**HARINGEY COUNCIL**

**NOTICE OF MEETING**

# Scrutiny Review - Mental Health

TUESDAY, 10TH JANUARY, 2006 at 10:00 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Councillors Jean Brown (Chair), Edge, E Prescott, Patel, Robertson and Santry

**AGENDA**

**1. APOLOGIES FOR ABSENCE (IF ANY)**

**2. URGENT BUSINESS:**

The Chair will consider the admission of any late items of urgent business. Where the item is already included on the agenda, it will be dealt with under that item but new items of urgent business will be dealt with at item 6.

**3. DECLARATIONS OF INTEREST, IF ANY, IN RESPECT OF ITEMS ON THIS AGENDA**

A member with a personal interest in a matter who attends a meeting of the authority at which the matter is considered must disclose to that meeting the existence and nature of that interest at the commencement of that consideration, or when the interest becomes apparent.

A member with a personal interest in a matter also has a prejudicial interest in that matter if the interest is one which a member of the public, with knowledge of the relevant facts, would reasonably regard as so significant that it is likely to prejudice the member's judgement of the public interest.

**4. MINUTES: (PAGES 1 - 14)**

To receive and confirm the minutes of the meetings of 6, 12 and 14 December 2005.

5. **MENTAL HEATH SERVICES (EARLY INTERVENTION): CONCLUSIONS AND RECOMMENDATIONS (PAGES 15 - 30)**

To consider appropriate conclusions and recommendations for the review. An issues paper that aims to bring togther key themes and evidence from the review is attached.

6. **NEW ITEMS OF URGENT BUSINESS:**

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HARINGEY COUNCIL

# OVERVIEW AND SCRUTINY COMMITTEE - SCRUTINY REVIEW OF MENTAL HEALTH

**NOTES OF MEETING OF 6 DECEMBER 2005**

**Members:**

Councillors *Jean Brown, *Edge, Erline Prescott, Patel, Santry and Robertson

*Member present

Also present: Dolphi Burkens and David Hindle (PPIF for Barnet, Enfield and Haringey MHT), Stanley Hui (HAVCO), Dermot Boyle (MIND), Stephen Wish (Polar Bear Community), Chris Henderson and Gillian Lacey (Social Services)

1. **APOLOGIES FOR ABSENCE:** Councillors Santry and Robertson.

2. **URGENT BUSINESS:** None.

3. **DECLARATIONS OF INTEREST:** None.

4. **MENTAL HEALTH SERVICES – RESPONSE FROM THE VOLUNTARY SECTOR**

4.1 The Panel received a response on behalf of a range of voluntary sector health and social care organisations. Stanley Hui, the Chief Executive of Haringey Association of Voluntary and Community Organisations (HAVCO) presented the response as follows:

- Accessing help in the early stages of mental illness was difficult and this was especially true for people whose needs were low level. This applied particularly to young people and people with disabilities. If needs were at the higher end of the spectrum, services were very responsive and this was particularly true of the Crisis Team.

- Several voluntary sector organisations provided services to people in the early stages of illness. This included the following:
  - Pyramid Health and Social Care, who provided counselling
  - Open Door Project. This was not Council funded but grant aided. It provided counselling, psychotherapy and consultation services for teenagers. It was either free or low cost, depending on circumstances. Self-referral was available.
  - Mental Health Carers Support Association
  - Tulip Mental Health Group. This provided housing related support as well as a drop-in. It worked in several London boroughs and provided a supported housing service as well as a small residential home.
  - MIND, who provided a range of services including counselling and a drop in centre. A Care Programme Approach (CPA) assessment was not

required to access their services. They received referrals from a range of sources, including GPs.

- The Panel noted that a distinction could be made between between (i). services that prevented the onset of a major illness and (ii). more general services for people with less pressing mental health needs. The MHT had stated that the effectiveness of services aimed at the first category had not yet been fully proven. In respect of the latter, there were a plethora of services that could be said to have some relevance available including those that provided respite care, training, self-help and counselling. There were at least 42 of these in Haringey. Some of these particularly addressed early intervention. A low percentage were commissioned. The majority were grant aided and this was particularly true of black and minority ethnic organisations. There were many groups whose prime focus was not mental health but nevertheless provided relevant services. HAVCO played a strategic role in procurement and helped voluntary sector organisations to bid for contracts. The market was becoming increasingly competitive with private companies also involved.

- It was felt that there were a number of specific gaps in services:
  - There was a lack of general awareness of early symptoms
  - There was some public information on mental health but not enough. It needed to be available widely and particularly in GP surgeries and community organisations.
  - Low level intervention services were insufficient
  - There needed to be more provision for young people.
  - There needed to be more drop-in provision
  - There needed to be more funding for community and social centres so they could set up specific programmes to address mental health needs
  - More work was needed with homeless people
  - The environment within the Borough could have a negative effect on mental health and regeneration could help to improve this
  - People with disabilities could suffer from poor mental health due to isolation and could find it difficult to access services. Disability organisations did not currently have the resources to deal with such issues.

- The use of neighbourhood centres to allow for the development of locality-based services, and other mainstream services would be useful for mental health service users and carers. Such services would probably be welcome for people who did not have difficulties in engaging with services. It might not necessarily be the same for people who did not find this as easy and users would need to be consulted on the feasibility of this.

- Services could be made more accessible to all communities by:
  - Closer working between the statutory and voluntary sector
  - More drop-in facilities
  - Bringing localised and specialised services into the mainstream
  - The setting up of some additional services for people with disabilities and from ethnic minorities
  - Providing publicity in community languages and improving access to interpreters
  - The avoidance of jargon

- There needed to be more choice in the provision of treatments so people could more often get what they needed and wanted.

- There was an over representation of African Caribbean men accessing services via the criminal justice system. Police officers did not always have a great awareness of mental health issues although the service was starting to address the issue. The Panel noted that there were two specific liaison officers that dealt with the Police at St. Ann's Hospital. In addition, there was an appropriate adults scheme for people who found themselves in custody and did not have immediate family/friends to assist them. There were concerns that the Turkish and Kurdish communities might also be starting to experience the same problems as the African Caribbean community was. MIND had collaborated with Derman, an organisation that worked with these communities, in a bid for funding to the Kings Fund to provide mental health services.

- There were not many services available for people who did not have a Care Programme Approach (CPA) assessment. MIND provided such services and were funded for this by the PCT. However, the PCT had a substantial financial deficit and had already given advance warning that this might lead to cuts.

- The Panel noted that it had been estimated that one in four people had suffered some sort of mental health crisis or problem. This used a very broad definition of mental illness. In terms of providing services, it was open to debate what proportion of such people would need help of some description and to what extent.

- Mental health promotion was an important area. Many community groups organised events that might not immediately be considered as being relevant to mental health but helped to promote well being through addressing isolation and building self-confidence.

- There were a number of barriers to rehabilitation:
  - Discrimination and stigma
  - People not being diagnosed or treated sufficiently early
  - Lack of awareness and empathy with mental health issues amongst employers and services
  - Lack of ongoing therapeutic support for patients
  - Lack of financial support, training and employment opportunities
  - Lack of understanding within the community
  - Environmental issues

- The Panel noted that for many people a cure was unlikely and they instead had to cope with living with their condition on a long-term basis. Good quality care could improve the chances of rehabilitation.

- A number of actions could help to counter stigma and discrimination:
  - Specific mental health events
  - Working with schools so that children were taught about mental illness
  - Promoting good mental health
  - Greater involvement of users in the planning of services
  - Community based treatment

- ➢ Improving the environment
- ➢ Agencies providing employment opportunities for people that have been mentally ill

- Services n general could be improved by:
  - ➢ Mapping and better information on early intervention services
  - ➢ Commissioning and funding community based organisations to provide services. This could also help to reduce stigma.
  - ➢ Strengthening community support
  - ➢ Addressing social and environmental issues
  - ➢ Better transport facilities
  - ➢ A focus on mental *health* rather than illness

- There could be difficulties with accessing benefits and services could be more sensitive to the needs of mentally ill people. Housing was also a problem for many people. People quite often lost their accommodation when they became ill if they were renting. The Panel noted that the Housing Service and Benefits were generally sympathetic to people who had been admitted to hospital and lived in Council provision. It was difficult to provide a desirable standard of housing for people who needed support as providers could fall foul of housing benefit regulations regarding the maximum levels of rent that could be paid.

- Efforts by the Council and its partners to improve employment levels of people who had been mentally ill would have more credibility if they were seen to be taking people on themselves through supported placements or permanent employment.

4.2 We thanked Mr Hui for his kind assistance and the other voluntary sector attendees who contributed to our discussion.

**5. FUTURE MEETINGS:**

We noted that meetings had been arranged on the following dates:

- 12 December at 4:00 p.m.
- 14 December at 4:00 p.m.
- 10 January at 10:00 a.m.
- 23 January at 4:00 p.m.

HARINGEY COUNCIL

# OVERVIEW AND SCRUTINY COMMITTEE - SCRUTINY REVIEW OF MENTAL HEALTH

**NOTES OF MEETING OF 12 DECEMBER 2005**

**Members:**

Councillors *Jean Brown, Edge, Erline Prescott, Patel, Santry and *Robertson

*Member present

Also present: Mr D. Cole and Mr. D Fazey (Haringey PCT), Dr. M. Gor (GP and Chair of Haringey Professional Executive Committee), Mr. M. Pelling (Supporting People Manager, Haringey Council) and Mr. D. Hindle (PPIF for Barnet, Enfield and Haringey MHT),

1. **APOLOGIES FOR ABSENCE:** Councillor Santry.

2. **URGENT BUSINESS:** None.

3. **DECLARATIONS OF INTEREST:** None.

4. **MENTAL HEALTH SERVICES**

**Haringey PCT**

4.1 We received evidence from Dorian Cole, Dave Fazey and Dr. Mayur Gor concerning the PCT's strategy to improve primary based care for people suffering from the early symptoms of mental illness:

- The PCT was working closely with GPs to develop primary care as this was one of the key areas of the new mental health strategy. They were currently in the process of determining what practices were currently doing and patients receiving in terms of services. GP practices currently had different thresholds for referring which resulted in variable levels of service. The intention was to seek to agree common thresholds and information was currently being obtained on the respective stages where patients were being referred onwards.

- The onset of practice based commissioning and its enhanced contract scheme provided an opportunity to develop the PCT's approach. Collaborative clusters of GP practices would be set up with an identified lead GP on mental health in each of them, who would be responsible for support and training. The intention was to map out provision that currently existed and to consider how this could be made available to all patients. There was currently a graduate mental health worker scheme, which would be extended, as well as a link workers scheme with the Mental Health Trust and these would be linked into the clusters.

- Access to a variety of services was to some degree currently dependent on whether people were able to speak English. Consideration was being given on how to improve the availability of interpretation services to primary care providers.

- Many people with mental health problems might not visit their GP primarily with such symptoms – they often instead presented with physical problems. The PCT would be working with GPs to help them identify better those people who needed primary care led interventions and those who needed secondary services. Primary care had a particularly important role to play in addressing mild to moderate illnesses such as anxiety and depression.

- People who had had a specialist package of care could, if need be, re-access services through primary care. Re-entry was generally improving. Services were working on the principle that there should be one conduit into services and that this should be through the GP.

- There were to be link workers in Community Mental Health Teams (CMHTs) for each cluster of practices. When people came off CPA programmes, there should still be a plan of ongoing care and GPs should be provided with details of signs and symptoms to look for in the event of any relapse by CMHTs.

- Since 2004 there had been named consultants within the Mental Health Trust whose role was to link up with practices across Haringey and this was working well. This had improved communication in respect of the more serious cases but improvement was still necessary in respect of less serious cases.

- The clusters would all be of similar size and cover a specific geographic area. There would be a CMHT linked into each of them and they would include provision for specific language and cultural needs. The clusters would include all commissioned services. The aim was to provide equitable access to services. There were approximately 60 different GP practices in Haringey of which around half were single practices.

- It was accepted that provision for people with milder mental illnesses required development. This was not merely an issue that affected Haringey – it was a London wide and possibly a national problem. There were some pockets of excellent practice within Haringey and the question was how this could be better shared. The cluster model was progressing well and was in line with the future direction of the NHS. It provided “critical mass” with 70 – 80,000 patients within each cluster. The aim was to be able to provide a level of care that would help prevent mental health problems from getting worse.

- A key concern would be to ensure that services worked well together and it was hope that better communication could enable effective co-operation and sign posting. The local authority had an important role to play in this.

- Practices collected data in different ways and a huge change was required with them moving from being isolated to working collaboratively. Clusters were now collecting anonymised data and this would enable comparison of

rates of referral. Practices would be much more involved in the commissioning of new services. It might be possible for some patients who were currently dealt with by secondary services to be treated by primary services. Practices could also look at switching investment to areas which were most effective, thus freeing up resources from elsewhere.

- In respect of “talking therapies “, it needed to be borne in mind that resources were limited. Consideration was being given to extending the availability of such services within practices, with the assistance of the graduate mental health workers. Some practices currently provided a range of therapeutic services including family therapy whilst others had a far smaller range

- There were currently four Graduate Mental Health Workers in post within Haringey and it was intended to increase this seven by next year. The scheme was part of a national training programme and helped provide Cognitive Behavioural Therapy (CBT) for people between the ages of 16 and 65.

- There were no additional resources available for improving primary care and the PCT would need to look at existing practice and determine if there were other ways of working that might free up resources that could be used in this area. There was nevertheless optimism that a collaborative approach between GP practices would deliver results. It would facilitate earlier intervention and detection as each practice would be able to compare its referral rates with others. There would also be a specific role for the PCT in education and training.

- Good communication between GP practices and acute trusts was very important when patients were being stabilised. Review dates on prescriptions were non negotiable and patients had to see their GP when they arose. However, there was as yet no system for checking that patients were continuing their medication and getting repeat prescriptions. The monitoring of outcomes framework has lessened the risk of this by giving GPs and incentive to check up.

4.2 We thanked Mr Cole, Mr Fazey and Dr Gor for their evidence.

**Supporting People Programmes**

4.3 The Panel received evidence from Matthew Pelling, the Supporting People Programme Manager:

- He was unable to speak for the Housing Service as a whole as Supporting People provided supported housing to vulnerable groups of people and his brief did not go beyond this. Supporting People was aimed at assisting people at risk of social exclusion. It had a problem solving approach and provided a level of support that enabled vulnerable people to live independently.

- The programme was funded by the Office of the Deputy Prime Minister (ODPM). Nationally the programme funded 6,000 different support services that provided assistance to approximately a million households.

25% of the schemes involved mental health and this represented 14% of expenditure. Within Haringey, there were 350 housing units that were linked to support for mental health and these covered 12 different providers. There were two different types of support; accommodation based and floating support.

- In respect of accommodation based schemes, they provided varying levels of support up to 24 hours/7 days per week. In the case of floating support, this was in mainstream housing and normally involved a support worker visiting on a regular basis. The schemes aimed to prevent crises and were not designed to cope with them. The schemes could be accessed via a number of referral routes including self-referral.

- The government had required local authorities to review all of their schemes by 2006 to ensure that they were providing value for money. The review of mental health schemes had just been completed. Part of this process involved a mapping of need as there had previously been a lack of relevant information. There would be a major re-commissioning of provision on 2006-7.

- The results of the review had been mixed. Whilst some services had been found to be of a very good standard, a number of providers were considered to be some way below minimum standards or just below. Contracts would not be granted to providers who failed to meet the minimum. Some providers had action plans to bring them up to standard whilst others had had their contracts terminated.

- Providers needed to demonstrate that they were providing appropriate support and not merely “warehousing” people. Early indications were that a majority of people needed some sort of long term support but the extent of support required was variable. There was a considerable amount of drug use amongst people with approximately 90% active users. If this was the case, all providers would have to have the ability to manage drugs issues. Not all people wanted to be rehabilitated.

- It was unclear whether the current supply of mainstream housing that was suitable for vulnerable people was sufficient to meet demand. People generally preferred to be provided support in their own homes via floating support. However, there were difficulties in finding accommodation of the right quality in the right location.

- The Housing Service was changing the way that it addressed homelessness. Officers would advise on a range of options and there would be greater emphasis on preventing homelessness. The Vulnerable Adults Team would manage all mainstream housing cases that involved mental health issues. The team included staff who were experienced in dealing with vulnerable people and had links to CMHTs and the Drug Action Team. The service was currently in a state of transition following the setting up of the ALMO and would be one of the parts of the service that would not be transferred out.

- Awareness of housing issues and legislation amongst mental health services could be improved and front line housing staff could also benefit

from increased awareness of mental health issues. Any further information on these issues would best be sought by the Panel from the Housing Service.

- There were particular actions that mental health workers could undertake to ensure that the accommodation of patients was maintained such as ensuring that there was regular contact with housing managers and housing benefits.

- There was to be a full time person employed by the Mental Health Trust (?) at St Ann's Hospital to address delayed discharges.

- The Anti Social Behaviour Team (ASBAT) in Housing had strong links to floating support services and was also developing them with CMHTs. Around 20% of people who had been given ASBOs were thought to have some sort of mental health problem. However, the level of understanding of the implications of action by the team amongst mental health professionals was variable. Work was being undertaken with the Mental Health Trust to address this issue. Further issues in relation to this would best be addressed by the Panel directly to the ASBAT team.

- The Housing Service was currently in a period of transition and there was an acknowledgement that some areas required improvement In the meantime, it was possible that rates of delayed discharge might increase. It was possible that current provision for vulnerable people was not of the sort that people wanted but delayed discharges were probably more driven by the shortcomings in the process rather then the supply. The re-organised Vulnerable Adults Service would have specific manager whose sole and direct responsibility would be to cater for the needs of this client group.

4.4 We thanked Mr. Pelling for his assistance.

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HARINGEY COUNCIL

# OVERVIEW AND SCRUTINY COMMITTEE - SCRUTINY REVIEW OF MENTAL HEALTH

**NOTES OF MEETING OF 14 DECEMBER 2005**

**Members:**

Councillors *Jean Brown, *Edge, Erline Prescott, Patel, *Santry and *Robertson

*Member present

Also present: Councillor Wynne (Executive Member for Social Services and Health), Ms. A. Bristow (Director of Social Services and Health), Ms. K. Hostettler (Social Services and Health) and Mr. D. Hindle (PPIF for Barnet, Enfield and Haringey MHT).

1. **APOLOGIES FOR ABSENCE:** None.

2. **URGENT BUSINESS:** None.

3. **DECLARATIONS OF INTEREST:** None.

4. **MENTAL HEALTH SERVICES – RESPONSE FROM SOCIAL SERVICES AND HEALTH**

4.1 The Panel received evidence from Councillor Wynne (Executive Member for Social Services and Health), Anne Bristow (Director of Social Services and Health) and Kathy Hostettler (Social Services and Health in response to various issues that had arisen during the review to date:

- The strategy for mental health was aimed at moving the focus away from institutional to community care. This would, amongst other matters, assist in helping to reduce the stigma associated with mental illness. There were currently 1600 people receiving health and social care services connected to mental health within the Borough and 427 receiving just social care through establishments such as the Clarendon and Six8Four Centres.

- In respect of the mental health strategy, this had been jointly developed by the Council and the PCT, who were commissioners of services. The Mental Health Trust had to work within this framework. They way that they proposed to work was in line with the strategy.

- Whilst there was a good level of take up of day services, there had been less success in finding routes into employment. People were currently accessing learning and developing their skills but this was not being translated into employment. Some people had developed particular skills in creative arts such as pottery, art and jewellery and had managed to use these as a career path.

- People could sometimes attend Day Centres for a long time. It was felt that more people should be progressing onwards. It was now a specific priority to ensure that more people made significant progress as they passed through the system. This would be addressed by working with the Department for Work and Pensions (DWP).

- In terms of closer working with neighbourhoods, there were funding difficulties that needed to be considered. The Council was working with HAVCO and Volunteer England to set up a volunteer bureau for the Borough and this would provide opportunities for people who were recovering from mental illnesses. It was hoped that a vetting process could be set up that was commensurate with the nature and level of the work being done.

- Work placements were to be created across the Council although the first priority was currently year 10 pupils. The scheme was to be launched in January. In addition, the Mental Health Trust now offered placements. It was recognised that the transition onto work would have to be a gradual processes for many people.

- The aim of Day Centres was now to use mainstream facilities where possible. This helped people build up self confidence so that they were more likely to use facilities when they moved on.

- There was only limited amount of work in gardening and catering and most that was available was low level. A lot of people already had specific skills although they might have to upgrade them and re-gain their confidence before they were able to make use of them. It needed to be borne in mind that not all people were actively looking for work. Staff in Day Centres regularly undertook surveys on needs and aspirations in order to determine the sort of services that were required.

- Assurances had been received that people with mental illness were not being disproportionately subject to Anti Social Behaviour Orders. Around 20% of the people that the Anti Social Behaviour Team was working with were estimated to have a mental health problem. Action against them was not necessarily unreasonable. Assurances had been obtained from the Executive Member of Crime and Community Safety that the figures were no higher then in other comparable Boroughs. The team had links with mental health services and were required to refer such cases to strategy meetings with relevant services.

- People with mental illness were more likely to be victims of crime than perpetrators. There were very few people who came into the system via criminal justice. A more relevant issue was the number of people within the prison system who were not having their mental health needs addressed. The Panel noted that the Metropolitan Police Authority's report on mental health and the criminal justice system would shortly be considered by the Well Being Board.

- There were to be significant changes introduced in the way that housing issues were dealt with. There was a single conduit for all issues relating to mental health and this was the Vulnerable Adults Team. In addition,

particular emphasis would now be based on helping people to avoid homelessness. If interventions were made at an earlier stage, homelessness could be avoided.

- There were currently approximately 5,500 in temporary accommodation and this number needed to be reduced by half by 2010. Increasing the supply of housing was not necessarily the answer and consideration needed to be given on how to use resources better. There was also supported housing available for long tem cases. The Mental Health Trust sometimes wished to move long term patients faster them resources were available. Discussions were taking place on moving resources to support this process, in partnership with the PCT. There were currently approximately 20 patients that were not being moved out of hospital as quickly as the Mental Health Trust wanted them to. In some cases, the resources needed to support them were substantial. Last years figures for delayed discharges had been higher at around 40.

- Resources that were used to provide beds for people could not be used to provide community care. There was a need to move resources in order to develop the sort of community services that could prevent people becoming acutely ill. The additional support that the local authority could provide to support this was conditional on sufficient funding being freed up. Although local NHS managers sympathised with the overall approach, they had other budgetary pressures to deal with.

- The Mental Health Partnership was developing a communication strategy that was based on increasing awareness of mental health as an issue and de-stigmatising it. It affected large numbers of people – some figures put this as high as 1 in 4 people suffering from some sort of condition at some stage and, taking into account the impact had on families and others, it probably affected around 1 in 2 people.

- Specific publicity was shortly to be launched on mental health services. This would cover the whole range of services and would include information on how to access help and additional information. The publicity would be available to professionals, patients and relatives and in GP surgeries, customer centres and other public buildings. It included a comprehensive directory of services that had been complied in consultation with the voluntary sector.

- Most of the resources for mental health went on addressing the needs of people who were acutely ill. However, there was also a need to work on promoting good health and reducing stigma and there was a particular need to work with children and young people. Social Services were working with schools on this issue and were focussing on such messages as eating and acting healthily as well as other lifestyle issues. The issue was part of the well being agenda and work was also being undertaken with GPs in order that health issues could be addressed holistically.

- Men within some communities found it difficult to seek help due to the "macho" culture that existed within them. There were also a disproportionate number of African Caribbean men entering the system. A specific piece of research was being undertaken by Middlesex University

on pathways into care for black and ethnic minority communities. Due to the number and diversity of community within Haringey, the issues were far more complex then merely ensuring that the workforce reflected the local community. It was sometimes not possible to get interpreters for some languages.

- An element of mental health awareness was built into customer care training. However, there was no expectation for staff for people to have a high level of expertise. There were specific channels for people to refer individuals to should the need arise.

- There was benefits advice available for people within Day Centres. The CAB was commissioned to provide advice at the Clarendon Centre. In addition, social services were leading on the setting up of an anti poverty strategy which would look at how benefits advice was provided across the board.

- There were various statistics relating to mental health contained within the Public Health report on mental health. Such additional general information that existed would be made available to the Panel.

4.2 We thanked Councillor Wynne, Ms Bristow and Ms Hotettler for their evidence

5. **FUTURE MEETINGS;**

- 10 January at 10:00 a.m.
- 23 January at 4:00 p.m.

**SCRUTINY REVIEW OF MENTAL HEALTH**

**10 JANUARY 2005**

**ISSUES PAPER**

## 1. Introduction

1.1 The Review has considered a wide range of evidence, both documentary and verbal. The purpose of this meeting is to consider appropriate conclusions and recommendations and, in order to assist in this process, this report aims to highlight the key issues from evidence received.

## 2. Background to Review

2.1 It is estimated that nearly a third of GP consultations are related to mental health problems and that about one in six people in England has a mental health problem at any given time. The need to improve mental health and well being has been set a major public health priority for Haringey. In 2004, Haringey Teaching Primary Care Trust chose to report on the issue for its annual health promotion report. It identified areas where action needed to be taken to improve mental health and well being. These were:

- Reducing stigma and discrimination
- Preventing mental illness
- Increasing the ability to cope with mental distress in life
- Improving the quality of mental health services
- Improving data and information systems

2.2 The report highlighted the fact that Borough had by far the highest acute admission rate in London at 854 per 100,000 people in 2002/3, compared with the lowest figure of 241 per 100,000 in Havering. There was also considerable variation in the rates between electoral wards as well as between ethnic groups. The Borough also has a comparatively large number of refugees and asylum seekers within it and some have experienced torture and psychological trauma, which can make them particularly susceptible to mental illness and possibly suicide.

2.3 Mental health is a complex policy area and it was felt essential that the review focussed upon an area of manageable size and appropriate to the resources available. After discussion with stakeholders, the Panel decided to focus upon early intervention. This was felt a particularly appropriate area to focus on due to the comparatively high acute admission rates for the Borough and its cross cutting nature, as partnership working is an area that scrutiny may be particularly well placed to exert influence upon.

2.4 The following terms of reference were therefore set for the review:

"To consider, both strategically and from a users perspective, the provision of services for adults that seek to address the earliest symptoms of mental illness through early intervention and their effectiveness in helping individuals avoid acute illness or prevent its recurrence and to make appropriate recommendations for improvement to local NHS bodies and the Council's Executive".

2.5 The Panel may wish to give consideration to suggesting that further piece of work be undertaken on Child and Adolescent Mental Health Services which, due to the age of the people that they work with, are of considerable importance in helping to prevent long term mental health problems developing.

**3. Strategic Issues**

3.1 A joint health and social care mental health strategy for 2005 – 2008 has just been agreed by all relevant partners. It is within the overarching community strategy as agreed by Haringey Strategic Partnership, with accountability being to its Well Being Board, which includes membership from Haringey Council, the PCT, Barnet, Enfield and Haringey Mental Health Trust and the voluntary sector.

3.2 Beneath the Well Being Board are the Mental Health Executive and the Mental Health Partnership. The Executive comprises of the key senior officers of the statutory agencies i.e. Social Services, Haringey Teaching Primary Care Trust and Barnet, Enfield and Haringey Mental Health Trust. The Mental Health Partnership works alongside it and comprises of all partner agencies, including users and carers and the voluntary sector. Together they will be responsible for ensuring the implementation of the mental health strategy and other key strategies across all the partners.

3.3 The strategy will focus on a number of key areas:

- Promoting rehabilitation and recovery
- Using the least stigmatising and restrictive settings
- Providing socially inclusive care to reduce the social exclusion associated with mental health problems
- Challenging stigma and discrimination.
- Providing culturally appropriate services
- Involving service users
- Involving carers

3.4 The Panel noted the evidence from the service commissioners (the PCT and Social Services) that there were some particular challenges that needed to be addressed locally and which the strategy aimed to meet:

- An over reliance on outdated institutional forms of care across health and social care
- Underdevelopment of community based services
- A lack of coherent interfaces across the different parts of mental health care
- A failure to address the diverse population needs and marked differences in levels of need between east and west Haringey
- A lack of robust information across most areas of mental health
- Significant financial deficits across the local health and social care economy

3.5 There were recognised to be specific issues relating to the following:

- Waiting times for psychological therapies. These are undertaken by both voluntary sector and NHS providers. There are significant levels of demand and particular cultural and ethnicity needs. One particular initiative that is taking place is the development of a psychological therapies network.

- Accommodation in Haringey. This is currently under a process of review and reconfiguration. People often have complex needs and lack of accommodation can delay the discharge of clients from hospital. There are, however, a number of supported housing projects in the community.

- Employment. Whilst there are a number of local initiatives, it had only been possible to place a very small number of people.

3.6 The Mental Health Trust (MHT) is in the process of reconfiguring its services in line with the new service model and is considering, in particular, the capacity and location of services that they provide. The outcomes of this will be a key influence on the current moves to redevelop the St. Ann's Hospital site.

3.7 The Panel noted that nationally there are a sizeable number of people with milder mental illnesses either do not currently receive a service or have little choice in what they receive. Waiting lists for "talking therapies" are long – in some cases up to a year whilst many services are not accessible to people who do not have a current a Care Programme Assessment.

3.8 Improved IT was noted to be a major strategic priority and a national issue. NHS and local authority systems are currently not compatible. The majority of expenditure on IT in the NHS had historically been on acute hospital care which has left Mental Health at a low starting base.

3.9 80% of the staff in mental health are from the NHS and it can be dominated by the medical model of care. The links between NHS services and the Council are very important and, in particular, those with adults services, children's services and Housing. The Mental Health Trust felt that strong service commissioning function was essential and this was an area where the local authority could have a key role.

3.10 The Panel noted the view of Social Services that resources that are used to provide beds in hospitals for people cannot be used to provide enhanced community based care of the sort envisaged within the strategy. They felt that there is a need to move resources in order to develop the sort of community services that can prevent people becoming acutely ill. The additional support that the local authority and others can provide to support this is conditional on sufficient funding being freed up through actions such as reducing the amount spent on institutional based care. Although local NHS managers sympathise with this overall approach, they have other budgetary pressures to deal with.

**4. User Representative Views**

4.1 The Panel heard a range of views on particular areas that needed addressing and would facilitate successful earlier intervention:

- Services could be accessed very quickly in the event of a severe episode. Access was less timely for cases which required an initial GP referral which were not crises or on re-admittance into the secondary sector. Low level intervention services needed to be expanded.

- It was felt that there needed to be better information available on mental health services and this needed to be made available not only to patients, carers and the general public but also to professionals.

- There was variation in how GPs addressed mental illness and their awareness of services.

- Choice needed to be extended. The majority of people with less severe illnesses were treated with medication alone and it was often difficult for people to access "talking therapies" such as Cognitive Behavioural Therapy (CBT). Most care appeared to be focussed primarily on symptom stabilisation.

- Some people were likely to have long term needs and would therefore benefit from accessible help on how to manage their illness.

- Whilst the local authority had particular expertise in making services accessible to all communities, NHS bodies were not yet as adept at this. In addition, there were new challenges that needed to be addressed such as the continuing evolvement of communities within Haringey.

- Day services needed to be accessible. They were not always appropriate to the needs of all patients, particularly younger ones. In addition, encouragement needed to be given for people to use mainstream facilities in order to make them more independent.

- There was a lack of services available for people who did not have a Care Programme Approach (CPA) assessment.

- There were a lack of employment opportunities, including placements, for people who had been ill.

- Having good benefits advice was important.

4.2 In addition, representatives from the voluntary sector made the following additional comments on where they felt that services needed to be improved:

- There was a lack of general awareness of the early symptoms of mental illness.

- There needed to be more drop-in provision.

- There needed to be more funding for community and social centres so they could set up programmes that addressed mental health needs.

- More work was needed with homeless people.

- The environment within the Borough could have a negative effect on mental health and regeneration could help to improve this.

- People with disabilities could suffer from poor mental health due to isolation and could find it difficult to access services. Disability organisations did not currently have the resources to deal with such issues.

**5. Primary Care**

5.1 The view that the Panel received from a range of sources was that people should only enter the mental health system if absolutely necessary. This is due to a number of reasons including stigmatisation and the prevention of social exclusion. Nationally, 91% of people with a mental health condition are treated entirely within

primary care and the view that the Panel received was that this is probably appropriate. Good primary care and early interventions can help reduce the need for secondary services and help to keep people well enough to stay outside of the system. If services are to prioritise well being and the prevention of mental health problems, then resources will need to be shifted to primary care.

5.2 The Panel heard evidence from users who stated that the timeliness of interventions that require a GP referral needed to be improved. In addition, the Panel heard that there were lot of people with relatively mild but potentially disabling illnesses, such as those with obsessive compulsive disorder and suffering from anxiety and depression, who currently do not receive services. There are also many people with mental health problems who do not visit their GP primarily with such symptoms but present instead with physical problems.

5.3 The Mental Health Trust's view was that, whilst early intervention could help prevent illnesses from becoming worse, better detection would be the most significant improvement that could be made to the ability of services to respond at an early stage. Signs and symptoms are not always recognised and many people only come to the attention of services when having their second or third episode. GPs are probably best placed to address this issue. They felt that the ability of GPs to respond effectively was hampered by a lack of time and that their knowledge base needed to be expanded.

5.4 GP practices in the Borough are characterised by long lists, inflated by the transient nature of the population. There are approximately 60 different GP practices in Haringey of which around half are single practices. A large number of GPs are due to retire within the next 5 years.

5.5 The PCT reported on how it was working with GPs to develop primary care. They were currently in the process of determining what practices were currently doing and what services patients were receiving. GP practices had different thresholds for referring onwards and this resulted in variable levels of service. The intention was to seek to agree common thresholds and information was being obtained on the respective stages where patients were being referred.

5.6 The local enhanced service proposal from the PCT involved a lead GP being appointed to each of the four GP commissioning clusters. The lead GP will take a specific lead for primary care mental health in the cluster and have particular responsibility for support and training. The clusters will provide "critical mass" with 70 – 80,000 patients within each one. The model will bring together a key part of each clusters commissioning function for primary care mental health. Clusters will all be of similar size and cover a specific geographic area. There will be a Community Mental Health Team (CMHT) and specific link workers allocated to each cluster and they will include provision for specific language and cultural needs. The aim is to provide equitable access to services.

5.7 The PCT is working with GPs to help them detect better those people who needed primary care led mental health interventions and those who needed secondary services. In addition, people who had had a specialist package of care will re-access services through primary care. Services will work on the principle that there should be one conduit into services and that this should be through the GP.

5.8 The PCT accepted that provision for people with milder mental illnesses required development. This was not merely an issue that affected Haringey – it was a

London wide and possibly a national problem. There were some pockets of excellent practice within Haringey and the question was how this could be better shared.

5.9 In the case of "talking therapies ", the PCT stated that it needed to be borne in mind that resources were limited. Consideration was being given to extending the availability of such services within practices, with the assistance of the graduate mental health workers. Some practices currently provided a range of therapeutic services including family therapy whilst others had a far smaller range and it was hoped that the new model would enable services to be spread more evenly.

5.10 There are currently four Graduate Mental Health Workers in post within Haringey and it is intended to increase this to seven by next year. The scheme is part of a national training programme and helps provide self help and guided interventions based on Cognitive Behavioural Therapy methodologies for people between the ages of 16 and 65.

5.11 GP practices currently collect data in different ways and a huge change is required with them moving from being isolated to working collaboratively. Clusters are now collecting anonymised data and this will enable comparison of rates of referral. Practices will be much more involved in the commissioning of new services and could look at switching investment to areas which were most effective, thus freeing up resources from elsewhere.

5.12 When people come off CPA programmes, there should be a plan of ongoing care and GPs should be provided by CMHTs with details of signs and symptoms to look for in the event of any relapse. Since 2004, there have been named consultants within the Mental Health Trust whose role was to link up with practices across Haringey and this was working well. This had improved communication in respect of the more serious cases but improvement was still necessary in respect of less serious ones.

5.13 Review dates on prescriptions are non negotiable and patients have to see their GP when they arose. However, there is as yet no system for checking that patients are continuing to take their medication and getting repeat prescriptions. The monitoring of outcomes framework has lessened the risk of this by giving GPs and incentive to check up.

5.14 The Panel noted that there were no additional resources available for improving primary care and the PCT would need to look at existing practice and determine if there were other ways of working that might free up resources that could be used in this area. They were nevertheless optimistic that a collaborative approach between GP practices would deliver results. It would facilitate earlier intervention and better detection as each practice would be able to compare its referral rates with others. There would also be a specific role for the PCT in education and training.

## 6. Community Based Services

6.1 The only service that the Mental Health Trust stated that it specifically provided in Haringey that is aimed at early intervention was Antennae, which addresses the needs of African Caribbean young people between the ages of 18 and 25 and can cater for 50 patients at a time. This compares with the caseload of the CMHTs, which have around 300 for each team. They are therefore able to provide a high

level of input to their patients. They work with a range of external services and use an assertive outreach model, which involves engaging proactively with individuals.

6.2 The Mental Health Trust is considering, in consultation with commissioners, setting up a specific early intervention in psychosis (EIP) service for Haringey as recommended by National Service Framework (NSF) guidelines. The original guidance specified that there should be one such team per half million of population, which would mean one team for the whole of Barnet Enfield and Haringey. An EIP team has been set up in Barnet by the Mental Health Trust. Whilst this is unlikely to be sufficient for the needs of all three Boroughs, there is not enough funding for one team per Borough. One option that is being looked at is the development of a "hub and spoke" model whereby CMHTs would seek advice and guidance from the central team.

6.3 The Mental Health Trust reported mixed views on the effectiveness of such teams. Those who worked within them tended to be convinced but this view was not always shared by those who did not. The service that they typically provided was well resourced and of the type that all mental health services should ideally be able to provide. However, this could only be provided during the first instance of illness and the care provided when patients transferred to CMHTs was not comparable, due to fewer available resources. Whilst early intervention in itself could help prevent illnesses becoming worse, the Mental Health Trust feels that there is currently a lack of evidence to support the proposition that having a discreet team made a significant difference since this particular model is relatively new.

6.4 In addition, assertive outreach work can be seen as a form of early intervention as it aims to prevent re-admission or relapse. However, the Trust reported that there had also been mixed views regarding their effectiveness. Patients were appreciative of them as they were able to devote more time to them than CMHTs, who normally work under considerable pressure. The Panel noted that accommodation for the CMHTs was inadequate, with not enough space for staff or rooms for group work.

6.5 The Mental Health Trust felt that, in the event of sufficient funding becoming available, improved liaison with the North Middlesex Hospital would possibly be a higher priority then the setting up of a discreet early intervention service. Such a service could provide a link between psychiatric services and A&E and the medical wards. Amongst other benefits, it would enable post natal depression to be detected and addressed at an earlier stage.

6.6 The Panel visited a range of day care provision throughout the Borough. It was acknowledged that they there needed to be more focus on getting patients to progress and that centres should not be seen as a long term option. However, some provision is aimed at people with a severe and enduring mental health problem who require long term support. Both the Clarendon Centre and Six8Four only take patients with a current CPA and a risk assessment. The view was that day centres were not equipped to deal with all eventualities and there needed to be a support network that they could turn to if required.

6.7 Day services can play an important role in helping to rehabilitate people who have been mentally ill. Appropriate day services can also, in some instances, also help to prevent people from becoming hospitalised. The Panel received evidence from the Council on the current review of the Day Care strategy for mental health. The aim of day centres is now to use mainstream facilities where possible. This helps people build up self confidence so that they are more likely to use facilities when they move

on. The new strategy would be aimed at providing opportunities rather than care. The previous emphasis had been more on containment.

6.8 A particular difficulty is that CMHT assessments are often limited in scope as they concentrate on medical issues and tend to not look at the wider needs of the person. In the absence of necessary detail, it can be difficult to know how to address a persons particular needs. The Panel heard that care plans from Boroughs like Camden and Islington could be long but arrived quickly. This showed that the issues were resolvable as others were achieving in this area. There is also a problem with not having an aggregation of recorded need over a significant period of time on which to base future commissioning decisions. The new strategy is being based on the hope that the necessary information will be forthcoming in the future.

6.9 Alexandra Road Crisis Centre and Haringey Therapeutic Network are probably the most relevant current commissioned day services in terms of their role in early intervention. The Network opened earlier this year following the closure of the day hospitals, which were felt to have greater emphasis on medical issues and did not recognise sufficiently the potential of patients. It has only two rooms at the Canning Crescent Centre and can cater for just 12 patients at a time. It is open four days per week and has a budget of £120k, which comes from the PCT and is currently funded until April 2006. All permanent staff are currently temporarily seconded. It was necessary to use a number of agency staff as, due to the uncertainly about the future of the service, it is difficult to recruit.

6.10 It is a popular and well regarded service and there are a large number of people on the waiting list. The Network stops taking referrals if the waiting list becomes more then 3 months as the service was geared to provide short term assistance in rehabilitation and longer waiting times were not consistent with this aim. Strict eligibility criteria had been introduced in order to ensure that the service was targeted at those patients that were likely to gain most from it and to keep demand manageable. It is not necessary to have a CPA to obtain a place. Patents came with a range of conditions. It appeared to the Panel that future of the service was subject to uncertainty and not able to cope with demand.

6.11 The Network provides assistance for 12 weeks and offered a wide range of activities. It concentrates on non medical and holistic issues such as leisure activities and further education. The aim is to facilitate rehabilitation and they aim to get patients out into the community as much as possible and use mainstream facilities. Although there is some assistance available to enable people to get into work, development of a full programme is required. They aim to ensure that all patients are linked up to something after 12 weeks e.g. college, voluntary work, part time employment. It is therefore important that those patients referred to them are committed to making progress. The service would like to have access to a psychologist but there was currently insufficient funding for this.

6.12 Alexandra Road Crisis Centre can take people for a maximum of three weeks. It can be used as a place of safety and refuge for people in mental health crisis or as a preventative measure if it seems a person may be relapsing. It could also be used as a means of providing respite for carers. A CPA is not essential. Self referrals as well as referrals from GPs and from other support organisations are accepted. Clients between 18 and 65 are taken and had to have a predominantly mental health problem. There are 8 beds and demand is subject to periodic peaks and troughs. The Panel noted that there might be a need to increase awareness of the service in order to ensure that it is fully utilised all of the time.

6.13 They provide a limited range of activities such as yoga, relaxation and pottery. The intention is to encourage clients to attend activities in the community so as not to create dependency. Out of hours telephone support is available and clients can still phone after they have left the Centre. The service is staffed by residential social workers and managed by social services. Part of the funding comes from the PCT. It is the only unit of its type in the Borough. If waiting times go above a week, referrals were no longer accepted. Whilst there are times when this is the case, there are other times when demand was not as heavy.

6.14 The Panel noted that there are no obvious career paths for care staff who work in day care services. Efforts have been made to develop an NVQ but these have so far not been successful. Users of day care services have access to IT training but this has proven to be costly. In particular, IT support was only provided to staff and not users, which had cost implications. Centres are anxious to involve volunteers and, in particular, would like to include ex-patients in this. However, the need for Criminal Records Bureau (CRB) checks and the delay and cost associated with this has made this difficult to achieve.

## 7. The Role of the Voluntary Sector

7.1 The voluntary sector is felt by the joint commissioners to have a good mix of provision. It was reported to the Panel that several voluntary sector organisations provided services to people in the early stages of illness. This includes the following:

- Pyramid Health and Social Care, who provide counselling
- Open Door Project. This is not Council funded but grant aided. It provides counselling, psychotherapy and consultation services for teenagers. It is either free or low cost, depending on circumstances. Self-referral is available.
- Mental Health Carers Support Association which provides a range of services for carers including advocacy, advice, training and casework.
- Tulip Mental Health Group. This provides housing related support as well as a drop-in.
- MIND, who provide a range of services including counselling, housing and a drop in centre. A Care Programme Approach (CPA) assessment is not required to access their services. They receive referrals from a range of sources, including GPs.

7.2 There are a plethora of general services for people with less pressing mental health needs provided by the voluntary sector including ones that provide respite care, training, self-help and counselling. There are at least 42 of these in Haringey and a number of these specifically aim to intervene at an early stage. A low percentage are commissioned. The majority are grant aided and this is particularly true of black and minority ethnic organisations. There are many groups whose prime focus is not mental health but nevertheless provide relevant services. HAVCO play a strategic role in procurement and help voluntary sector organisations to bid for contracts. The market is becoming increasingly competitive with private companies also involved.

7.3 There are not many services available for people who do not have a Care Programme Approach (CPA) assessment. MIND provides such services and are funded for this by the PCT. However, the PCT had a substantial financial deficit and had already given advance warning that there might be cuts.

## 8. Health Promotion and Prevention of Ill Health

8.1 The joint Mental Health Strategy states that particular priority will be given to promoting good mental health and preventing illness. This will include:

- Specific action aimed at children and parents
- Reviewing day services and employment schemes that are currently provided
- Exploring opportunities for increasing access to employment, especially employment of service users within statutory organisations
- Developing service to prevent of loss of employment, particularly working with community services and primary care

8.2 The Panel heard evidence from many sources that mental health promotion was an important area and requires specific attention.

8.3 It was noted that the Mental Health Partnership was developing a communication strategy based on increasing public awareness of mental health as an issue and de-stigmatising it. Most of the resources for mental health are used on addressing the needs of people who are acutely ill but it is acknowledged that there is also a need to work on promoting good health and reducing stigma and a particular need to work with children and young people. Social Services are working with schools and focussing on such messages as eating and acting healthily as well as other lifestyle issues. The issue is part of the well being agenda and work is also being undertaken with GPs in order that health issues can be addressed holistically.

8.4 Specific multi agency publicity is shortly to be launched on mental health services. This will cover the whole range of services and include information on how to access help and additional information. The publicity will be available to professionals, patients and relatives and in GP surgeries, customer centres and other public buildings. It includes a comprehensive directory of services that has been complied by the Mental Health Partnership in consultation with the voluntary sector.

8.5 Voluntary sector organisations pointed out that many community groups organise events that might not immediately be considered as being relevant to mental health but help to promote well being through addressing isolation and building self-confidence.

8.6 One particular action that could help to de-stigmatise mental illness is locating services in community settings which people use in their everyday lives, such as community centres, GP surgeries, leisure centres etc. One suggestion that was made in the course of the Panel's discussions was the use of Neighbourhood Centres. This would have the added advantage of easing accommodation pressures that some mental health services in the Borough face.

**9. Diversity**

9.1 The Panel noted that it is often difficult for people from minority ethnic communities to access appropriate help when they suffer from mental illness and that this is particularly true in the case of less serious illnesses. There were also specific issues in relation to detection.

9.2 The Mental Health Trust reported that there was over representation/under representation of particular cultural ethnic groups in mental health services. On a local basis, Haringey is linked into the Black and Ethnic Minorities Network for Mental Health and services are linked into the national network wide membership.

There are specific needs of refugees and asylum seekers that needed to be addressed. There are particular concerns about the comparatively large numbers of Turkish and Kurdish young people who are coming into contact with the CAMHS team and appear likely to graduate onwards into adult services.

9.3 There is no specific team that deals with the needs of refugee and asylum seekers although the Halliwick Centre has capacity to deal with post traumatic stress disorder. The Mental Health Trust felt that effective engagement would be facilitated best by better liaison with primary care and a proactive approach by GPs. Mental health staff would benefit from improved training in this area and could be constrained by difficulties in accessing appropriate interpreters. There is some anxiety on what might happen after the closure of the asylum team in April.

9.4 The Panel noted that is an over representation of African Caribbean young men in acute care, particularly amongst forensics (services for patients who have committed criminal offences whilst ill). The Trust felt that an academic piece of research on the issue would be useful and this might have relevance for the Turkish/Kurdish communities as well.

9.5 The Panel spoke to Derman, an organisation that works with Turkish, Kurdish and Turkish Cypriot communities, who have been offering counselling to people in Haringey. They had initially been funded by the New Deal for Communities (NDC) but this funding is coming to an end shortly and the PCT has stepped in to keep them going temporarily. They can offer only 6 hours counselling a week and have a budget of £8,000 for this. They do not promote the service as they cannot cope with current levels of demand. Their waiting list is currently three months and is closed if it becomes longer than this. Referrals are accepted from a range of sources including self referral and from GPs. They have also applied to the Council for funding but had been turned down. One of the reasons given was that the majority of their work was in Hackney.

9.6 There is a stigma attached to mental health problems amongst the communities that they cover and many people will not accept that they have a problem. Language difficulties and the presence of an interpreter could make it even more difficult for people to admit that they had a problem. The stigma is especially difficult for men as they come from a “macho” culture which makes it hard for them to acknowledge that they need help.

9.7 People arriving in Britain are often traumatised and some needed counselling and/or mental health support. A sizeable number of their clients did not speak Turkish or are illiterate in their mother tongue. Many people come from rural areas which had a traditional outlook and where many women are not sent to school. Adjustment to a different culture can put substantial strain on families.

9.8 It is difficult for them to estimate how much demand that there is for counselling within Haringey as there is little demographic information available on the community. In one year, the project had assisted 2,000 people from Haringey with health advocacy. Of these, 98% were Kurdish and it was felt that around 90% needed some sort of psychological help. Derman was able to assist with the less severe problems, but not with severe need.

9.9 They felt that research is required into the needs of the Kurdish community, which is the largest of the three communities that they cover within Haringey. They estimate that there are about 80–90,000 within the Borough. There are divisions within the

community which are politically based and this could make effective research difficult, particularly if it was perceived to be associated with a specific faction.

9.10 The Panel also received evidence from the Ethiopian Community Centre. There were about 2,000 members of the community within Haringey. Many people did not understand how the healthcare system worked or that they needed to register with a GP. They went directly to hospital instead when ill. Many GPs referred patients to them for counselling and support and they had also assisted in CPA meetings.

9.11 There was a stigma attached to mental health which made it very difficult for people within the community to admit that they needed help. In Ethiopia, provision was only available for people who were acutely ill. People therefore did not seek help for depression and other less serious mental health problems or appreciate that mental illness was preventable. It was very difficult to get people to admit that they needed help.

9.12 They received no specific funding for providing counselling. Mental health issues could be related to a range of issues e.g. trauma, unrealistic expectations, loneliness, isolation, HIV. People could access mainstream services with the assistance of community organisations, if need be. In a three month period, they had been aware of six suicides amongst members of the community in north London. There is little specific information on differences in suicide rates between different ethnic groups because death certificates in Britain do not routinely record ethnicity.

9.13 It was often difficult for people to talk about their experiences. Mental health was a delicate issue and needed to be handled sensitively. People were wary of psychiatrists and, due to their limited understanding of the requirements of the system, could easily feel that they were being oppressed. Education was very important because, if people are encouraged to seek help at an earlier stage, more serious problems and possibly suicides can be avoided. Support services are inadequate at the moment. The community is very complex with over 80 tribes, each with their own language or dialect.

9.14 There are some members of the community who are highly educated. The person that the Panel spoke to happened to have a medical background and had trained at Guys Hospital and therefore was in a position to assist with counselling. This was a happy coincidence rather then planned provision. He also provided an alternative to the anti depressants that were normally prescribed by GPs and had assisted people from other communities. Most of the problems identified are likely to be common to other asylum seeker communities.

9.15 The Panel noted and welcomed the fact that a piece of research on pathways in to care for black and minority ethnic communities has been commissioned from Middlesex University. Social Services felt that, due to the number and diversity of community within Haringey, the issues were far more complex then merely ensuring that the workforce reflected the local community. It was sometimes not possible to get interpreters for some languages.

## 10. Employment

10.1 Employment is widely acknowledged as having a crucial role in maintaining and promoting good mental health and therefore can help people stay outside of the mental health system. It can play a particularly positive role in helping recovery and

rehabilitation. People who have suffered mental illness have the lowest employment rate of any disability group and this equates to around 900,000 nationally being economically inactive and around 8,500 to 10,000 locally. It was difficult to know how many of these would like to work. Nationally, the problem is getting worse.

10.2 The Panel heard that there were a number of local initiatives:

- College Link
- Employment Link
- First Step Trust

10.3 In addition, Welfare to Work for the Disabled provides a limited number of supported employment opportunities. Around 50% of their clients have mental health problems. CONEL also had a mental health support worker.

10.4 There are particular barriers to accessing mainstream employment:

- Lack engagement of major employers e.g. placement opportunities
- Lack of employment opportunities
- Attitudes of receiving staff
- Lack of flexibility and support in the workplace.
- The benefits gap
- Low levels of education and skills

10.5 The numbers of people progressing from day centres into work was noted to be particularly low. The Panel noted that only one person from the Six8Four Centre had found work since its opening and had then found that the benefits regime was such that it was likely that going into work would not yield much additional financial benefit.

10.6 The Panel also noted that there were a number of things that major employers could do such as:

- Taking steps to reduce stigma and discrimination
- Healthy work place initiatives
- Placements

10.7 It has only been possible to find work placements for a very small number of people. The Council is a very large local employer and efforts have been made to encourage it to take placements but these have not yet been successful. The Council's Welfare to Work Co-ordinator is currently involved in trying to place clients across the Borough. The voluntary sector pointed out that the Council would little credibility in this area until it was seen to be taking on people itself.

10.8 Social Services reported that work placements were to be created across the Council although the first priority was currently year 10 pupils. The scheme was to be launched in January. In addition, the Mental Health Trust now offered placements.

10.9 It was noted that the Council had a number of disabled employees and a positive attitude to taking on such staff. There was currently a pilot scheme for placements for people with disabilities but nothing specific in respect of mental health. He understood the reservations that managers might have and they needed to be convinced of the benefits. There needed to be structured support in place, such as

support from a mentor for the beneficiary. The role of human resources was important and developing. It needed to be borne in mind that the Council received a lot of requests for placements but resources to support these were finite.

10.10 It was also noted that the Council was working with HAVCO and Volunteer England to set up a volunteer bureau for the Borough and this would provide opportunities for people who were recovering from mental illnesses. It was hoped that a vetting process could be set up that was commensurate with the nature and level of the work being done.

10.11 There is benefits advice available for people within day centres. The CAB was commissioned to provide advice at the Clarendon Centre. In addition, Social Services were leading on the setting up of an anti poverty strategy which would look at how benefits advice was provided across the board.

## 11. Housing

11.1 Housing is a particular problem for many people who suffer mental ill health. Loss of housing can exacerbate a crisis and difficulties in re-housing patients can hamper rehabilitation. Some people can damage their property when they became ill and this can cause them to lose their accommodation as well as making them difficult to re-house. People can often stop paying their rent when they become ill and this can result in eviction. Difficulties have been experienced accessing supported housing for patients.

11.2 The Panel noted evidence from the Mental Health Trust that there was a national lack of supported housing for people with mental health problems and there were issues with some providers being choosey about who they accepted as tenants. Mental health staff felt that efforts to re-house patients would be assisted by better information on what was available and contact details. In addition, there needed to be more awareness amongst Council front line officers of mental health issues. There was a particular need for provision with night time support as this was when many problems could occur. Some supported housing was time limited, which was not always beneficial to patients. Links with the vulnerable adults unit in housing had existed but their accessibility could be improved.

11.3 The Panel received evidence from the Supporting People manager. This service provides supported housing to vulnerable groups of people and is aimed at assisting people at risk of social exclusion. It has a problem solving approach and provides a level of support that enables vulnerable people to live independently. The programme is funded by the Office of the Deputy Prime Minister (ODPM). 25% of the schemes involve mental health and this represents 14% of expenditure. Within Haringey, there are 350 housing units that are linked to support for mental health and these cover 12 different providers. There are two different types of support; accommodation based and floating support. In respect of accommodation based schemes, they provided varying levels of support up to 24 hours/7 days per week. In the case of floating support, this is in mainstream housing and normally involves a support worker visiting on a regular basis. The schemes aim to prevent crises and were not designed to cope with them. The schemes can be accessed via a number of referral routes including self-referral.

11.4 The government has required local authorities to review all of their schemes by 2006 to ensure that they are providing value for money. The review of mental health schemes has just been completed. Part of this process involved a mapping of need

as there had previously been a lack of relevant information. There will be a major re-commissioning of provision on 2006-7.

11.5 It was noted that the results of the review have been mixed. Whilst some services have been found to be of a very good standard, a number of providers were considered to be some way below minimum standards or just below. Contracts will not be granted to providers who fail to meet the minimum standard. Some providers had action plans to bring them up to standard whilst others had had their contracts terminated.

11.6 Providers need to demonstrate that they are providing appropriate support and not merely “warehousing” people. Early indications are that a majority of people needed some sort of long term support but the extent of support required was variable. There was a considerable amount of drug use amongst people with approximately 90% active users. If this was the case, all providers would have to have the ability to manage drugs issues. Not all drug users want to be rehabilitated.

11.7 It is unclear whether the current supply of mainstream housing that was suitable for vulnerable people was sufficient to meet demand. People generally preferred to be provided with support in their own homes via floating support. However, there were difficulties in finding accommodation of the right quality in the right location. For example, most available one bedroom flats tended to concentrated on a few large estates.

11.8 The Panel noted that there were to be significant changes introduced in the way that housing issues were dealt with. There was to be a single conduit for all issues relating to mental health and this was the Vulnerable Adults Team. In addition, particular emphasis would now be based on helping people to avoid homelessness. If interventions were made at an earlier stage, homelessness could be avoided. There were currently approximately 5,500 people in temporary accommodation and this number needed to be reduced by half by 2010. Increasing the supply of housing is not necessarily the answer and consideration needed to be given on how to use resources better.

11.9 Social Services felt that the Mental Health Trust sometimes wished to move long term patients faster than resources were available. Discussions were taking place on moving resources to support this process, in partnership with the PCT. There were currently approximately 20 patients that were not being moved out of hospital as quickly as the Mental Health Trust wanted them to. In some cases, the resources needed to support them were substantial. Last years figures for delayed discharges had been higher at around 40.

11.10 The Housing Service was currently in a period of transition and there is an acknowledgement that some areas require improvement. In the meantime, it was possible that rates of delayed discharge might increase. It was possible that current provision for vulnerable people is not of the sort that people wanted but delayed discharges were felt to be driven more by the shortcomings in the process rather then the supply.

11.11 It was noted that there were particular actions that mental health workers could undertake to ensure that the accommodation of patients was maintained such as ensuring that there was regular contact with housing managers and housing benefits.

11.12 It was noted that assurances had been received by the Executive Member for Social services and Health that people with mental illness were not being disproportionately subject to Anti Social Behaviour Orders. Around 20% of the people that the Anti Social Behaviour Team was working with were estimated to have a mental health problem. Action against them was not necessarily unreasonable. Assurances had been obtained that the figures were no higher then in other comparable Boroughs. The team had links with mental health services and were required to refer such cases to strategy meetings with relevant services.