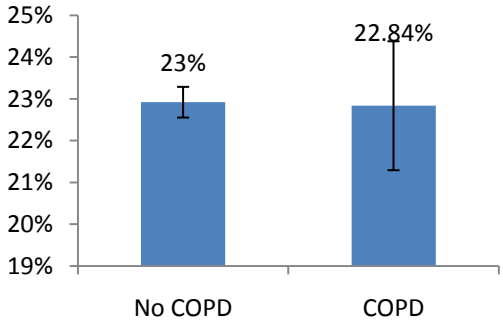


Figure 24: Prevalence of depression in those with and without COPD



For the relationship between diabetes and SMI, the relationship was inverse to that expected: there was a higher prevalence of diabetes amongst those without SMI and a higher prevalence of SMI amongst those without diabetes (Figure 25 and Figure 26). This may be due to an unknown factor in the relationship, for example a difference in ethnicity between the two groups. Alternatively, it could represent a difference in data recording or healthcare practices, for example those with SMI are less

likely to have their diabetes detected as healthcare professionals are focused on their mental health care or as patients have more chaotic lives and therefore less likely to access services. This is an interesting finding nonetheless and should prompt further enquiry as to the root causes.

Figure 25: Prevalence of Diabetes in those with and without an SMI

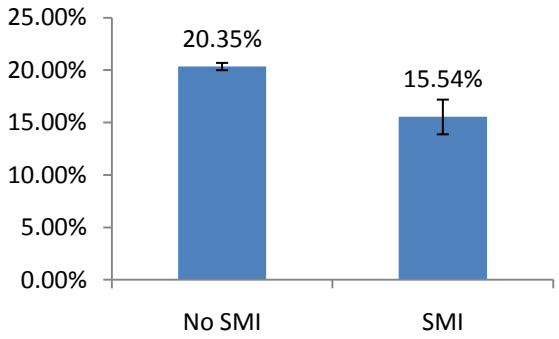
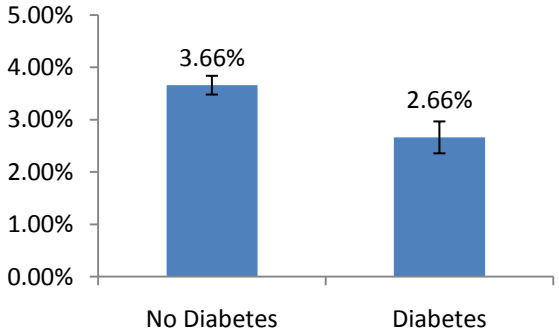


Figure 26: Prevalence of SMI in those with and without diabetes



Mental health services can meet these needs through ensuring that existing services focus on the physical needs of patients (such as annual reviews in primary care) and commissioning services targeted at those with mental illness, such as targeted smoking cessation services.

Mental illness in Inner North East London

The previous chapter described the population of Inner North East London and demonstrated that there is a high prevalence of risk factors for poor mental health, principally stemming from high levels of deprivation and associated socioeconomic risk factors.

This chapter builds on this information to ask whether the levels of mental wellbeing and mental illness are commensurate with this profile. One would expect a high burden of mental health problems. However, the purpose of this chapter is to:

- assess whether this burden is higher or lower than expected
- highlight what are the needs for mental health services
- determine whether these needs are being met by mental health services.

Serious Mental Illness (SMI)

Summary:

- Prevalence of SMI in the sector is 0.9%.
- There is a higher prevalence in Tower Hamlets and a lower prevalence recorded in Newham, which could be attributed to a range of factors.

Serious Mental Illness (SMI) is a term used to refer to a collection of mental illnesses such as schizophrenia and bipolar disorder. This Health Needs Assessment uses the term SMI in line with other organisations, but recognises that other mental health conditions will be 'serious' to the person that is affected by them.

SMI conditions are routinely measured by the Quality and Outcomes Framework (QOF) and are also recorded locally by CEG. However, caution should be used in directly comparing figures obtained from these two sources as each use a different definition. Details on this are included later in Appendix 1. In broad terms, the QOF definition contains more conditions than CEG as CEG define 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.

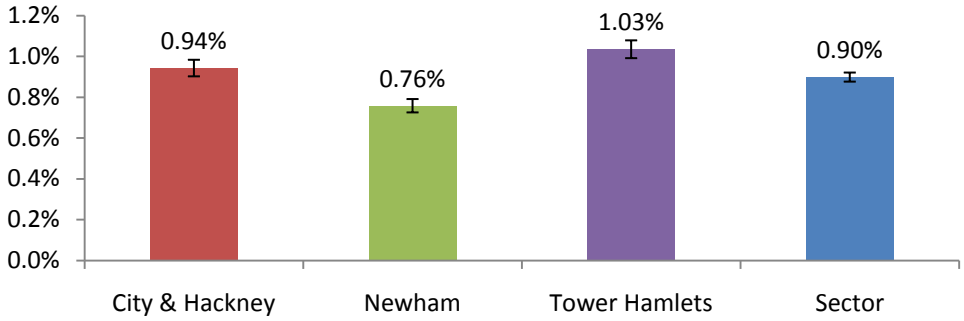
CEG provided data on SMI for this Health Needs Assessment, which is used below for comparisons between sub-populations within INEL. Therefore, as the same data source is used for these analyses, it valid comparisons can be made. However, it is important to understand that this data cannot be readily compared to national QOF data given the different definitions of SMI, without taking this into account.

Figure 27 shows SMI prevalence in each other INEL boroughs and a total for the sector. It shows that Tower Hamlets has a significantly higher prevalence (1.03%), Newham has a lower prevalence (0.76%) and City and Hackney has a similar prevalence (0.94%) to the sector (0.90%). Reasons for this include:

- Differences in recording of SMI between PCTs
- Better detection of SMI in Tower Hamlets
- Fewer barriers to access in Tower Hamlets
- A different population profile between boroughs, with greater proportion of people at risk of SMI living in Tower Hamlets.

Some of these issues will be explored in this Health Needs Assessment, or are addressed in other components of the Whole Systems Review, such as the stakeholder analysis.

Figure 27: SMI prevalence between boroughs in INEL



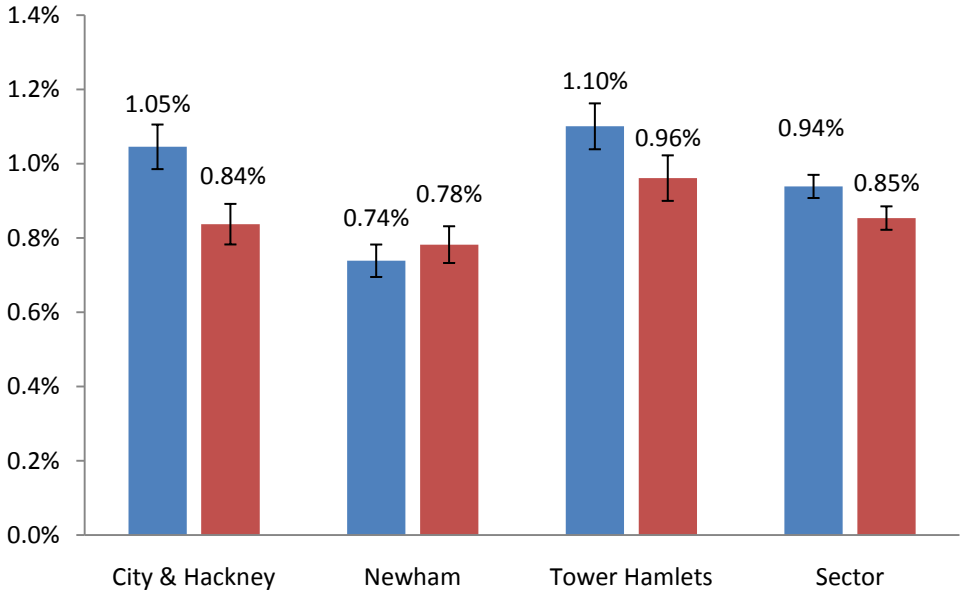
Gender inequalities

Summary:

- Overall, men are more likely to have SMI than women, although no large difference was seen in Newham.

Figure 28 shows differences in SMI prevalence between men and women in the three PCTs and overall sector. In City and Hackney, Tower Hamlets and the sector, prevalence is higher amongst men. However, in Newham, there is no difference between men and women.

Figure 28: SMI prevalence between males and females in INEL



Age inequalities

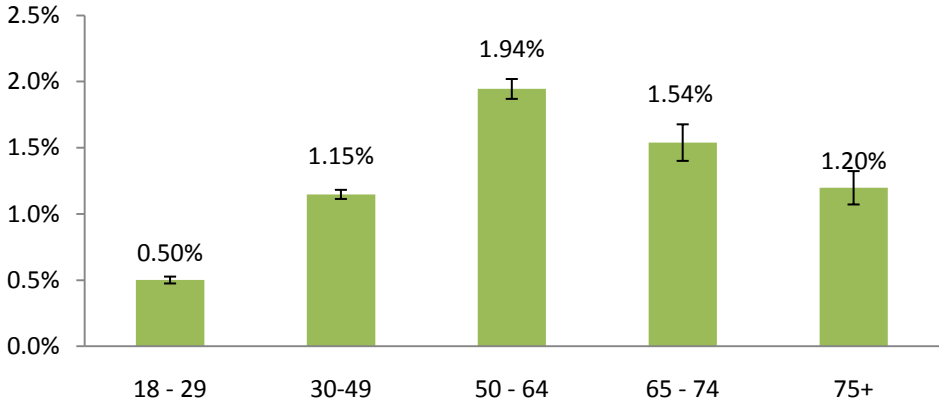
Summary:

- The recorded prevalence of SMI is highest in those 50-64 years
- However, the majority of recorded SMI cases are in the 30-49 year category due to the young population in INEL.
- Older people with SMI are at risk of being overlooked if health services are orientated towards to younger population.

Figure 29 shows SMI prevalence by age groups in the INEL sector using CEG data. There is a higher recorded prevalence in people aged 50-64 years and a lower prevalence in younger people aged 18-29

years. There are a number of explanations for this pattern. Firstly, the data is obtained from GP records and it is recognised that once a patient's records are assigned a diagnosis, they are less frequently unassigned should the patient recover from a condition. As a recovery rate of up to 80% after first episode of schizophrenia has been reported[10], this data therefore may include cases where schizophrenia has resolved, but patients continue to have the code on their records, leading to an overestimation of prevalence, especially in latter age groups.

Figure 29: SMI Prevalence by age groups in the INEL sector



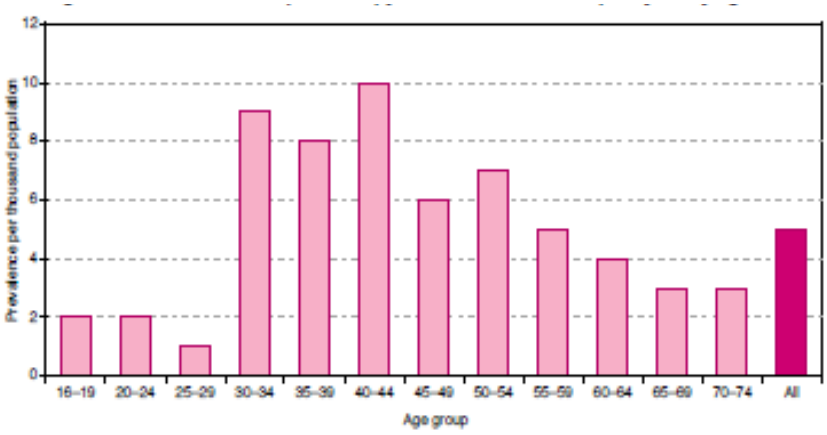
The onset of schizophrenia can be at any age, however it is most common in early adulthood. Similarly, bipolar disorder frequently starts in early adolescence or early adulthood[11]. The age profile of SMI prevalence in INEL is similar to the national picture demonstrated in Figure 30.

Figure 30 shows that nationally, the prevalence of psychotic disorder is particularly high in mid-adulthood. 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. When compared to Figure 2, 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 in the sector.

1. [10] **Picchioni MM, Murray RM**; Schizophrenia. BMJ. 2007 Jul 14;335(7610):91-5.

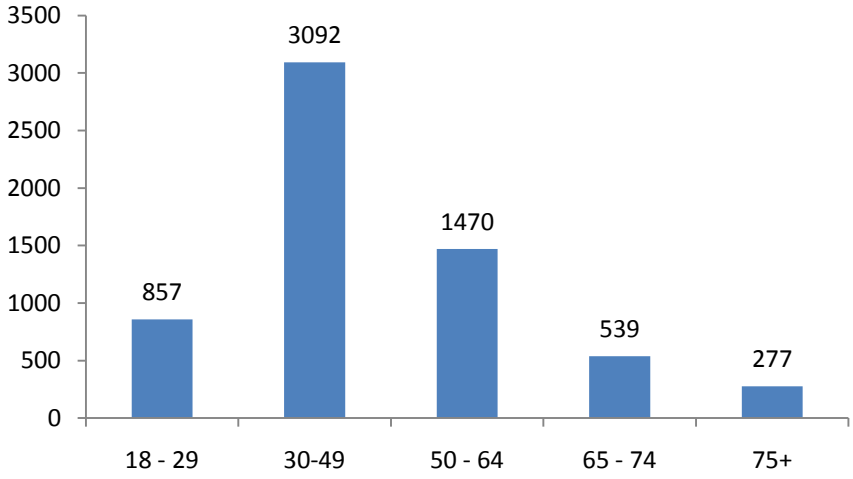
[11] http://www.patient.co.uk/doctor/Schizophrenia.htm#ref3 and http://www.patient.co.uk/doctor/Schizophrenia.htm#ref3

Figure 30: Prevalence of probably psychotic disorder in the past year by age - National Psychiatric Morbidity Survey 2007



Indeed, when the number of cases of SMI are broken down by age group, the largest burden of disease is carried in the 30-49 age group, as shown in Figure 31. Similar charts for the three PCTs are located in Appendix 2.

Figure 31: SMI cases (numbers) in INEL by age group



Ethnicity inequalities

Summary:

- SMI prevalence is significantly higher in the Black population
- There are Asian population have a slightly higher prevalence than the White population
- This reflects a national picture, which has complex reasons underpinning it
- These inequalities are stark and demand further exploration and action to minimise them
- The pattern in Newham is different to the rest of the sector, which also warrants further exploration to determine the reasons for this geographical inequality

Figure 32 shows the difference in SMI prevalence between ethnic groups across the whole INEL sector. It shows that there is a significantly higher proportion of Black people who have SMI, compared to White, Asian or Other ethnic groups. This pattern is replicated in City and Hackney and Newham, but is not seen in Newham. Here, the confidence intervals overlap between the White and Black groups, meaning that there is no statistical evidence of a difference between the SMI prevalence in these groups. This could be due to a variety of reasons and certainly warrants further explanation. For example, it may indicate that the White population in Newham is different to that in City and Hackney

or Tower Hamlets – there could be higher levels of deprivation in this group leading to an increased risk of SMI. Alternatively, there could be different use of healthcare, or differences in healthcare practice or coding in Newham. This finding will be fed into the broader whole systems review.

Figure 32: SMI Prevalence between ethnic groups in the INEL sector

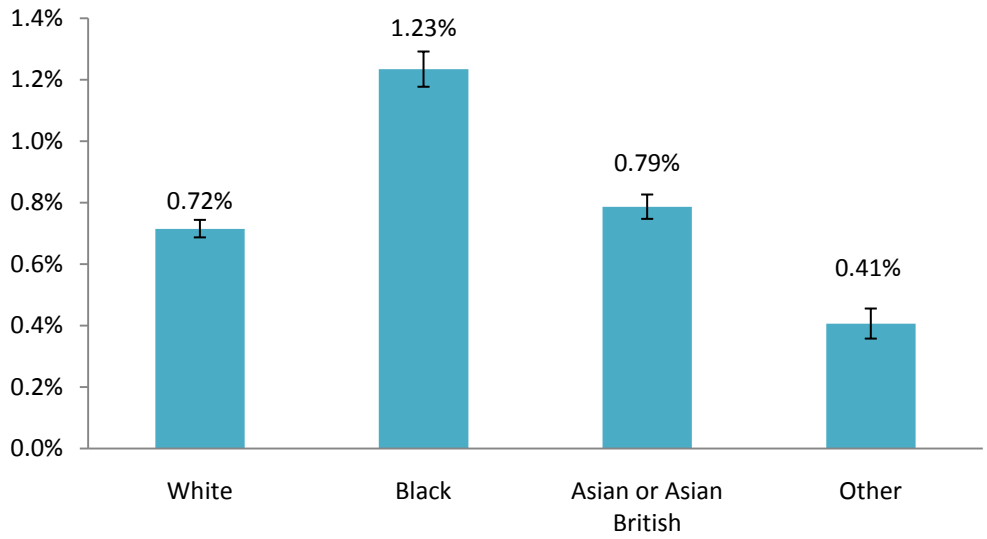


Figure 33: SMI Prevalence between ethnic groups in City and Hackney

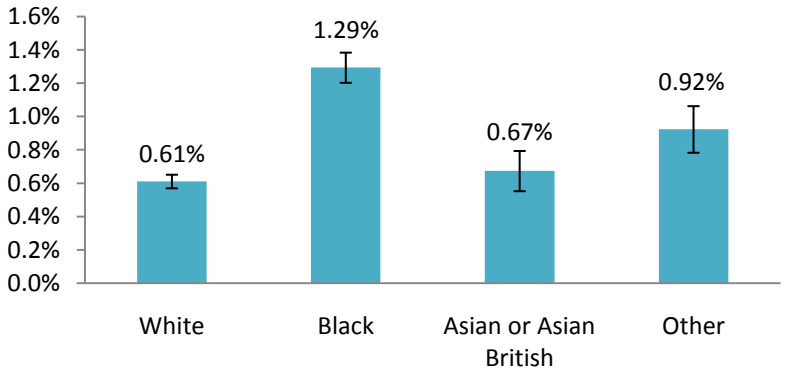


Figure 34: SMI Prevalence between ethnic groups in Newham

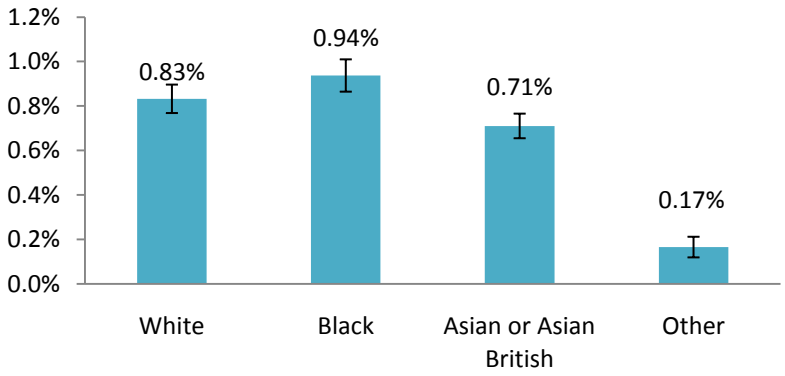
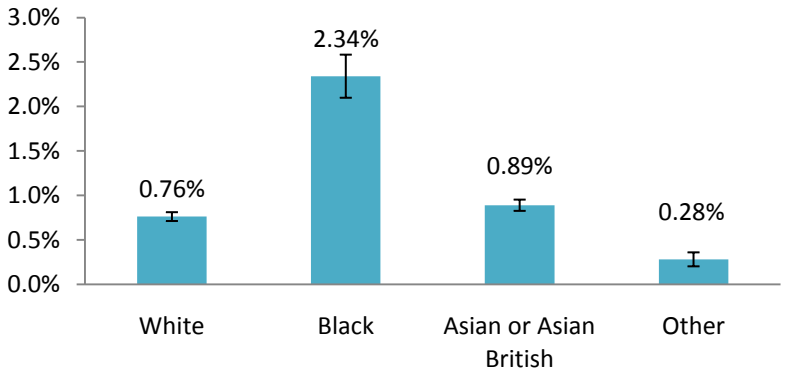


Figure 35: SMI Prevalence between ethnic groups in Tower Hamlets



Prevalence between GP practices

Summary:

- There is a wide range in prevalence by GP practice
- This can be attributed to data issues, different practice populations or variations in health care.
- Further exploration of these inequalities is required.

The following three charts show differences in prevalence between GP practices in the three INEL boroughs.

Figure 36: Prevalence of SMI by City and Hackney GP practice

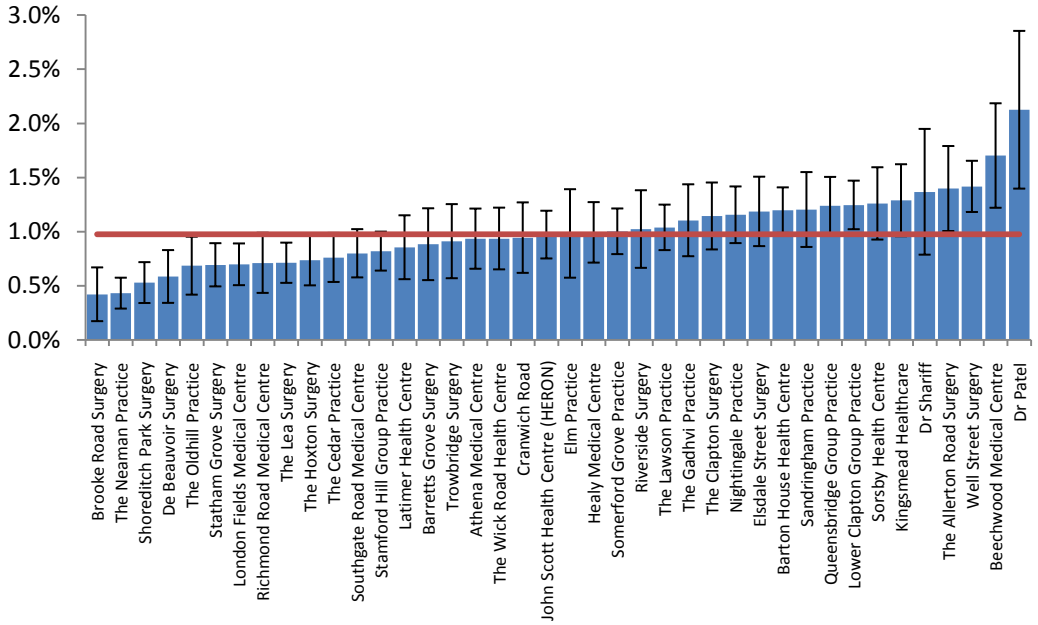


Figure 37: Prevalence of SMI by Newham GP practice

(See Appendix 3 for a larger version)

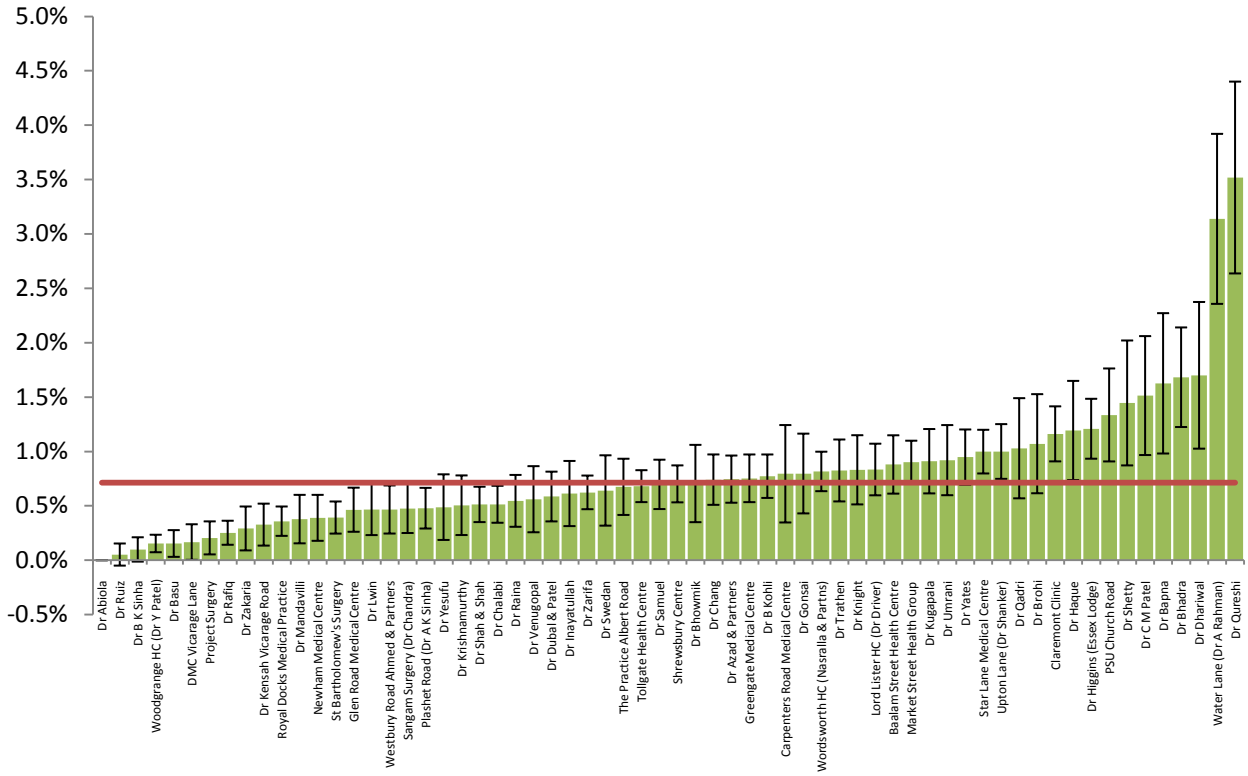
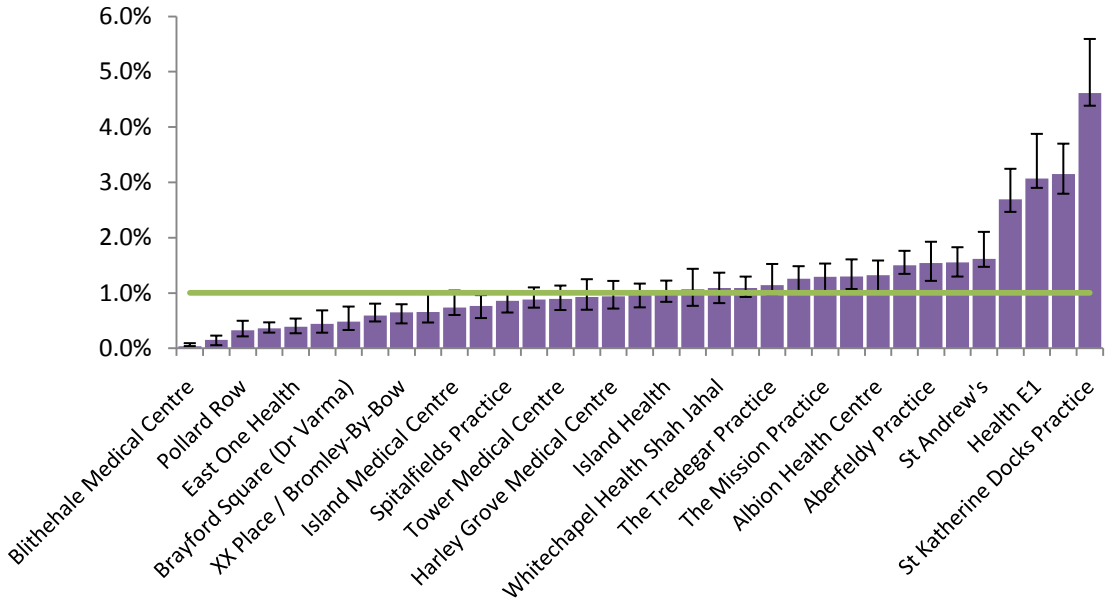


Figure 38: Prevalence of SMI by GP practice



The charts (Figure 36,

Figure 37, Figure 38) show that there are differences in prevalence between GP practices in INEL. In City and Hackney, these differences are comparatively small, with only a few practices significantly above or below the borough average. However, in Tower Hamlets and Newham, there are about 8 practices above or below the borough average. These differences may be due to:

- Variations in underlying prevalence, driven by different underlying population and associated risk factors e.g. age, deprivation, ethnic group
- Variations in recording of data
- Variations in health care practice e.g. access, diagnostic practices

Relationship between practice prevalence, deprivation and service use

It may be logical to assume that practices in more deprived areas are more likely to record a higher SMI prevalence than practices in more affluent areas. Consequently, these deprived practices, with a higher burden of SMI may be more likely to have greater secondary care use.

The following charts explore this hypothesis. The findings will be discussed below.

Figure 39: Relationship between deprivation and SMI prevalence in GP practices in INEL

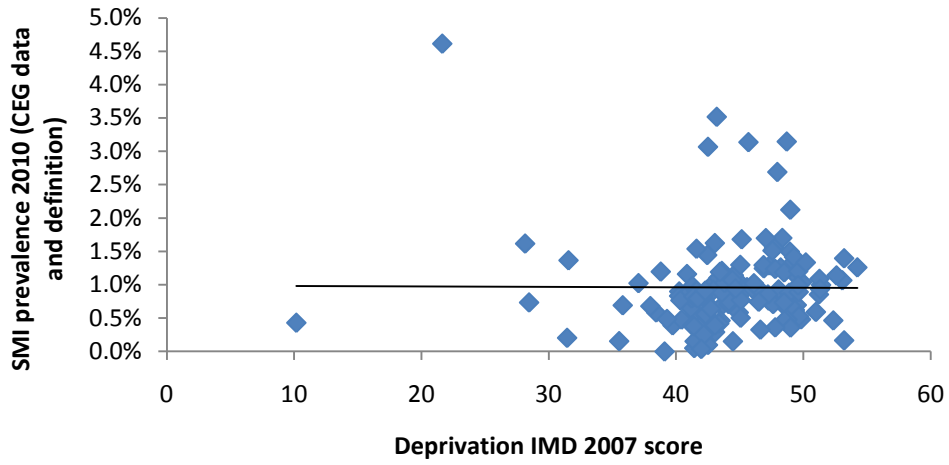


Figure 40: Relationship between secondary care use and deprivation in GP practices in INEL

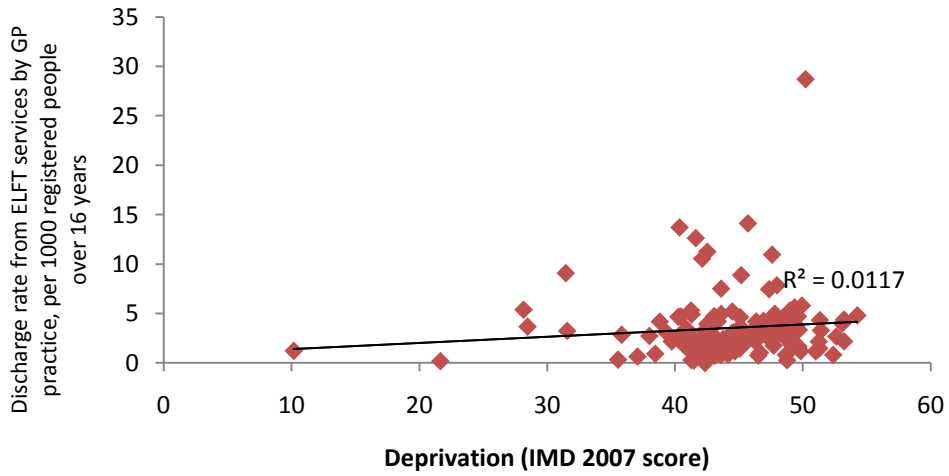
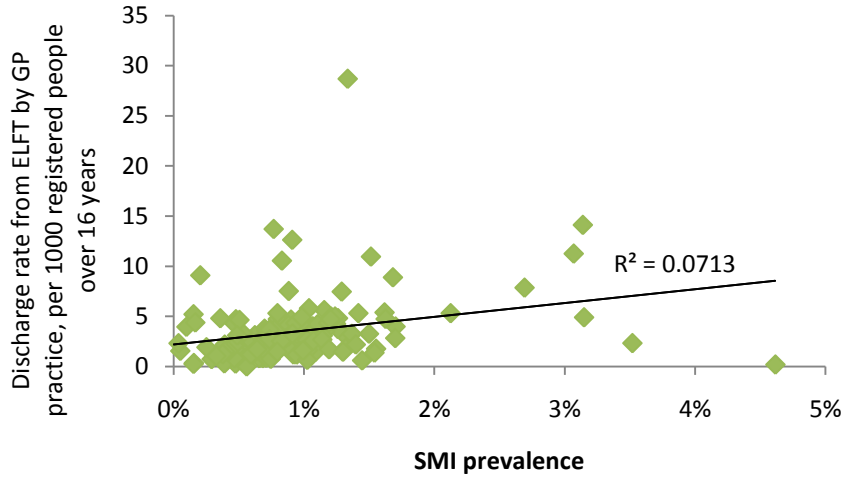


Figure 41: Relationship between secondary care use and SMI prevalence by practice in INEL



In summary, these charts do not show a relationship between deprivation, prevalence and secondary care use at a GP practice level in INEL.

Explanations for this include:

- Errors in measurement of these factors.
  For example, deprivation is based on the practice area, which is not a perfect measure of socioeconomic status of all patients in the practice. This is partly because patients may not live in the practice area and may also raises issues regarding underlying assumptions in what is meant by 'deprivation', how that relates to mental health and how that can be measured. SMI Prevalence measures only people who have been diagnosed, so may underestimate the prevalence. Secondary care use is measured as a discharge rate from ELFT, and doesn't include community services that might provide an equivalent service for patients.
- Other unmeasured factors (confounding).
  The above charts have not taken into account other factors that are related to each pair of variables. For example, age is related to both having SMI and service use, yet these charts haven't taken these into account. Other factors could include variations in practice, patient expectations and service use, proximity to and use of other services, variations in protective factors for poor mental health etc.
- Without taking these factors into account, we cannot conclude that in reality there is no relationship between these factors.

These charts help to generate ideas about what might underlie these patterns. However, it is important to acknowledge that this is a simple analysis and more detailed work, using a range of methods (such as those used in other areas of the WSR) will be required before strong conclusions can be made.

Comparison to national prevalence of SMI

Summary:

- Prevalence of SMI in comparison to London is not as high as might be expected, given the sector population characteristics
- There are a variety of explanations for this, which warrant further investigation

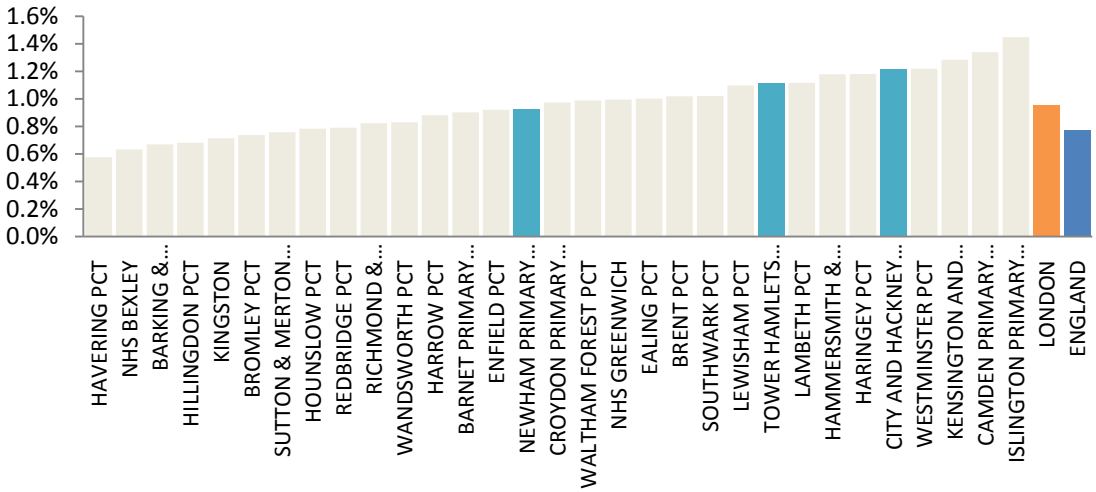
Given the high levels of deprivation in the borough which are a risk factor for psychotic conditions, we would also expect deprivation to contribute to a high prevalence of psychosis. Therefore, it is of note that prevalence data obtained from QOF (GP) records, as shown in Figure 42, show that the

prevalence in Newham is average for London, and whilst Tower Hamlets and City and Hackney PCTs have higher than average levels, one could expect, given the levels of deprivation and young population, that all INEL PCTs would have amongst the highest in London.

Possible explanations for this finding:

- Artefact: there is under-recording of SMI in INEL compared to other London PCTs, or GPs use different coding systems.
- Population-based: there is a genuinely lower prevalence of psychoses in the population
- Health service based: there is under-diagnosis of psychosis, for example because there are barriers to access of healthcare, preventing patients being diagnosed.

Figure 42: Prevalence of schizophrenia, bipolar disorder and other psychoses in London PCTs and England[12]



[12] Source: QMAS 2009-2010

Common mental disorders

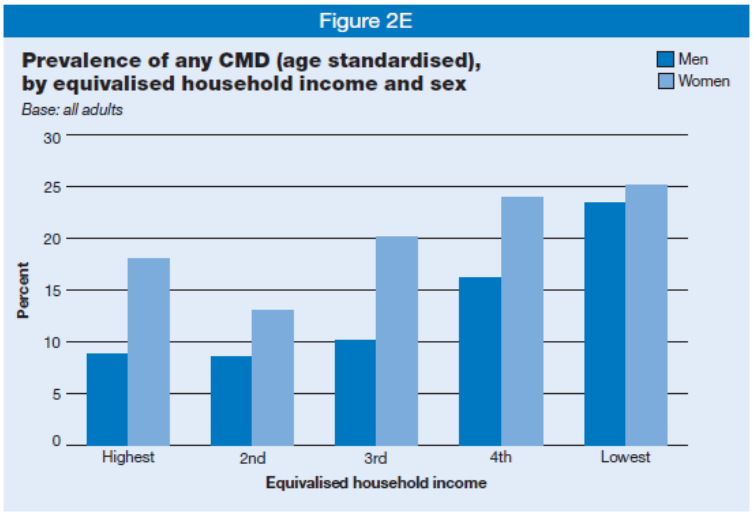
Summary:

- The recorded prevalence of depression is not as high as might be expected, given the population characteristics of the sector
- This finding warrants further exploration to assess whether this difference is amenable to interventions by health services.

Common mental disorders include conditions such as depression and anxiety, and are usually managed at a primary care or community care level. These are common, increase with age and are associated with socioeconomic deprivation, as discussed earlier.

Figure 43 shows that common mental disorders are more prevalent in those with low household incomes and amongst women.

Figure 43: National prevalence of any common mental disorder (age-standardised) by household income and sex[13]



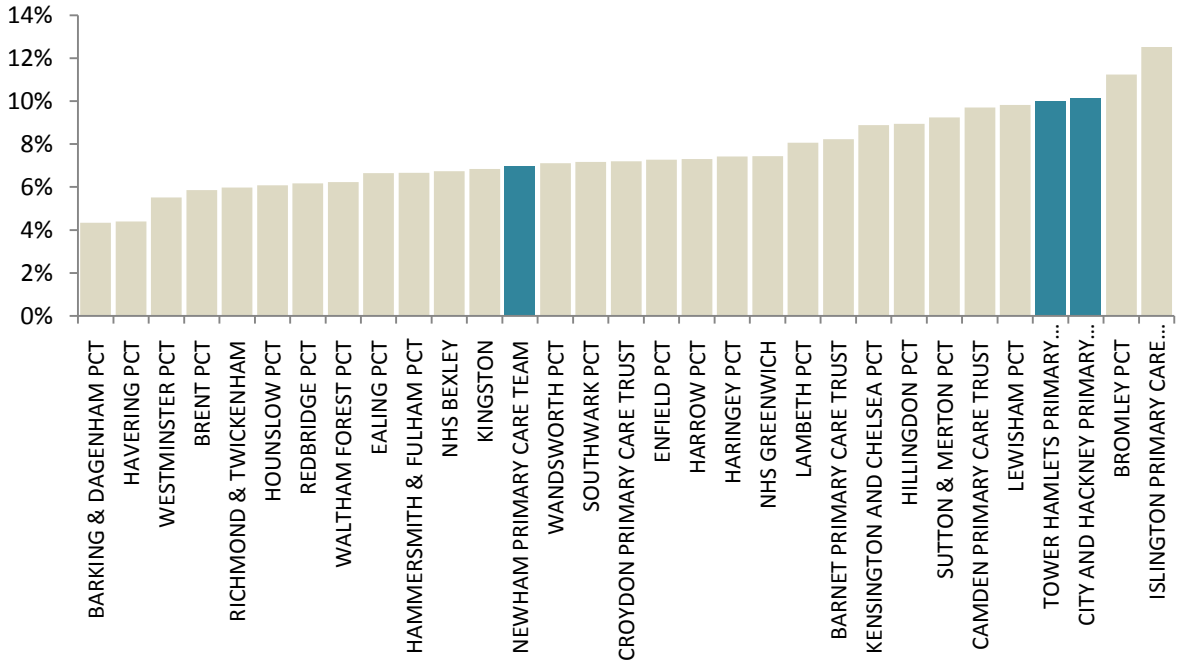
Prevalence of depression is measured routinely in general practice through QOF. However, there is a second QOF target that measures whether patients undertake a repeat depression questionnaire within a narrow time period on first follow up after diagnosis. Significant practical difficulties can occur in administering the questionnaire, such as the patient may attend before or shortly after the designated follow up period, leading to GPs needing to repeat the questionnaire just to hit a target measure. Therefore, GPs may avoid using a QOF coding for depression, instead using a code such as "Complains of feeling depressed", which enables clinical care to continue and QOF targets to be met. However, for data purposes, it means that depression prevalence using QOF data is likely to underestimate this. In light of these significant issues, a data request for depression (or common mental disorders) was not submitted to CEG. Therefore, there is limited data on common mental disorders in this HNA.

Figure 44 however does use nationally available QOF data. It shows that there is a high prevalence of depression in Tower Hamlets and City & Hackney, which is commensurate with high levels of risks factors for poor mental health in the boroughs. Interestingly, Newham has an average prevalence of depression in London. This is unexpected, as there are high levels of risk factors for poor mental health in the borough. There are a number of potential explanations for this:

[13] National Psychiatric Morbidity Survey 2007

- Variations in coding of depression, as discussed above
- A genuinely lower prevalence of depression, possibly due to a higher prevalence of protective factors such as family support, which have not been measured in this HNA
- Variations in healthcare, such as poorer access or poorer recognition by healthcare professionals, or different health care-seeking behaviours, all contributing to under-diagnosis.

Figure 44: Prevalence of depression in London boroughs (QOF 09/10)



Postnatal depression

Summary:

- Data on PND is limited, but the national incidence is estimated at least 13%

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 incidence of depression in the first month after childbirth is three times the average monthly incidence in non-childbearing women. A meta-analysis of studies mainly based in the developed world found the incidence of PND to be 12-13%, with higher incidence in developing countries such as England.[14]

Risk factors include past history of psychopathology, low social support, poor marital relationship, and potentially unplanned pregnancy, unemployment, antenatal parental stress or having two or more children.

It was not possible to obtain local data for this health needs analysis, 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 incidence of PND is at least 13% if not more, which would have been about 570 women in 2009 (based on 4358 births), and 580 women in 2010/2011, assuming a projected number of births of 4,468[15].

[14] www.patient.co.uk; NICE Clinical Guideline CG45 Antenatal and postnatal mental health

[15] Source: Tower Hamlets JSNA Core Dataset/ONS

Further exploration of this issue using local data was not possible for this HNA, however, there are opportunities for a better understanding to be made in other components of the HNA.

Suicide

Summary:

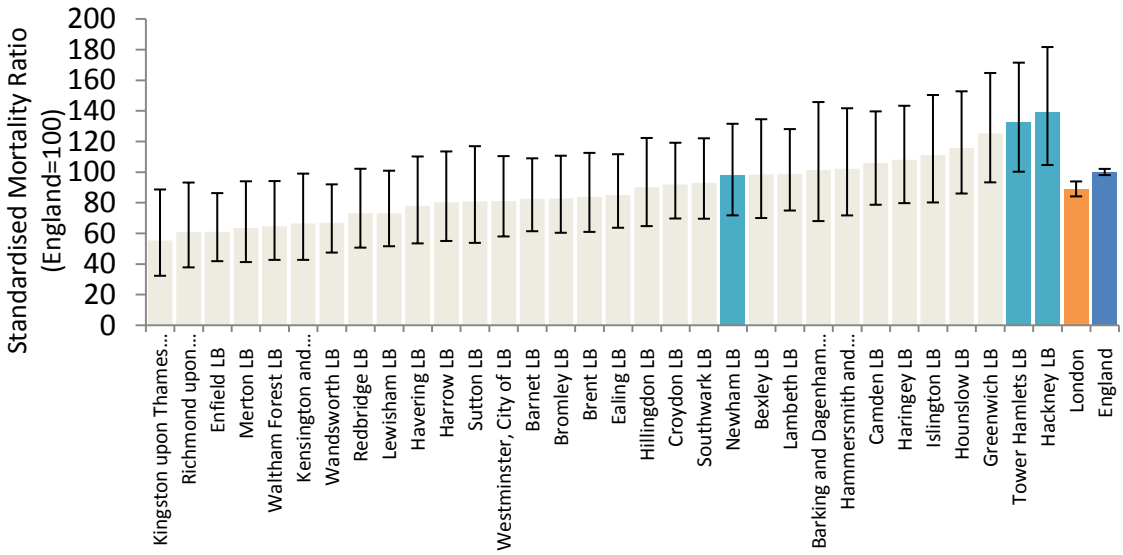
- Suicide levels are higher than the London average in Tower Hamlets and City and Hackney
- There is no statistical difference in rates for Newham
- Suicide is a high level indicator of unmet need, so this finding is an important sign that the mental health system is not meeting the needs of the local population

Suicide is a high level indicator of unmet need in a population. Figure 45 shows that suicide levels in Tower Hamlets and Hackney are significantly higher than in London. In Newham, there is no statistical difference between the London and England figures.

This is commensurate with previous findings, indicating high levels of risk factors for poor mental health and high prevalence of both common mental disorders and serious mental illness in both Tower Hamlets and City and Hackney. Suicide is an uncommon event, which makes it difficult to compare between areas due to small numbers. Using these statistics, it is not possible to see a difference between Newham and London/England figures. This may indicate lower levels of unmet need in Newham. This fits with other data presented, which showed a lower prevalence of schizophrenia (or SMI) and depression. However, it does not reflect the high levels of risk factors in Newham, particularly high levels of deprivation.

Further exploration of this is required. Firstly, these findings will be compared to later sections of this report that will discuss health service use. Secondly, the findings will be put into the context of the Whole Systems Review to assess whether explanations can be found in other components of the project. However, it may be that further investigation is required to ascertain whether there are protective characteristics in the Newham population that might be applied to the City & Hackney and Tower Hamlets populations.

Figure 45: Mortality from suicide and injury undetermined, all ages, males[16]



[16] Source: NCHOD 2006-2008

Medically unexplained symptoms

In discussions with a mental health lead in the sector, the issue of Medically Unexplained Symptoms (MUS) was raised. This had already been highlighted by GPs, who expressed difficulties in caring for patients who present with a range of symptoms (e.g. pain, fatigue) that, after investigation, could not be attributed to a physical cause. These GPs suspected that in many patients, there may often be a psychological explanation for symptoms but felt that the current norms resulted in referrals for extensive and costly physical investigations.

Medically unexplained symptoms have also been raised highlighted in the government's mental health strategy 'No Health without Mental Health' which stated that,

"Medically unexplained symptoms have been shown to cost the NHS in England £3 billion every year. A review of a large number of studies found that cognitive behavioural therapy is very effective for those with identified mental health problems."

Whilst MUS was out of the agreed scope of the HNA, it has been included in the report to highlight a potential need for further exploration, either as the WSR progresses or as a stand-alone piece of work.

Mental health services: Are services provided meeting the needs of the population?

The previous two chapters outlined the need for mental health care within the Inner North East London population. This chapter will compare these needs with the services provided to assess the extent of unmet need by drawing on available data. This information will be triangulated with other components of the WSR, such as the stakeholder analysis and best-practice review to answer this question fully.

Data has been drawn from three principal sources:

1. Publicly-available data sources e.g. Quality and Outcomes Framework (QOF)
2. A bespoke data request to the primary care Clinical Effectiveness Group, which has access to GP records in the sector
3. A bespoke data request to East London NHS Foundation Trust (ELFT)

The data requests were kept as brief as possible to meet the short project deadlines. Publicly available data was limited that that could be obtained rapidly.

Primary Care: Are primary care services meeting the mental health needs of the population?

Summary:

- Indicators of quality in primary care show a mixed picture

The following section explores indicators of quality in primary care. An overall analysis of whether primary care services are meeting need is integral to the whole document so is not specifically addressed in this chapter.

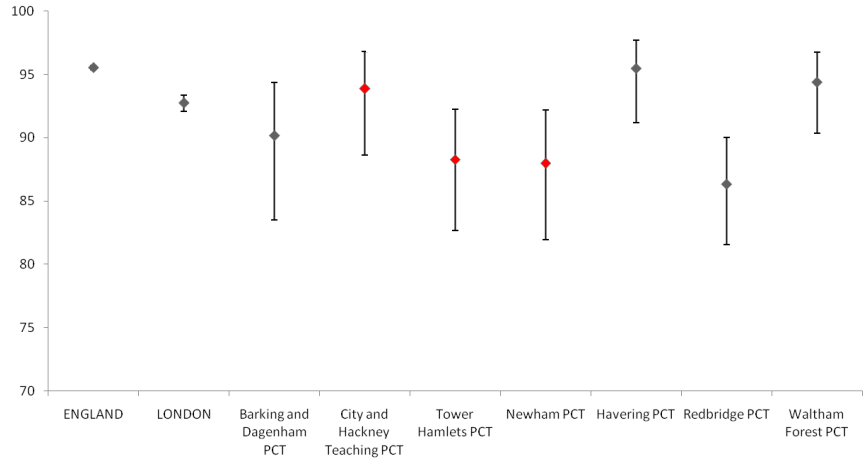
Lithium is a drug that is used as a mood-stabiliser in conditions such as bipolar disorder. It has a narrow therapeutic range, meaning that it is easy to inadvertently 'underdose' or 'overdose'. Therefore, lithium levels in the blood need to be checked regularly.

Figure 46 shows the proportion of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous 6 months. It is a measure of quality and safety of primary care for mental health patients in and is measured routinely for QOF. The figure shows no difference between England and London averages. However, for both Tower Hamlets and Newham PCTs, a lower

proportion of patients have their lithium checked than the England average and there is some evidence that it is lower than the London average too.

This indicator suggests an unmet need for patients on lithium around receiving safe healthcare.

Figure 46: Proportion of patients who have had a lithium level checked (QOF)



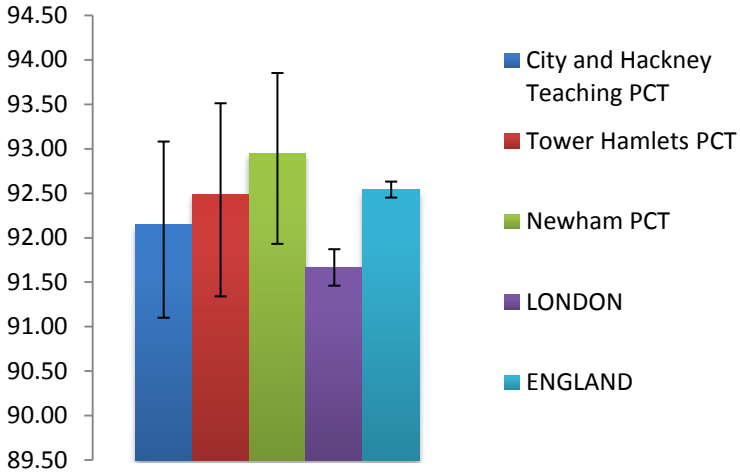
Annual reviews are important for mental health service users. They aim to address both the physical and mental needs of patients and include[17]:

- Physical health checks, health promotion and prevention advice (such as BP, BMI, smoking status, alcohol intake, contraceptive advice, smears, healthy living advice, employment opportunities)
- Medication review
- Mental health checks and care plan
- Liaison with secondary care
- Carers details

Figure 47 shows that the sector has higher levels of recording of annual reviews to London, but this is not statistically significant except for Newham. On a comparative level, this is an indication of met needs, but that figures still show that up to 8% of patients do not receive this level of care. Furthermore, the data does not reflect the quality of care provided in the review (for example, whether the points listed above were covered), only that a review took place.

[17] QOF Toolkit – mental health and depression. Sheffield PCT

Figure 47: Proportion of patients with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the preceding 15 months (08/09)
Source: QOF



Secondary care services: Are services meeting the mental health needs of the population?

Summary:

In comparison to other PCTs, INEL has high secondary care use. Drivers for this could include:

- High levels of mental health need
- High prevalence of mental health problems
- Artefact issues, such as data recording differences between PCTs
- Failure to prevent admissions at a primary/community care level

There are a number of ways to assess whether health service is meeting the needs of the population. In this section, the supply of services will be compared to other areas both in terms of volume and spend.

Secondary care services in the sector are provided by East London NHS Foundation Trust (ELFT). The Trust have shared data for this HNA for all adult inpatient admissions to the trust in 2010. Figure 48 shows the number of admissions by discharge diagnosis, indicating that schizophrenia, schizotypal and delusional disorders and mood disorders comprise the majority of admissions. In comparison to the low prevalence of disorders of adult personality and behaviour, admissions for these conditions also contribute relatively substantial numbers.

Figure 48: Discharge diagnoses for all adult inpatient admissions to ELFT in 2010

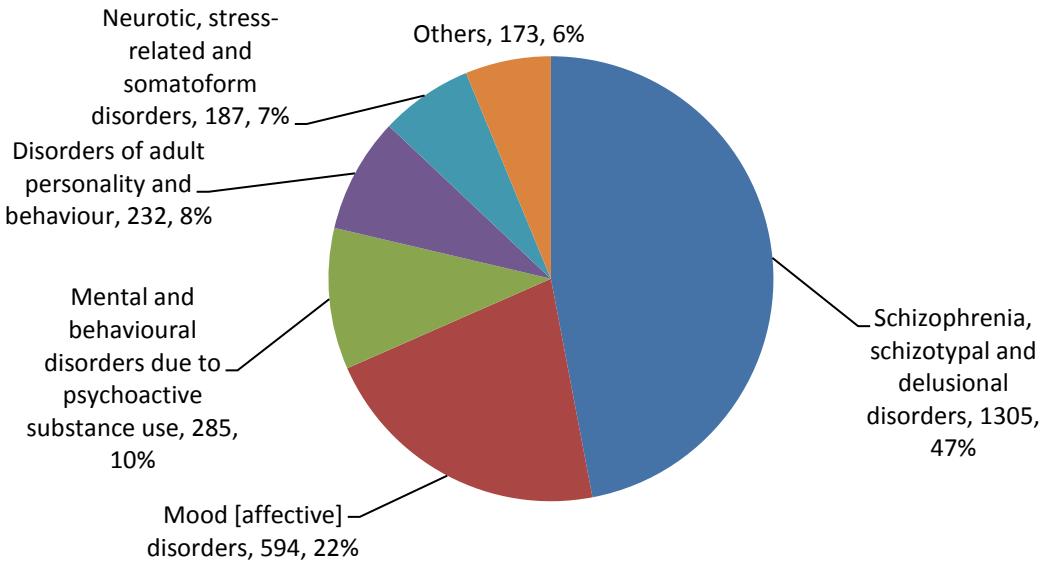


Figure 49 shows that admissions for affective disorders are amongst the highest in London and significantly above the London average.

Figure 49: Admissions from affective disorders in London PCTs (2008/2010)[18]

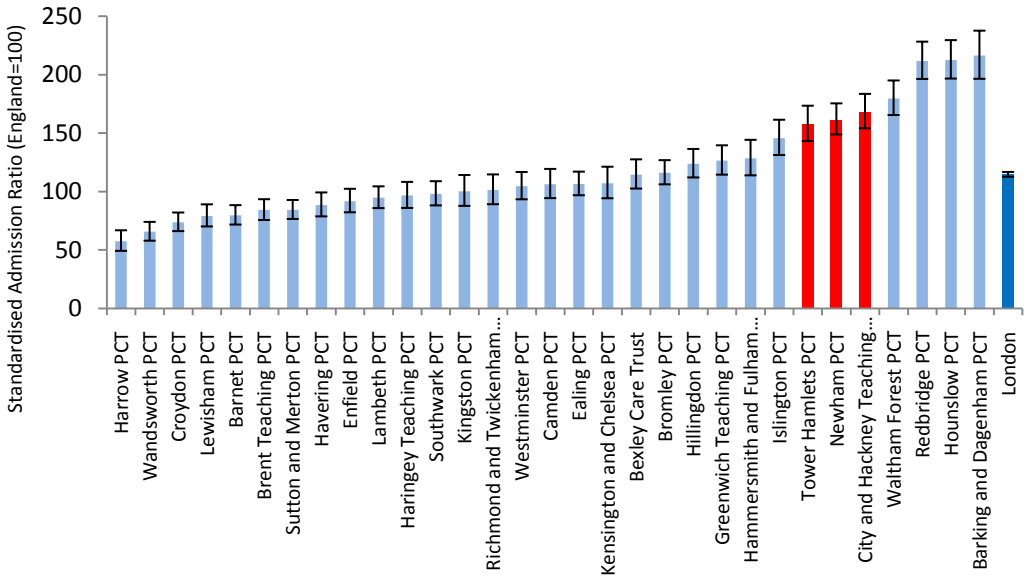
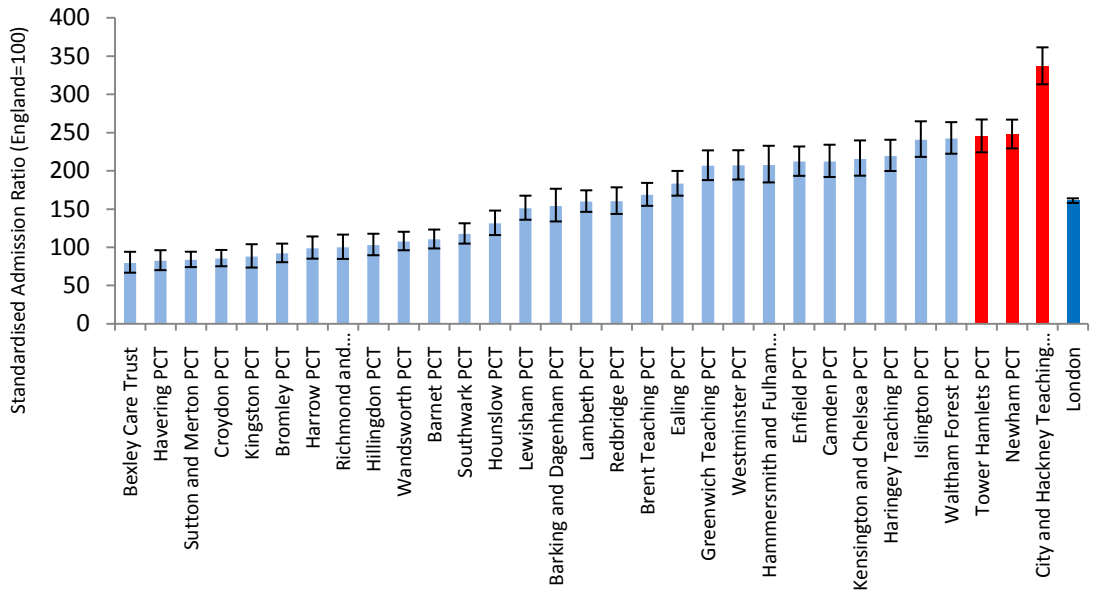


Figure 50 shows that INEL has the highest admissions rates for schizophrenia and related disorders in London.

[18] Source: Dr Foster

Figure 50: Admissions from schizophrenia and related disorder in London PCTs (2008/2010)[19]



This admissions data shows that there is very high demand for secondary care services in the INEL area. Whilst this reflects high levels of risk factors for poor mental health in the area, it needs to also be compared with the prevalence data presented earlier. This showed that there was a high prevalence of SMI in Tower Hamlets and City & Hackney, which would go some way to explaining the high admission rates for SMI. However, the prevalence of depression in INEL was not quite as high as the admission rates for depression in all boroughs. This may be due to data recording issues, but could raises questions about primary care in the sector. For example, the data could be reflecting a situation where there may be under-diagnosis in primary care or barriers to access, such that patients are being admitted directly to hospital in crisis. Alternatively, the data does not control for differences in underlying characteristics of the population, such as different age structures. However, given that SMI is exists throughout adulthood, this is unlikely to fully account for the picture seen. The uncertainties and questions raised by this discrepancy will be fed into the WSR for greater exploration.

A second issue raised by this data relates to Newham. In previous sections, Newham has demonstrated average prevalence of depression, SMI and suicide. Data issues are less common with suicide, due to the Confidential Inquiry process. This data shows however, that there are very high admission rates despite this average prevalence. This finding raises similar concerns to those above - that there may be some failure to prevent admissions in the health service system. This will be explored in later sections of this report and in the WSR.

Figure 51 shows an analysis of ELFT admission data shows inequalities in admissions between ethnic groups. There are clear inequalities, most notably:

- Admission rates for schizophrenia and other disorders are over twice as high amongst Black patients than White or Asian patients
- Admission rates for personality and behavioural disorders are over twice as for White patients that Black or Asian patients.

These inequalities are well known already and have been explored both nationally and locally. The limited scope of this HNA means that this issue will not be analysed further, instead it will be raised within other components of the Whole Systems Review.

[19] Source: Dr Foster

Figure 51: Inequalities in adult inpatient admission rates to ELFT by ethnic group (2010)[20]

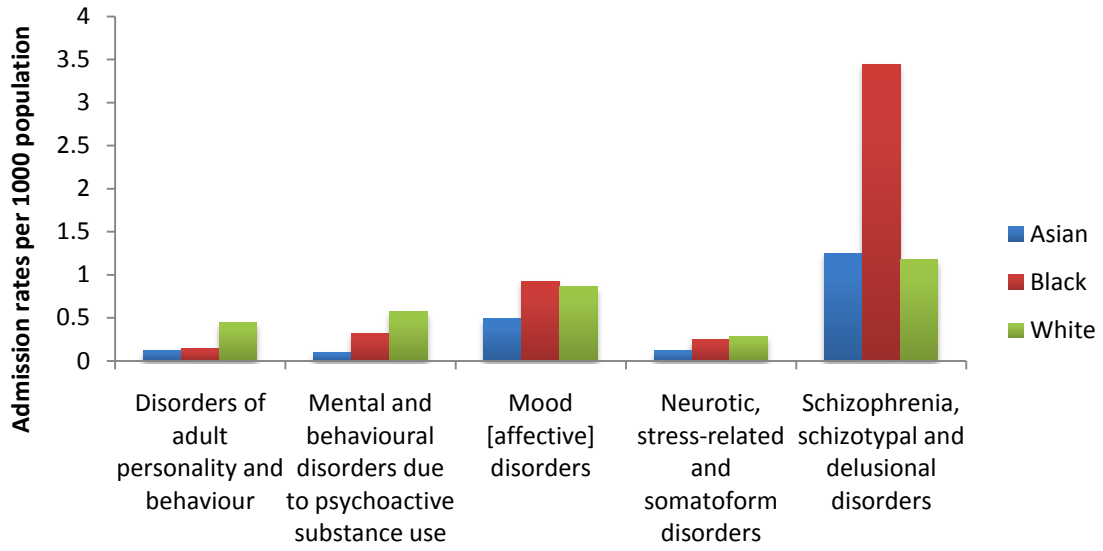


Table 5 shows that City and Hackney spends more per head of population that similar PCTs (those in the same ONS cluster, indicating similar socioeconomic characteristics, for example). Newham underspends in comparison, spending £136 less per head of population that City and Hackney. Tower Hamlets spends £325 per head, which is £10 less than the ONS cluster.

Table 5: Comparative spend per head of population by PCT[21]

PCT	08/09	09/10	ONS Cluster
City and Hackney	£275	£365	£285
Newham	£205	£229	£285
Tower Hamlets	£263	£325	£335
London	-	£255	-
England	-	£204	-

When this expenditure is broken down by condition, as shown in Table 6, we can see that spending on psychotic disorders is lower than the London average for all INEL boroughs. Similarly, Newham underspends in comparison to London on all conditions. In total, City & Hackney and Tower Hamlets spend more than London. However, these figures do not taken into account the comparative need within these populations. Given this though, the high need demonstrated earlier in Newham is not reflected in higher investment in mental health services.

[20] ELFT admission data (adhoc request)

[21] APHO Spend and outcome factsheet 2009/10 http://yhpho.org.uk/quad/default.aspx

Table 6: Comparative total spend by condition PCT in 08/09[22]

	City and Hackney			Newham			Tower Hamlets		
	Spend	% change	Comparison to London average	Spend	% change	Comparison to London average	Spend	% change	Comparison to London average
Substance misuse	£2,455,645	314	Higher	£1,764,873	-10.6	Lower	£2,324,178	1.8	Higher
Organic mental disorders	£137,848	12	Lower	£300,561	2	Lower	£787,627	15.1	Lower
Psychotic disorders	£873,471	10	Lower	£610,895	-18.3	Lower	£1,526,366	12.7	Lower
Other	£21,333,069	-6	Higher	£16,463,362	3.2	Lower	£19,232,349	3.5	Higher
Total	£27,530,401	11	Higher	£20,464,827	5.2	Lower	£26,276,854	11.7	Higher

Community mental health services

Summary:

- There are differences in the level of provision of mental health community services between the different boroughs in INEL.
- In City & Hackney and Newham, there are fewer people in contact with non-inpatient secondary mental health services, which may represent an under provision of services given the high levels of mental illness in the borough.
- However, the data raises the question of comparative over-provision of Crisis Resolution and Early Intervention in City and Hackney.
- These findings need to be compared to other findings from the WSR before conclusions can be reached.

Community mental health services have an established role in the mental health service system. A lack of appropriate, timely or accessible community services could lead to a greater use of inpatient services or many service users not receiving the support they require.

Table 7 shows the contacts with non-inpatient secondary care mental health services in the INEL boroughs and compares this to London averages. It shows that there is a lower provision of community mental health services in City & Hackney and Newham compared to London and a higher provision in Tower Hamlets. Given the high levels of mental health problems described earlier, this demonstrates an opportunity to improve community services in City & Hackney and Newham to reduce inpatient admissions, which have also been shown to be amongst the highest in London.

Table 7: People in contact with adult and elderly secondary care mental health services, excluding inpatient services, per 100,000 population (08/09)[23]

	Total	Compared to London
City and	2475.7	Lower

[22] Data from London Adult Mental Health Scorecard (LHO/CSL). % change – compared to 07/08.

[23] London Mental Health Scorecard (LHO/CSL)

Hackney		
Newham	2358.8	Lower
Tower Hamlets	2901.2	Higher

Table 8 shows the caseload of the Crisis Resolution Home Treatment team (CRHT), who provide rapid care to patients who have had a sudden deterioration in their mental health and/or coping ability. The data is 'weighted', i.e. it takes into account need for services. There is a substantially higher caseload in City & Hackney compared to London, which is over three times higher than in Newham. In Newham, there is a far lower caseload than London, and in Tower Hamlets, it is average. This data prompts the question around the necessity for such a large provision of CRHT in City and Hackney, given the needs of the population, and indicates a need for greater provision in Newham. Given that inpatient admission rates are very high in all boroughs, the data also raises questions about the quality of provision and its effectiveness in preventing admissions to hospital. This will be explored in other areas of the Whole Systems Review.

Table 8: Crisis Resolution Home Treatment (CRHT) caseload on 31/3/09, per 100,000 weighted population

	Caseload	Compared to London
City and Hackney	43.9	Higher
Newham	13.9	Lower
Tower Hamlets	25.5	Average

Table 9 shows the caseload of Early Intervention for Psychosis service (EIP), again weighted to take into account the additional need in a population. Here, the data shows that provision of EIP is in line with average London investment in Newham and Tower Hamlets, and higher in City and Hackney. As before, this data prompts the question that, with high admission rates, whether addition investment is needed, or whether the quality of the existing provision needs to be improved to better reduce demand for inpatient mental health services.

Table 9: Early Intervention for Psychosis' (EIP) service caseload on 31/3/09, per 100,000 weighted population

	Caseload	Compared to London
City and Hackney	64.6	Higher
Newham	60	Average
Tower Hamlets	52.7	Average

Headline Findings

This report has documented the following key issues from the data available:

- There are high levels of deprivation in INEL, which increase the risk of poor mental health
- People with poor mental wellbeing or mental illness have poor physical health and risky health behaviours
    - Of particular note, smoking prevalence in SMI patients is 44%
- The recorded prevalence of SMI and depression in primary care is not as high as might be expected given the levels of deprivation in the area
- There are very high admission rates to secondary care services relative to other London boroughs
- There is a variable volume of provision of community mental health services compared to INEL and other London boroughs

The data underpinning these findings has a number of limitations, as described in each relevant section. However, there is an emerging pattern seen which may be indicating a failure to prevent admissions to secondary care. This assertion is supported by the high admission rates but comparatively low recorded prevalence of SMI and variable provision of community mental health services, which may act to prevent admission. The low recorded prevalence of mental illness is also of interest, not least because it is unexpected given the other findings, and because they may reflect an element of under-diagnosis.

These findings demand a greater exploration of indications of unmet need at primary and community care level. This should be triangulated with other findings of the Whole Systems Review in order to identify the key measures that should be undertaken to maximise the mental health of Inner North East London.

Key recommendations for action

Wider determinants

- Commission services that aim to increase employment opportunities and tackle stigma in the workplace.
- Explore the needs and interventions for housing amongst mental health care users in INEL.

Healthy lifestyles and mental wellbeing

- Target smoking cessation services at people with SMI. Explore the evidence-base for interventions to reduce smoking prevalence in this population.
- Ensure that the physical health needs of mental health patients are met within the health service, drawing on best available evidence of effectiveness.

Healthcare Service structure

- Ensure equity of investment in mental health services between INEL boroughs.
- Explore reasons for the relatively low recorded prevalence of SMI and depression in primary care to ascertain whether this reflects under-diagnosis and barriers to care in primary care.
- Ascertain whether other data from the WSR also points to a gap in service provision at a primary and community care level.
    - If this is the case, draw on findings from the best-practice review for evidence-based interventions to address this.

Recommendation for further work

- The broad scope of this project meant that population subgroups were not specifically addressed, for example, homeless people, prisoners etc.
- Similarly, SMI was the focus of this project, so there are significant gaps in knowledge around certain mental conditions, for example, eating disorders. These could also be explored further.
- The project has only raised potential issues, and stopped short of assessing the evidence base for potential interventions (as this was contained in the WSR). However, further questions were raised by this work (see relevant sections), which could form the basis for further research.
- Data from ELFT was only briefly analysed, so there are opportunities to look at this further, particularly around geographic distribution of ELFT patients with INEL.
- Data on prevalence by GP practice did not control for deprivation, so this should be performed later in the WSR process.
- Linking primary care data with ELFT data would also identify differences in referral patterns.
- Further analysis of prevalence data, for example to control for age, to assess whether there is evidence of under-diagnosis.
- Modelling of expected cases of SMI and depression to assess whether there is evidence of under diagnosis.
- Data on SMI and alcohol consumption would highlight the prevalence of dual diagnosis, which has not been addressed in this project.

Abbreviations

HNA	Health Needs Assessment
ELCA	East London and City Alliance
ELFT	East London NHS Foundation Trust
WSR	Whole Service Review
PCT	Primary Care Trust
QOF	Quality and Outcomes Framework
QMAS	Quality Management and Analysis System
GLA	Greater London Authority
NCHOD	National Centre for Health Outcomes Development

Appendix 1

QOF definition of SMI

Appendix 2

Figure 52: SMI Prevalence between age groups in City and Hackney

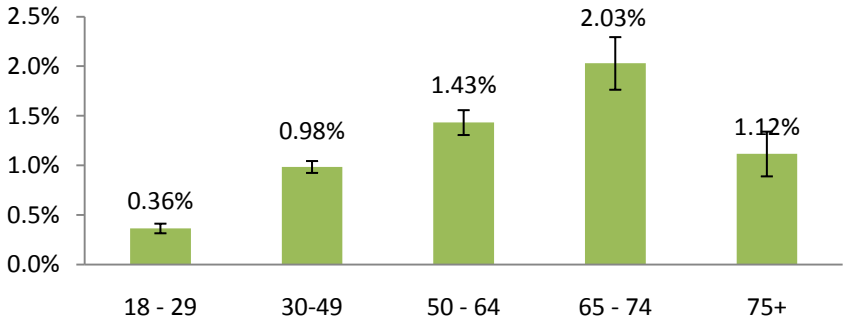


Figure 53: SMI Prevalence between age groups in Newham

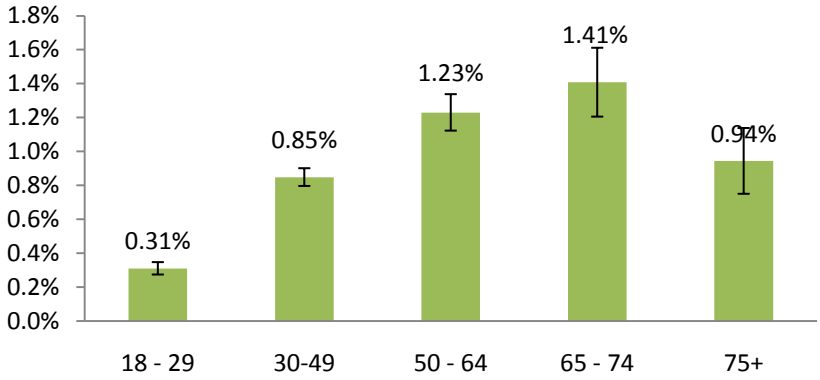
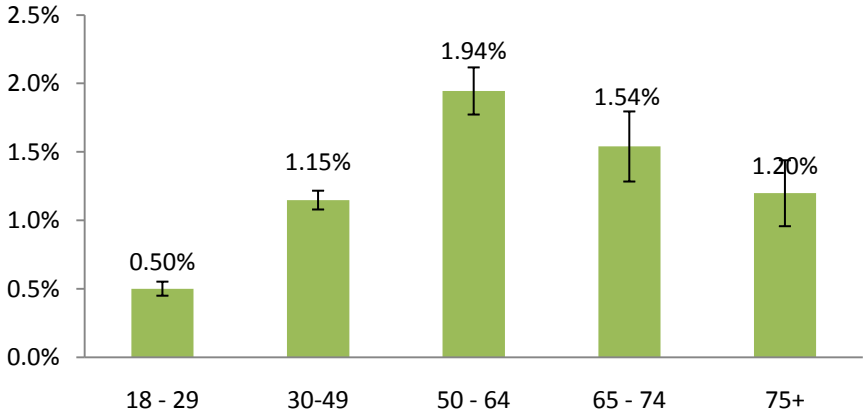


Figure 54: SMI Prevalence between age groups in Tower Hamlets



Appendix 3

Figure 55: Prevalence of SMI in Newham GP practices (larger version)