Mental Health and Wellbeing Framework in Haringey

CONSULTATION DOCUMENT

NHS
Haringey Clinical Commissioning Group

Haringey Council

Haringey's Mental Health and Wellbeing Framework

Consultation on the draft Framework – tell us your views

We value your feedback and we are interested to hear your thoughts on the following questions:

1. **What do you think of the overall vision? Does it capture balanced focus on the whole population as well as those most at risk and those with mental ill health?**

2. **What do you think of the outcomes? Do you agree with proposed key measures in Appendix II? Is there anything else that we are missing?**

3. **Do you agree with our priorities? Is there anything else that we need to focus on over the next three years?**

4. **We would welcome your views on how could you contribute, as a resident, in achieving each of these priorities?**

5. **For organisations: How could the support and services of your organisations contribute to meeting each of the priorities?**

6. **Have we captured, in a balanced way, the described needs of our diverse population?**

☐ **Yes** ☐ **No**

7. **Have we represented currently provided services and interventions in a comprehensive and balanced way?**

☐ **Yes** ☐ **No**

8. **Is there any significant information missing that would better inform the Framework and proposed action plan?**

THANK YOU FOR TAKING TIME TO ENGAGE IN SHAPING MENTAL HEALTH AND WELLBEING SERVICES AND INTERVENTIONS FOR HARINGEY RESIDENTS.

Please send your viewsby **20th February 2015** to **publichealth@haringey.gov.uk**

CONTENT

1 EXECUTIVE SUMMARY

Joint Mental Health and Wellbeing Framework – Plan on a page

Our vision:	All residents in Haringey are able to fulfil their mental health and wellbeing potential
Context:	Haringey's Health and Wellbeing Strategy focuses on improving the mental health and wellbeing of our residents. Over recent years, there has been a greater emphasis on improving services, tackling stigma and discrimination, and a focus on prevention to improve the overall mental health state of the people living in the borough. We now need to scale up our ambition and work together to transform mental health and wellbeing services locally. This will require a cross-partnership response which seeks to address the causes of poor mental health, promote positive mental health and resilience, tackle stigma and discrimination, offer early help and engage fully with those affected by mental ill-health, their families and communities.
Our priorities:	1. Promoting mental health and wellbeing and preventing mental ill health across all ages; 2. Improving the mental health outcomes of children and young people by commissioning and delivering effective, integrated interventions and treatments and by focusing on transition into adulthood; 3. Improving mental health outcomes of adults and older people by focusing on the three main areas: meeting the needs of those most at risk; improving care for people in mental health crisis; improving the physical health of those with mental-ill health and vice versa; 4. Commissioning and delivering an integrated enablement model which uses individuals, families and communities' assets as an approach to support those living with mental illness to lead fulfilling lives.
What would success look like?	➔ More people will have good mental health ➔ More people with mental health problems will recover ➔ More people with mental health problems will have good physical health ➔ More people will have a positive experience of care and support ➔ Fewer people will suffer avoidable harm and die by suicide ➔ Fewer people will experience stigma and discrimination
Principles:	➔ Working together in partnership to co-design services with residents ➔ Offer person-centred services based on individual choice that is reflected in commissioning ➔ Promote asset based approach that builds individual, family and community strengths ➔ Strive for quality and right services at the right time ➔ Commission and deliver efficient and effective services based on robust evidence Integrate commissioning and delivery of services, whenever possible, where those with mental ill health, their families and carers feel supported
Enablers:	Health and social care integration, Value Based Commissioning, Working with communities National and local policies, Effective monitoring and evaluation

2 INTRODUCTION

Our mental health and wellbeing has a great impact on our ability to live happy and fulfilling lives, to achieve our goals, have good social relationships and to contribute positively to society. However 1 in 4 people will experience some form of mental health problems during their lives ranging from mild anxiety and depression to severe mental illness. Those who experience poverty, unemployment, social isolation, poor quality housing and lower levels of education, are exposed to crime, violence or substance misuse, are at greater risk of developing mental illness.

What is mental health?

Good mental health is not just the absence of a mental health condition but the foundation for the wellbeing and effective functioning of individuals and communities. It is defined as 'a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community'. (World Health Organisation).

What is wellbeing?

The Care Act 2014 defines the wellbeing of an individual in relation to all of the following:

- personal dignity (including treatment of the individual with respect);
- physical and mental health and emotional well-being;
- protection from abuse and neglect;
- control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
- participation in work, education, training or recreation;
- social and economic well-being;
- domestic, family and personal relationships;
- suitability of living accommodation;
- the individual's contribution to society.

What is mental ill health?

Mental illness is generally categorised in Common Mental Disorders (CMD) and Severe Mental Illness (SMI).

Common mental disorders are those which tend to occur most often. People with CMD have more severe reactions to emotional experiences than the average person. For example, this may mean developing depression rather than feeling low, or having panic attacks rather than experiencing feelings of mild anxiety.

CMD includes conditions such as depression, anxiety disorders, obsessive compulsive disorders and post traumatic stress disorder.

Severe mental illness is less common. It disrupts person's perception of reality, their thoughts and judgement, and affects their ability to think clearly. People affected may see, hear, smell or feel things that nobody else can. This includes conditions such as schizophrenia and bipolar disorder. Severe mental health illness may be referred to as psychotic conditions.

Haringey's Health and Wellbeing Board, Haringey CCG and the London Borough of Haringey (LBH) identified mental health and wellbeing as one of three priorities for the next three years. This Framework sets out our vision, ambition and joint commitment for improving the outcomes for residents starting from early years, through adulthood and into older age. The Framework articulates commissioning intentions and calls on effective partnership working to transform mental health services, tackle stigma and discrimination, promote mental health, offer early help and engage fully with those affected by mental ill health, their families and communities.

As we are developing the Framework, it is important to reflect on the current Health and Wellbeing Strategy, evaluate its progress and identify further challenges. The success achieved in these areas should encourage us to achieve our greater ambitions through this Mental Health Framework. Here are just a few main achievements of the 2012 – 2015 HWB Strategy, Outcome 3: Improving mental health and wellbeing:

- **Reduced risk factors** for mental ill health such as the number of young people not in education, employment or training (NEET), crime by 40% and helped 320 adults and 100 young people to find jobs (third of them maintained job after six months);
- Commissioned a range of interventions on mental health awareness raising, **mental health promotion and mental ill health prevention** in a range of settings including schools, voluntary sector, Tottenham Hotspur Foundation etc.;
- The Clarendon Recovery College has been established as a **community based initiative** which, working with a range of partners, assist people with mental ill health to find employment, pursue education and training and improve social life;
- **Service improvements:** commissioned Recovery House run by Rethink, developed value based commissioning approach to mental ill health, re-commissioned 185 mental health units by Housing Related Support, re-commissioned drugs and alcohol services informed by the needs of the local population;

- Four **Overview and Scrutiny** reviews, recently completed, focused on mental health and physical health, mental health and accommodation, Children's and Young People Mental Health Services in transition, and mental health and community safety. Recommendations of these reviews can be found at http://www.minutes.haringey.gov.uk/ieListDocuments.aspx?CId=128&MId=6266

Further challenges are ahead of us as we seek to transform mental health care to person-centred and seamless provision of integrated services based in and within the communities. Over the last couple of years we have seen real improvements locally in how we support people with mental ill health to access adequate interventions and treatments. We now need to reach more people and scale up our offer for recovery and enablement. By recovery and enablement we mean supporting people to meet their potential to live independently, to have meaningful social relationships, maintain good quality housing, find and/or maintain employment and live a satisfying life.

The scope of the Framework will include: the importance of promoting wellbeing and developing community assets; a life course approach to mental health from early years to older age; a cohort of people with dual diagnoses needs such us those with mental health problems who also have dementia, substance misuse, learning disabilities or autism.

Due to their specific and complex needs the following groups of people and the services they require will be excluded from the Framework:

- Older people with dementia and frailty;
- People with learning disabilities;
- Adults with autism

Separate strategic and commissioning approaches are taken for these services.

To inform the development of the Framework, we have set up an Expert Reference Group with a range of stakeholders that met in a series of workshops over the last six months. Details on the process of the Framework development are set out in Appendix I.

3 VISION AND OUTCOMES

Haringey's Mental Health and Wellbeing Framework Expert Reference Group proposed the following vision:

> *All residents in Haringey are able to fulfil their mental health and wellbeing potential*

This articulates the need to focus on prevention and mental health promotion. It also recognises that there is a wide range of mental health and wellbeing experiences within Haringey's communities, and encompasses principles of services being flexible and tailored for a range of individual needs.

In Haringey, by 2018, we would like good mental health and wellbeing to be a main focus of all frontline services. Certainly, there will be a group of people that would need extensive multi-disciplinary service support and for those, we would work towards commissioning and providing care that will be wrapped up around their individual, their family and their carer's needs. There will be equal partnership between services and individuals and intervention models will be designed together.

Emphasis on the importance of good mental health will start from early years. Families will be supported, whenever needed, to access a range of community interventions to help and support when there is an emotional or behavioural concern for any member of the family. There will be greater focus on improving maternal mental health. Schools will aspire to mainstream emotional literacy and emphasis on resilience in curricula, fully and consistently. They will also be able either to offer or signpost to appropriate support, those pupils who may be at risk of developing mental or emotional problems.

Focus on mental health promotion will be integrated and delivered from a range of community settings: libraries, schools, GPs, pharmacies, third sector. A large proportion of frontline staff will be trained to raise awareness, offer prevention advice and advocacy and spot early signs of mental and emotional problems, where appropriate. The model of prevention will be based on building community capacity and strengths and focusing on asset based community development to enable residents to actively improve their mental wellbeing and learn essential coping skills.

Case study: John: 45 year old male

John suffered with depression and anxiety along with a history of alcohol misuse. He also had financial issues with mounting debts. He was seen and assessed by the community mental health team who discovered John walking around at night, sometimes shouting and causing disturbances resulting in unhappiness within the local community.

At first John reluctantly engaged with the services. Joint visits held by the Community Mental Health team and a Community Psychiatric Nurse were helpful and treatment with medication proved successful. John was also assessed by the Dual Diagnosis team who referred him onwards to the Primary Care Alcohol Mental Health Counsellor based at his local surgery. On completion of this programme, he engaged with the Substance Misuse recovery service run by St Mungos. Regular support from his key worker has seen him getting back into employment starting with voluntary work. His debt has now cleared and he is currently in receipt of disability living allowance. As John's life became stable, he had a support and recovery plan that set out the support he needed over 18 months. Currently John continues to receive peer support from BUBIC (Bringing Unity Back into the Community – community organisation).

We would like to see a whole system approach in enabling people to be supported in the community to live independently. This will be achieved by designing innovative models for enablement in the community (including support for obtaining and maintaining employment, appropriate housing with care wrapped around individual needs, a focus on assets and individual resilience, and promoting social connections). Also, by partnership working with a range of stakeholders including residents, primary care, NHS, local authority, housing associations, police and the third sector.

Given the current financial climate, it is really important to reduce inefficiencies and duplication, and provide services based on robust evidence. We will strive to integrate at both levels, commissioning and provision of services, whenever possible. We will modernise current models of care to be delivered in line with the national and regional guidelines. We recognise that successful examples of mental health service modernisation did not happen overnight and we will reflect this in a phased approach over the next three years in the Framework Delivery Plan. This Plan will be aligned to the North Central London (NCL) 5-year strategy, the CCG's 5-year strategy, Haringey's Health and Wellbeing Strategy 2015-2018 and Haringey's Corporate Plan.

In achieving the proposed vision, we commit to improve mental health and wellbeing outcomes for all residents and, in particular, those with mental ill health. Below is a set of locally defined outcomes aligned to the national mental health strategy. Further details of on how we will measure these outcomes are included in Appendix II.

Haringey's Mental Health and Wellbeing Outcomes

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support, including carers
- Fewer people will suffer avoidable harm or die by suicide
- Fewer people will experience stigma and discrimination

4 NATIONAL AND LOCAL POLICY CONTEXT

4.1 National policy context

The national mental health strategy: **'No Health Without Mental Health**[1]**'** was published in 2011. It sets out six main objectives and emphasises the role of the individual and that of the community, in strengthening and managing their own mental health, with appropriate support provided by statutory services. The strategy also describes a life course, outcomes based preventative approach to responding to mental illness and notes the importance of significantly increasing the involvement of primary care, education, employment and housing in the prevention of and recovery from mental health problems.

In January 2014 the Department of Health (DoH) published **'Closing the GAP**[2]**'** which aims to bridge the gap between long-term ambition and shorter term action in mental health. The strategy sets out four priority areas focused on increasing access to mental health services, integrating physical and mental health care, starting early to promote mental wellbeing and prevent mental health problems, and on improving the quality of life of people with mental health problems.

Launched in February 2014, the '**Mental Health Crisis Care Concordat**[3]**'** seeks to improve outcomes for people experiencing mental health crises by ensuring services are working with a shared commitment to provide the proper level of care in the right environment. Haringey CCG and LBH will be working with partners from Barnet, Enfield and Haringey Mental Health Trust (BEH MHT), the Police, the London Ambulance Service and the Voluntary and Community Sector (VCS) to ensure there is a local action plan to support this national policy.

The Care Act, which received Royal assent on 14 May 2014, places a range of new duties on local authorities. The aim of the Care Act is to put people and their carers in control of their care and support, and to change the way in which people are cared for with the concept of 'wellbeing' being central to the act. This means local authorities have a duty to consider the physical, mental and emotional wellbeing of the individual needing care.

The new **'National Tariff Payment System'** has been implemented from April 2014. This new way of commissioning mental health services based on 'tariff payments' rather than activities and processes will assist in commissioning services across the whole pathway and focusing on the outcomes. In preparation for the implementation of Mental Health Tariffs, each Trust has been clustering patients under 21 groupings. Patient clusters are determined through the use of specified clinical tools and protocols and are based on specific diagnostic, severity and risk characteristics, which will inform the basis of treatment and payment mechanisms.

The Mental Health Promotion, Mental Health Prevention: Economic Case[4] and the **Chief Medical Officer's Annual Report on Public Mental Health**[5] clearly describe a range of low-cost, evidence-based prevention services that could be implemented across life course pathways to promote mental health, prevent mental ill-health, detect mental health problems early, improve outcomes and subsequently reduce high care costs further along the pathway[6].

Plans from NHS England such as the 'Five Year Forward View' and the CCGs Operating Plan propose additional funding for mental health. Additionally, the Autumn Statement announced national investment in eating disorder services for children and adolescents of £150 million.

Work is being undertaken locally to look at how these national policies will be implemented in Haringey to better achieve balanced investment across the whole pathway and implementation of this Framework.

Children and Young People's Mental Health Services are starting to attract significant national attention. **The Health Select Committee Report** published in November 2014 on Children and Adolescent Mental Health Services (CAMHS) articulates concerns about commissioning and provision of CAMHS across the country. A DoH and NHS England Taskforce will be developing plans on how to support local commissioning and provision over the coming months.

4.2 Local policy context

The draft **Haringey Council Corporate Plan 2015-2018** and the draft **Health and Wellbeing Strategy 2015-2018** are currently out for consultation. The importance of mental health and emotional wellbeing has been

1 Department of Health 2011: No Health Without Mental Health https://www.gov.uk/government/publications/the-mental-health-strategy-for-england
2 Department of Health 2014: Closing the Gap
3 HM Government 2014: Crisis Care Concordat http://www.crisiscareconcordat.org.uk/

4 Department of Health 2011: The Mental Health Promotion, Mental Health Prevention: Economic Case
5 Department of Health 2014: Chief Medical Officer Report on Public Mental Health
6 Department of Health 2011: Mental health promotion and mental illness prevention: The economic case https://www.gov.uk/government/publications/mental-health-promotion-and-mental-illness-prevention-the-economic-case

articulated throughout the Corporate Plan with a specific focus in Priorities 1 and 2 and it is defined as one of the three priorities in the Health and Wellbeing Strategy. Additionally, one of the proposed cross-cutting themes for the Corporate Plan is 'Working with Communities' – an approach to strengthen communities and support them to lead positive change and be more involved in service re-design and delivery.

The vision of **Haringey's Community Safety Partnership (CSP) Strategy 2013-17** is to make Haringey one of the safest boroughs in London. The CSP works closely with health and safeguarding partners to address alcohol, drugs and mental disabilities as critical drivers of offending, disorder and ill health across all crime types.

Tottenham is the most deprived area in the borough and has a high prevalence of mental ill health. **Tottenham's Strategic Regeneration Framework** – a landmark 20-year vision for the future of Tottenham – sets out how local people's priorities could be achieved through long-term regeneration including creating more opportunities for employment, affordable housing and making the place safe and pleasant to walk, cycle and play.

The Haringey Clinical Commissioning Group Five-Year Plan focuses on partnership working to deliver a major shift from provision of services from hospitals to primary and community care, whenever possible. Better management of people with mental ill health is dependent on strong primary care that takes an active part in early detection of cases but also management of those living with severe mental illness in the community. Haringey CCG, with their role in improving the quality of primary care, has been supporting practices to work together 'at scale' to run services more effectively, and organise themselves in a federation model. This might include seeing each other's patients, running call centres or sharing back office functions. These models encourage a mixing of skills and professionals to work together in one place or as part of one network e.g. welfare advice, nurses, health care assistants. This model could, in the future, include hubs with multidisciplinary primary care mental health teams in areas of greatest need.

The NHS North Central London (NCL) five-year strategic plan aligns the plans across Barnet, Camden, Enfield, Haringey and Islington Clinical Commissioning Groups and proposes stronger partnership with local authorities. The vision is to develop an integrated care network between organisations focused on outcomes with patients taking greater responsibility for their own health and accessing care appropriately. One of the focuses in the plan is supporting people with mental health needs.

Across North Central London, there are areas of excellent practice and some trusts (including BEH) are piloting these approaches. However, pathways and indicators used to monitor how 'good' services are delivered, need to be strengthened. There is a significant investment imbalance between preventative services and services for those in crisis, with the majority of resource directed at inpatient acute services and more generally at the higher end of need. Furthermore, the pattern of provision is not best equipped to respond to service user and carer wishes to ensure that their care is co-produced, personalised and responds to individual preferences and needs. As tariff, choice and personal budgets are being introduced locally; we need a reshaping of pathways to ensure these policies have positive and meaningful outcomes for people with mental health needs in Haringey.

NHS England and Clinical Commissioning Groups have a statutory duty[7] to work with local authorities to promote integrated health and social care, making person-centred coordinated health and social care the norm for people with multiple health problems, including mental ill-health. The London Borough of Haringey and Haringey CCG are progressing a structured approach to development and provision of integrated services. This work is led by the newly-established **Health and Social Care Integration Programme Board**. It will enable Haringey to achieve better outcomes for local people, improve the experience of service users and deliver efficiencies and value for money. Mental health and wellbeing is one of the main priorities identified for the integration, especially with a focus on commissioning and providing integrated enablement model and the integration of mental health and wellbeing services for children and young people.

Under the **Public Services (Social Value) Act**, all public bodies in England and Wales are required to consider how the services they commission and procure can improve the economic, social and environmental wellbeing of the area. 'Social value' is a way of adding further benefit to contracts where resources are being directed towards improving people's lives, opportunities and the environment. Commissioning and procuring for social value can help join up all the strategic aims of public services. Haringey Council, in partnership with the CCG is part of the national programme that aims to use the implementation of the Public Services (Social Value) Act 2012 as a catalyst for maximising social value through a cross sector partnership approach to health and care commissioning and delivery. We will pilot this approach on future commissioning and procurement of mental health and wellbeing services.

7 http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf, para 14Zi

5 LOCAL NEEDS AND SERVICE LANDSCAPE

This section summarises the mental health needs of Haringey's residents from various sources such as local Joint Strategic Needs Assessment on mental health in children, young people, adults and older people; Mental Health HaringeyStat; Public Health England's mental health profiles; NHS Benchmarking tools; Healthcare Information System (HCIS); local adult social care; Community Mental Health Profile 2014 and the CCG's and the Council's financial information. Full details are enclosed in Appendix III.

5.1 Local needs

Children and young people

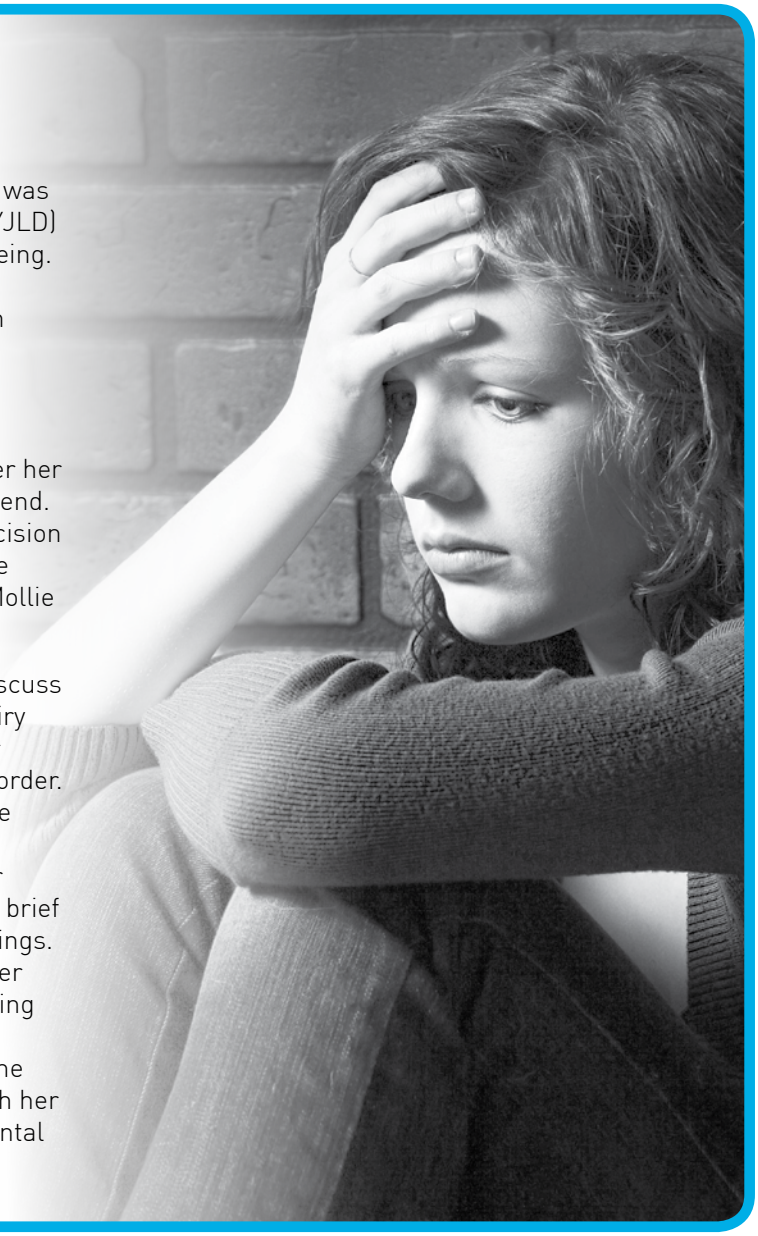
Some children and young people in Haringey may be at greater risk of developing mental health problems than those living elsewhere in London and nationally. This is attributed to the number of factors impacting on mental health such as lack of education, rates of offending, levels of deprivation, unemployment and children living in lone parent households. Mental health needs of children and young people are greater in the east part of the borough. The pyramid diagram below summarises the estimated prevalence and current service utilisation by children and young people in Haringey with mental ill health.

Case study: Mollie, 15 year old girl

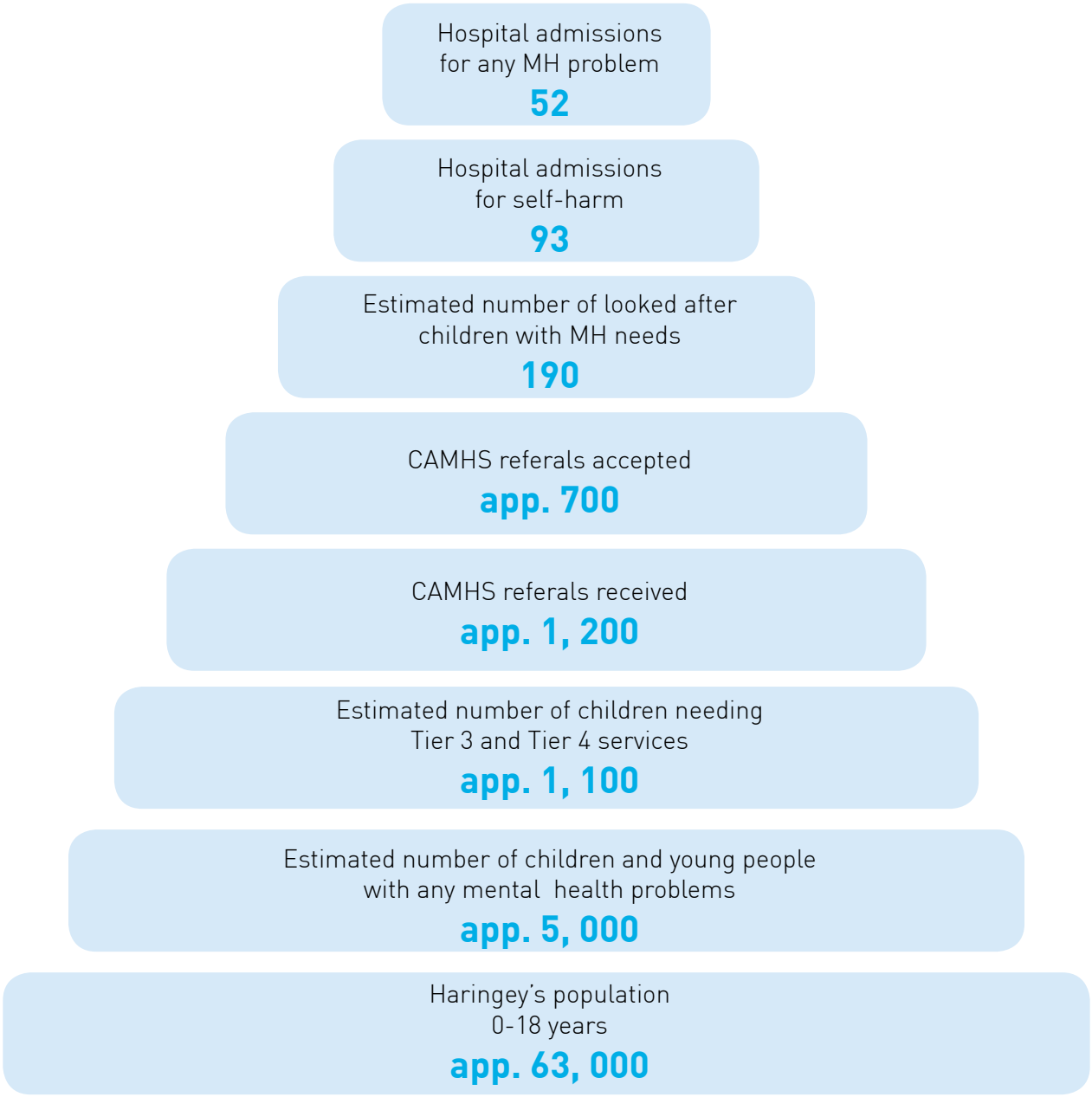
Mollie was arrested for common assault. She was triaged under Youth Crime Action Plan (YCAP) and was referred to a Youth Justice Liaison and Diversion (YJLD) worker for her mental health and emotional wellbeing. Through her interviews it was revealed Mollie had self harmed in the past and was having difficulty in managing her anger.

Mollie's grandfather passed away a year ago. She was very close to him, as she has never had any meaningful contact with her father. Quite soon after her grandfather's death Mollie was raped by her boyfriend. Even though police were involved at the time, a decision was made not to pursue the matter further and the assailant was subsequently only given a caution. Mollie is still very angry about the outcome.

The YJLD worker offered a series of sessions to discuss her issues and offer a way forward. An initial enquiry questionnaire was completed to establish whether Mollie was suffering with posttraumatic stress disorder. Mollie scored very high in this and has agreed to be referred on further for specialist help within Tier 2 service at the St Ann's Hospital to help her recover from her trauma. The YLJD worker also organised brief therapeutic sessions to explore her mood and feelings. She has learnt non-violent strategies to manage her anger. Mollie has kept herself out of trouble following the YJLD intervention. She completed her work experience last summer and is now back in full time education. The YJLD worker continues to meet with her fortnightly to monitor the situation and provide mental support when she needs.



Children and young people in Haringey with any mental health problems, 2013/14*



*Information used from different sources including Public Health England, CHiMAT, Haringey's JSNA, Census 2011 and children's social care.

Local data suggests that we have a higher number of referrals to CAMHS but a lower number of those seen by Tier 3 and Tier 4 services it is estimated by Public Health England (PHE).

PHE also estimated a higher prevalence of mental ill health in children and young people compared to England, in particular conduct disorders. Almost 50% of children with conduct disorders engage in crime activities by the age of 20 and are at higher risk of suicide and substance misuse[8].

Our local information on self-harm referrals in children and young people seems much lower than that reported anecdotally by schools, general practitioners and accident and emergency departments. It is therefore important to understand real need in local communities and focus on prevention, particularly in school settings.

Adults and older people

The risks to mental ill health in adults and older people vary by age, sex and ethnicity. The borough has high levels of factors impacting on mental ill health such as large proportion of ethnic minorities, deprivation, low levels of education, unemployment, substance misuse, violence and crime, social isolation and homelessness. These risk factors and mental health needs are greater in the east part of the borough.

The pyramid diagram below provides details of the estimated prevalence of mental ill health in adults and

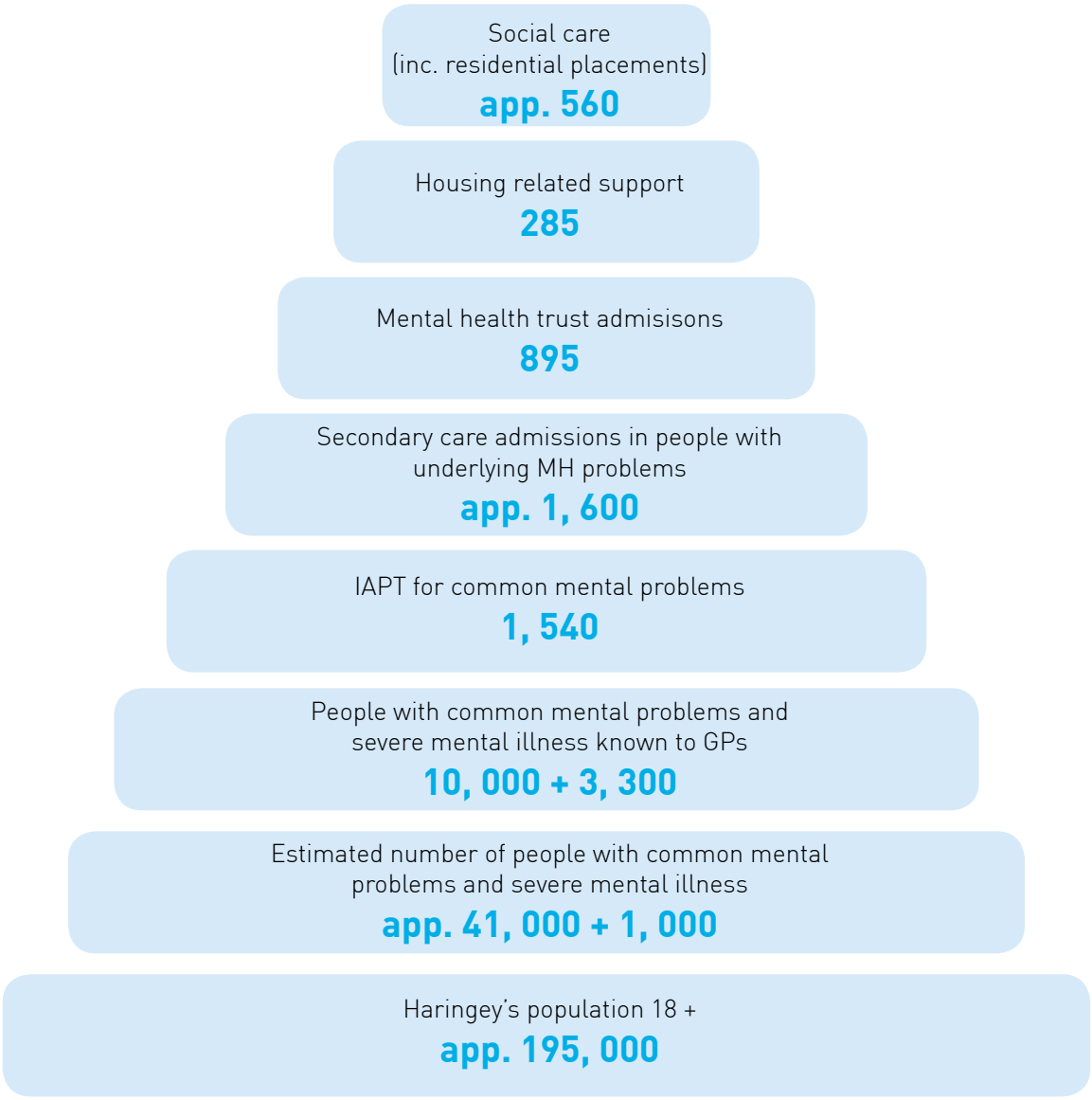
8 Friedli L and Parsonage M (2007): Mental health promotion: building an economic case

older people and their utilisation of services. Only one third of people living with mental ill health are known to health services. This is possibly due to the stigma and discrimination surrounding mental illness coupled with a lack of trust and understanding of how statutory health services work.

Undiagnosed depression is one of the main risk factors for suicide; these people are more likely to live in the east and central part of the borough. Haringey's suicide rates are higher than London and England, especially in men 30 to 45 years of age. About 26 Haringey residents commit suicide each year. The highest numbers of deaths by suicide are in men aged 25-44, living in east part of the borough.

Public Health England estimated that common mental disorders will be increasing over the next ten years by 25-30%. This is probably due to people living longer and in a more challenging economic climate.

Adults and older people with mental ill health in Haringey, 2013/14*



*Information used from different sources including Public Health England, Haringey's JSNA, Census 2011, adult social care and supported living activity data

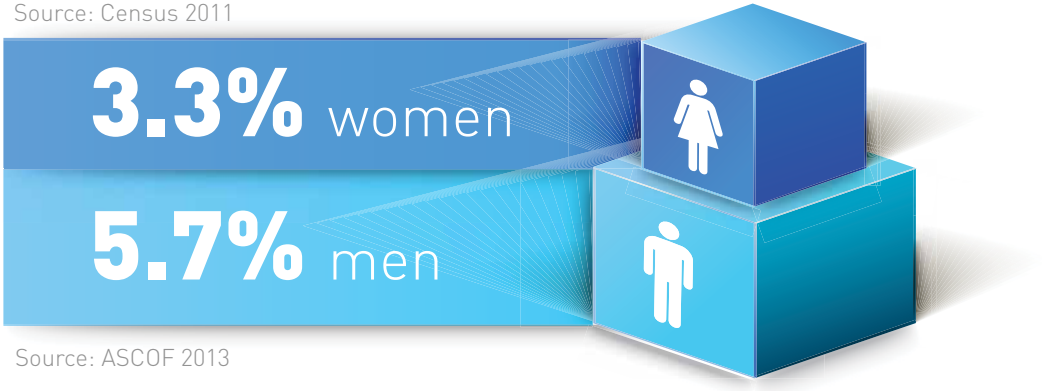
Local data from GP registers suggest that there are three times more people living with SMI than estimated; the 6th highest prevalence of SMI in London. People with SMI have complex care needs often requiring a number of different services at some point on their care pathway. They are at higher risk of dying earlier and are affected by lifestyle risk factors that often cause long term physical conditions. Local primary care information suggests that over 20% of people with SMI have diabetes, 44% are smokers and 34% are obese. This is coupled to a high number of admissions to the acute trusts for people with underlying mental ill health seeking care for their physical conditions.

In terms of understanding how people known to mental health services live in the community, it is important to note that only 65 per cent of people with care programme approaches were in settled accommodation and overall 3.9 per cent in employment in 2012/13.

People with severe mental illness known to mental health services and in employment

Haringey overall employment rate **69.1%**

Source: Census 2011



Source: ASCOF 2013

HaringeyStat on mental health identified a number of unmet mental health needs in high risk groups such as offenders, those of Black Caribbean and Black African origin, those with mental ill health and substance misuse, and young men.

Mental health and substance misuse problems are major public health and social issues. Studies suggest that dual diagnosis may affect between 30 and 70 per cent of those presenting to health and social care settings.

In Haringey, 28% of people who access mental health services also access drug misuse services, compared to 17% for England. This suggests higher prevalence of dual diagnosis locally.

It is important to note that one in three offenders on probation have either mental ill health, substance misuse or both. These cohorts of people are more likely to have late diagnosis of mental illness that often comes to light after the offence.

Case study: Esther, 27 year old woman

Esther was diagnosed with schizoaffective disorder following referral and assessment by the Community Forensic Mental Health Team. She had been under forensics due to offences pertaining to a series of assaults mostly on her mother and on some occasions, involving members of the public.

Due to her illness, her physical health was also affected and was monitored by her GP. Over the course of treatment, she put on 5 stones in weight and her thyroid and asthma started to become affected. It was very difficult for her to find the right medication that worked for her.

Working with a Community Psychiatric Nurse, Esther has now found the right medication and is slowly reducing it. In consultation with her GP, Esther developed weight management programme, she is now looking after her physical health and has lost 2 stones. Esther has gone through cognitive behavioural therapy (CBT) which was very positive. It enabled her to go back to university, where she is now in her final year. Currently Esther has a support plan along with wellness and recovery action plans that help her identify the early warning signs of poor mental health as well the plans and advise she can implement to prevent any deterioration or worsening of her condition.

5.2 Current service landscape

Our current local offer of services for people with mental ill health is based upon highly specialised hospitalised services, a few beds for recovery and rehabilitation, and high cost care packages and residential care. This offer does not always result in long-term improvement of health outcomes and it creates a community that is highly dependent on the services. Individuals are seldom supported to move on and have a fulfilling, independent life.

Furthermore, the current emphasis on the treatment at the severe end of illness rather than prevention and early help results in costly and inefficient commissioning of services that are often reactive and have limited impact on health outcomes.

Mental health services in Haringey are commissioned by Haringey CCG, NHS England (specialist services) and Haringey Council. Services are provided by a range of providers including Haringey Council, NHS Trusts, primary care, VCS and the independent sector.

The main provider of mental health services for Haringey is Barnet, Enfield and Haringey Mental Health Trust. Most of the current activity is commissioned in a block contract making it challenging to support the shift of resources to prevention and early help, or to develop further community based services.

Barnet Enfield and Haringey Mental Health NHS Trust (BEH MHT) provides a range of mental health services principally to the London Boroughs of Barnet, Enfield and Haringey. They provide a comprehensive range of services for children and young people working closely with the local authority (public health, education, youth justice and social care departments) and the voluntary and community sector.

BEH MHT Children and Adolescent Mental Health Services (CAMHS) are provided in the four-tier framework (Appendix I) and there is a single point of referral[9] for all children. Most referrals to CAMHS are from GPs, followed by schools and social services.

There is a variety of services provided in Tier 1 and Tier 2 ranging from interventions in the community, schools, and primary care and parenting initiatives provided by the Council. However, at present, there is no system in place to monitor comprehensively the referrals to Tier 1 and 2 and follow children and young people along the whole pathway. Appropriateness of referrals depends on the information being disseminated to all stakeholders and the communities. Commissioning arrangements for Tier 1 and Tier 2 services could also be better integrated to reduce duplication and improve efficiency. At present, over 40 services and interventions are being commissioned by schools, the Council, the CCG, the Public Health Department and a number of external agencies (Appendix I). Some of these services are general and include a component of mental health and wellbeing such as health visiting and school nursing. Other services provide a more targeted approach such as Open Door, a charity that provides counselling and psychotherapy to young people age 12-24. At present, there is no single directory of Tier 1 and Tier 2 services in Haringey that would enable full utilisation of this diverse offer. Also, fragmented provision arrangements make it challenging to consistently apply quality standards for commissioned services across the whole borough and in line with the national evidence and best practice.

Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) is the main provider of nearly all specialist adults and older people mental health services in Haringey, including forensic services. The Trust services operate from over 30 locations across Barnet, Enfield and Haringey, some of them large hospital sites but most are small units in the community. Haringey's main site is at St. Ann's Hospital. The services available from the Trust in Haringey are described in more details in Appendix III. There were over 6,000 outpatient contacts and over 90,000 community contacts last year. Only a small proportion of these contacts are new patients suggesting that the Trust has a significant demand from patients with severe and enduring mental health problems that need a lot of support, coupled with a lack of capacity to discharge these patients safely into a variety of community settings, including adequate supported housing.

The Trust also provides substance misuse services and dual diagnosis services for Haringey residents while talking therapies in Haringey are provided by the Whittington Hospital.

The second largest provider of mental health services in the borough is Haringey Council which provides social worker input to Community Mental Health Services and day services. It also provides social care to people with severe mental illness such as domiciliary care, supported living, day care centres, home care, direct payments, personal budgets and adaptation equipment.

The Council also provides Clarendon Recovery College (CRC) aimed at assisting the recovery process for people with severe mental illness. There are currently 230 enrolled students who are seen by secondary mental health services. This service has been recently evaluated by Middlesex University and has been shown to be very effective in assisting people to move on, find appropriate employment and pursue further education.

Residential accommodation and supported housing is provided by a range of independent providers and some VCS, the majority of which are in east of the borough. A large proportion of residential care placements (40%) are being utilised by people living outside the borough although this figure has been decreasing recently. The independent sector and VCS also provide supported accommodation, floating support and domiciliary care.

Haringey has a number of supported living providers (mostly independent providers and some VCS), working with people with mental ill health that do not reach a threshold for social care support, including those funded through the Council's Housing Related Support.

9 Emotional wellbeing and mental health for children and young people in Haringey Needs Assessment 2011

It typically provides the service user with a flat or shared housing within a warden controlled scheme. Schemes vary in terms of the level of support provided to cater for a wide ranging level of user need. Including Supporting People funded schemes; there are 13 main providers of supported living, offering around 285 places.

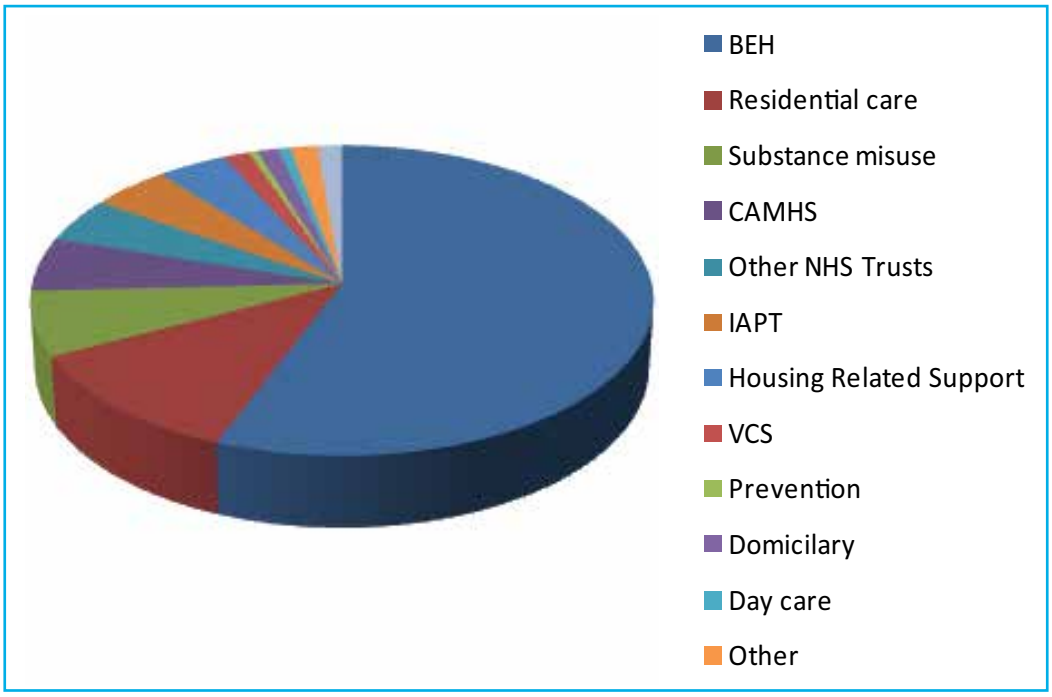
Mental Health and Wellbeing prevention and promotion interventions are largely commissioned by Council's Public Health team. These include awareness raising and training in schools, tackling stigma and discrimination in the community (such as interventions targeting specific risk groups such as Turkish and Kurdish men) and digital peer support for mild to moderate anxiety and depression.

Information and advocacy services are provided by a range of VCS in the borough. These arrangements will be reviewed in the near future to align this offer with Care Act 2014 requirements.

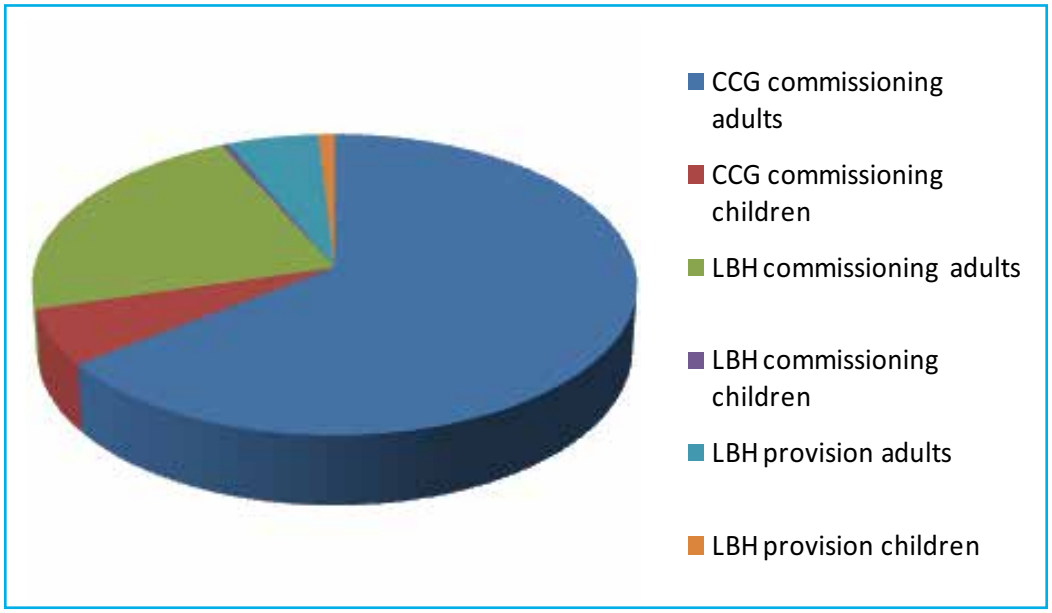
5.3 Total spend on mental health services

Total spend on mental health in Haringey (including substance misuse) for 2013-14 was over £51m. This equates to 11% of the total CCG budget and 6% of the Council's budget. Below is a chart describing total spend by services and total budgets by commissioners.

Total spend on mental health in Haringey in 2013/14 by services



Total spend on mental health in Haringey 2013/14 for the CCG and L



Benchmarking data from various sources suggests that spend on residential care, housing related support, children's and young people mental health, specialist adult mental health services (forensic services), prescribing on psychosis in primary care and the overall spend on secondary mental health per head of population is higher in Haringey compared to England.

Expenditure on community mental health teams and outreach services per head of the population is lower than England's average. This information should be treated with caution as the quality of data depends on accurate and complete returns. However, the overall trend analyses suggest that local spend is highest at the severe top end of the pathway (secondary care, residential placement and supported housing) while there is underinvestment in outreach and community services. Furthermore, lower spend in secondary care for people with psychosis coupled with high spend in primary care for the same cohort of patients suggest that, probably due to high demand, these people are more likely to be cared for in the community.

Considering that the Council's and other partners investments' are indirectly related to tackling root causes of mental ill health (such as employment, affordable housing, community safety and clean and safe environment), it is likely that the overall spend on tackling mental ill health in Haringey is much higher than could be easily quantified.

6 WHAT GOOD LOOKS LIKE?

National evidence suggests that access to effective care for people with mental illnesses is only available to approximately 30 per cent of those that need it, and that standards of care across the country vary greatly[10]. Even though 50% of all mental illness starts before age of 14, investment in prevention and early identification and in children and young people's services is limited .

Effective mental health services should represent a continuum from prevention, promotion and early help through primary care, secondary care and highly specialised services. It should ideally be delivered through an enablement model in collaboration with a range of partners and service users. The model should be based on individual, family and community assets and designed to promote social connectivity and reduce isolation. However, currently the pathways, often being very complex, are delivered disjointedly, resulting in fragmentation of care for patients and carers. Patients, GPs and other professionals have found access to services difficult and management across interfaces and boundaries unachievable.

Over the last few years, there has been a focus on building a body of evidence on what integrated and modern mental health and wellbeing services should look like. The Joint Commissioning Panel for Mental Health, the London Strategic Mental Health Network and the National Institute of Clinical Excellence have published a series of commissioning guides, quality standards and guidelines to assist commissioners and providers at the local level in transforming mental health services across the life course. Brief summary of wealth of national evidence is enclosed in Appendix IV.

In Haringey, we are committed to using robust evidence to transform services to be more effective, to improving quality and outcomes and to offer best value for money.

Based on the evidence, it is proposed that Haringey's whole system mental health and wellbeing model contains the following components:

- **A better start in life** – ensuring that services for 0-5 year olds support lifelong mental health and wellbeing, by promoting emotional and social resilience and strong and positive parental attachment;
- **Promotion of mental health and wellbeing for all children and young people**, working with schools and other parts of the community to ensure there is early intervention as well as support for ongoing emotional and social development;
- **A prevention and early help offer based on working with communities** to build emotional resilience, to tackle root causes of mental illness such as unemployment, low levels of education and reduce social isolation, stigma and discrimination;
- **Integration of mental health and wellbeing aims** into the delivery of major regeneration and development in the borough – particularly through ensuring that more residents are able to live in good quality accommodation, access stable employment and to have attractive places for walking, cycling and children's play;
- **Effective, evidence based primary care mental health services** - models focusing on multidisciplinary teams based in communities and arranged as 'hubs'. The aim of these teams would be to manage people with stable and ongoing mental ill health holistically as a part of their social system and network to support enablement and independent life. One of the leading roles of primary care mental health is to support people with long-term conditions to manage their mental ill health and also for those with mental ill health to manage their physical health effectively.
- **Secondary and specialist services** that are

10 Joint Commissioning Panel for Mental Health: Practical Mental Health Commissioning (2011)

commissioned based on the outcomes, with co-ordinated single point of entry with information about services, waiting times and support to access services readily available to service users, carers and professionals. Referral and treatment pathways should be clear and transparent and arranged around nationally defined clustered funded by Mental Health Tariff.

- **A whole system approach to integration and enablement** that include:
  - Integrated commissioning and service provision of Child and Adolescent Mental Health Services across all tiers;
  - Integrated commissioning which supports integrated delivery, through value based commissioning and by exploring whole system approaches to creating a more joined up system;
  - Integrated service provision between the mental health trust, social care, residential care, housing related support and primary care, including through multi-disciplinary hubs, to support a more seamless service for users;
  - Effective pathways into employment and housing for those with mental ill health, based on the evidence;

7 PROPOSED PRINCIPLES AND PRIORITIES FOR ACTION

The aim of the Framework is to mobilise effective, whole system partnership working to deliver integrated pathways for mental health and wellbeing that will improve the outcomes of our residents. We recognise that such an ambitious task is complex and will take time. We therefore set principles that we would embed in our work while we are approaching major transformation of services:

Proposed Principles

- Working together in partnership to co-design services with residents;
- Offer person-centred services based on individual choice that is reflected in commissioning
- Promote assets based approach and interventions that build on individual, families and community strengths at every level
- Strive for quality and right services at right time
- Commission and deliver efficient and effective services based on robust evidence on what works
- Integrate commissioning and delivery of services, whenever possible, where those with mental ill health, their families and carers feel supported

This set of principles will underpin our approach to the delivery of the four main priorities that we are focusing on over the next three years. These priorities are informed by the national and local policy context, evidence review, needs of our population and local expertise. Below is a brief rationale for these priorities. Detailed recommendations for actions are enclosed in Appendix V.

Priority 1: Promoting mental health and wellbeing and preventing mental ill health across all ages

Why is this priority?

Current resources are locally directed towards the higher end severe mental health needs. This model of care is not sustainable and it does not improve outcomes. There is a strong financial case for shifting some of the resources towards prevention and tackling root causes of mental ill health on a universal basis. This would include access to good housing, work and leisure facilities, and for children and young people, particularly through schools. Additionally, there is a significant number of children, young people and adults living with mental ill health in the community who are not accessing services. We need to tackle stigma, provide better information on the existing interventions and promote benefits of early access to services.

What are we going to do about it?

We will establish a baseline on mental health and wellbeing in Haringey by commissioning a community based survey. This would give us a good basis for monitoring the effectiveness of any interventions over the life of the Framework. We will also work on raising awareness, by providing better information on existing services and tackling stigma through working together with community leaders. This priority will focus on developing resilience at the individual, family and community level. This priority will also include interventions aimed to prevent suicide in Haringey.

Priority 2: Improving the mental health outcomes of children and young people by commissioning and delivering effective, integrated interventions and treatments, by focusing on transition into adulthood

Why is this priority?

Good mental health and wellbeing starts from conception and continues into early years. Given that Haringey is a borough with stark inequalities and many risk factors for developing mental ill health, it is important to focus on giving children the best start in life and then support those who have emotional or mental health concerns as early as possible. It is estimated that we have a higher number of children with mental ill health and a high number of children at risk, including children in care. Our services are fragmented and not necessarily co-ordinated in best possible way.

What are we going to do about it?

We will use evidence from the recent Overview and Scrutiny review to inform planning on the transition pathways between adolescent and adult services. By working in partnership with other family services in the community, we will develop quality standards based on the evidence to support commissioning of children and young people mental and emotional wellbeing interventions by schools and other organisations and develop clear pathways across Tier 1 to Tier 4.

Priority 3: Improving mental health outcomes of adults and older people by focusing on the three main areas:

- ➔ meeting the needs of those most at risk;
- ➔ improving care for people in mental health crisis;
- ➔ improving the physical health of those with mental-ill health and vice versa;

Why is this priority?

Haringey has a large number of those at highest risk of developing mental ill health such as offenders, children in care, young people and adults with substance misuse, a large proportion of BMEs, homeless, older people and those who are socially isolated. These groups of people are often accessing services late when they are acutely ill and have worse outcomes.

It is a national priority to strengthen services for those who are in crisis and work has started to implement Crisis Care Concordat locally. Both LBH and the CCG have signed the local concordat.

Finally, people with serious mental illness are more likely to die early and have poor physical health. We are committed to tackle those inequalities and work on parity of esteem.

What are we going to do about it?

We will explore how to improve access to people who are at high risk of mental ill health by strengthening pathways between primary care and mental health services and establish fast-track for those most at risk, including people in crisis.

We will develop a Crisis Concordat action plan in partnership with a wide range of stakeholders and also develop suicide post-vention interventions to help individuals, communities and families to deal with aftermath of suicides/attempted suicides.

We will strive to further improve relationships between mental health service users, primary care (especially GPs) and secondary care services and ensure that people with mental ill health are followed up more regularly in primary care. Care co-ordinators can play important role in promoting physical health in those with mental ill health.

Priority 4: Commissioning and delivering an integrated enablement model which uses individuals, families and communities' assets as an approach to support those living with mental illness to lead fulfilling lives

Why is this priority?

At present, the mental health care model focuses on high cost secondary and residential care with under-investment in community mental health teams and outreach services. People stay longer in hospital even if they are clinically fit to be discharged due to complex pathways for securing accommodation and care support. We need to radically change the way we care for people with mental ill health in the community, help individuals to be able to achieve their goals and provide opportunities for adequate employment, affordable housing and timely care packages. We also need to reconnect people into communities to better achieve their potential.

What are we going to do about it?

We will integrate at both levels, commissioning and provision of services to develop an enablement model where people will receive seamless holistic care that focuses on their social problems at the same time as providing ongoing and stable clinical treatment. GPs and care co-ordinators will be at the centre of this model supported by a range of providers such as housing associations, jobcentre plus, VCS and independent sector. We will link this work with Tottenham regeneration to create safer environments in the community as part of wellbeing and work on reducing stigma and discrimination.

8 RECOMMENDATIONS FOR ACTIONS, TIMESCALES AND MONITORING ARRANGEMENTS

Governance for ensuring implementation of the Framework will be via the Health and Wellbeing Board Delivery Group for Mental Health and Wellbeing Outcome Three. Support will be provided by both the Mental Health Expert Reference Group and the Children's Partnership Board.

The impact of the proposed outcomes and priorities will be monitored regularly. A draft National Mental Health Services Dashboard illustrating a set of indicators aimed at monitoring six outcomes is enclosed in Appendix II.

Appendices

Appendix I: Development process and governance framework

This Appendix sets out the process for developing the Mental Health and Wellbeing Framework and how the process will be governed. The final framework will be approved by the Health and Wellbeing (HWB) Board which has senior representation from the council, Clinical Commissioning Group (CCG), Healthwatch and the voluntary sector. Before the final framework is sent to the Health and Wellbeing Board, we are planning the following process:

1. A draft framework will be co-produced by an expert reference group. The expert group will consist of one or two representatives from the following groups:

- Users of mental health service and carers of people with mental health needs (representatives drawn from the Adult Partnership Board and its sub-groups).
- Local voluntary sector organisations that specialise in mental health care
- Local providers from independent sector
- Clinicians from the Barnet, Enfield and Haringey Mental Health Trust
- GPs or other primary care practitioners as providers of primary care and GPs as commissioners
- Public health
- Senior council officers managing social workers in the Mental Health Teams
- Commissioning managers from the council
- Commissioning managers from the CCG

The expert group is expected to meet 2-3 times to develop the draft framework.

2. The draft framework will then be consulted on more widely in the following ways:

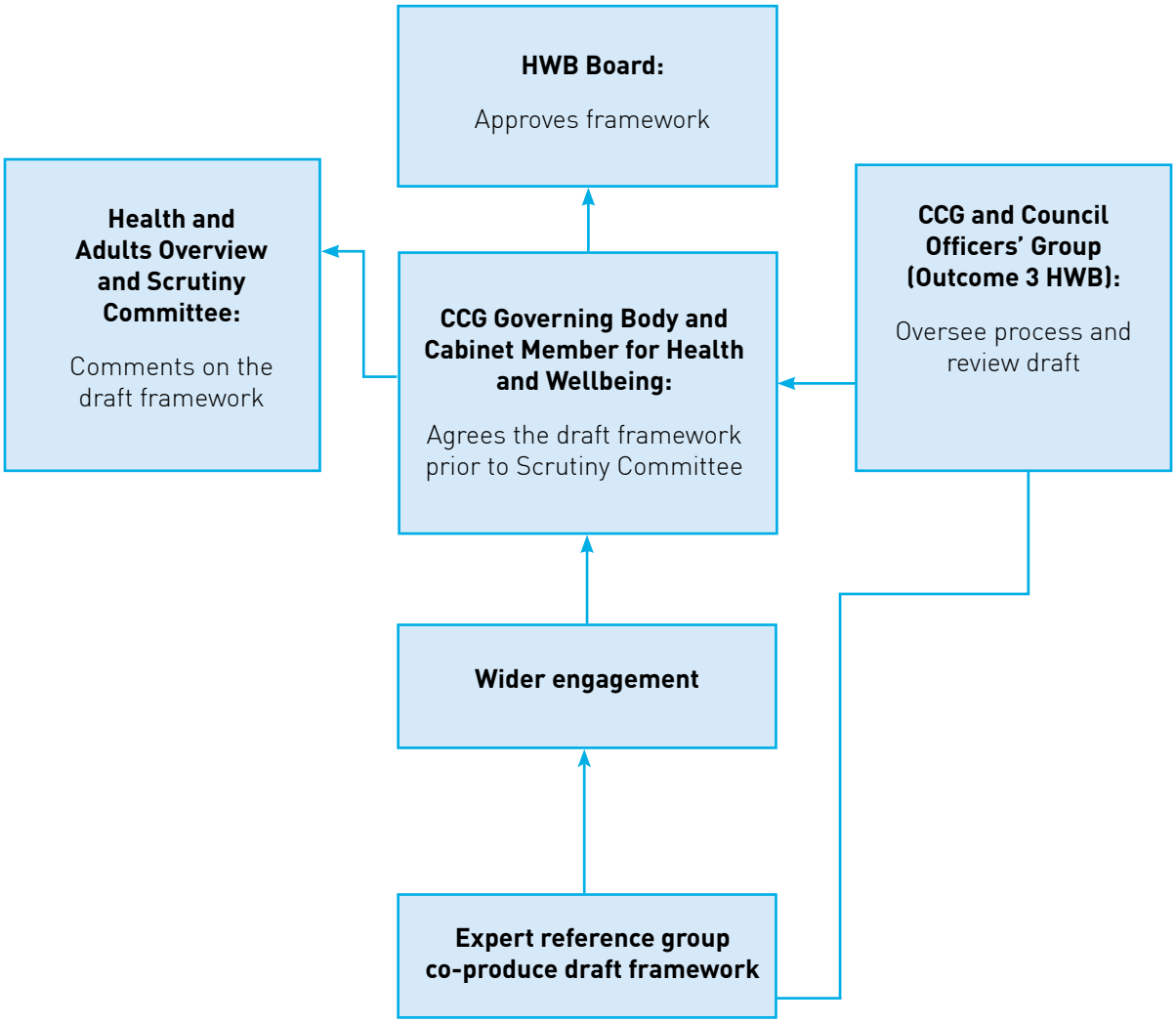
- Commissioners will write to all local providers of mental health services and other services commonly used by people with mental health needs and ask them to comment on the framework;
- Commissioners will meet with wider groups of carers and service users to get their comments;
- The draft framework will be taken to the CCG's Governing Body, GP Collaboratives and Cabinet Member for Health and Adult Services for agreement that the document can be taken to Adults and Health Overview and Scrutiny Committee;
- The draft framework will then be discussed at Scrutiny before being sent to the HWB Board for final approval.

3. The process will be overseen by a Council and CCG officers' group (called the Health and Wellbeing Outcome Three Group) chaired by the Director of Commissioning at the CCG. The role of this group is to:

- Ensure that the process described above is followed;
- Review the draft framework to ensure that it is aligned with existing council and CCG strategic priorities and deliverable within available resources.

The process and governance is shown as a diagram below:

Governance of the development of the Haringey Mental Health and Wellbeing Framework



Appendix II: National Mental Health Dashboard

PHOF-Public Health Outcomes Framework; MHMDS-Mental Health Minimum Data Set; NHSOF – NHS Outcomes Framework; ASCOF-Adult Social Care Outcomes Framework

More people have better mental health	More people with mental health problems will recover	Better physical health
WHOLE POPULATION **Self-reported wellbeing (PHOF)** **Self-reported of children and young people** **Prevalence of MH problems** Possible mental health problems (HSE) Long-term mental health problems (HSE) Days lost due to common mental illness (LFS) WIDER DETERMINANT **Homelessness (PHOF)** **Absolute low income (HBAI)** Illicit drug use Social isolation Child development at 2, 2.5 years (PHOF, Placeholder)	CARE AND TREATMENT Improving access to psychological therapies (IAPT, NHS OF) Access to IAPT Recovery rates Patient outcomes following Children and Adolescent Mental Health Services (CAMHS) Treatment outcomes for people with severe mental illness RECOVERY AND QUALITY OF LIFE Employment of people with mental Illness (NHS OF) People with mental illness or disability in settled accommodation (PHOF). The proportion of people who use services who have control over their daily life (ASCOF) IAPT Recovery Rate (IAPT Programme)	Excess under 75 mortality rate in adults with severe mental illness (NHS QF & PHOF, Placeholder).
More people have positive experience of care and support	**Fewer people will suffer avoidable harm**	**Fewer people will experience stigma and discrimination**
Patient experience of community mental health service (NHS OF). Overall satisfaction of people who use services with their care and support (ASCOF). The proportion of people who use series who say that those services have made them feel safe and secure (ASCOF) Proportion of people feeling supported to manage their condition (NHS OF). Indicator to be derived from Children's Patient Experience questionnaire.	Safety incidents reported. (NHS OF) Safety incidents involving severe harm or death (NHS OF) Hospital admissions are a result of self harm (PHOF). Suicide (PHOF) Absence without leave of detained patients (MHMDS)	National Attitudes to Mental Health survey (Time to Change) Press cutting and broadcast media analysis of stigma (Time To Change) National Viewpoint Survey – discrimination experienced by people with MH problems (Time To Change)

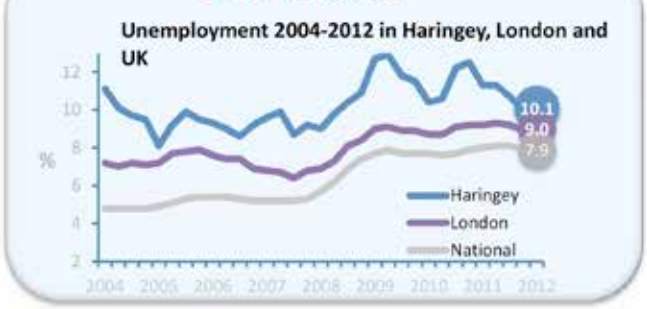
Appendix III – Mental Health Needs and Service Landscape

This section summarises the mental health needs of Haringey's residents from various sources such as local Joint Strategic Needs Assessment on mental ill health in children, young people, adults and older people; Mental Health HaringeyStat; Public Health England's mental health profiles; NHS Benchmarking tools; Healthcare Information System (HCIS); local adult social care; Community Mental Health Profile 2014 and the CCG's and the Council's financial information.

Children and Young People

Factors influencing mental health and wellbeing

Unemployment



Involvement in the criminal justice system

Family environment

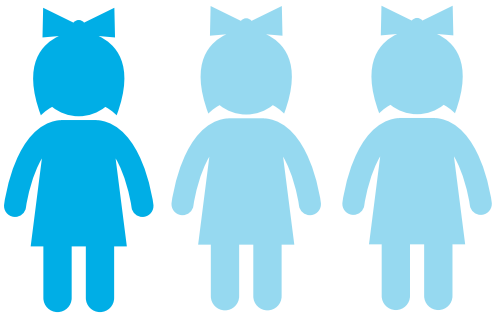
10,647 lone parent households with dependent children. Higher proportion of households with dependant children are lone parent households (34% compared to 28% in London)

7,338 households with dependant children with no adults in employment. Higher proportion of households with dependant children have no adults in employment (23% compared to 18% in London)

Source: 2011 Census

Disability

11,258 0-19 year olds have a long-standing disability (6,155 boys and 5,103 girls)



One child in **three** live in poverty

Mental ill health

It is estimated that approximately 4, 600 children and young people 5-16 years of age have mental health concerns locally. Below is table that summarises various conditions.

Estimated prevalence of any mental health concerns in children and young people 5-16 years of age

Condition	Prevalence	Estimate
Emotional disorder	3.9%	1463
Conduct disorder	6.6%	2288
Hyperkinetic disorder (ADHD)	1.6%	600
Less common disorder	0.7%	262

Source: Public Health England CYP Profile and 2011 Census

Children in the care of local authorities are at particular risk of mental ill health. At the end of March 2014, there were 511 looked after children. Of those 50% were without any concerns, 13% had borderline mental health concerns and 37% had mental health concerns, as identified by the Strengths and Difficulties Questionnaire (SDQ) screening tool.

Young offenders are at high risk of suffering mental ill health. It is estimated that up to 40 per cent of young people in the youth justice system have mental ill health. The rate for first time entrants to the youth justice system in Haringey (417 per 100,000) was similar to London and England.

Adults and older people

Factors influencing mental health and wellbeing

Marital status

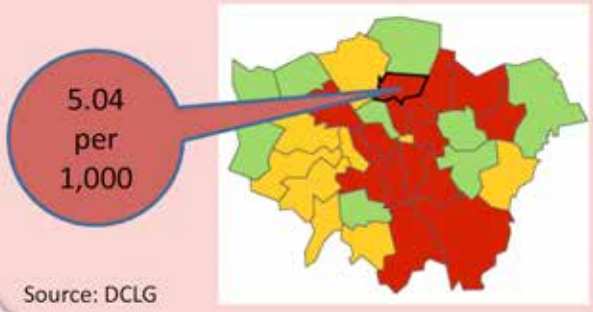
33% of people are married compared to 39% in London and 46% in England and Wales.

Living alone

A lower proportion of people over 65 live alone (7.8% compared to 9.6% in London)

However, a higher proportion of all people live alone in (24% compared to 22% in London and 18% in England and Wales)

Statutory homelessness



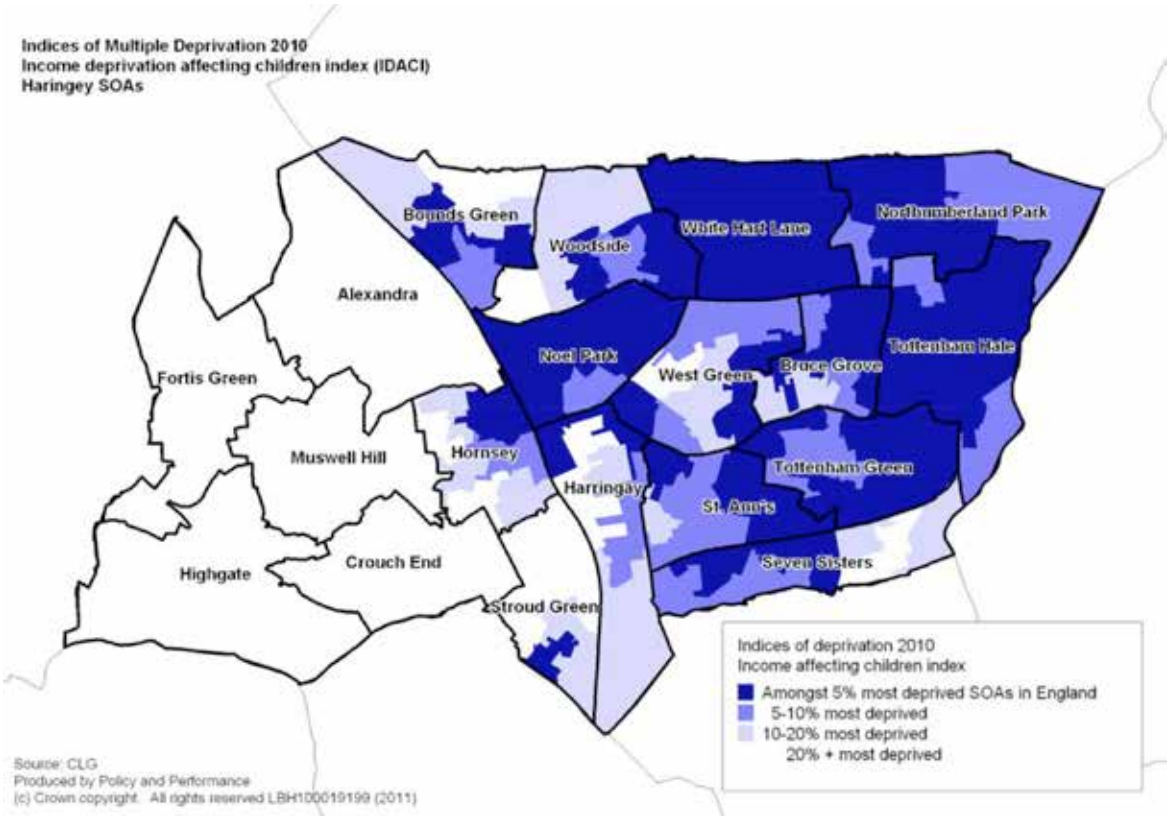
Source: DCLG

Unemployment

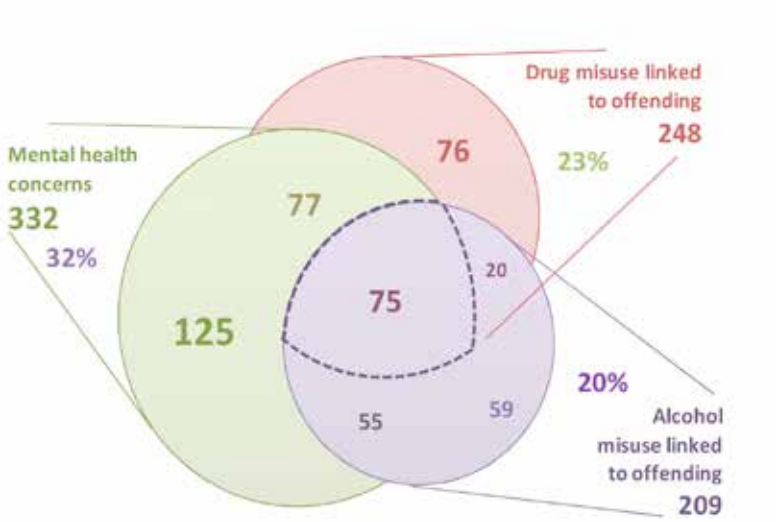
85 out of 1,000 people of working age in Haringey are unemployed compared to 59 per 1,000 in England.

Haringey is 4th most deprived borough in London and unemployment rates are still high, especially in younger age groups. Almost 2,000 adults are claiming job seekers allowance and 48% of those have mental health behavioural disorders. Estimated 27 per cent adults have no qualification or level one qualifications and a high proportion of those under 65 years of age live alone. On the other hand, borough has significantly higher household crowding (16.3%) and households living in rented accommodation (58.2%) compared to London and national figures. Five in every 1,000 residents are homeless and statutory homelessness (5.8%) is significantly higher than London (3.9%) and nationally (2.3%).

Employment and support allowance claimants in Haringey whose condition in mental and behavioural disorders



Key issues linked to offending (Of the 1062 statutory offenders commencing probation Sept - Aug 2011/12

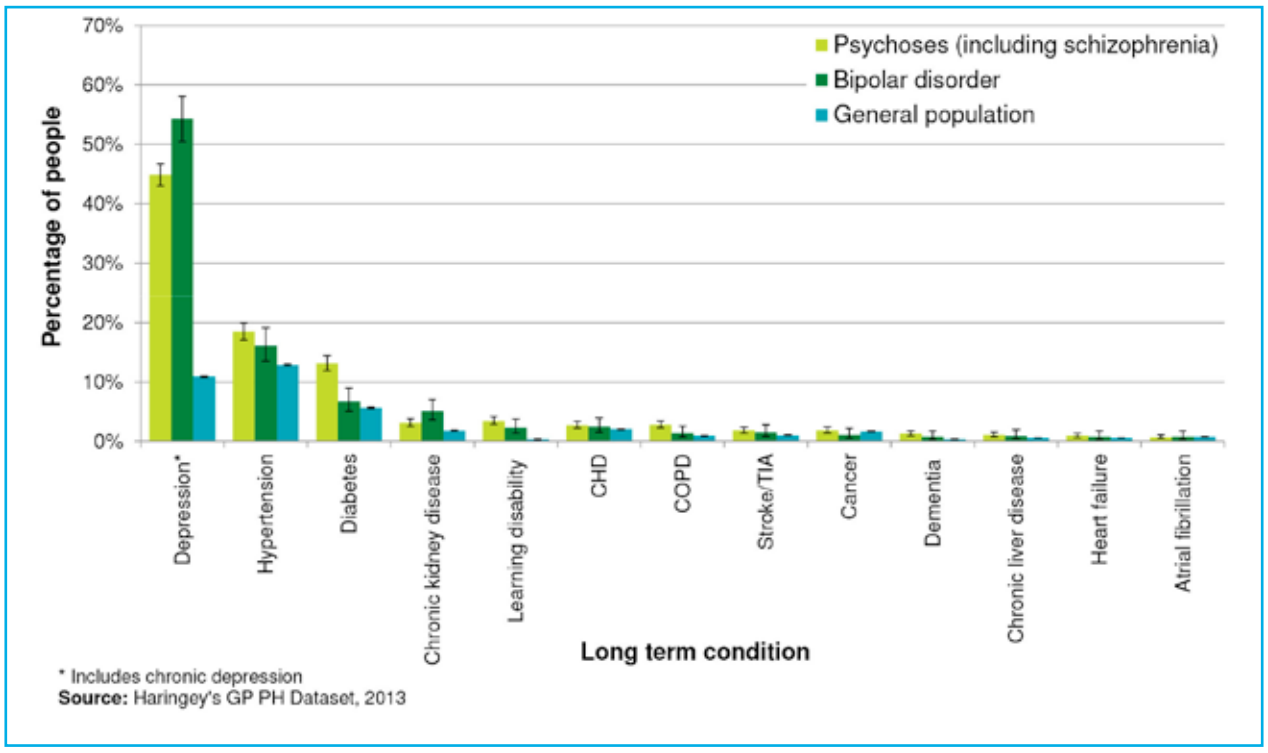


207 offenders (19.5%) had mental health problems and substance misuse problems

In Haringey, 28% of people who access mental health services also access drug misuse services compared to 17% in England. This suggests higher prevalence of dual diagnosis locally.

Mental health problems are associated with long term physical conditions. Graph below suggests that a large proportion of people with SMI have one or more long-term conditions.

Prevalence of long term conditions among people diagnosed with serious mental illness compared to Haringey's registered population

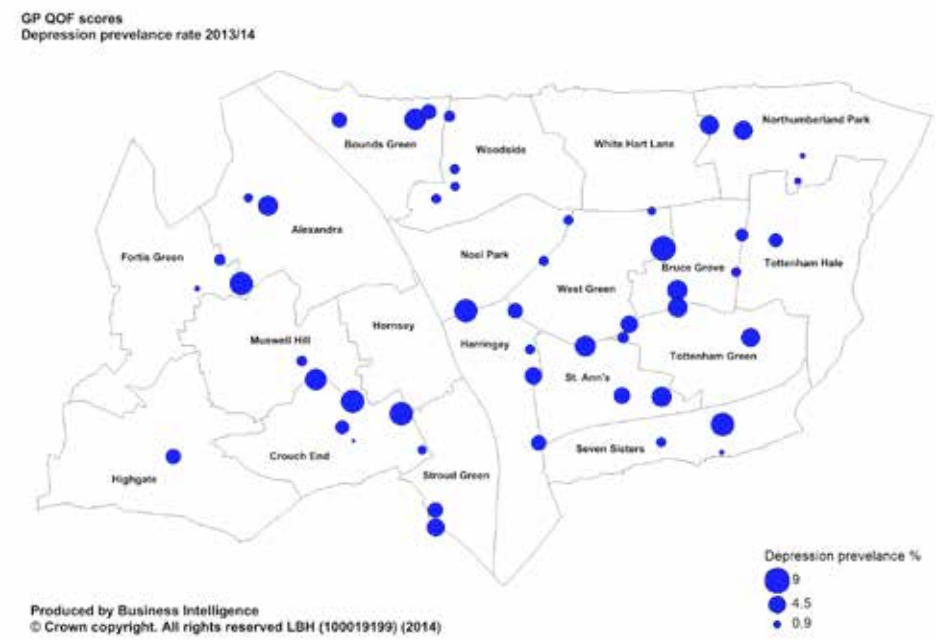


Source: Camden and Islington Public Health Intelligence

Mental ill health

Locally there are over 41, 000 adults (16-74 year olds) who are estimated to have a common mental health disorder. Of those, only 9,452 adults with depression known to Haringey GPs and 1,184 adults have a new diagnosis of depression (QOF 2013-14) . It is estimated that this will rise by 26% in 2021.

Diagnosis of depression by Haringey GPs



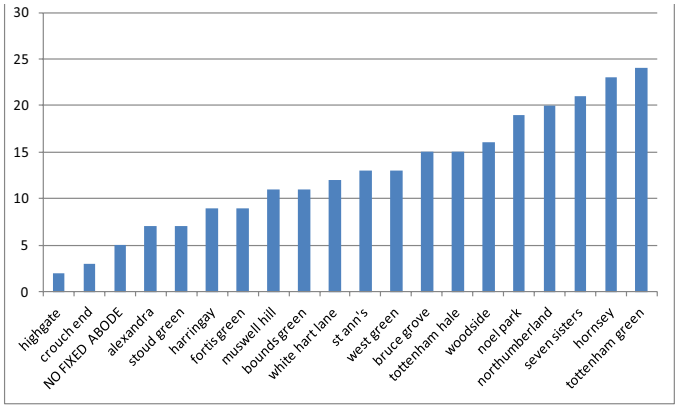
Source: Haringey JSNA

In March 2014, 10.4 per cent (300) people entered Improved Access to Psychological Therapies (IAPT) services as a proportion of those estimated to have anxiety and/or depression and 39.4 per cent (65) have completed IAPT treatment and 'moving to recovery[11]' . This figure is lower than expected national standard and particularly low for people over 64 years of age.

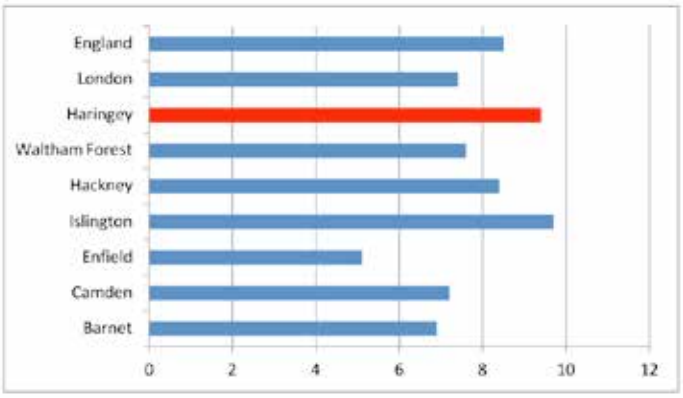
Haringey's suicide rates are higher than London and England, especially in men 30 to 45 years of age. About 26 Haringey residents commit suicide each year. The highest numbers of deaths by suicide are in men aged 25-44. In the last 10 years, 62% of suicides were people born in the UK compared to 34% born abroad (Haringey's Suicide Audit).

11 Health and Social Care Information Centre: Quality and Outcomes Framework, October 2014

Suicides by ward 2002-2012



Suicide rates by 100, 000 population, by borough



Clustering Outcome - Haringey Ccg (Based On Current Caseload As At 2 Dec 2014)

		Number of Registered Service Users			Proportion of Registered Service Users	
		Services Users on CPA	Services Users Not on CPA	Total Service Users	% Services Users with CPA	% Services Users Without CPA
CCG - HARINGEY						
1	Common mental health problems (low severity)		5	5	0%	100%
2	Common mental health problems		10	10	0%	100%
3	Non-psychotic (moderate severity)	12	57	69	17%	83%
4	Non-psychotic (severe)	13	68	81	16%	84%
5	Non-psychotic (very severe)	34	113	147	23%	77%
6	Non-psychotic disorders of overvalued Ideas	9	50	59	15%	85%
7	Enduring non-psychotic disorders (high disability)	72	275	347	21%	79%
8	Non-psychotic chaotic and challenging disorders	22	68	90	24%	76%
10	First episode in psychosis	131	15	146	90%	10%
11	Ongoing recurrent psychosis (low symptoms)	378	179	557	68%	32%
12	Ongoing or recurrent psychosis (high disability)	318	48	366	87%	13%
13	Ongoing or recurrent psychosis (high symptom and disability)	258	127	385	67%	33%
14	Psychotic crisis	14	10	24	58%	42%
15	Severe psychotic depression	1	3	4	25%	75%
16	Dual diagnosis (substance abuse and mental illness)	5	6	11	45%	55%
17	Psychosis and affective disorder difficult to engage	24	8	32	75%	25%
18	Cognitive impairment (low need)	7	329	336	2%	98%
19	Cognitive impairment or dementia (moderate need)	18	135	153	12%	88%
20	Cognitive impairment or dementia (high need)	14	44	58	24%	76%
21	Cognitive impairment or dementia (high physical or engagement)	6	9	15	40%	60%
Sub Total		**1336**	**1559**	**2895**	**46%**	**54%**

Haringey has high levels of severe and enduring mental illness, the 6th highest prevalence (1.3%) of serious mental illness (SMI) in London; 82 per cent (2,900) are diagnosed with psychoses and 18 per cent (650) with bipolar disorders[12] . Men have higher prevalence than women and men from Black and Ethnic Minority Groups (BME) have the higher prevalence of SMI. The borough has estimated 1,000 living with severe mental health problems against actual 3,381 patients registered with GPs who have a diagnosis of a psychotic disorder; 917 in the west and 2,462 in the east. Of those with SMI, 2,959 people had a comprehensive care plan in primary care[13] . In 2014, nine GP practices administer antipsychotic injections for their patients and those practices are scattered around the borough.

There were 65 new cases of psychosis serviced by Early Intervention teams and it is significantly higher in Haringey compared to national figures suggesting higher demand and good access to services[14] . The rate of people

12 Camden and Islington Public Health Intelligence: Serious mental illness in Haringey: The facts

13 Serious Mental Illness profiles, Public Health England, 2014
14 Severe Mental Illness profiles: Public Health England, 2014

receiving assertive outreach services in Haringey (12%) was significantly lower than London (40.9%) and England (25.7%). Given such a high need locally, this information would suggest concerns with access to outreach teams.

Below is table with details on people seen by BEH MHT (as of December 2014) and their conditions split by Clusters. In total, BEH MHT have seen 2, 895 patients compared to 2, 972 in Enfield and 3, 033 in Barnet. Majority of Haringey's patients had severe psychosis followed by those with cognitive impairment and non-psychotic severe illness.

The rate of social care mental health clients receiving services was significantly low in Haringey (189) compared to London (419) and England (404) per 100,000 population. This may be a result of service reduction over the recent years where social care is only accessible to those at the highest end of needs. Also significantly low was the rate of social care mental health clients aged 18-64 receiving home care (28.2 per 100, 000 population) in comparison to London (46.6) and England (47.6).

Current service landscape

Our current local offer of services for people with mental ill health focuses on highly specialised hospitalised services, few beds for recovery and rehabilitation, and high cost care packages and residential care. This offer does not always result in long-term improvement of health outcomes and it creates a community that is highly dependent on the services and individuals that are seldom supported to move on and have fulfilling, independent life.

Furthermore, the current emphasis on the treatment at the severe end of illness rather than prevention and early help results in costly and inefficient commissioning of services that are often reactive and have limited impact on health outcomes.

Mental health services in Haringey are commissioned by Haringey CCG, NHS England (specialist services) and Haringey Council. Services are provided by a range of providers including Haringey Council, NHS Trusts, primary care, VCS and independent sector.

Main provider of mental health services for Haringey is Barnet, Enfield and Haringey Mental Health Trust. Most of the current activity is commissioned in a block contracts making it challenging to support shift of resources to prevention and early help and develop further community based services.

Barnet Enfield and Haringey Mental Health NHS Trust (BEH MHT) provides a range of mental health services principally to the London Boroughs of Barnet, Enfield and Haringey. They provide a comprehensive range of services for children and young people working closely with the local authority (public health, education, youth justice and social care departments) and voluntary and community sector.

BEH MHT Children and Adolescent Mental Health Services (CAMHS) are provided in the four-tier framework and there is a single point of referral[15] for all children. Most referrals to CAMHS are from GPs, followed by schools and social services.

15 Emotional wellbeing and mental health for children and young people in Haringey Needs Assessment 2011

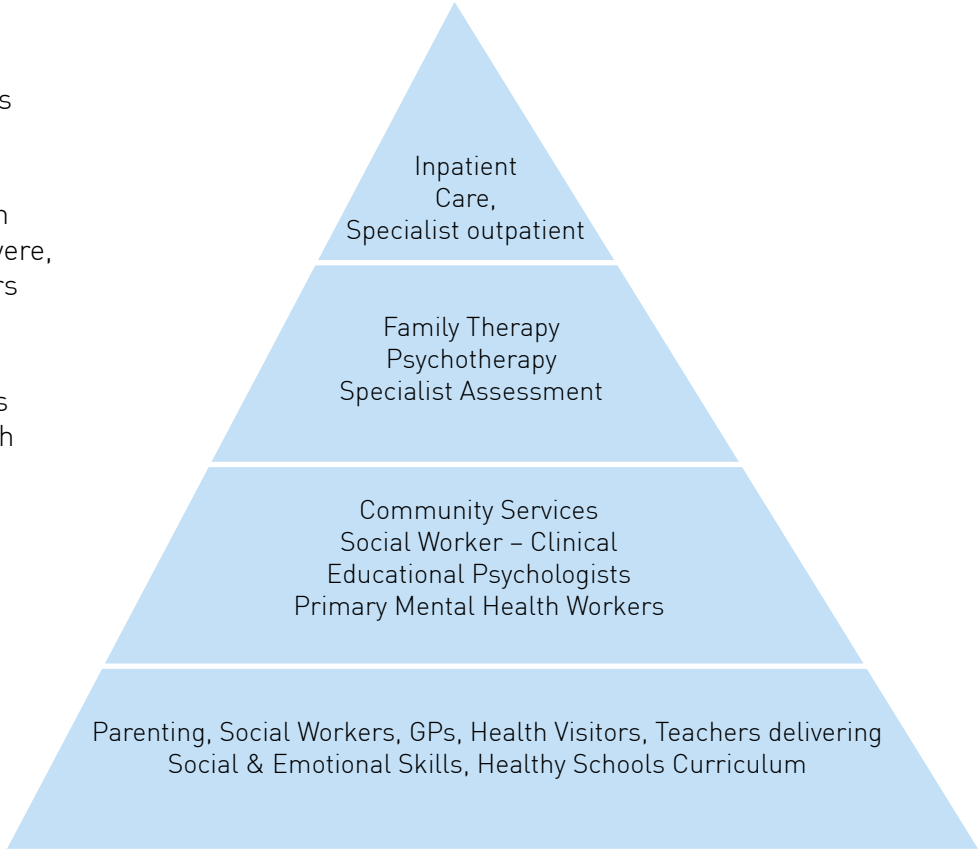
Mental health services for Haringey's Children and Young People

Tier 4 - Inpatient and highly specialist mental health services

Tier 3 – Specialist mental health services for those with more severe, complex and persistent disorders

Tier 2 – consultation for families and other practitioners, outreach to identify complex needs, and assessments and training to practitioners at Tier 1

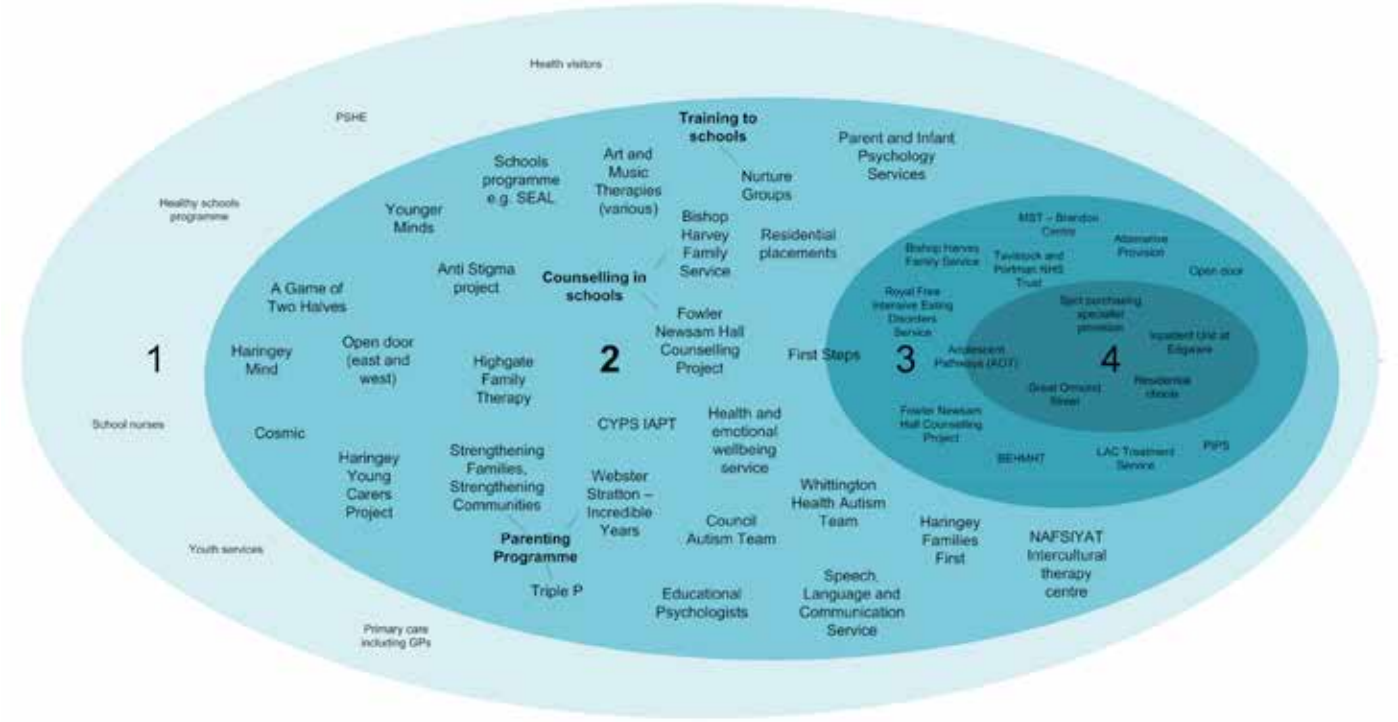
Tier 1- promote mental health, early identification of problems and refer to more specialist services



Source: National Service Framework for Children, Young People and Maternity Services, 2004

There is a variety of services provided in Tier 1 and Tier 2 ranging from interventions in the community, schools, and primary care and parenting initiatives provided by the Council however, at present, there is no system in place to monitor comprehensively the referrals to Tier 1 and 2 and follow children and young people along the whole pathway. Appropriateness of referrals depends on the information being disseminated to all stakeholders and the communities. Commissioning arrangements for Tier 1 and Tier 2 services could also be better integrated to reduce duplication and improve efficiency. At present, over 40 services and interventions are being commissioned by the schools, Council, CCG, Public Health Department and a number of external agencies. Some of these services are general and include a component of mental health and wellbeing such as health visiting and school nursing. Other services provide more targeted approach such as Open Door, a charity that provides counselling and psychotherapy to young people age 12-24. At present, there is no single directory of Tier 1 and Tier 2 services in Haringey that would enable full utilisation of this diverse offer. Also, fragmented provision arrangements make it challenging to consistently apply quality standards for commissioned services across the whole borough and in line with the national evidence and best practice.

Children and young people services currently commissioned in Haringey



Specialist Children and Adolescent Mental Health Services (CAMHS) are NHS services offering assessment and treatment when children and young people have emotional, behavioural or mental health difficulties. In 2012, there were 1,080 children in Haringey who required Tier 3 and 45 for Tier 4 CAMHS services (Public Health England 2014. Current data (March 2014) from CAMHS shows 40% of children referred into CAMHS tier 3 were 10-14 years old. About one in five referrals were made for children age 5-9 years and nearly a third (31%) were referred into CAMHS among the 15-18 year age range. The greatest numbers of referrals were from General Practitioners, equating to 45%. Local Authority referrals were mainly from Education (24%) and Social Services (14%).

In 2012-13, inpatient admission rate (89 per 100,000) for mental health disorders for 0-17 year olds was similar to London and England. Young people's hospital admission rate for self harm (191.7 per 100,000 directly standardised) was lower than London and England figures (Public Health England 2014).

Adults And Older People Services

Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) is the main provider of nearly all specialist adults and older people mental health services in Haringey including forensic services. The Trust services operate from over 30 locations across Barnet, Enfield and Haringey, some of them large hospital sites but most are small units in the community. Haringey's main site is at St. Ann's Hospital. The services available from the Trust in Haringey are described in more details in Appendix I. There were over 6,000 outpatient contacts and over 90,000 community contacts last year. Only a small proportion of these contacts are new patients suggesting that the Trust has a significant demand from patients with severe and enduring mental health problems that need a lot of support, coupled with a lack of capacity to discharge these patients safely into a variety of community settings, including adequate supported housing.

The NHS Benchmarking assessment suggests that BEH MHT has the overall slightly lower number of adult beds (22 vs. 23[16] national average), with significant variation across the Boroughs - lowest in Barnet (14), followed by Enfield (21.5) and Haringey (32.5). There has been an overall 25% reduction in adult beds over the last five years.

The overall availability of inpatient beds in the Trust is aggravated by a slow throughput, especially in Enfield and Haringey. Evidence suggests that service users in these two boroughs tend to stay longer than clinically required (Delayed Transfers of Care or DTOC) mostly due to their more complex social needs (e.g. unemployed, homeless, history of offending). Organising adequate support in the community for this cohort of people is a very challenging process due to a lack of integration and communication between the Trust and other key stakeholders locally. This issue was also highlighted in the service users' survey[17] where concerns were raised with the level of advice and support given to carers and service users on getting back to employment, accessing benefits and securing suitable accommodation.

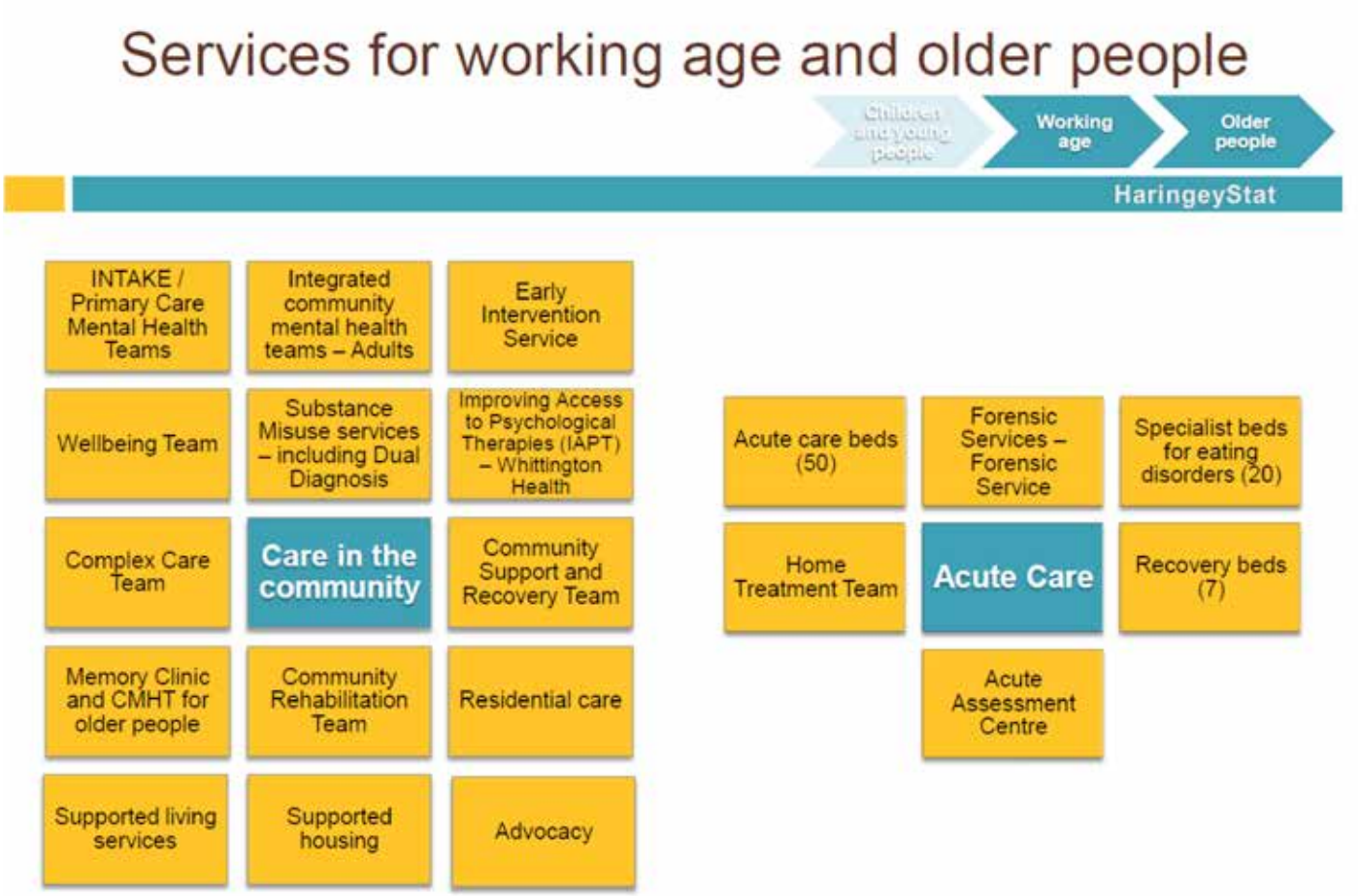
NHS Benchmarking data also suggests that BEH MHT has relatively lower reference cost which, at 87, are the lowest

16 Number of beds are per 100, 000 population so it would equate to app. 3.2x for Barnet, 3x for Enfield and 2.6x for Haringey to get the total number

17 Care Quality Commission: Patient Survey on BEH Mental Health Trust, April 2014

of any London NHS mental health inpatient provider and are considerably lower than those of neighbouring Camden and Islington NHS Foundation Trust (at 107) and Central and North West London NHS Foundation Trust (at 112).

The Trust also provides substance misuse services and dual diagnosis services for Haringey residents while talking therapies in Haringey are provided by the Whittington Hospital.



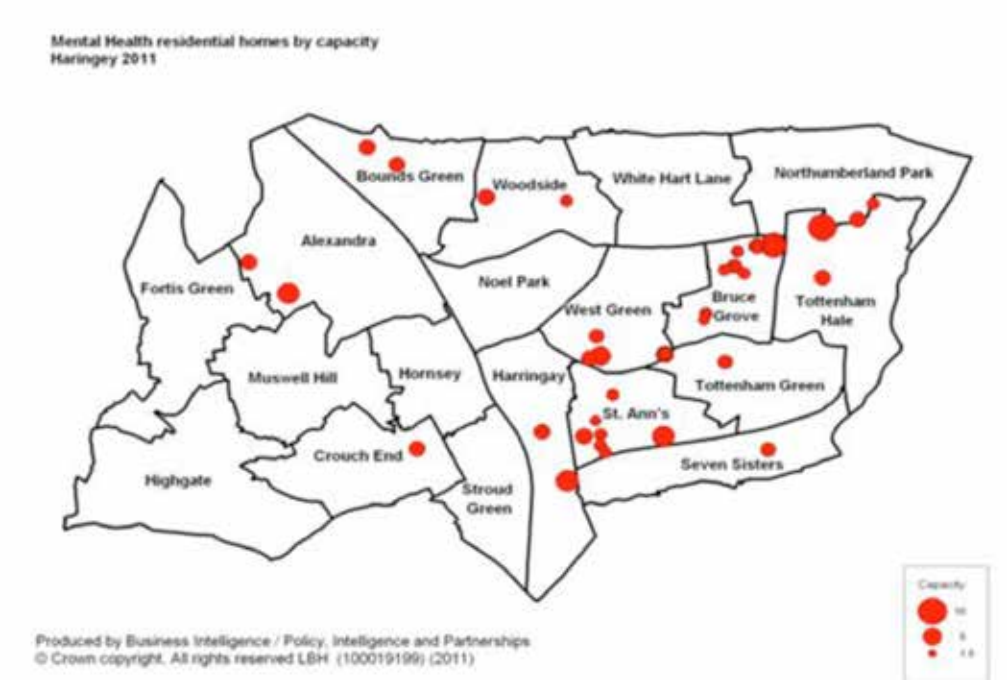
Second largest provider of mental health services in the borough is Haringey Council that provides social worker input to Community Mental Health Services and day services. It also provides social care to people with severe mental illness such as domiciliary care, supported living, day care centres, home care, direct payments, personal budgets and adaptation equipment.

The rate of social care mental health clients receiving services was significantly low in Haringey (189) compared to London (419) and England (404) per 100,000. Also significantly low was the rate of social care mental health clients aged 18-64 receiving home care (28.2) in comparison to London (46.6) and England (47.6) per 100,000 population. In 2012-13 there were 389 people with mental health condition who were provided a care package from the Council. In total 529 adults (18-64 year olds) had a service brought to them through a mental health budget code. Between April 1, 2013 and January 2014 566 people 65 per cent patients aged 18-69 years of age on CPA were in settled accommodation and 3.9 per cent in employment[18].

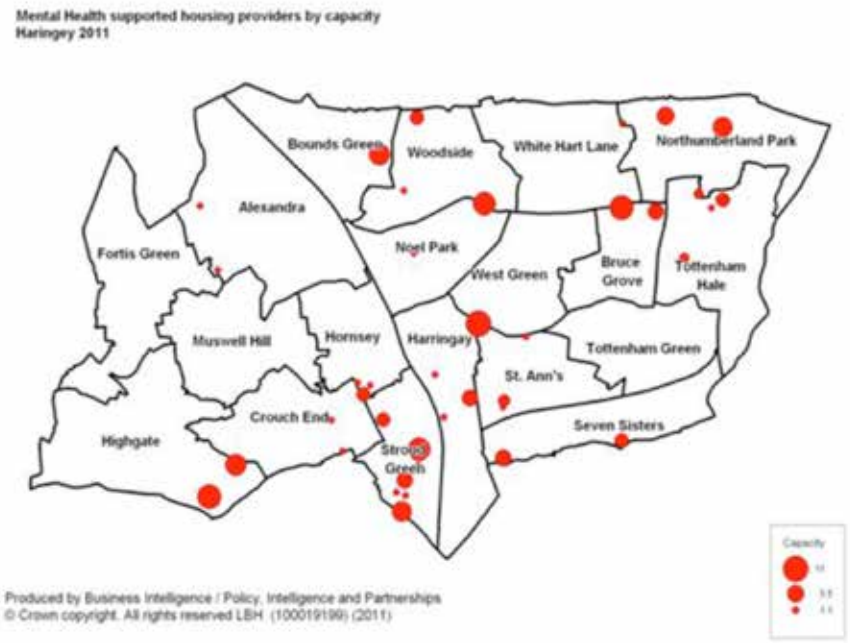
The Council also provides Clarendon Recovery College (CRC) aimed at assisting recovery process for people with severe mental illness. There are currently 230 enrolled students who are seen by secondary mental health services. This service has been recently evaluated by Middlesex University and it is showing to be very effective in assisting people to move on, find appropriate employment and pursue further education.

Residential accommodation and supported housing is provided by a range of independent providers and some VCS, the majority of which are in east of the borough. A large proportion of residential care placements (40%) are being utilised by people living outside the borough although this figure has been decreasing recently. Independent sector and VCS also provide supported accommodation, floating support and domiciliary care.

18 Mental Health Minimum Dataset 2014



Haringey has a number of supported living providers (mostly independent providers and some VCS), working with people with mental ill health that do not reach a threshold for social care support, including those funded through the Council's Housing Related Support. It typically provides the service user with a flat or shared housing within a warden controlled scheme. Schemes vary in terms of the level of support provided to cater for a wide ranging level of user need. Including Supporting People funded schemes; there are 13 main providers of supported living, offering around 285 places.



Mental Health and Wellbeing prevention and promotion interventions are largely commissioned by Council's Public Health team ranging from awareness raising and training in schools, tackling stigma and discrimination in the community ranging from interventions targeting specific risk groups such as Turkish and Kurdish men to digital peer support for mild to moderate anxiety and depression.

Information and advocacy services are provided by a range of VCS in the borough. These arrangements will be reviewed in the near future to align this offer with Care Act 2014 requirements.

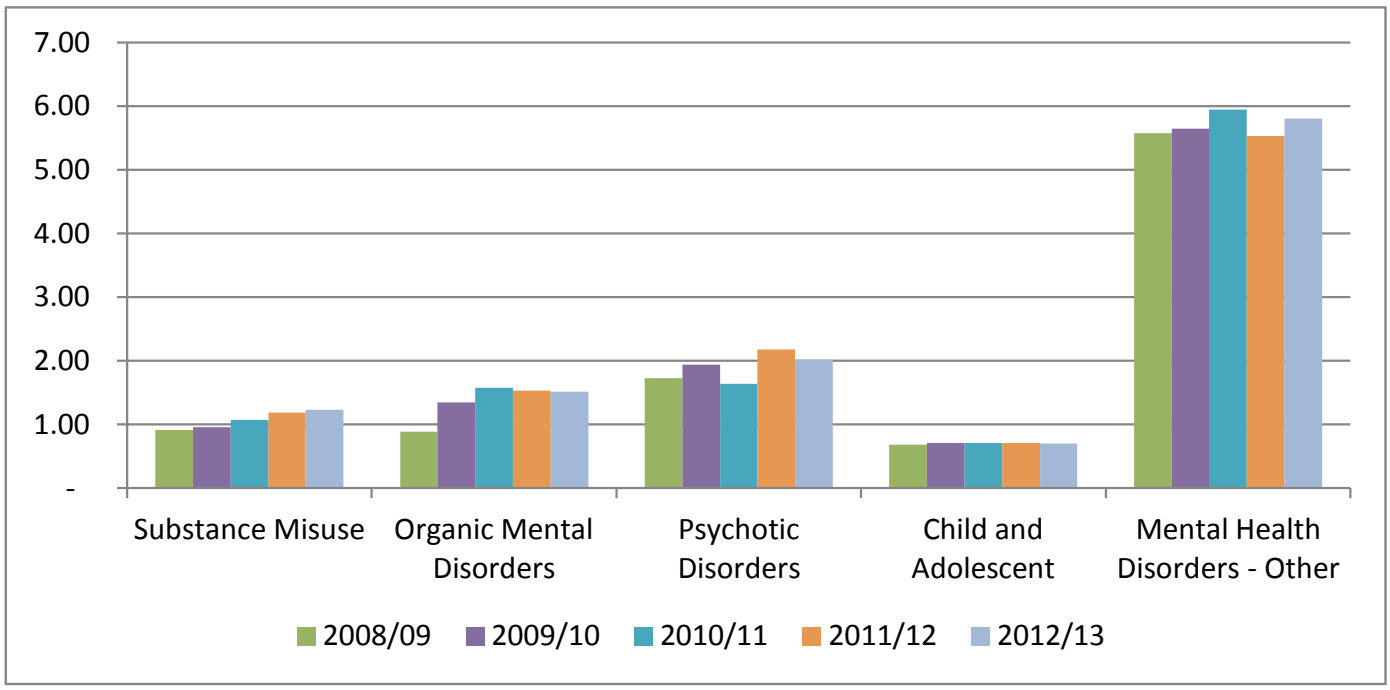
Total spend on mental health services

Total spend on mental health in Haringey (including substance misuse) for 2013-14 was over £51m. This equates to 11% of the total CCG budget and 6% of the Council's budget. Table below provides breakdown, by main commissioners.

Total spend on mental health in Haringey in 2013/14 by services

	LA	CCG
BEH MHT	1m (Section 75)	28.3m
Other NHS Trusts		2.9m
CAMHS		2m
IAPT		2.36m
VCS	600k	188k
Adult social care (including residential homes)	11m	
DAAT	3.5m	
Prevention and promotion	260k	
Other services		260k

Mental Health Gross Expenditure in last 5 years



Source: 2012-13 Benchmarking tool

Benchmarking data from various sources suggest that spend on residential care, housing related support, children's and young people mental health, specialist adult mental health services (phorensic services), prescribing on psychosis in primary care and the overall spend on secondary mental health per head of population is higher in Haringey compared to England.

Secondary care spend on psychosis, community care and outreach services care spend on mental health per head of the population is lower than England's average (Table below). These information should e treated with caution as the quality of data depends on accurate and complete returns. However the overall trend analyses suggest that local spend is highest at the severe top end of the pathway (secondary care, residential placement and supported housing) while there is underinvestment in outreach and community services. Furthermore, lower spend in secondary care for people with psychosis coupled with high spend in primary care for the same cohort of patients suggest that, probably due to high demand, these people are more likely to be cared for in primary care settings. Considering that the Council's and other partners investments are indirectly related to tackling root causes of mental ill health such as employment, affordable housing, community safety and clean and safe environment (open spaces etc.), it is likely that the overall spend on tackling mental ill health in Haringey is much higher than what could be easily quantified.

Haringey's expenditure on adults mental health for 2012-13, compared to England and based on the population size

High Low

Indicator	Haringey	England
Specialist mental health services spend (per 100,000 population) (rates are calculated for PCT and then mapped to CCG)	£33,167	£26,756
Primary care prescribing spend on mental health (rate (£000s) per 100,000 18+ population)	£1,791	£2,021
Primary care prescribing spend on psychosis (rate (£000s) per 100,000 18+ population)	£934	£541
Cost of GP prescribing for psychoses and related disorders (net ingredient cost per 1,000 population)	£713 (quarter 4)	£657
Secondary care spend on mental health (rate (£000s) per 100,000 18+ population)	£18,8480	£12,518
Secondary care spend on psychosis (rate (£000s) per 100,000 18+ population)	£1,356	£3,051
Community care spend on mental health (rate (£000s) per 100,000 18+ population)	£1,974	£5,094
Spend on psychosis services (rate (£000s) per 100,000 18+ population) (rates are calculated for PCT and then mapped to CCG)	£3,712	£4,789
Spend on psychological therapy services (IAPT and non IAPT) (rate (£000s) per 100,000 18+ population) (rates are calculated for PCT and then mapped to CCG)	£1,069	£1,021

Source: Mental Health Dementia and Neurology Intelligence Network, Public Health England, 2014

Appendix IV – Summary of evidence on best practice for mental health services

National evidence suggests that access to effective care for people with mental illnesses is only available to approximately 30 per cent of those that need it, and standards of care across the country vary greatly[19]. Even though 50% of all mental illness starts before age of 14, investment in prevention and early identification and children and young people's services is limited[20].

Effective mental health services should be integrated and include the whole pathway from prevention and early help through primary care, secondary care, highly specialised services and enablement model delivered in collaboration with a range of partners and service users.

Recent years have seen an increase in the body of evidence for investment in prevention of mental ill health and promotion of mental and emotional wellbeing that result in long-term cost savings and improve the outcomes. Some of the interventions cited having most impact across life course are parenting interventions for preventing conduct disorders, school-based emotional wellbeing learning programmes to prevent conduct problems, workplace initiatives for improving wellbeing and screening for anxiety and depression, befriending for older adults etc[21].

The effectiveness of current services for children and young people or Children and Adolescent Mental Health Services (CAMHS) has been debated nationally and the evidence is emerging that focus on four tier services actually lead to service fragmentation. Tavistock is proposing to replace the tiered model with a conceptualisation that is aligned to emerging thinking on payment systems, quality improvement and performance management, observed for adult mental health services. The THRIVE[22] model below conceptualises four clusters (or groupings) for young people with mental health issues and their families, as part of the wider group of young people who are supported to thrive by a variety of preven¬tion and promotion initiatives in the community.

Current commissioning arrangements for adults and older people services are based usually on block contracts with mental health trusts and do not allow for an approach where multiple providers are supported and encouraged to provide integrated services based on the outcomes[23]. Value Based Commissioning has become a recent focus in health care as commissioners seek to ensure more innovation and integration in services and across providers in order to improve patient outcomes and quality of services. The Joint Commissioning Panel for Mental Health (JCPMH), published a guidance for implementing values based commissioning in mental health noting that the approach will achieve higher levels of patient and carer engagement than in traditional managerial or medical approaches.

19 Joint Commissioning Panel for Mental Health: Practical Mental Health Commissioning (2011)
20 NHS England, 2014, A Call to Action
21 Department of Health 2011: The Mental Health Promotion, Mental Health Prevention: Economic Case
22 The Tavistock and Portman NHS Foundation Trust and Ana Freud Centre, 2014: Thrive: The AFC-Tavistock Model for CAMHS
23 Joint Commissioning Panel for Mental Health 2014, Guidance for implementing values-based commissioning in mental health

JCPMH has published a series of commissioning guides to assist commissioners at CCGs and Local Authorities in transforming the overall mental health services[24]. Their website provide a wealth of information on different services aimed to support local commissioners in the CCG and Local Authorities. Furthermore, recent Kings Fund publication[25] identified some underpinning principles for the overall effective mental health provision:

- A collaborative or integration strategy to the delivery of mental health care,
- Equality and equity, ensuring a parity of esteem between physical and mental health,
- Involvement and engagement of patients and clinicians is central to all aspects of mental health service design, delivery and monitoring,
- Patient centred in order to improve patient experience and enable staff deliver high quality care,
- Embedded within the community taking account of the holistic needs of the individual and the interaction between health and other areas of people's lives,
- Holistic with a shift of focus from ill health to one that offers support to enable people maintain their health and wellbeing,
- Prevention focussed,
- Recovery/enablement oriented care supporting people to take an active role in determining their needs and goals and supporting them to achieve this.

One of the main pillars in transforming mental health services is effective primary care mental health. One in four of the population will need treatment for mental health problems at some time in their lifetime and the majority of these will be managed in primary care. There are pockets of good practice in primary care regionally, nationally and internationally however the level of mental health support and training in primary care in general does not often reflect the level of need and responsibility. London Strategic Clinical Network[26] produced guide for commissioners based on a summary of over 60 case studies collated across the country and internationally. Primary care mental health models proposed are focusing on multidisciplinary teams based in communities and often arranged as 'hubs'. Those teams aim is to manage people with stable and ongoing mental ill health holistically as a part of their social system and network to support enablement and independent life. One of the leading roles of primary care mental health is to support people with long-term conditions to manage their mental ill health and also those with mental ill health to manage their physical health effectively.

The ultimate outcome of any effective system is to enable people to recover and to help them better manage their own health and care needs. This is best supported by timely evidence based interventions using an integrated care model that assist people to regain hope and motivation, control over their own life while providing opportunities to participate in a wider society by having adequate employment, decent housing and socially fulfilling life. 'Recovery is For All'[27] publication describes integrated models of care and challenges current mental health services to radically change the way people with mental illness are perceived and treated. Their proposed model is based on enablement and 'social recovery'. The benefits of the proposed model include improving employment outcomes based on the best evidence of Individual Placement and Support (IPS) model[28]; users involvement in decision making about their treatment and management; peer support by those with lived experience helping others with similar problems; and self management that aims to enable people to develop practical tools of everyday living.

Evidence suggests that housing issues are more common in people with mental illness in terms of maintaining adequate tenancy and the overall satisfaction with housing conditions[29]. Housing support is therefore an essential part of a good enablement model. National and international reviews that looked at the best model of housing support for people with mental illness are however inconclusive but do suggest that best outcomes are achieved where housing solution is secured first followed by adequate care wrapped around a person that is flexible and changing with needs over time[30].

Holistic enablement model in current commissioning landscape can only be achieved by integrated commissioning and provision of a range of services that are working across organisational boundaries. This could be achieved effectively by focusing on the Value Based Commissioning.

24 Joint Commissioning Panel for Mental Health access @ http://www.jcpmh.info/
25 Kings Fund 2014, Transforming Mental Health- A Plan of Action for London
26 London Strategic Clinical Network: A commissioner's guide to primary care mental health. July 2014
27 South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust (2010) Recovery is for All. Hope, Agency and Opportunity in Psychiatry. A Position Statement by Consultant Psychiatrists. London: SLAM/SWLSTG.
28 Sainsbury Centre for Mental Health (2009c) commissioning what Works: The economic and financial case for supported employment. Briefing paper 41. London: The Sainsbury Centre for Mental Health
29 Johnson R, Griffiths C, Nottingham T (2006). At home? Mental health issues arising in social housing. London: NIMHE. www.socialinclusion.org.uk/publications/GNHFullReport.doc
30 Crisis UK and University of York: Staircases, elevators and cycles of change, 2010

Appendix V – Proposed recommendations for actions with timescales for delivery

	2015/16	2016/17	2017/18
Priority 1: Promoting mental health and wellbeing			
Conduct mental health and wellbeing survey to establish the baseline locally	✓		
Work with schools to include/commission emotional and mental wellbeing training as part of their standard curriculum	✓		
With Health Visiting services being commissioned from the Council from 2015, explore opportunities to deliver specific programmes for early years on promoting positive attachment and good parenting		✓	
Capitalise on the opportunities with Tottenham regeneration re. employment, affordable housing, built environment			✓
Integrate, whenever possible, prevention and awareness raising within a wide range of frontline services;		✓	
Re-commission mental health awareness raising for frontline staff			
Review information, advice and advocacy services to provide single web-base information portal and to integrate commissioning and delivery of the eservices in line with Care Act 2014		✓	
Prevention of mental ill health and promotion of good mental health to be delivered in and by the communities – retender prevention and promotion contracts to focus on community development;	✓		
Tackling social isolation – some services existing for older people, important to broaden out to all people who are at risk of mental illness (e.g. people with LTCs). Innovative models e.g. Family Mosaic projects;	✓		
Commission prevention of self harm training and education for schools;	✓		
Suicide prevention – training on suicide prevention for primary care professionals and provision of bereavement services and lessons learnt from incidents (recent suicides);	✓		
Tackling mental ill health amongst offenders and gang members (MAC-UK)		✓	
Develop joint pathways for women and their families affected by perinatal mental ill health;		✓	
Include prevention element in contracts with all service providers			
Evidence-based prevention interventions for families with children at risk of conduct disorders;			✓

	2015/16	2016/17	2017/18
Commission interventions based on assets in the community (e.g. time bank)	✓		
Priority 2: Improving mental health outcomes of children and young people			
Review all CYP mental health services in order to focus on prevention and early help and strengthen referral pathways, avoid duplication and commission care model based on the evidence;	✓		
Strengthen Tier 2 services with targeted youth offending teams and provide targeted interventions at schools for those children at risk in line with quality standards and best evidence;		✓	
Implement NICE guidelines for severe mental illness in CYP, in particular review Early Intervention in Psychosis (14-35 years of age);		✓	
Review transition from CAMHS to adults, subject to Children's O&S Panel;	✓		
Review of mental health services offer for Looked After Children (LAC). Also, pilot jointly with Enfield and Haringey swifter completion of care proceedings where LBH applied for care order. Work towards 26 weeks against average of 56 weeks. Mental and emotional wellbeing assessment is a crucial part of this process.	✓		
Priority 3: Improve mental health outcomes for adults and older people **Improving care for people in mental health crisis**			
Develop Crisis Concordat Action Plan and implement London Mental Health Strategic Clinical Network commissioning standards;	✓		
S136 – Implement London MH Partnership Board guidelines and refresh local joint protocols in line with the new standards.	✓		
Including crisis plan in CPA on discharge with specific guidelines on how to recognise early signs of worsening conditions and mechanisms to prevent crisis occurring		✓	
Provision of crisis houses with psychiatric care and support		✓	
Dedicated areas for mental health assessment in A&E and 24 hours psychiatric liaison service	✓		
Mental health crisis care training for GPs, practice nurses and community care staff	✓		
Commission a place of safety for children		✓	
Improving physical health of those with mental-ill health and vice versa			
Implement the NHS Five Year Forward View standards in relation to access to mental health services (Actions included in the 5-year NCL plan);			✓

	2015/16	2016/17	2017/18
There should be greater focus on smoking cessation, weight management and physical activities interventions and referrals to these pathways for people with mental ill health;		✓	
Increase awareness of services offering behavioural change support such as Health Trainers and Health Champions amongst people with mental ill health;		✓	
Review current pathways between primary and secondary care referrals and update to strengthen management of physical and mental health;	✓		
Agree and establish role of pharmacies in relation to mental and physical health;	✓		
Review current model of liaison psychiatric service (Rapid Assessment and Interface Discharge scheme) in order to improve the outcomes and impact on the wider system and agree a standardised performance framework based on the outcomes;	✓		
Primary care is currently performing well on recording physical illness in people with severe mental illness, review if this is the case for people with long term conditions (LTCs);	✓		
Audit a random sample or Trust-wide of care plans to understand if those with co-morbidity have clear plans on how to manage their physical illness;	✓		
Develop strong relationships between those working with people with mental illness and primary care staff	✓		
Meeting the needs of those most at risk			
Improve waiting times for referrals in people in contact with Criminal Justice who have mental health problems.	✓		
Establish more effective liaison between mental health services in the criminal justice sector to achieve a seamless treatment pathways		✓	
Ensure that all mental health services are culturally appropriate for Haringey's diverse communities by developing minimum standards for training frontline services	✓		
Focus on mental health and wellbeing in 'Violence against women and girls' Council's workstream	✓		
Improve information sharing between Integrated Offender Management Unit, primary care, accident and emergency department and primary care		✓	
Link mental health prevention with antisocial behaviour initiatives based on the best practice		✓	
Forge links with Serious Youth Violence Strategy	✓		
Promote mental health and wellbeing for homeless people within 'Homeless Health and Wellbeing Charter		✓	

	2015/16	2016/17	2017/18
Priority 4: Commission and deliver integrated enablement model			
Explore possibilities of further integration between adult social care, housing related support and prevention public health programmes;	✓		
Develop service specification for enablement model that improves the outcomes such as good housing, employment, social relationships) and tailored to individual needs;	✓		
Strengthening role of primary care in management of mental illness (implement Joint Commissioning Panel for Mental Health guidelines: Commissioning primary care mental health services);	✓		
Strengthen pathways between Community Mental Health Teams, Home Treatment teams and primary care;	✓		
Provide local evidence on needs and service effectiveness to support BEH MH Trust to develop enablement model;	✓		
Support third sector to deliver enablement model in collaboration with mental health trust, LBH and other stakeholders;	✓		
Commission and implement housing based solution for people with mental ill health;	✓		
Develop flexible pathways for accommodation that promote choice;	✓		
Develop jointly between the CCG, MHT and LBH care packages in line with the mental health tariff care clusters;	✓		
For those who are known to have experienced crisis, include crisis management plan in their CPAs;	✓		
Enable people with mental ill health to enter employment market and maintain their job;			✓
Promote 'Time to Change' model for all local employees;		✓	
Develop asset based community approach that promotes independence, self-reliance and resilience in partnership with voluntary and community sector;	✓		
Review care-coordination against minimum standards in terms of capacity and competencies; offer training on welfare benefits, housing pathways and the importance of physical and mental health (Manchester model).	✓		