Hackney

REPORT OF THE HEALTH IN HACKNEY SCRUTINY COMMISSION		
Preventing depression and anxiety in working age adults Health in Hackney Scrutiny Commission 16th March 2015	**Classification** **Public**	**Enclosures**

1. FOREWORD

I'd just sat down to write this introduction when I was interrupted by an unsolicited phone call from Ipsos Mori asking me to answer a health questionnaire for Hackney Council. From the questions it was clear that answers were being sought not just about my physical health but my mental health too. "How often had I felt useful in the last week? " "Could I make decisions?", "Did I feel I was thinking clearly?" Promoting mental health is one of Hackney's four priorities in the joint Health and Wellbeing strategy and this was independent confirmation that Hackney is putting in the work to ask residents' about their mental health in order to better shape its services.

Why do scrutiny commissions do reviews when Hackney Council and partners are already prioritising this work? Scrutiny commissions can choose to review areas precisely because it is already a priority. The work of a scrutiny commission can be both collaborative and combative. It is used to suggest new ideas, but also as a check that what is being done is enough and in the right way. The commission had previously looked at Community Mental Health Services in 2011, Hackney Council is also about to go-live with its new integrated mental health network (IMNH) and given the harsh economic climate and its potential negative affect on well-being it seemed timely to return to this subject area.

We wanted to find out how the healthcare commissioners and providers are responding to the high prevalence of depression and anxiety. In prevention services are we targeting the right groups? What can be achieved by partners in looking at the wider mental health determinants of housing and employment? Are we identifying people at risk early enough?

Our recommendations encompass support for front line housing officers, improving 'move-on' accommodation, hospital discharge processes and BME access to services, the operation of the new IMHN, the need for job retention programmes and how Hackney Council and the NHS, as employers themselves, can provide leadership on best practice in supporting employees to avoid anxiety and depression and with a managed return to work.

I would like to thank all of those who generously gave their time to give evidence to the commission or to host a site visit.

Cllr. Ann Munn
Chair – Health in Hackney Scrutiny Commission

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1. INTRODUCTION

1.1 Mental health means more than just the absence of clinically defined mental illness and the need to promote positive mental health and wellbeing is increasingly recognised. Promoting good mental health and wellbeing contributes not only to lower rates of mental illness but also to improved physical health, better educational performance, greater workforce productivity, and improved relationships within families and safer communities.

1.2 Depression and anxiety disorders which include panic disorder, generalised anxiety disorder, obsessive compulsive disorder, social phobia and post-traumatic stress disorder, vary considerably in their severity but all conditions may be associated with significant long-term disability either as a cause, a consequence or else accompanying it. They may certainly have a substantial impact on a person's social and personal functioning.

1.3 Our review focused on mild to moderate mental illness[1], specifically depression and anxiety and we decided to place a particular emphasis on four of the wider determinants of the causes of depression and anxiety: housing, employment, debt and low income and people living with long-term medical conditions.

1.4 Evidence for this review was gathered during three commission meetings, five site visits and through carrying out desk research. The Commission received detailed and extensive reports from the commissioners and service providers who are involved in supporting those with depression and anxiety and for brevity **we will not repeat that information here,** but it can be found with the agendas for 8 Sept, 13 Nov and 9 Dec meetings. Instead, in this report we draw out the main themes from our findings and the basis for our recommendations.

1.5 *City and Hackney's Health and Wellbeing Profile*[2] tells us that 10.25% of patients visiting Hackney's GPs' surgeries suffered from depression in 2011/12, the fourth highest prevalence in London (albeit significantly lower than the average in England of 11.68%). This is likely to be a serious underestimate as it only includes people who have been coded by GPs as having clinical depression whilst milder cases of depression are not always formally coded. Latest figures from Hackney's Local Economic Assessments[3] show that 48% of those claiming Incapacity Benefit/Employment Support Allowance in Hackney do so for reasons of mental ill health and the rate of emergency mental health admissions in Hackney is the highest in London (2010/11)[4]. In addition, common mental health disorders such as depression, anxiety and obsessive compulsive disorder are known to be more prevalent in

[1] Mental health conditions are typically rated on a scale of mild-moderate-severe-very severe

[2] See bibliography.

[3] The Local Economic Assessment is a current picture of Hackney's economy. Details on employment, Hackney's businesses and unemployment can be found in it as well as research on particular aspects of Hackney's economy.

[4] http://www.hackney.gov.uk/Assets/Documents/2014_LEA_Headlines.pdf, page 5.

poorer households and poverty, unemployment, bad housing and physical ill-health are all associated with mental illness.

1.6 Nationally it has been estimated that one in four adults will experience a mental health problem at some time in their lives and one in six adults of working age will experience symptoms of mental illness that impair their ability to function. It has also been estimated that a sixth of the population have symptoms (such as anxiety or depression) that are severe enough to require healthcare treatment.

1.7 '*Promoting mental health, focusing on relieving depression and anxiety for working ages adults'* is one of the 4 priorities in *Hackney's Joint Health and Wellbeing Strategy 2013-14*[5] and has been the driver for the re-commissioning of a new Integrated Mental Health Network which we describe in our report.

1.8 The recently published *Mental Health Needs Assessment* outlines some of the key factors influencing mental health in the borough[6] and which partly prompted our review. Here are some headline points:

- Hackney has a relatively young population compared to the national average and a large percentage of new diagnoses of serious mental illness are identified in early adulthood.
- People of black-Caribbean or Pakistani origin are more likely to suffer severe mental illness and Hackney has a relatively high black, Asian and minority ethic population.
- Research has shown that migrant groups and their children are at greater risk of mental illness including psychosis and we have significant numbers of both new migrants and refugee/asylum seekers.
- There is a strong association between poor housing and mental health problems and Hackney has a higher rate of households in temporary accommodation than the average in England. We also have a higher proportion of over-crowded households than in comparable London boroughs and in, 2012/13, we saw a 20% increase in rough sleepers compared to the previous year.
- Hackney has one of the highest proportions in the UK of people whose day to day life is limited by long-term health conditions (7%) and this cohort is two to three times more likely to experience mental health problems than the general population. Demographic change here means that this proportion is expected to rise creating an additional burden, though it is unclear how the effect of regeneration will impact on the incidence of mental illness.

1.9 There is significant evidence (from the Marmot Review[7] and elsewhere) on the impact of the financial crisis on mental wellbeing. The London Health Forum

[5] Hackney's Joint Health and Wellbeing Strategy explains the joint approach to be taken by senior leaders from the NHS, Hackney Council, Healthwatch and the voluntary and community sector to improve the health and wellbeing of people in Hackney and reduce health inequalities. The strategy focuses on a small number of key issues that can be improved through joined-up working, shared vision and effective collaboration across a range of partners.

[6] Data from a) '*A mental health needs assessment for the residents of Hackney and the City of London'*, Public Health, Hackney Council, Jan 2015 b) *'Integrated Mental Health Network Service Specification',* Adult Social Care, Hackney Council 2014 and c) City and Hackney Health and Wellbeing Profile, Hackney Council and City of London, updated 2014..

reported that three in five people seeking debt advice have reported receiving treatment, medication or counselling as a result of debt related health problems.

1.10 Services to help prevent anxiety and depression in Hackney residents are commissioned by the City and Hackney Clinical Commissioning Group (the "CCG") and Hackney Council (both its Public Health team and its Adult Social Care team). Primarily, these services are provided by the following bodies, all of which are based at St Leonard's hospital: the Homerton University Hospital NHS Foundation Trust's (HUHFT) *Improved Access to Psychological Therapies* **(**IAPT) team and the Tavistock and Portman NHS Foundation Trust's Primary Care Psychotherapy Consultation Service (PCPCS).

1.11 Services provided by the East London NHS Foundation Trust (ELFT")[8] were generally outside the scope of this review because they treat patients with severe and enduring mental illness, whereas the focus of this report is on patients with the mild to moderate illness. Nevertheless, we heard from their BME Access Service because it has been working on the key area of improving outcomes for BME residents in mental health which is just as relevant to those at the mild and moderate end of the spectrum. In addition, when mental health issues are not addressed, they soon move from being mild to moderate.

1.12 To make this review more manageable in the limited time available to us, we had to rule a number of areas out of scope. We did not consider children and young people's mental health (which is the remit of another of Hackney Council's scrutiny commissions, the Children and Young People scrutiny Commission "CYPSC"), parental mental health, the transition from CAMHS[9], perinatal mental health, dual diagnosis, drug and alcohol issues. At the end of our report, however, we make a suggestion to CYPSC on these issues.

1.13 Our work here also builds on this Commission's 2011/12 review on '*Community mental health services*' and our 2009/10 review '*Health and worklessness'* as well as Hackney Council's Community Safety and Social Inclusion (CSSI") scrutiny commission's 2008/9 review entitled '*Tackling worklessness routes to employment for those in receipt of long term inactive benefits'* which ended up having a significant health and mental health focus.

1.14 As we publish our report, Hackney Council's Governance and Resources scrutiny commission has embarked on a "*whole place, whole person*" review of long term unemployment in Hackney relating to mental illness. It will attempt to identify the barriers for this group in re-entering the labour market (*i.e.*, finding jobs) or engaging in education and wider social participation and it will develop proposals for more effective approaches in engaging with Hackney residents affected in this way. We will request that the CSSI scrutiny

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[7] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[8] Which covers the City of London and the London boroughs of Hackney, Newham and Tower Hamlets.

[9] Child and asolescent mental health services, specialist NHS children and young people's mental health services. They offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties.

commission take forward the employment issues that we raise in our review, particularly in relation to job retention.

1.15 We sought to address the following core issues with this review:

- *How are healthcare commissioners and providers in Hackney responding to the continued high prevalence of depression and anxiety in working age adults?*

- *Who is accessing services for the prevention of depression and anxiety in working age adults in Hackney? Who is being targeted by prevention programmes? Are we targeting the right groups who may be at risk – BME, unemployed, those with poor physical health?*

- *What can be achieved by partners in dealing with the wider determinants of mental ill-health in Hackney (debt, housing, employment, long term conditions)?*

- *Are people at risk being identified early enough in Hackney and what is being done to reduce the factors that lead to poor mental health in the first place, e.g. housing, employment issues?*

2. EXECUTIVE SUMMARY AND RECOMMENDATIONS

2.1 Our review set out to examine whether the health and social care commissioners and providers in Hackney are responding appropriately to the high prevalence of depression and anxiety in our working age adult population. We also wanted to ensure the right people were being targeted by prevention programmes and to find out what Hackney Council and its partners are doing about the wider causes of mental ill health in Hackney. In the limited time available to us, we were unable to examine in detail the determinants debt and, long term conditions and we took a closer look at just two of these 'wider determinants', namely housing and employment.

2.2 We spoke to commissioners and providers, including officers from Hackney Council's Adult Social Care Commissioning department and the Council's Public Health department as well as Hackney Homes, City and Hackney CCG, HUHFT and ELFT. We heard from the key providers of psychological therapies locally - the IAPT service at St Leonard's hospital which is provided by HUHFT and a more specialist service provided by the Tavistock and Portman NHS Foundation Trust.

2.3 We went on site visits to City and Hackney Mind, the Vietnamese Mental Health Service, I.R.I.E. Mind Recovery Centre, Bikur Cholim, Derman, the IAPT service at St Leonard's hospital and Family Mosaic's Supported Housing service, where we spoke to frontline officers and many service users. We also heard from Family Action, the national organisation the Centre for Mental Health and from local GPs.

2.4 We examined how the new "Integrated Mental Health Network" (IMHN) was developed and we listened to concerns from providers about the change. City and Hackney Mind is the lead provider and services will be delivered by them and a network of 10 other local voluntary organisations. This new initiative is key in terms of early intervention for those with depression and anxiety and we look forward to seeing how it will develop. It has replaced a more fragmented system which had broadly the same providers but lacked effective co-ordination. We debated with a range of local stakeholders the challenges of treatment vs prevention in service provision. In that discussion, the role of 1:1 vs group therapies featured prominently, particularly within BME communities, where linguistic and cultural barriers are significant and there is a pressing need to reduce the factors which lead to poor mental health in the first place.

2.5 Our recommendations encompass support for front line housing officers, improving 'move-on' accommodation, hospital discharge processes and BME access to services, the operation of the new IMHN, the need for job retention programmes and how Hackney Council and NHS, as employers themselves, can provide leadership on best practice in supporting employees to avoid anxiety and depression and with a managed return to work.

2.6 Our recommendations are:

Recommendation One
The Commission requests the Health and Wellbeing Board to ensure that with the roll out of the Integrated Mental Health Network (the IMHN) from 1 February 2015 that:

a) Talking therapies, particularly culturally specific, one-to-one, therapies provided by BME community organisations, do not lose out to solely generic provision.
b) Any funding gaps arising from the creation of the IMHN which impact on the prevention and early intervention stages are addressed so that those who are unable to make progress via group therapy are also catered for.
c) Consideration is given to whether the provision of IAPT might include a BME voluntary sector element.
d) The role of BME organisations in delivering preventative services which are wider than direct mental health support is better acknowledged as they are providing services to service users who provide difficult to reach for mainstream providers and are thus contributing to wider social capital.
e) Local health and social care partners examine how they might actively recruit staff or volunteers from local BME communities, such as Turkish/Kurdish, with a view to training them or encouraging them to qualify in the health and social care professions.
f) Preventative programmes are better co-ordinated with local health partners and commissioners do not act in isolation when making changes aimed at delivering on their own cost saving programmes.
g) Although the focus of these services is on helping people to become well and able to function in society, there needs to be a range of services to allow people to access continuing support after an initial period of therapy.

We will be expecting evidence of this implementation in the 6 month update.

Recommendation Two
The Commission recommends that the Council's "Housing Needs Service" jointly with Hackney Homes and ELFT:

a) Expand on the existing initiative on mental health awareness training for staff. This needs to build on existing best practice and focus on clear pathways that staff know will work.
b) Ensure that frontline workers are kept up to date on the available care pathways**,** the resources open to them in giving support to vulnerable residents, and that clear escalation procedures are in place. This needs to include dealing with complaints from neighbours about erratic or anti-social behaviour.
c) Consider how they could work with Registered Housing Providers to develop a joint crisis line to which clients with mental health problems could be referred.

Recommendation Three
The Commission recommends that the Cabinet Members for Housing and for Health Social Care and Culture ensure that the opportunities created by the management of Hackney Council's housing stock coming back in-house after 31 March 2016 are harnessed to foster closer working relationships between the management of Hackney's housing stock and the health and social care staff in Hackney. A good model here is the success of the joint working on anti-social behaviour between Hackney Homes and the Council departments. It is suggested that having a mental health worker as part of the Hackney Homes team would represent a useful first step here.

Recommendation Four
The Commission recommends that the Cabinet Members for Housing and Health Social Care and Culture review the provision of move-on accommodation for those in the mental health supported housing pathways. This would involve looking at whether the current Nominations Agreements between the Council and Registered Housing Providers are working in the best interests of tenants with mental health needs and in particular provide the stability which can help prevent crises. These tenants often move in and out of short-term supported housing, typically have fluctuating conditions and their needs often get addressed only when they reach crisis point.

Recommendation Five
The Commission recommends that ELFT reviews planning for discharge for mental health patients in the Homerton Hospital's Mental Health Unit. In particular, housing issues need to be identified at the admissions stage and acted upon through the provision of housing advice in the hospital wards/at GPs' surgeries, as appropriate. Furthermore, the Commission requests that this issue be picked up in the 'Hackney Vulnerable People's Protocol' being developed in Hackney in response to the Care Act 2014

Recommendation Six
The Commission requests the CCG and the Council to consider a proposal from City and Hackney Mind to establish a steering group of the Floating Support Providers in the borough so as to assist in better co-ordination of services and to improve communication.

Recommendation Seven
The Commission requests the Council and the CCG to explore with Job Centre Plus and the Council's own Ways Into Work team the commissioning of services to help people with mild to moderate mental health support needs to either retain their jobs and or find new employment. This acknowledges the significant proportion of people in the borough who are workless because of mental illness.

Recommendation Eight
The Commission suggests that the public sector employers should aim to lead the way in developing practices to ease the path back into work for those who are suffering from depression and anxiety, if the overall cost to society is to be reduced. The Commission requests that the Council's HR and Organisational Development department and the Council's Public Health department as well as the HR departments of the local NHS Trusts and the CCG publish information explaining what initiatives they have in place to improve mental health in their own work environments (*e.g.* anti-bullying, stress management) and how they currently support individuals with lower level mental health problems to remain in work and to plan for a managed return to work after periods of sick leave.

Recommendation Nine
The Commission requests that the CCG's Mental Health Programme Board report back on how it will work with local providers to tackle the ongoing challenge of under-representation of BME people, particularly black men, with mental health issues in primary care settings and their over representation as in-patients. The Commission acknowledges that this is a long term issue but seeks assurances that it does not fall down the agenda in a climate of fiscal constraint.

Recommendation Ten
The Commission requests that the Council and the CCG demonstrate how they are including the 'user voice' in commissioning services for lower level mental health issues.

3. FINANCIAL COMMENTS

3.1 This report explores opportunities for reducing and preventing depression and anxiety in working age adults across Hackney. The recommendations are cross cutting and involve partner organisations such as the East London NHS Foundation Trust and our Clinical Commissioning Group.

3.2 The taking forward of the ten outlined recommendations will need to be managed within existing cash limits, with awareness of savings to come in future years.

3.3 Any specific operational changes that come about as a result of this report will need to be scrutinised separately, in order to assess financial implications.

4. LEGAL COMMENTS

4.1 On 14th May 2014, the Care Bill received the Royal Assent and as such the Care Bill became the Care Act 2014. The Care Act 2014 introduces a single, national threshold to accessing care and support right across England. The Care Act has made changes to Section 117 of the Mental Health Act 1983 by section 75 of the Care Act 2014. The Care Act amends section 117 MHA 1983 and will for the first time provide a definition of what comprises "after care services". It now defines "after care services" as services which (i) meet a need arising from or related to the person's mental disorder; and (ii) reduce the risk of a deterioration of the person's mental condition (and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for the disorder).

4.2 The report of the Scrutiny Commission and its recommendations falls in line with the Government's initiatives on Mental Health and as set out by NHS England. NHS England has published updated guidance to help commissioners, GPs and providers support mental health patients exercising their legal rights to choose who provides their care and treatment.

4.3 This follows extensive consultation on the interim guidance published earlier this year. In April 2014, the Government established for people with mental health conditions the same legal right to choice of provider as has existed for several years in physical health, representing a major step towards realising parity between physical and mental health.

4.4 NHS England published interim guidance in May 2014 and consulted widely on this. In response to the feedback received, the guidance has been updated to ensure that it provides the clarity that commissioners, GPs and providers need. In addition, a set of clinical scenarios to illustrate how mental health patients' legal rights should work in practice have been published.

4.5 There are no immediate legal implications arising out of this report and its recommendations.

5. FINDINGS

5.1. CONTEXT AND PREVALENCE

5.1.1 At our first meeting on 8 September 2014, we received detailed reports on the context and prevalence of depression and anxiety in Hackney and these can be referred to here. For brevity we will not repeat that detail here.

5.1.2 National estimates of the incidence of depression within the general population range from 3% to 6% of adults, and it is estimated that the number of people identified with and requiring treatment for depression will increase by 17% by 2026[10]. Mild depression accounts for 70%, moderate depression 20% and severe depression 10% of all cases. It is estimated that depression is two to three times more common in people with a chronic physical health problem (such as cancer, heart disease, or diabetes), occurring in about 20% of this population. The annual service costs of treating people with depression in 2007 were estimated to be £1.7 billion, far less than the cost to the economy attributed to depression (£7.5 billion).[11]

5.1.3 The Council's Public Health team pointed out to the Commission that combining the current estimates for the City of London and Hackney of 4,919 adults with severe depression; 16,396 with mixed anxiety and depression and 4,190 with depressive episode suggests that there could be up to 25,505 people with depression in the City of London and Hackney. Alternatively, they say that applying a 6% incidence rate to the City of London's and Hackney's combined population suggests that there could be 15,583 people in the City of London and Hackney with depression. These two figures provide a very broad ranging estimate for the total number of people in City and Hackney with depression of between 15,583 and 25,505 people.

5.1.4 The CCG gave the Commission the following data for what they define as Mental Health (MH) need in the City of London and Hackney, although not all of this need will be depression/anxiety:

- 33,600 people estimated to have common MH disorder;
- 27,700 people who self-report a common MH disorder; and
- 11,500 people with common MH disorder known to GP.

5.1.5 In addition, the CCG gave us their most recent annual data on the local IAPT service, which they commission and which is provided by HUHFT. This data is based on the Hackney population being 257,379[12]:

- 8,700 IAPT service referrals (per year);
- 5,300 people entering IAPT service (per year);

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[10] NICE (March 2011), "Depression in Adults Quality Standard", www.nice.org.uk/guidance/qs8
http://www.nice.org.uk/guidance/qs8/resources/qs8-depression-in-adults-cost-impact-and-commissioning-assessment2

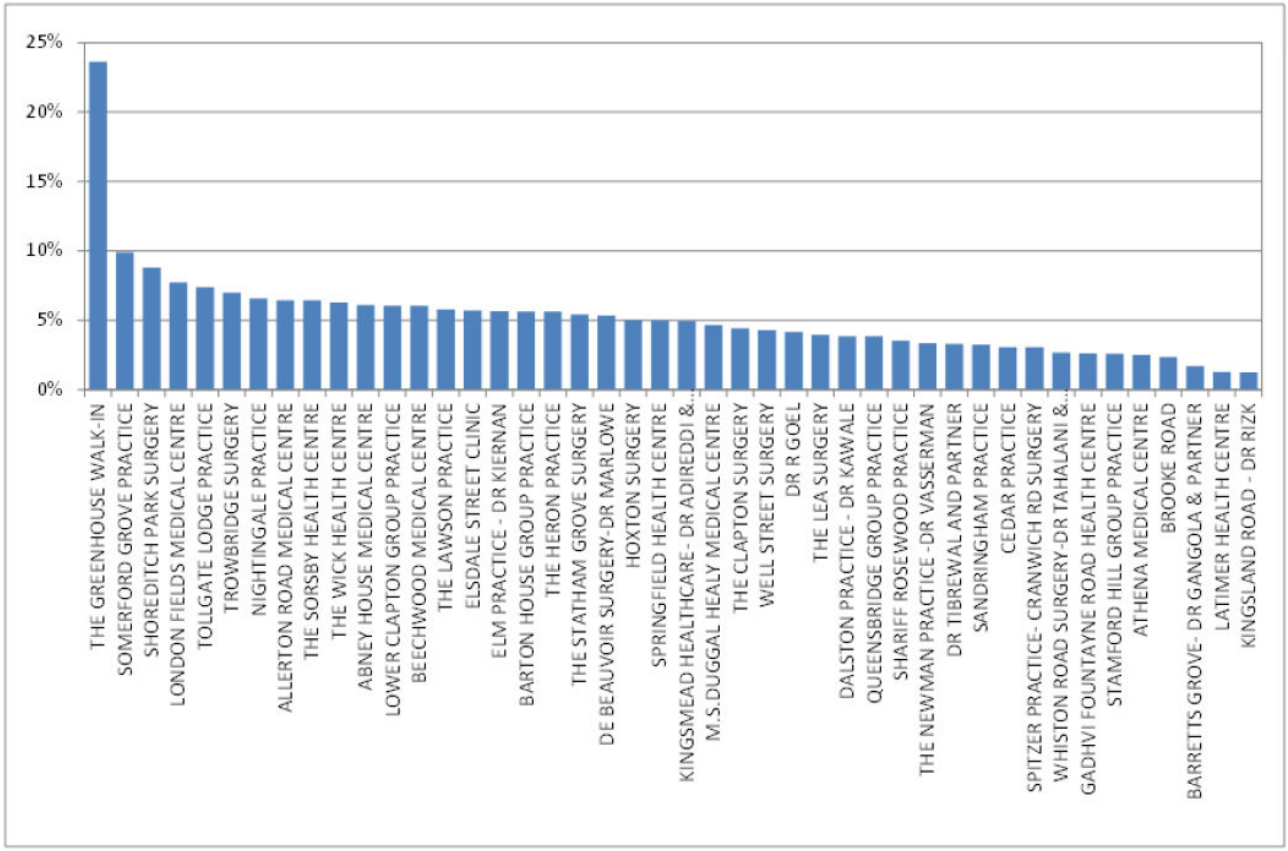
[11] *Ibid.*

[12] http://www.hackney.gov.uk/Assets/Documents/Facts-and-Figures.pdf at Oct 2014

- 2,020 people completing IAPT treatment (per year);
- 904 people achieved reliable recovery following IAPT (per year); and
- 606 people moved to recovery following IAPT.

5.1.6 Figure 1 below shows the percentage of the adult population (aged 18 and over) at each GP practice in the City of London and Hackney for which depression was recorded on the practice depression register in 2012/13. In total, there were 11,500 patients with recorded depression across the 44 practices within the area. The Greenhouse Walk-in Centre had by far the highest proportion of patients on the depression register and it should be noted that this service was established to provide free health care services and housing and welfare advice for homeless people in Hackney.

Figure 1: proportion of practice population aged 18+ who were on the practice depression register, 2012/13.



Source: Quality Outcomes Framework

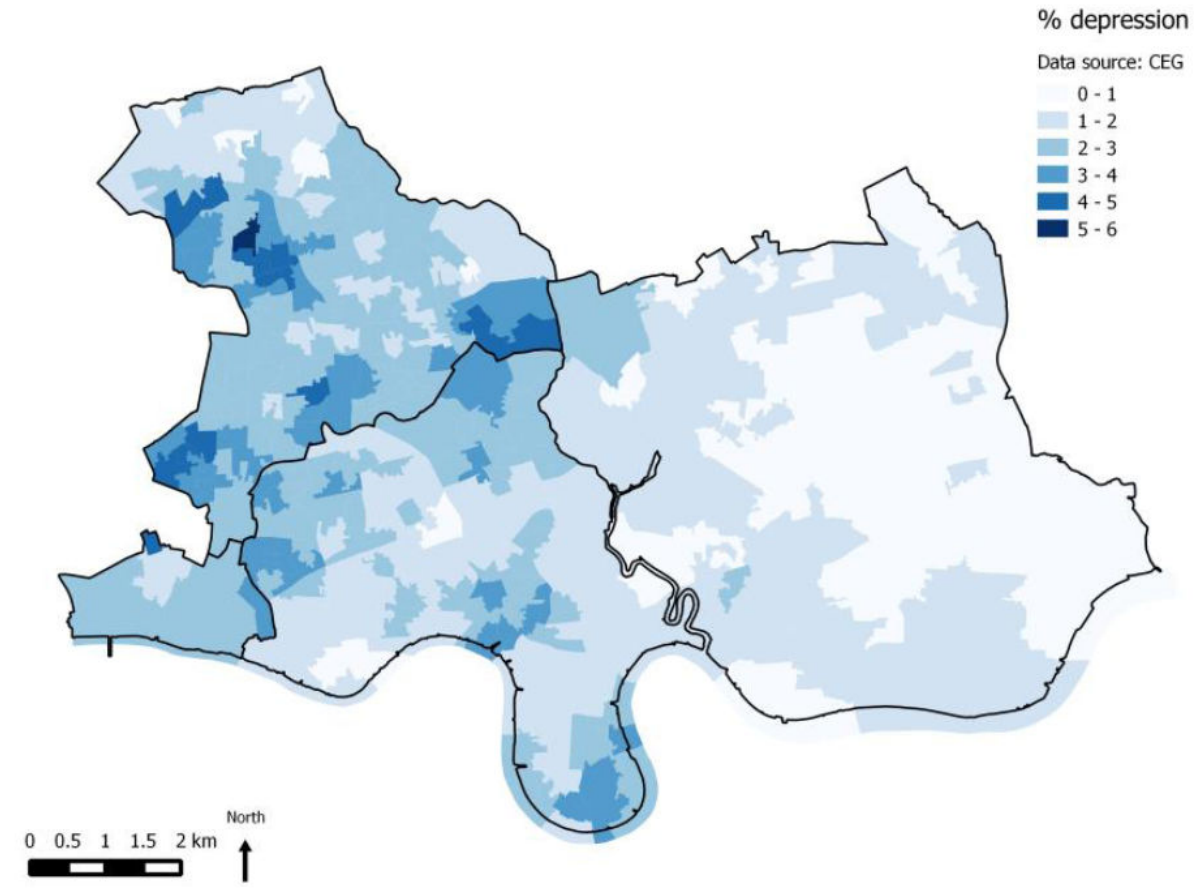
5.1.7 We learned that the figure of 11,500 people on GP registers with depression is fewer than the bottom of our estimated range of people suffering from depression in the City of London and Hackney (15,583 people[13]) suggesting that there is under-recording of depression by GPs. Officers from the Council's Public Health team pointed out that it is possible, however, that this could be due to coding-errors rather than under-diagnosis alone. They estimate too that the available data from the national Quality Outcomes Framework may underestimate those with depression/anxiety by nearly 50%.

[13] [*Cross-reference to para. 5.1.3 above.*]

They add that these figures only include those who are receiving antidepressants, and a large proportion of those with a clinical diagnosis of depression do not receive antidepressants.

5.1.8 Figure 2, below, shows the estimated prevalence of depression by place of residence for the registered population of the City of London and Hackney CCG, the Newham CCG and the Tower Hamlets CCG. This figure shows higher recorded levels of depression (as recorded on GPs' registers) within the Hackney wards of Wick, Stoke Newington, Clissold, London Fields and Hoxton West.

Figure 2: map showing percentage prevalence of depression in City and Hackney, Newham and Tower Hamlets by residence 2012/13.



Source: Clinical Effectiveness Group, extracted April 2013.

5.1.9 The data provided by the Council's Public Health team showed that there is a higher proportion of females than males with recorded depression in Hackney and that the rate of recorded depression was also highest in the 25-39 year old age groups. When viewed as a percentage of the population by age group, however, it was noticeable that prevalence is significant throughout adulthood, particularly within the 40-49 year old and 50-64 year old groups. In terms of ethnicity, the level of recorded depression was highest in white people although a relatively high proportion in the Clinical Effectiveness Group data (referred to in Public Health's evidence) did not state their ethnicity.

5.1.10 Estimating prevalence of depression and anxiety is difficult. One can count those in treatment but often depression and anxiety will take a year or more to develop and a patient may have physical symptoms masking depression. Counting is difficult for GPs and they may not all use the same approach to coding patients. Affluent residents might be more likely to raise the issue with a GP than unemployed residents. Economic deprivation affects BME communities disproportionately and self-referral is likely to be to be higher amongst the affluent, so among BME residents' self-referral is lower. The CCG adds that, in terms of modelled prevalence, there is higher need in the City of London and Hackney than nationally. The Council's Public Health team tells us that estimates of the local prevalence of depression and anxiety from the Public Health Observatory and estimates extrapolated from respondents to a local GP survey who self-report depression and anxiety are well matched but there is a large disparity between this prevalence data and the numbers known to GPs. We also see very high numbers of referrals to IAPT locally and of people entering IAPT treatment compared to the numbers of depression and anxiety patients known as such to GPs.

Seeking care – the first steps

5.1.11 GPs are usually the first service to identify depression and anxiety and they may refer patients to other providers. In Hackney, interventions to help prevent depression and anxiety are delivered by a wide range of statutory and voluntary sector providers. These are commissioned by both the CCG and Hackney Council (both the Council's Public Health department and its Adult Social Care department). Two key providers of IAPT are the Homerton University Hospital NHS Foundation Trust (HUHFT) and Tavistock and Portman NHS Foundation Trust. The services provided by the East London NHS Foundation Trust (ELFT) generally treat those with more severe and enduring mental illnesses. For many from BME groups, however, their first approach will be to their community's own organisation *e.g.* Derman (Turkish/Kurdish), Bikur Cholim (Charedi Jewish) and the Vietnamese Mental Health Service (Vietnamese). Community-specific organisations such as these may either provide support themselves or refer people onwards. Likewise, GPs commonly refer individuals from these communities to their respective community organisations. Many people from these communities will, instead, use the generic provision provided through IAPT either by approaching the IAPT providers themselves or by being referred to IAPT by GPs.

5.1.12 The Council also commissions *Targeted Preventative Support* aimed at individuals who may be starting to develop a mental health support need or who are experiencing severe social isolation. The aim of that support is to reduce or delay the need for specialised or more intensive services. The Council also commissions in-house employment support services and 'Floating Support' (services designed to support people to live independently in their homes) for people with mental health needs (including people suffering from depression and anxiety), the latter being provided by Family Mosaic. A

pilot project to increase the take-up of direct payments[14] for mental health service users is also underway.

5.1.13 At the lower levels of need, Hackney residents struggling with depression and anxiety can also now access free online support via the *Big White Wall* web portal. Residents can visit Big White Wall and enter a Hackney postcode to access the service. It provides 24/7 peer and professional support, plus a range of wellbeing tools to help people self-mange in a way that is both safe and anonymous.

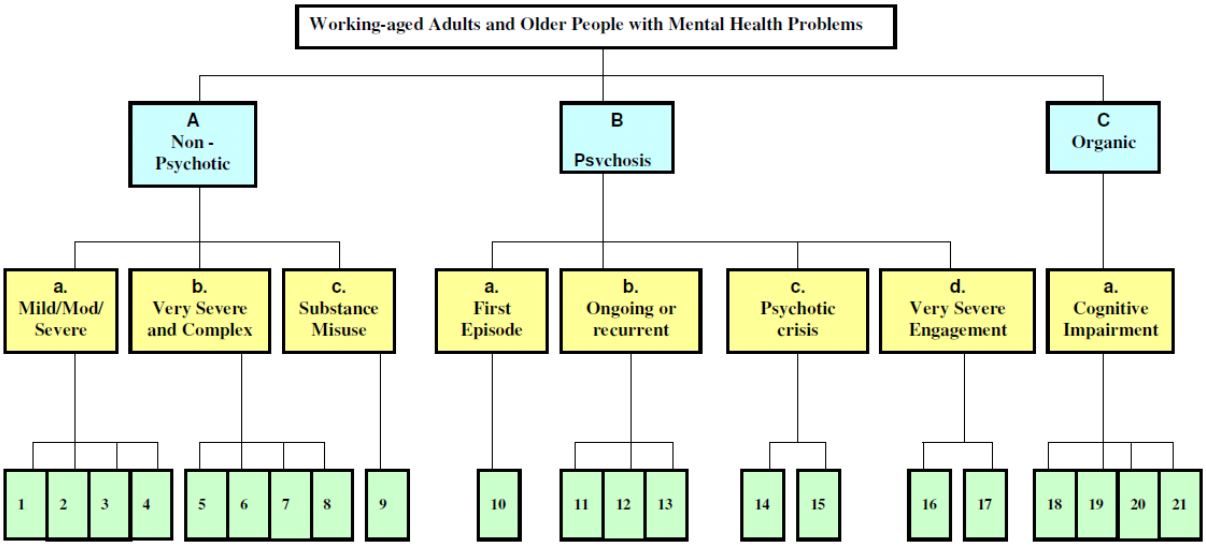
What is IAPT?

5.1.14 The original blueprint for the national programme of *Improved Access to Psychological Therapies* (IAPT) was based on treating depression and anxiety in working age adults through a stepped care approach based on the most current NICE guidance. IAPT services typically offer access to therapies, including guided self-help Cognitive Behavioural Therapy (CBT)-based interventions all of which are NICE approved. CBT is a talking therapy that seeks to help patients to manage their problems by changing the way they think and behave. Talking therapies involve a trained therapist listening to a patient and helping them to find their own answers to problems. CBT is most commonly used to treat depression and anxiety, but can be useful for other mental and physical health problems.

5.1.15 The IAPT model was originally dominated by CBT but it now provides a much wider range of therapies (counselling for depression, couples counselling, Dynamic Interpersonal Therapy *etc.*). All IAPT services use standardised measures to collect and monitor patient outcomes – measuring recovery and patient feedback – at every session. Need is assessed through the use of 'Care Clusters' based primarily on the needs and characteristics of a service user. Clinicians allocate a patient to one of 21 care clusters which are mutually exclusive, in that a service user can only be allocated to one cluster at a time. The focus of this review, as with IAPT, was on clusters 1-8 but predominantly concerned clusters 1-4. The care clusters are as follows:

DECISION TREE – CARE CLUSTERS USED ASSESSING MENTAL HEALTH

[14] Direct payments and personal budgets are offered by local authorities to give patients more flexibility over how their care and support is arranged and provided. They are given to both people with care and support needs, and also to carers.



5.1.16 Treatment approaches used in IAPT for those with low intensity conditions are a mixture of 1:1 telephone and face-to-face therapy, plus education and skills groups and condition-specific interventions for long term conditions. For those with more high intensity conditions, the mix of treatment includes CBT for common mental health problems, 'mindfulness'-based[15] CBT for depression, interpersonal therapy for depression, couples therapy *etc.*

5.1.17 In addition to the IAPT service, which is commissioned from HUHFT, the CCG has also commissioned a Primary Care Psychotherapy Consultation Service which is run from St Leonard's Hospital and provided by the Tavistock and Portman NHS Foundation Trust. The focus of the service is primarily on people with medically unexplained symptoms which are not being managed in secondary care. The service only takes referrals from GPs and puts support and capacity in place within GP surgeries to assist GPs with people who are suffering from depression and anxiety. The service aims to move away from purely psychological therapy to treatment where they look at a community response to help their patients relate to other people and to a wider group. The service often, for example, encourages patients to increase their physical activity. It complements IAPT by working with more challenging patients (clusters 4-8) who do not warm to statutory services. The service typically provides up to 16 sessions. It is not designed to provide long term support however, onward pathways are used should patients require them.

5.2. THE NEW INTEGRATED MENTAL HEALTH NETWORK

5.2.1 Our review took place just as the provision of support services for those with depression and anxiety was undergoing a major transformation. Lower level community-based mental health services were, up until now, provided via a number of small contracts with a range of local voluntary sector organisations.

[15] Mindfulness is a therapy that involves a patient paying more attention to the present moment – to the patient's own thoughts and feelings, and to the world around them – as a means of improving mental wellbeing.

The purpose of the re-commissioning was to create an overarching *Integrated Mental Health Network* (the "IMHN") to make more effective use of resources and to support both the Council's own 'Promoting Independence' and its 'Personalisation' agendas.

5.2.2 City and Hackney Mind has been appointed as the lead provider for the new IMHN. The IMHN will be accessed via a 'single entry process' but with multiple access points from the various network members. The members of the Network are:

City and Hackney Mind – Network Leader with a range of specialisms
Shoredich Trust – Health, wellbeing and alternative therapies
Bikur Cholim – Jewish orthodox specialist
Derman – Turkish specialist
St Mungos Broadway – Turkish and Kurdish specialist and complex needs
Core Arts – Creative arts for complex needs
Vietnamese Mental Health – Vietnamese/SE Asian specialist
Hackney Chinese Community Service – Chinese specialist
PACE – LGBT specialist
Off Centre – Young people including young black men specialism
Chizuk – Jewish orthodox specialist

The network will also engage with **North London Muslim Community Centre** to spot-purchase support for Asian and Muslim communities.

5.2.3 The IMHN will comprise two time-limited service components as follows:

- *Mental Wellbeing and Prevention* (provision for up to 1 yr)
- *Recovery and Social Inclusion* (provision for up to 2 yrs)

The IMHN began on 1 February 2015 and will focus on early access for people in the community who do not meet the thresholds for statutory services[16]. The IMHN will offer a wide range of support through outreach and partnership with other agencies in the areas of employment, housing, leisure services *etc.* The IMHN also aims to increase access for specific groups who have historically been under represented in community mental health services.

5.2.4 From the outset of the review we had heard concerns from some of the voluntary and community sector providers who were part of the previous network (specifically Derman, Bikur Cholim, Family Action) that the new service represented a cut, particularly in relation to one-to-one talking therapies. There were also criticisms that communications with the providers and the CCG during the development of the IMHN had been poor. There was a concern too that there was a lack of clarity on the wider funding picture and on the funding going into this sector both before and after the IMHN's inception.

[16] The 'critical and substantial' threshold to access social care services under the Fair Access to Care Services (FACS) criteria.

5.2.5 It is clear that these changes represented a significant shift in funding for some already fragile organisations which lack solid income streams but which, nevertheless, contribute greatly to the prevention and treatment of depression and anxiety in Hackney. The challenge for commissioners is to continue to support these organisations appropriately while making sure that health outcomes for those with depression and anxiety are improved.

5.2.6 In evidence to the Commission, the Director of Public Health at Hackney Council pointed out that specific funding for mental health support of around £2.4m had been included as part of the transfer of public health funding from the (now-abolished) primary care trust to the Council. The use of this funding was reviewed in terms of its effectiveness and value for money and, in particular, whether the funding was being used for its stated purpose, which was to build mental health resilience. In the Public Health team's analysis, they found that only roughly 50% of the previously contracted activity was used to help people to build resilience and there was not a sufficiently co-ordinated approach to how this money was spent. In developing the IMHN, the Council's Public Health team stated that they worked very closely with the CCG and the individual providers. They focused on developing a single point of access and in ensuring that resources could be used more flexibly across the IMHN.

5.2.7 We learned that the procurement of the IMHN had been delayed to ensure there was sufficient time to work through any problems, particularly around the user-involvement element, and that the CCG had been invited to all the planning meetings. The commissioners of the IMHN reminded us that they had gone to the market with the same budget as previously (£2.4m) so it was not correct to portray this as a cut. During the procurement process, the scope of the services being procured was slightly altered with the procurement of a separate "user involvement" element being paused. This might have accounted for some contractors believing that there had been a reduction in funding.

5.2.8 The contract for City and Hackney Mind to operate the IMHN had come in at £100K less than the previous total. Although the new funding arrangement involved payments being calculated according to the number of patients seen, there was a guarantee that 50% of the projected funding would be paid regardless of the actual caseload. In turn, the IMHN's sub-contractors also received a 60% upfront funding guarantee. Hackney Council's Assistant Director of Commissioning and the Council's Director of Public Health argued that while they understood the concerns of organisations at the passing of the previous model, the key principle underpinning the IMHN was to ensure that the Council paid providers for services received rather than by a block contract fee.

5.2.9 On the issue of communications, the commissioners assured us that conversations were ongoing with the CCG. We learned that, after February 2015, one-to-one therapy would continue to be provided for current service

users if no other arrangements could be made. The focus would be on finding alternative funding and support to enable people to recover and move on.

5.2.10 We noted that culturally-specific organisations such as Derman were struggling to provide vital services to very vulnerable service users. At Derman, we met a group which included people who had fled to the UK as refugees often after having experienced very severe psychological trauma in their country of origin, had then experienced long delays in securing residency during which time they were prevented from looking for work and so became dependent on welfare and had remained in social housing. This group exhibited the long term effects of post-traumatic stress disorder and had become very dependent on Derman. Some had been attending for 10 years or more. None had functional English and so would not be suitable for generic group therapy.

5.2.11 Bikur Cholim, whom we also visited, stressed that group therapy would be totally alien to their community also as it contravened cultural and religious norms relating to privacy. We noted on our visit to them that they had had to set up separate entrances and exits from their consulting rooms so that clients felt that their visit to the centre would remain confidential. They argued that nobody from the Charedi community would attend a generic IAPT service.

5.2.12 When we visited the HUHFT's IAPT service at St Leonard's hospital, we were told that they had both Charedi Jewish and Turkish clients. There is, therefore, a need to take into account (a) patients who cling to their community provision and find it difficult to access generic services outside of it, and (b) other patients from those communities, who will use IAPT provision precisely because it is separate from the community and therefore appears to provide greater anonymity. From the evidence we have seen, it is not realistic to suggest that all those from BME communities could easily be enticed into generic provision.

5.2.13 Following our site visits, we reflected that no commissioner in Hackney seemed to be taking responsibility for the totality of services which an organisation like Derman provides. The fragmentation of funding was part of the problem in that each commissioner only looked to its own deliverables rather than taking a more holistic approach to what these service users actually require. The commissioners of IMHN argued that the new network combines both generic and culturally-specific provision and that, in the former, they have workers who are culturally competent to serve particular local communities. The clinicians in the BME Access Service at ELFT, to whom we spoke, took issue with the whole concept of 'cultural competence', arguing that it involves much more than simply translating interventions and materials into another language but rather forging an understanding of the cultural, social and historical issues relevant to the communities concerned. We will address this further in 5.8.

5.2.14 .We noted that the Council's Assistant Director of Commissioning was meeting weekly with City and Hackney Mind and there were monthly discussions with providers. The Council will also fund clinical governance training which some of the providers require. Providers were encouraged to move towards more group therapy provision but the focus was always on how to ensure the support being provided was productive. The CCG also pointed out that they were making some non-recurrent funding available to fill any gaps in provision.

5.2.15 We noted that Family Action which had previously been commissioned by the (now-abolished) primary care trust had opted out of the IMHN. Local GPs and others had expressed concern about the loss of their valuable family therapy services which they delivered in local GPs' surgeries. The Council's Assistant Director of Commissioning clarified that Family Action had chosen not to be part of the IMHN and they had not been "de-commissioned". We were assured that City and Hackney Mind, as the IMHN's lead operator, was reinvesting this money and no monies were being banked as savings.

5.2.16 In terms of moving forward with the IMHN, the commissioners in the Council and in the CCG all argued that there was also responsibility on the voluntary sector too to know its market well and to develop business models such that commissioners could put in place the best range of funding to support them.

Recommendation One

The Commission requests the Health and Wellbeing Board to ensure that with the roll out of the Integrated Mental Health Network from 1 Feb 2015 :

a) Talking therapies, particularly culturally specific, one-to-one, therapies provided by BME community organisations, do not lose out to solely generic provision.
b) Any funding gaps arising from the creation of the Network which impact on the prevention and early intervention stages are addressed so that those who are unable to make progress via group therapy are also catered for.
c) Consideration is given to whether the provision of IAPT might include a BME voluntary sector element.
d) The role of BME organisations in delivering preventative services which are wider than direct mental health support is better acknowledged as they are providing services and are thus contributing to wider social capital.
e) Local health and social care partners examine how they might actively recruit staff or volunteers from local BME communities, such as Turkish/Kurdish, with a view to training them or encouraging them to qualify in the health and social care professions.
f) Preventative programmes are better co-ordinated with local health partners and that commissioners do not act in isolation when making changes aimed at delivering on their own cost saving programmes.
g) Although the focus of these services is on helping people to become well and able to function in society, there also needs to be a range of services to allow people to access continuing support after an initial period of therapy.

We will be expecting evidence of this implementation in the 6 month update.

5.3 WIDER DETERMINANTS OF MENTAL ILL-HEALTH

5.3.1 Mental health, including depression and anxiety, is affected by a range of factors including employment, education, living and working conditions, diet and nutrition, physical health, social networks and lifestyle choices, which can all, in turn, be affected by mental health. By better understanding these determinants, the Council and its partners can develop means to address them to promote good mental health and prevent the onset or deterioration of mental illness, through the delivery of local government services, as well as partner-led provision of services. Preventing depression and anxiety in Hackney is also likely to contribute to improving citizens' employment prospects, educational attainment, living and working conditions, dietary habits, physical health, social networks and lifestyle choices. Such a virtuous circle is a powerful reason for Hackney healthcare commissioners to take positive action to prevent depression and anxiety amongst our fellow citizens.

5.3.2 Public Health pointed out the broad set of community factors which are known to affect health and wellbeing for the population in general:

- strong association between **low income** and poor health;
- people in **work** enjoy better physical and mental health than those without work;
- people with low levels of **educational achievement** are more likely to have poor health as adults;
- there are important risks to health from the cold and damp associated with **poor housing**;
- **homelessness** can be a significant cause of ill health;
- there are ways in which the environment can have an adverse affect on health - for example, through **pollution**; and
- people are likely to be healthier when they live in 'healthy **neighbourhoods**'.

5.3.3 In the sections 5.4 onwards we address some of these wider determinants in more detail.

5.4 HOUSING/HOUSING-BASED SUPPORT

5.4.1 There is a strong association between poor housing and mental health problems, including depression and anxiety. Those living in local authority housing have, for various reasons, poorer mental health than those in owner occupied accommodation. Poor-quality housing, for example dwellings which are damp, lack security or are noisy, are particularly associated with depression. The decrease in social housing provision and the lack of affordable housing is leading to overcrowding, which damages family relationships and children's emotional development.

5.4.2 Homelessness can be both a cause and a consequence of major problems for a person's health, both physical and mental. A third to a half of homeless people sleeping rough have mental health problems. In particular, homelessness can be a consequence of living with a mental illness. Homelessness itself is a stressful situation and can lead to depression and anxiety, with mothers and children suffering significantly higher levels of mental health problems.

5.4.3 We looked at the types of housing offered by Hackney Homes and by Family Mosaic, which is the largest Registered Housing Provider in the borough, with the latter providing a mental health floating support service in one third of the borough. We also looked at how the Council's social care department commissions a range of targeted preventative services, some of which have a specific mental health component.

Hackney Homes

5.4.4 Hackney Homes manages 31,000 properties on behalf of Hackney Council. Within it, a "Tenancy and Leasehold Services Directorate" is responsible for providing tenancy management services, including enforcement and support. The directorate is divided into various teams, including "Centralised Housing Services" who provide specialist anti-social behaviour case management for high level and complex cases, and "Neighbourhood Services", who deliver generic, highly-localised tenancy management through estate management teams. These estate management teams are the main point of contact for tenants.

5.4.5 Prior to the start of a tenancy with Hackney Homes, any vulnerability and/or support needs are expected to be flagged in the information provided by the Hackney Council's Housing Needs department in a housing application and homelessness assessment. Support to maintain tenancies is generally provided on a reactive, individual basis as required, where a resident has a particular issue that comes to the attention of the estate manager; this can be anti-social behaviour, rent arrears, or general difficulty in managing their tenancy as manifested by hoarding or allowing the property to deteriorate into an unhygienic state. The tenancy management teams then work with colleagues in other parts of Hackney Homes, such as the specialist income and anti-social behaviour teams, and with colleagues in the Council's Adult Services and Mental Health teams to support the tenant. Officers can also

refer tenants on to external specialist support services, such as that provided by the Council's Targeted Preventative Services team.

Targeted Preventative Services

5.4.6 The Targeted Preventative Services (TPS) team forms part of the Council's "Promoting Independence Strategy". The team work on a prevention basis, available to Hackney residents aged 16 and above who would benefit from targeted support to help them with a particular set of issues, to cope in a crisis.

5.4.7 There are three main services offered by the TPS team:

- **Floating Support** to tenants in their own homes;
- A **Volunteering and Befriending** service; and
- A **Health and Wellbeing** service for the local Jewish orthodox and wider Jewish community in the north of Hackney.

5.4.8 The Floating Support service providers are **Family Mosaic** (for Shoreditch), **One Support** (NE and NW of the borough) and **SHP** (Homerton). The Health and Wellbeing Service is provided by **Norwood**, a Jewish charity supporting vulnerable children, families and people with learning disabilities. Referrals to each of these services are managed by **Outward**, who provide a single point of access for all referrals from Registered Housing Providers working in the borough.

5.4.9 The TPS services take referrals from residents considered to be vulnerable because of any of the following factors:

- severe social isolation;
- frailty caused by age;
- mild mental health needs;
- non-complex learning or physical disability;
- long term health needs;
- mild substance abuse issues; and
- who are on the verge of a crisis.

There were 1,500 referrals to TPS services in the last three quarters alone. Hackney residents with more severe mental health or other needs are referred to Council's Adult Mental Health team or the Community Mental Health team which is provided by the Homerton. Hackney Homes has also worked with an organisation known as "Making Room", which provides services to assist hoarders resolve the issues that lead to their extreme behaviour.

5.4.10 The 'Floating Support' service covers such areas as:

- developing skills and providing training to obtain work;
- assistance in contacting or maintaining contact with other agencies such as social services, probation or voluntary agencies;
- making connections with community, friends and family;
- participating in leisure, cultural, faith or informal learning activities;
- access to services such as care or counselling;

- help with registering with a GP or dentist;
- applying for welfare benefits;
- dealing with rent arrears or debt;
- arranging repairs or aids or adaptations;
- practical living skills; and
- dealing with anti-social behaviour.

5.4.11 The Volunteering and Befriending Service aims to tackle loneliness by matching people to a suitable volunteer who can provide emotional support and friendship. People are also encouraged to consider volunteering in order to feel more connected to their community.

5.4.12 The Health and Wellbeing service offers activities such as healthy eating, sports and leisure and work skills.

5.4.13 The intention with all the services is that they interlink.

'Homecheck Scheme'

5.4.14 Hackney Homes has recently developed a 'Homecheck Scheme' which is designed to provide informal support and a 'friendly face' to those residents that do not currently receive support from any other source despite being identified as potentially requiring some assistance. Requiring assistance can be something simple such as needing information or 'sign-posting' to appropriate organisations or - where a greater need is identified – being referred to formal support schemes such as those that fall under the umbrella of the TPS. Any referral to a third party will, in most instances, be made with the permission of the resident concerned. While referrals to more formal support services may be required, it should be noted that this scheme is hoped to be informal in nature, with a resident-centred approach, providing a 'friendly face'. Estate management staff are expected to use the scheme as a way of continuing to build relationships and trust with their residents rather than simply using it as a 'box-ticking' exercise for referring residents on to other provision.

5.4.15 By identifying and visiting residents in this way the estate management teams are, on behalf of Hackney Homes, bridging a gap in service provision. It is intended that estate management staff will help individuals to continue living independently thus preventing a number of low to medium level issues from developing into problems that would ultimately require more high-cost support in the future.

Family Mosaic's mental health services

5.4.16 We heard from and visited one of the 'Floating Support' providers, Family Mosaic, who are also one of the main housing providers in London and the South East with 3000 properties in Hackney alone. They also deliver a wide range of care and support services across the borough, supporting over 800

people aged 18 and over. The following table illustrates the range of provision in Hackney and the activity levels in November 2014:

Mental Health Floating Support	129 customers 18+
Mental Health Supported Housing	170 aged 18+
Health and Wellbeing Project	224 participants aged 50+
Shoreditch Floating Support (contract for 1/3 of the borough)	375 customers 18+
Older People's Services	109 aged 55+
Single Homeless Service	10 customers 18+
Learning Disability Services	36 customers aged 18+

5.4.17 Family Mosaic's floating support service is intended for residents living in their own homes and who are referred to the service by a body known as the "*Mental Health Supported Housing Panel*" (made up of officers from the Council, ELFT and Family Mosaic) when cases come to the attention of officers. Separately, they manage 170 units of mental health supporting housing accommodation on behalf of the Council. This accommodation is for clients with low/medium to high support needs who have to have met the criteria for receiving statutory support. In addition, Family Mosaic provides mental health support to Family Mosaic's own tenants in its 'General Needs' housing. This in-house support can cover tenancy sustainment, debt advice, welfare rights advice, employment support and social inclusion activities and events.

Issues from Housing Providers

5.4.18 We noted concerns from housing managers that they often felt left to manage all areas of concern affecting a resident suffering from mental illness. They reported that this was a strain on their resources as they were usually seen as the link between all agencies. There was also an issue with encouraging people to engage with services so that they could be diagnosed and receive appropriate treatment. They felt that if the tenants didn't engage, they would be discharged from services. Their focus was on trying to drive up mental health literacy and to reduce the stigma attached to and ignorance of mental illness, so people seek help for themselves and their relatives.

5.4.19 Another concern was that partners often only engaged with mental health issues when they reached crisis level. There was an understanding that most agencies, including local authorities, are constrained as to what they are able to accomplish depending on how serious a crisis has become. The Family Mosaic neighbourhood managers, for example, reported that they did not always have risk assessments from the Council prior to residents moving in to a Family Mosaic property and they were sometimes not aware of their new tenants' mental health issues until they moved in and began to show signs of their deteriorating mental health. Family Mosaic neighbourhood managers also reported that they were often unsure of the difference between generic vs community-based mental health support and found it difficult to identify the more specialist services – such as those which are culturally-specific – available locally.

5.4.20 Hackney Homes told us that their front line housing officers are not sufficiently trained to recognise the symptoms of clinical depression and the challenge for them is that many of these symptoms will lead to the sufferer refusing to engage with their support service, whilst behaving in a way that results in the housing provider being forced take enforcement action to deal with the problem (*e.g.*, failure to pay rent due to inability to deal with the benefits system, anti-social behaviour, deterioration in the condition of the property). We acknowledge here that the housing providers' priority is always to offer support in the first place but if the tenant refuses to engage with them, or with the specialist agency to which they are referred, the housing provider cannot force them to accept that support. In any case, there would appear to be both a training need and for solutions to be found to better share the burden on individual providers, for example by creating a joint crisis line.

Recommendation Two
The Commission recommends that the Council's "Housing Needs Service" jointly with Hackney Homes and ELFT:

a) Expand on the existing initiative on mental health awareness training for staff. This needs to build on existing best practice and focus on clear pathways that staff know will work.
b) Ensure that front line workers are kept up to date on the available care pathways**,** the resources open to them in giving support to vulnerable residents, and that clear escalation procedures are in place. This needs to include dealing with complaints from neighbours about erratic or anti-social behaviour.
c) Consider how they could work with Registered Housing Providers to develop a joint crisis line to which clients with mental health problems could be referred.

5.4.21 While there is a complex matrix of services here with some support being tied to tenure and some being universal and provided, albeit with qualification thresholds, by the Council, a provider like Family Mosaic is in many ways better placed than others to provide support because it also has expertise in delivering mental health specific support as well as general housing provision. We noted that because of its size Family Mosaic is in a good position to integrate and coordinate provision. Hackney Homes however appeared to suffer, at times, from disconnect with other agencies or with departments of the Council. With Hackney Homes coming in-house, we are asking Cabinet members to consider how Hackney Homes can better interact with the Council's Adult Social Care department and its Public Health department (also in-house) to better support its tenants in preventing depression and anxiety. There is history of good practice here in the unified approach which Hackney Homes and the Council's Community Safety Team and others have taken to handle anti-social behaviour on estates and we would urge that such an approach is replicated in the area of mental health.

5.4.22 Some frontline officers appear apprehensive about offering assistance because of the perceived complexity of the care pathways. They are concerned that, if they engage with a resident, they may not be able to follow up with some concrete support. While it is always easy to suggest better co-ordination then to implement it, there is certainly an opportunity with the management of Hackney Council's housing stock coming back in-house to look again at how mental health support could be provided more holistically to Hackney's social tenants and leaseholders.

Recommendation Three
The Commission recommends that the Cabinet Members for Housing and for Health Social Care and Culture ensure that the opportunities created by Hackney Homes coming in-house are harnessed to foster closer working relationships between Hackney Homes and the health and social care staff. A good model here is the success of the joint working on ASB between Hackney Homes and the Council departments. It is suggested that having a mental health worker as part of the Hackney Homes team would represent a useful first step here.

Move-on accommodation for those in mental health care pathways

5.4.23 Persuading residents with depression and anxiety to seek support can be difficult but there are further challenges down the line when they come to the end of their initial treatment. Those in Mental Health Supported Housing, for example, who like many people with mental health needs will have fluctuating conditions, can often find themselves moving in and out of short term supported housing. We noted there had been a small allocation of housing for such residents but that this accommodation had recently been withdrawn by Housing Needs and Family Mosaic was very concerned at this.

5.4.24 The Council allocates in the region of 80 units of housing quota to supported housing to facilitate move-on from short-term services. Currently, Hackney Council's Access and Inclusion Team makes 12 self-contained accommodation units available each year, to aid move-on from the mental health supported accommodation pathway. These units allow supported housing providers, of which Family Mosaic is one, to move people on, enabling new users with mental health needs to be accommodated, and preventing these services from becoming blocked. A decision has been made not to accept nominations to this quota from residents in these services housed by and/or receiving support from Family Mosaic. Family Mosaic currently support over 80% of the people in this pathway. The Council's rationale appears to be that, as Family Mosaic is the largest social landlord in Hackney, it should be able to house the people it supports itself. In summary, dedicated mental health move-on accommodation is being withdrawn from Family Mosaic and they are being asked to make up the shortfall from their own existing general needs housing stock. Family Mosaic has formally responded by saying that, if this continues, they will have to reduce the general needs housing that it offers to the Council by the same amount. This

would appear to be a zero sum game in terms of Hackney's stock allocation and it highlights the complexity here.

Recommendation Four
The Commission recommends that the Cabinet Members for Housing and Health Social Care and Culture review the provision of move-on accommodation for those in the mental health supported housing pathways. This would involve looking at whether the current Nominations Agreements between the Council and Registered Housing Providers are working in the best interests of tenants with mental health needs and, in particular, provide the stability which can help prevent crises. These tenants often move in and out of short term supported housing, typically have fluctuating conditions and their needs often get addressed only when they reach crisis point.

Housing as part of discharge planning

5.4.25 We also heard concerns that discharge pathways for mental health patients are not clear and there is insufficient support for these patients. Good practice should dictate that discharge planning happens at the admission stage and not soon before discharge. From our discussions, it is clear that these patients should be offered housing advice far earlier.

5.4.26 We also heard that people suffering from mental health illness generally struggled to navigate Hackney Council's "choice-based lettings system". Under this system, people on Hackney Council's waiting list for social housing must apply for available properties which are advertised, rather than being allocated a home. Quite apart from the difficulties that the person may encounter in understanding the bidding process, they may also, for example, be invited to view a property and, if they missed the appointment, they would then lose out. People with mental illness left to their own devices in navigating these systems could often end up in crisis. Helping these clients to attend Hackney Council's "Homelessness Persons Unit" was also suggested as a way forward. Providing specific housing needs advice in hospital wards/GPs' surgeries was suggested as another solution here. Likewise, we heard from City and Hackney Mind that if there were to be a steering group of the various floating support providers in place some progress might be made in this area.

Recommendation Five
The Commission recommends that ELFT reviews planning for discharge for mental health patients in the Homerton Hospital's Mental Health Unit. In particular, housing issues need to be identified at the admissions stage and acted upon through the provision of housing advice in hospital wards/at GPs' surgeries, as appropriate. Furthermore, the Commission requests that this issue be picked up in the 'Hackney Vulnerable People's Protocol' being developed in Hackney in response to the Care Act 2014.

Recommendation Six
The Commission requests the CCG and the Council to consider a proposal from City and Hackney Mind to establish a steering group of the Floating Support Providers in the borough so as to assist in better co-ordination of services and to improve communication.

5.4.27 One aspect of the welfare reforms which is impacting on people with mental illness are the restrictions on shared accommodation. In the past, there was an expectation that clients might be able to move to 1-bedroom housing. However, following the welfare reforms they must now share accommodation if they are single and under 35. Clinicians agree that shared accommodation is not appropriate for those recovering from mental health issues if their first tenancy is not in a supported housing environment.

'Health Begins At Home' report

5.4.28 We discussed the interim findings of Family Mosaic's major research project '*Health Begins at Home*'[17] which is being undertaken with the LSE. Central to these findings was the belief that good housing can help to reduce costs in the NHS. One way in which this can be achieved is by working with GPs and hospitals to provide home-based services that take the strain off expensive health facilities. Another approach is preventative, promoting health and wellbeing initiatives among tenants, so that their health improves and their NHS usage declines. The report's interim findings make a solid case for early intervention and draw on data from Family Mosaic's housing in Hackney, Islington, Hammersmith & Fulham and Haringey. Alarmingly, a headline finding in the report is that 71% of over-50s in Family Mosaic's housing have one or more long term medical conditions. It is clear from the interim report that need amongst their tenants and among social housing clients generally is much higher than in the general population. We look forward to the publication of the full report in April 2015.

5.5 EMPLOYMENT

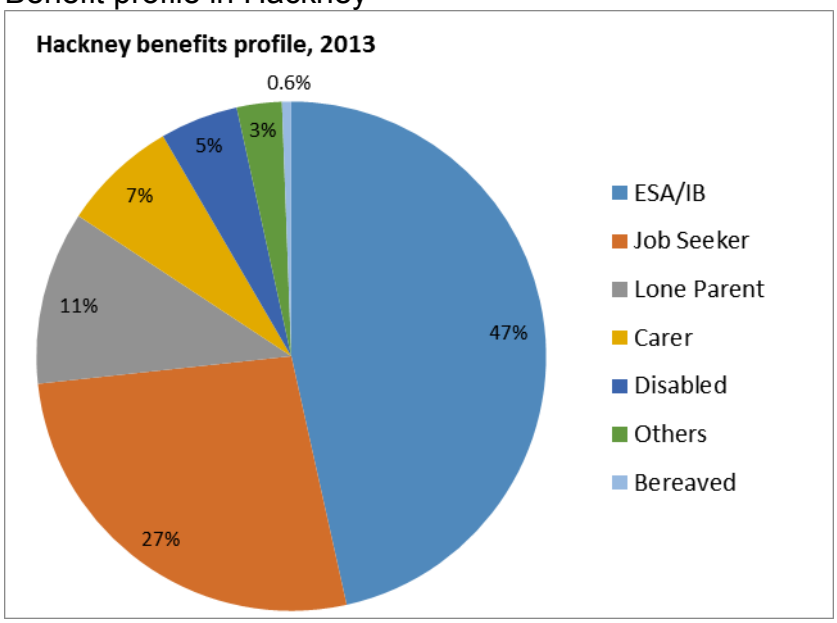
5.5.1 We learned from the Council's Public Health team of the important role that employment plays in maintaining good mental health and the extensive research which backs this up. The obverse of this is that unemployment has been recognised as having major links with poor mental health. National research has found that unemployed people are the group most likely to suffer high levels of all psychiatric disorders. This is a complex issue, because people may also be less likely to be in paid employment due to pre-existing mental illness. Alternatively, unemployment may lead to deterioration in mental health. Both may apply of course, but studies suggest the latter is significant.

[17] http://www.familymosaic.co.uk/userfiles/Documents/Research_Reports/Health_Begins_At_Home_web.pdf

5.5.2 Similarly, the research shows that people at higher risk of common mental health problems include those with no or few qualifications and who are unemployed. There is a well-established link between learning and mental health beyond the school years, with participation in learning opportunities leading to increases in human, social and individual capital, in terms of knowledge, skills, trust, dependency, positive self-image, assertiveness and confidence. Adult learning has an important part to play in promoting health and wellbeing also.

5.5.4 The latest data from the Council's Local Economic Assessment shows that 48% of the c14000 people in Hackney on long term inactive benefits (*i.e.*, 6,420 people) are claiming because of their mental or behavioural health.[18] In addition, 57% of benefit claimants have been claiming for 5 years or more.[19] The benefit profile in Hackney, below, shows that nearly half of all claimants are on ESA or Employment and Support Allowance (what was previously incapacity benefit).

Benefit profile in Hackney[20]



Source: DWP administrative data / nomis

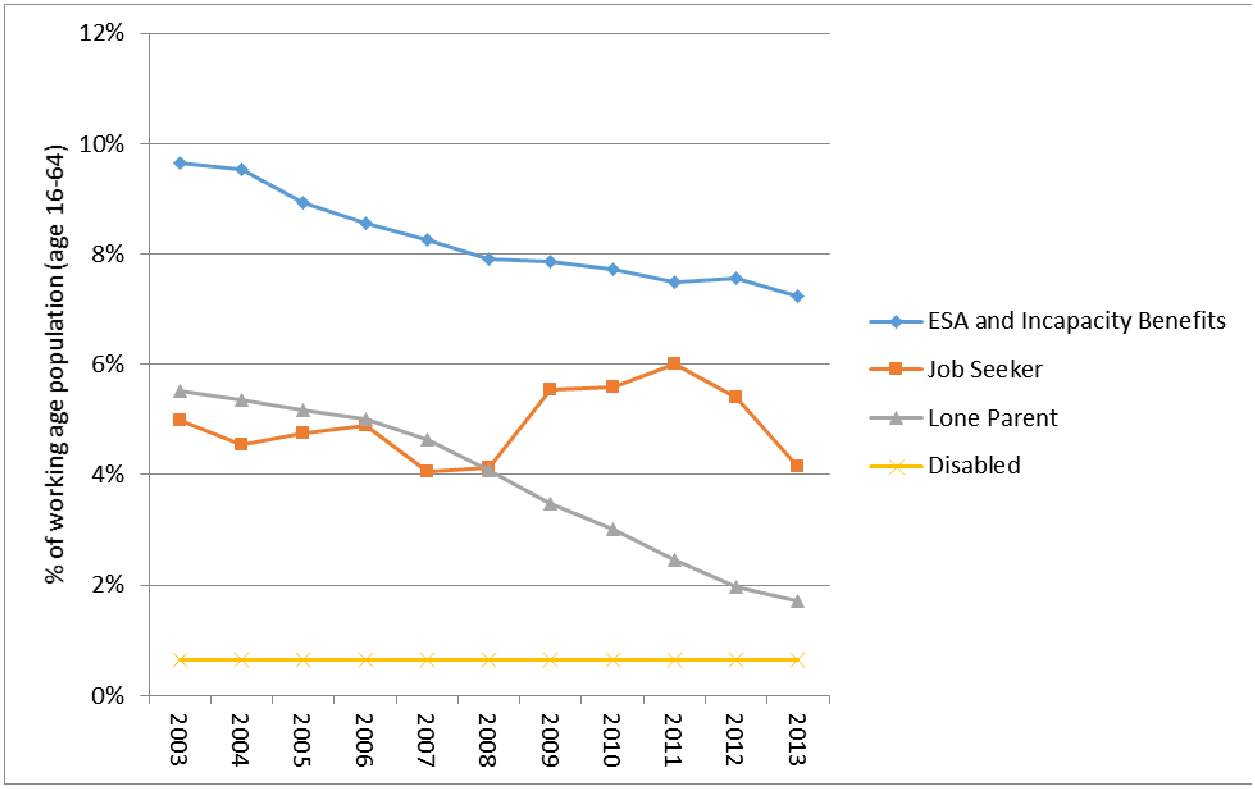
The following chart shows a slight decline in the numbers on ESA in Hackney as a proportion of the working age population:

Key out of work benefits, as proportion of working age population

[18] http://www.hackney.gov.uk/Assets/Documents/2014_LEA_Headlines.pdf, page 5.

[19] *Ibid.*, page 4.

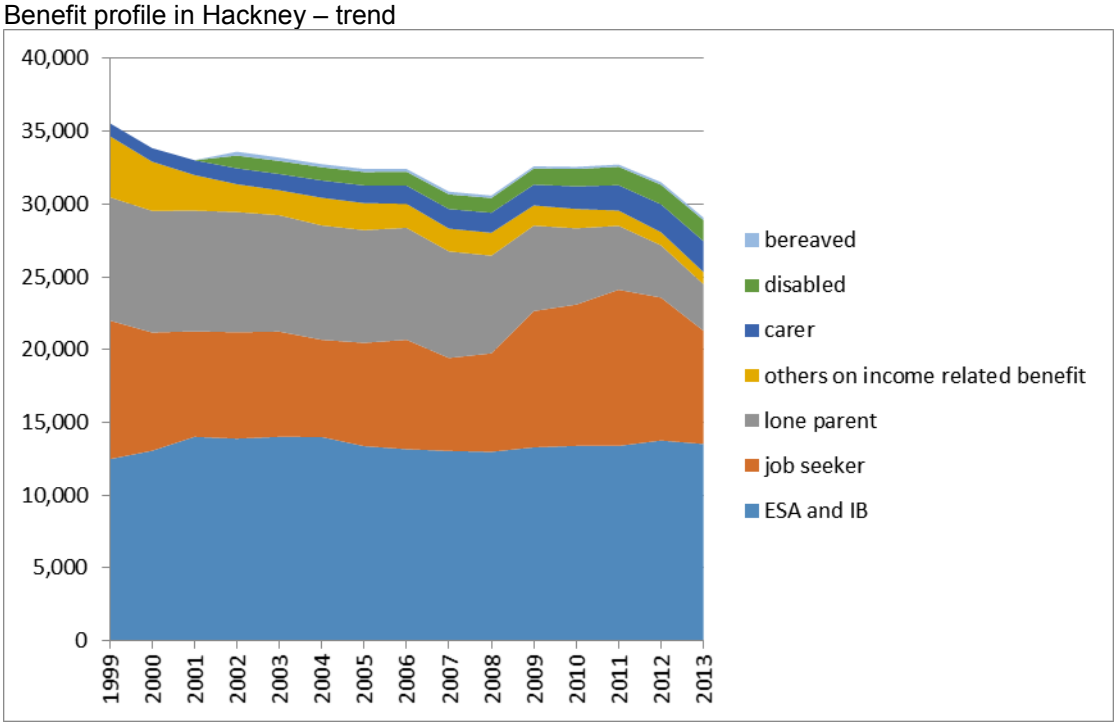
[20] Briefing on duration and characteristics of long term unemployed in Hackney, Policy Team, Oct 2014



Source: Source: DWP administrative data, nomis. Note: working age population figures are from ONS mid-year population estimates. 2013 data is not available yet, and so the 2013 figure has been extrapolated using the average working age population growth from 2007-12.

However little impact seems to have been made on overall numbers on ESA

Benefit profile in Hackney – trend



5.5.4 This persistent high level of long-term ESA claimants underlines the importance of having a greater focus on prevention and early intervention because, once an individual starts claiming ESA, they tend to remain on it in

spite of the greatly increased sanctioning taking place under the Coalition Government's welfare reforms. It is interesting too that most of the fall in long-term benefit claimants in Hackney over the past decade has occurred among women and this relates to a significant drop in the number of lone parent claimants. Increased conditionality under the welfare reforms and the redistribution to JSA are major contributors to this reduction however.

5.5.5 In the area of depression and anxiety, we learned that people often deteriorate to crisis or breakdown before they seek help. Typically, if they are working, they will be 'signed-off' and, if there isn't sufficient support in place to organise a managed return to work, their situation worsens. Some people can stay off work for long periods because they fear not being able to cope on return or because their managers lack confidence that they can handle them or their co-workers or a mixture of both. Obviously, if specific work-related stress was the cause of the breakdown in the first place then a return to the same job may not be the answer but there will be alternatives. Generally, we heard that if a person can negotiate or be assisted to negotiate an effective gradual return to work, then it is the best solution for both parties.

5.5.6 Helping people into employment or to return to work is a key part of the support which many of the organisations we heard from provide for those suffering from depression and anxiety. We were particularly impressed with the work of the job retention service run by City and Hackney Mind. In addition to their employment advisers, they have embedded an adviser within the IAPT service provided by the HUHFT. The service has supported 66 people to retain their jobs in the past year. Clients are referred generally by GPs and have been signed off sick with depression and anxiety. With the client's permission, the advisor might contact the client's HR manager or line manager to mediate a managed return to work or perhaps to draft a compromise agreement or help someone in dealing with an Employment Tribunal.

5.5.7 City and Hackney Mind works with employers to campaign to improve mental health and wellbeing in workplaces and have, for example, run courses on stress management with such large city employers as Société Generale. It was heartening to hear from them that, more often than not, employers are happy to engage although their advisers do not have any rights to accompany a person to an arbitration meeting. The main constraint on these services is the very limited number of hours that have been commissioned. We would encourage commissioners in the Council and the CCG to look more closely at developing this further.

Recommendation Seven
The Commission requests that the Council and the CCG explore with Job Centre Plus and the Council's own Ways Into Work team the commissioning of services to help people with mild to moderate mental health support needs to either retain their jobs and or find new employment. This acknowledges the significant proportion of people in the borough who are workless because of mental illness.

5.5.8 Our discussions on support to employees covered both private sector and public sector employers and we feel that if progress is to be made in this area, public sector employers must be seen to set an example. City and Hackney Mind and the IAPT providers told us they had a number of clients who were staff of local authorities or the NHS. We heard directly from clients at the IAPT service about their varied experiences with managing a return to work and the clinicians at the IAPT service underlined again the importance of returning as an aid to recovery.

5.5.9 Flexible hours, compressed hours, some home working and stress management courses should be used better by managers. Often, modifications such as simply moving a person's desk to a more discrete position or providing a quiet room for someone to regain composure if they have experienced panic or distress can be transformative in this context. Being able to take short breaks or a short walk away from a desk can also be vital and none of these measures should place an undue burden on employers. At the early stages of a return to work, a manager's flexibility in allowing a staff member time to attend clinician appointments is important as is being understanding should an employee experience problems during a changeover of medication. City and Hackney Mind told us that employers were less sympathetic and less likely to make reasonable adjustments for employees with mental health problems than they would if those same employees had physical problems. This stigmatisation needs to be actively challenged in 'mental health in the work place' campaigns. Most support measures cost little or nothing to implement and the investment in existing staff can produce large returns, so greater flexibility should be heavily promoted to all employers.

5.5.10 We heard from the Centre for Mental Health about the NHS's system called "*Individual Placement and Support*" where they would find a job for the individual in the NHS and then support them while in it. The Centre argues that a key focus must be to get people real jobs quickly rather than parking them in 'Work Programme'-type placements. The aim is to move the risk for the individual from high level to low level and get support in early.

5.5.11 We noted too the successes thus far of the Council's "*Ways Into Work*" team in helping mostly younger people into employment and we ask Hackney Council's Cabinet to consider if a similar focus might also be brought to bear on helping back into work, even a small proportion, of the over-6,000 Hackney residents who are on ESA for mental and behavioural health reasons. In terms of the Council's in-house employment support services we request that they be reviewed to take into account the model of intensive employment support which could be offered to people with low level mental health needs.

5.5.12 We learned that the Council is working to gain accreditation to the "*London Healthy Workplace Charter*" (which includes workplace standards relating to mental health and wellbeing) and we look forward to seeing what initiatives the Council's HR&OD and Public Health departments will be implementing as part of this.

Recommendation Eight
The Commission suggests that the public sector employers should aim to lead the way in developing practices to ease the path back into work for those who are suffering from depression and anxiety, if the overall cost to society is to be reduced. The Commission requests that the Council's HR and OD department and its Public Health department as well as the HR departments of the local NHS Trusts and the CCG publish information explaining what initiatives they have in place to improve mental health in their own work environments (*e.g.*, anti-bullying, stress management) and how they currently support individuals with lower level mental health problems to remain in work and to plan for a managed return to work after periods of sick leave.

5.6 DEBT, POVERTY AND DOMESTIC VIOLENCE

5.6.1 The relationship between high levels of deprivation and high rates of mental ill-health is well established. We heard from the Council's Public Health team that studies have found an association between mental health and socio-economic status, showing higher rates of psychiatric admissions and suicides in areas of high deprivation and unemployment. Regardless of age or gender, there is an increased risk of mental illness for the poor when compared to the better-off.

5.6.2 Similarly, those living in poverty are more likely than average to be victims of crime, suffering more home break-ins, vandalism or deliberate harm to their home or car, or theft. Fear of crime is also greatest amongst the poor and the elderly, and this is linked closely to poor mental health. Crime, especially violent crime, is linked to mental health issues in a number of ways: links with drugs, alcohol and deprivation; victims of crime are more likely to suffer mental health problems; and violent crimes which are committed by people with mental disorders are more frequently reported. Consequently, areas with high levels of violent crime are likely to have higher levels of mental illness.

5.6.3 The links between mental health and deprivation also have a bearing on domestic violence. Men and women with all types of mental health disorders have increased odds of involvement in domestic violence compared to people without a mental disorder, with prevalence rates being higher for women. Officers from the Council's Public Health team told us that the median prevalence rate for having experienced partner violence in the last year was 35.3% for women with depressive disorders and 28.4% for women with anxiety disorders. These prevalence rates are between two and seven times higher than for women without mental health problems. All this evidence points to the importance of early intervention in mental health.

5.6.4 We heard about the support which the Council and social housing providers offer. Hackney Homes, for example, provides in-house debt management support to tenants via the welfare reform team within Hackney Homes' "Income Services". These work on financial inclusion, and the provision of debt and welfare rights advice. Their *Money Smart* project takes referrals with

the aim of assisting tenants to avoid eviction for rent arrears. All of these facilities must be sustained, particularly during a period of austerity when the need for these services is going to be higher.

5.7 LONG TERM CONDITIONS/ SOCIAL ISOLATION

5.7.1 Mental health and physical health are intrinsically related. The national mental health strategy "*No Health without Mental Health*" states that having a mental health problem increases the risk of physical ill health. Overall, the evidence suggests that at least 30% of people with a long-term physical illness also have a mental health problem. In relation to common mental health disorders, the Council's Public Health team reminded us that:

- depression is two to three times more common in people with a chronic physical health problem, such as cancer, heart disease, diabetes or a musculoskeletal, respiratory or neurological disorder.
- depression increases the risk of mortality by 50% and has been associated with a four-fold increase in the risk of heart disease, even when other factors are controlled for;
- untreated depression and anxiety disorders are associated with increased health care usage - not only ongoing consultations and treatment in relation to the specific mental health condition, but also increased health care usage more generally; and
- co-morbid mental health problems have a significant impact on the costs related to the management of long-term conditions. For example, the total cost to the health service of each person with diabetes and co-morbid depression is 4.5 times greater than the cost for a person with diabetes alone.

5.7.2 The CCG detailed for us the diverse range of long-term condition (LTC) care pathways which they have in place. These cover: gastroenterology, dermatology, ASD/Aspergers, cardiac disease, chronic obstructive pulmonary disease, diabetes, older adults (*e.g.*, dementia), women's health and tinnitus/hyperacusis. Their research on older people locally revealed that 71% stated that they, or a family member, had a LTC and 49% had multiple LTCs. 25% of those with LTC experienced depression or other mental health issue and 76% of those who were depressed had LTC. 44% of this group were living alone.

5.7.3 Social isolation has been recognised by the government as a major issue when addressing mental illness as highlighted by the National Institute for Mental Health in England: "*Tackling isolation is fundamental and may be the most significant area in which mental health promotion strategies can support the mental health of older people. After income and poverty, lack of social participation was the key issue*."[21] There is therefore a clear relationship

[21] National Institute for Mental Health in England (2005), "Making it possible: Improving mental health and well-being in England", Web: www.apho.org.uk/resource/item.aspx?RID=22605

between social support and the risk of mortality and morbidity. Social networks are quantified as the number, frequency and density of contacts with other people. There is a strong relationship between social networks and mental health: those with few social contacts are at increased risk of mental health problems. Social networks can prevent problems arising from stress. Research suggests that they can help people to recover from depression. The focus of Hackney's new Integrated Mental Health Network (IMHN) in helping reduce isolation is therefore a vital one and we support commissioners here in identifying the need to 'build resilience' as playing a key role for the IMHN.

5.7.4 We noted that the CCG has been running a primary care referral pilot called the "*Social Prescribing Project*". This is being run in 3 of the 6 GP consortia areas in the City of London and Hackney and the aim is to test out the effectiveness of providing a social prescription offering a menu of community-based activities provided by voluntary and statutory services as part of their core business. We understand the pilot is for patients experiencing social isolation, those over 50 and those with Type 2 diabetes. It has the potential to deliver improved outcomes for those with anxiety and depression and we will be keen to see whether it has succeeded and what lessons have been learned.

5.7.4 Physical activity is also known to be associated with less depression and anxiety, better sleep, better concentration and possibly a reduced likelihood of problems with memory and dementia. Structured group physical activity programmes are one of the treatment options recommended by the National Institute for Health and Care Excellence for people with mild to moderate common mental health disorders and again developing this aspect of the IMNH and building on links between mental health support programmes and physical activity programmes needs to be a focus for the CCG and the Council's commissioners.

5.7.5 A neglected area here is the mental health of carers. Again, national research has revealed that 40% of carers experience psychological distress or depression,[22] carers have an increased rate of physical health problems[23] and 51% of carers for someone with dementia report that they don't feel they get support to talk about their needs[24]. Allied to building this support is the benefit which carers and sufferers can get from improved neighbourliness. Neighbourliness relates to the percentage of adults speaking to their neighbours, the number of neighbours known and how many are trusted, as well as whether people have received favours from their neighbours in the previous week. It is considered an important aspect of social capital and provides protection from mental health problems, particularly depression and anxiety.

[22] RCGP, 2007

[23] Carers UK, 2007

[24] Carers Trust Report, 2013

5.8 IMPROVING ACCESS AND LISTENING TO SERVICE USERS

5.8.1 We were not looking at East London NHS Foundation Trust (ELFT)'s services as part of this review but the work of their BME Access Service was brought to our attention. Although their work is in secondary care, some of the principles and practices are relevant to people with mild to moderate anxiety and depression. The service consists of one full time Clinical Psychologist (currently a job share) within ELFT's secondary care Psychology Service. Their approach has been developed in response to a substantial body of evidence highlighting how lack of trust becomes a barrier for people from BME communities in accessing statutory services. For these reasons, clients will often disengage from services, *e.g.*, following a traumatic compulsory admission to hospital or after experiences of racism. In light of this, the focus of the service's work is to culturally-adapt therapies to meet the needs of BME communities in secondary care.

5.8.2 There is much evidence of over-representation of BME communities in mental health in-patient settings with an under-representation of these groups in primary care (mostly, GPs' Surgeries). Among the key barriers to people from BME communities accessing primary care are a lack of knowledge of talking therapies, stigma within the communities, language and culture and a general mistrust of services. This cohort also has concerns about the relevance of talking therapies and specific fears that talking therapies will lead to a loss of religiosity. ELFT's main recommendation to services is to develop much closer links with local BME community groups and a substantial amount of their time therefore is spent on outreach activities and in providing training.

5.8.3 ELFT argues that generic and culturally-specific services must work in partnership. They described how the presentation of 'anxiety and depression' among BME communities may be different to that of the white British population. They explained how depression and anxiety are common western idioms or conceptions of distress. In exploring BME women's beliefs and attributions around illness and pain, for example, they showed that for them pain was the physical expression of anxiety, depression and trauma and that it needed to be understood within the context of their history, migration experience and current social situation. The Tavistock and Portman's PCPCS service similarly reported to us that their clients from BME communities (who represent 60% of their patients) are more likely to have manifest physical symptoms or somatisation.[25] For some of these communities, there has been a high incidence of trauma (related to coming from war torn counties) and there are issues of community integration.

5.8.4 We learned about the Trailblazer Project for African and Caribbean men where culturally-specific interventions have been designed around the needs of this group. This project has made great strides in tacking the mistrust of mental health services. They also pointed to research which showed that black men, in particular, may not view primary care as an appropriate place to

[25] Somatisation disorder is a long-term (chronic) condition in which a person has physical symptoms that involve more than one part of the body, but no physical cause can be found.

seek support for psychological distress and that outreach initiatives may therefore be more appropriate.

5.8.5 The Trailblazer team also talked about the need to challenge stereotypes and assumptions about who benefits from talking therapies. These include African and Caribbean men being labelled as "*hard to reach*" or assumptions that they don't want talking therapies. The Trailblazer research made clear that this was not the case. They also wanted to challenge assumptions they found among service providers that the mental health needs of African and Caribbean communities were synonymous with psychosis, *e.g.*, comments like "*We probably won't be working with African or Caribbean community because we don't work with psychosis*".

5.8.6 In terms of their recommendations to improve services for African and Caribbean communities in particular, they argue that work needs to be done to build trust and to develop partnerships with trusted organisations including engaging in proper consultation from the outset. Outreach activities need to promote good practice and they cite the "*Black men on the couch*" initiative of the UK Council for Psychotherapy. These are events in which famous black men have a public 'therapy session' with a black male psychotherapist and which aims to promote the relevance of psychological therapy to black men both as clients and as a career[26]. They also argued that there is a need to work with service providers and those making referrals to challenge stereotypes and assumptions about who benefits from talking therapies. Finally, they suggest that multiple points of access, including self-referral be prioritised because there is some evidence that self-referral selectively favours black communities. We would ask City and Hackney Mind and the commissioners of IMHN to take on board these suggestions as they develop the network.

Recommendation Nine
The Commission requests the CCG's "Mental Health Programme Board" to report back on how it will work with local providers to tackle the ongoing challenge of under-representation of BME people, particularly Black males**,** with mental health issues in primary care settings and their over representation in in-patient settings. The Commission acknowledges that this is a long term issue but seeks assurances that it does not fall down the agenda in a climate of fiscal constraint.

5.8.7 Issues about barriers to access were echoed to us by Heatlhwatch Hackney who pointed to the research done as part of the 'Fund for Health'[27] community research projects. This research revealed that 100% of Vietnamese community surveyed did not know how to access services of a memory clinic or talking therapy. Also, 83% of the Halkevi/Alevi community surveyed did not know how to access mental or emotional health support if they needed it.

[26] These recordings are online at www.psychotherapy.org.uk

[27] *Fund for Health 2014*, report of Healthwatch Hackney and City and Hackney CCG,

Similarly their research on those who have a hoarding condition identified a clear lack of awareness by them of where they could turn to for support.

5.7.8 The evidence from the BME Access team about the need for statutory providers to go into BME community organisations and begin the work of building trust there is an important one. More broadly, there is a greater need for the 'user voice' to be listened to. We learned from the Centre for Mental Health that a lot of mental health care is now being co-produced, with service users involved even in the commissioning stage and their input is threaded through every part of the system. There are examples even of user representatives being represented on recruitment panels within health trusts and provider organisations. It is clear that mental health services as opposed to physical health services have a longer journey to travel here.

Recommendation Ten
The Commission requests thatthe Council and the CCG demonstrate how they are including the 'user voice' in commissioning services for lower level mental health issues.

5.9 A NATIONAL PERSPECTIVE

5.9.1 Our review benefited from input from, Andy Bell, the Chief Executive of the national Centre for Mental Health. The Centre came to our attention since it carried out an evaluation, which we considered of the Tavistock and Portman's Primary Care Psychotherapy Consultation Service at St Leonard's hospital. The Centre acts as a bridge between the research/policy world and service providers but does not provide services itself.

5.9.2 Some of the key points he highlighted have a resonance for Hackney and we would urge commissioners and providers to take them into consideration:

- There is no age when people are not vulnerable to mental health issues and the vast majority of those affected receive no support.
- Despite the vast quantities of NICE guidance published on mental health, unlike the situation with physical health guidance, it is not always implemented with the same rigour.
- There is a critical point of opportunity in mental health prevention and having people other than mental health professionals with the knowledge and capacity to offer help is vital
- Front-line officers in both housing and education must be 'mental health confident' not just 'mental health aware'. They need to be able to convince clients that if they intervene to help them, they won't be deemed 'sub-threshold' by mental health services and denied support.
- A key problem nationally is the significant disparity between the provision of physical and mental health services with the former swallowing up a disproportionate amount of funding. Another was the disconnected nature of the commissioning systems.

- The Tavistock and Portman's PCPCS service was a good example in their opinion of taking a relatively small pot of funding but targeting it so it could have a wide impact
- A better balance needs to be struck between generic and culturally-specific provision. Maintaining a job or securing a job is a key part of recovery for anyone with mental health issues and so spending on mental health awareness at work is vital. The self-enablement agenda such as the Council's 'Promoting Independence' one means that there will be a larger cohort who will require support for longer periods and building the flexibility to deliver this is a major challenge for commissioners. Some people with long term conditions will have associated mental health issues and some may not and this relationship will fluctuate. Time-limited interventions need to be planned therefore with a view to where a client will 'move-on' to.
- The old system, under which there was a tendency for clients to become stuck in a service over an extended period, was not effective either. Clients need to have the ability to drop back in to services and so Floating Support is a vital start.

5.9.3 Mr Bell concluded his evidence to us by arguing that demonstrating or realising 'cashable savings' in mental health is difficult. The Tavistock and Portman's PCPS service might result in clients going to their GPs 25% less frequently but this saving may not mean it is possible to close part of a nearby mental health ward as a consequence. GPs might have a slightly lower caseload but it would be hard to demonstrate how services could be cut because of a successful intervention. However, if we aligned physical and mental health interventions better there would be less need for many pointless GP appointments

5.9.4 We would agree with him that the fundamental justification for health interventions is "better health" and this should be sufficient. We do not judge cancer interventions on the basis of cashable savings elsewhere and there should be no such need in relation to mental health. Building up preventative services in order to reduce bed-based provision is justifiable on the grounds that people do not want to be in hospital, rather than that hospital costs are very high.

6. CONCLUSION

6.1 In our review, we examined whether the commissioners and providers in Hackney are responding appropriately to the high prevalence of depression and anxiety in our working age adult population. We also wanted to ensure the right people were being targeted by prevention programmes and to find out what the Council and its partners are doing about the wider determinants of mental ill health. In the limited time available to us, we looked closely at just two of these in particular - housing and employment. A key focus must be whether those at risk are being identified early enough and what is being done to reduce the factors which lead to poor mental health in the first place.

6.2 Our investigations coincided with the introduction of the Integrated Mental Health Network (IMHN) which will be crucial in helping people to build resilience and it will hopefully reduce the incidence of depression and anxiety in Hackney. We noted some disagreements between providers and commissioners here but ultimately the change to the IMHN involved the same level of funding but a slightly different organisation of it. We noted the Cabinet Member's comments that the (now-abolished) Primary Care Trust had not always been a robust commissioner of services and it was perfectly legitimate for the Council to review how this £2.4m of the public health budget was being spent and to spend it in a different way. Having listened to both sides of the argument, we are confident that misunderstandings can be overcome. The challenge which the Cabinet Member must now set the IMHN is to make sure they demonstrate that it is a significant improvement on the previous uncoordinated and fragmented service. Too often the old model created dependency amongst clients who were not 'moving on' even if this was not the intention of providers who were doing their best to support people. The needs of service users must be central to the IMHN and vital services should not be lost to them because of any lack of clarity between commissioners. We recognise too the wider role which the voluntary sector plays in terms of social capital and how the providers here deliver much more than just mental health support for some clients. We note that in bringing together partners including the CCG and the Council's Public Health team, the Health and Wellbeing Board has a key role in identifying what the local community's needs are and in ensuring that there is sufficient partnership working in place to deliver it.

6.3 On the subject of 'moving on', we saw the challenge faced by Housing Needs and the local Housing Providers to maintain levels of provision for those with mental health problems who need to move-on from supported housing. The current, national financial climate has resulted in greater pressure on services and the Council and social housing providers will need to fight their corner in maintaining the numbers of floating support contact hours and resisting further pressure to increase access thresholds. We can see that, in the new financial climate, the support offered by statutory agencies is now generally confined to those in the greatest or most extreme need and those with low or medium level need will often be classified as ineligible for support. Unless floating support services can engage with and assist these "sub-threshold" clients, there will be a real danger that their housing providers will take action, against them, or even evict them. Such action creates even greater burdens on the

public purse in the longer term. There is a need for longer term thinking in this area as budget holders scramble to protect their own budgets.

6.4 A key issue is to challenge stigma. Too many of those seeking help do so too late and they feel humiliated or alienated by their condition. Too often problems are only recognised when they have reached crisis levels. Progress with employers in both the public and private sectors is vital if we are to reduce the number of wasted lives and the numbers on long term incapacity benefits. As we learned, the adjustments needed to assist employees with a managed return to work are generally not onerous on employers. The social costs of not funding 'job retention' programmes for example means that such programmes deserve much greater attention from commissioners.

6.5 There is a need to strike a balance in service provision between social facilitation vs mental health treatment models such as counselling. Arguments about what is prevention and what is treatment are ultimately futile in that the approach required locally demands providers of both public health services and clinical care to work together. Similarly, generic and culturally-specific provision of therapies must exist in tandem. We acknowledge that arguments about community-based vs generic provision are much wider than just in mental health and that it is an ongoing debate within the Council.

6.6 In relation to improving access, the disparities in treatment in the mental health system remain of great concern. For example, black men are disproportionately being detained by police or in in-patient settings and fewer have their mental health issues picked up by GPs. There is an issue to be explored here in how mainstream services go about identifying local need and how they shape services to meet the specific needs of black men. The key to improving this situation would appear to be the provision of a range of community-based organisations which are credible in their communities and with whom the Council and the CCG can work closely.

6.7 NICE Guidance has highlighted access to IAPT services as vital as well as the encouragement of self-referral and a stepped-care approach. The problem appears to be however that those lower down the level of need generally have their funding cut first. The role of councils here is to ensure a range of support at different levels of need. City and Hackney's IAPT service is mandated to meet a national standard of 15% of need and, while this is low, it is very expensive to meet. Recovery rates are poor but City and Hackney's IAPT service has a target of meeting 18% of need as opposed to the national target of 15%. It is hoped that the IMHN will begin to improve this situation.

6.8 Finally, during the review we heard from a number of sources about the importance of early intervention with children's mental health in order to prevent adult onset problems. Children and young people's issues are outside the scope of our Commission and of this review but we would ask our colleagues in Hackney Council's Children and Young People Scrutiny Commission to give serious consideration in its work programme for 2015/16 to a review on *Children and Adolescent Mental Health Services (CAMHS).* In

particular we ask that such a review address perinatal mental health and the issue of the transition from children's to adult services.

7. CONTRIBUTORS, MEETINGS AND SITE VISITS

The review's dedicated webpage includes links to the terms of reference, findings, final report and once agreed, the corporate response. This can be found here

Meetings of the Commission

The following people gave evidence at Commission meetings or attended to contribute to the discussion panels.

8 September 2014

Dr Nicole Klynman	Consultant in Public Health, LBH
Gareth Wall	Public Health Manager, LBH
Genette Laws	AD Commissioning, LBH
Krishna Maharaj	Chief Executive, City and Hackney Mind
Hana Vilar	Head of Clinical Services, City and Hackney Mind
Dr Rhiannon England	Chair Mental Health Programme Board, CCG

13 November 2014

Ann Thomas	Employment Advisor, City & Hackney Mind
Ian Causer	Employment Advisor, City & Hackney Mind
Dr Brian Rock	Service Lead, Primary Care Psychotherapy Consultation Service, Tavistock & Portman Trust
Dr Angela Byrne	Clinical Psychologist, BME Access Service, ELFT
Dr Naomi Scott	Clinical Psychologist and Service Head, BME Access Service, ELFT
Dean Henderson	Borough Director, City and Hackney, ELFT
Dr Lucy Carter	GP at Well St Practice and LMC Member
Paul Fleming	Board Member, Healthwatch Hackney
Dr Clare Highton	Chair, City and Hackney CCG
Paul Haigh	Chief Officer, City and Hackney CCG

9 December 2014

Dr Penny Bevan CBE	Director of Public Health, City and Hackney, LBH
Genette Laws	AD Commissioning, LBH
Heather Bates	Commissioning Manager – Supporting People and Prevention, LBH
Kate Simpson	Operations Manager – Health and Wellbeing, Family Mosaic
Alex Reeve	Regional Director of London Supported Housing,

	Family Mosaic
Sarah Chapman	Head of Neighbourhoods, Hackney Homes
Andy Bell	Chief Executive, Centre for Mental Health
Emel Hakki*	Hackney Services Manager, Family Action
Heather Loxley*	Director of Services, Family Action

*produced paper but not presented at committee due to illness

Site Visits

The Commission conducted site visits for this review where Members also had an opportunity to meet with service users.

1.) City and Hackney Mind, Tudor Rd headquarters and their site (IRIE Mind) at the Homerton hospital on Fri 26 September 2014 from 10.00 hrs

Present: Cllrs Munn, Etti and Sales.

C&H Mind staff:
Krishna Maharaj, Chief Exec
Psychological Therapies Team – Hana, Nichola, Shane, Abeola
Employment Team – Anne, Ian, Kalpna, Michelle, Resma, Abdul, Anna, Stephanie, Michaela
IMHN Implementation Team – Jess, Vicky, Becky, Becky, Sahil

Vietnamese Mental Health Service who have weekly drop-in sessions at Mind. Met with the Jack Shieh (Director), staff and service users.

Also visited *IRIE Mind Centre for Recovery* at 15a Homerton Row, E9 and met with **14** service users including some peer supporters and staff.

2.) Launch of the Centre for Excellence and Innovation in Mental Health and Wellbeing on Wed 17 September 2014 at City University.

Cllr Sales and Cllr Snell attended this event which launched this Centre.

3.) Site Visits to:

Bikur Cholim, Ground Floor, 2a Northfield Rd, N16
Derman, The Basement, 66a New North Rd, N1
Local IAPT Service operated by HUHFT, Louis Freedman Centre, St Leonard's Hospital, Nuttall St, N1

All on Thursday, 30 October 2014 from 14.00-21.00 hrs

Present were: Cllrs Munn, Hayhurst, Etti, Peters, Sales, Snell

At Bikur Cholim
Yocheved Eiger, Manager
Dr Lisa Shostall, Consultant Clinician
A support worker
A service user

At Derman
Nursel Tas, Chief Executive Officer
2 counsellors
6 service users

At IAPT
Dr James Gray, Consultant Clinical Psychologist
Mervyn Freeze, Service Manager
Dr Victoria Roberts, Consultant Psychologist
Lisa Hoyles Principal Psychologist
Megan Prowse, Senior Psychologist and Wellbeing Practitioner
Fabienne Palmer, Psychological Wellbeing Practitioner
2 service users.

Also received input from the service head - Dr Paul Sigel, Head of Primary Care Psychology

4. Site Visit to Family Mosaic, Supported Housing Scheme, 2-26 Link St, E9 on Wed 3 December 2014 at 17.00hrs

Present were: Cllrs Munn, Hayhurst, Etti, Sales and Snell

Family Mosaic
Kate Simpson, Operations Manager – Health & Wellbeing
Gunter Gosain, Team Leader – Link St

8. MEMBERS OF THE SCRUTINY COMMISSION

Councillor Ann Munn (Chair)

Councillor Ben Hayhurst (Vice Chair)

Councillor Sade Etti

Councillor Sally Mulready

Councillor James Peters

Councillor Rosemary Sales

Councillor Peter Snell

Overview and Scrutiny Officer: Jarlath O'Connell ☎ 020 8356 3309

Legal Comments: Dawn Cater McDonald ☎ 020 8356 4817

Financial Comments: Deirdre Worrell ☎020 8356 7350

Lead Director for the review: Kim Wright, Corporate Director, Health and Community Services ☎ 020 8356 7347

Lead Cabinet Member for the review: Cllr Jonathan McShane, Cabinet Member for Health, Social Care and Culture

9. BIBLIOGRAPHY

The following documents have been relied upon in the preparation of this report or were presented to the Scrutiny Commission as part of the investigation.

- **Minutes and agendas of the meetings of Health in Hackney Scrutiny Commission held on 8 September, 13 November and 9 December 2014.**
- Notes on Site Visits carried out by the Commission Members presented to 21 January 2015 meeting of the Commission

The following are further reading:

Local

- City and Hackney Health and Wellbeing Profile: Our Joint Strategic Needs Assessment, 2011/12, updated 2014. Hackney Council and City of London
- *Hackney's Joint Health and Wellbeing Strategy 2013-14*, Hackney Council and City and Hackney CCG.
- A mental health needs assessment for the residents of Hackney and the City of London', Solutions for Public Health, for Public Health Dept, Hackney Council, Draft. Sept 2014
- *'Integrated Mental Health Network Service Specification'*, Adult Social Care, Hackney Council 2014
- http://www.hackney.gov.uk/Local-Economic-Assessment.htm#.VNd1PuasWxU
- Voice of Men – Mental Health Needs Assessment of Turkish/Kurdish and Cypriot/Turkish Men in Hackney, Derman, Mar 2008
- *Bikur Cholim Annual Review and Accounts 2013*, Bikur Cholim
- *Impact of Welfare Reform on Turkish and Kurdish Communities in Hackney, Survey of Derman Service Users*, Derman, 2013
- *Commissioning third sector counselling: valuing and enabling services*, British Association for Counselling and Psychotherapy, 2014
- *City and Hackney Mind Annual Impact Report 2012-13*, CHM, 2014
- *Vietnamese Mental Health Services Annual Report 2013-14*, VMHS, 2014
- *Job Retention Practitioner's Handbook*, Roger Butterworth/Dave Costello, Lorraine Looker/Heidi Cuming, CHM, 2011
- *Mental Health and Employment: A Mind to Work – a good practice guide*, CHM, 2011
- *A range of reports from East London Foundation Trust's BME Access Service relating to their Trailblazer Project*
- The second Trailblazer report
- Extracts from the first Trailblazer report (Carlin, 2009)
- Article on the Trailblazer project
- *Report of Health in Hackney Scrutiny Commission's review on 'Community mental health services', 2011/12*
- *Report of Health in Hackney Scrutiny Commission's review on 'Health and worklessness', 2009/10*
- *Report of Community Safety and Social Inclusion Scrutiny Commission's review on 'Tackling worklessness – routes to employment for those in receipt of long term inactive benefits', 2008/9*
- *Fund for Health 2014, Report of Healthwatch Hackney and City & Hackney CCG, 2014.*

National:

- Health Begins at Home, Family Mosaic, Nov 2013
- Making Mental Health Services More Effective and Accessible, Department of Health, April 2014
- NICE guidance on mental health and wellbeing, NICE, 2014.
- Fair Society Healthy Lives, The Marmot Review - Strategic Review of Health Inequalities in England post 2010, UCL Institute of Health Equity, Feb 2010
- Social Determinants of Mental Health, UCL Institute of Health Equity for WHO and Gulbenkian Foundation, June 2014

- No Health Without Mental Health, A cross government mental health outcomes strategy for people of all ages, Dept of Health, Feb 2011

- A range of reports from the **Centre of Mental Health** including

  - Barriers to employment, what works for people with mental health problems, Centre for Mental Health, Sept 2013
  - *Managing patients with complex needs: Evaluation of the City and Hackney Primary Care Psychotherapy Consultation Service* by Michael Parsonage, Emily Hard and Brian Rock, March 2014
  - *The Bradley Commission – BME communities mental health and criminal justice*, a briefing, Sept 2013
  - *The Bradley Report five years on* by Graham Durcan, Anna Saunders, Ben Gadsby and Aidan Hazard; Bradley Commission and Centre for Mental Health, June 2014
  - *A place for parity –Health and Wellbeing Boards and mental health*, Jonathan Scrutton, Nov 2013
  - *Welfare advice for people who use mental health services – developing the business case*, Michael Parsonage, Dec 2013
  - *Building a better future – the lifetime costs of childhood behavioural problems and the benefits of early intervention*, Michael Parsonage, Lorraine Khan and Anna Saunders, Jan 2014
  - *Doing what works – individual placement and support in employment* – a briefing, Sainsbury, Feb 2009.
  - *Long term conditions and mental health – the cost of co-morbidities*, Chris Naylor, Michael Parsonage, David McDaid, Martin Knapp, Matt Fossey, Amy Galea; The Kings Fund/ Centre for Mental Health, Feb 2012
  - *Bridging the Gap – the financial case for reinvesting in mental health – briefing paper*, Royal College of Psychiatrists and Centre for Mental Health, Sept 2013

10. GLOSSARY

CCG	City and Hackney Clinical Commissioning Group
HUHFT	Homerton University Hospital NHS Foundation Trust
ELFT	East London NHS Foundation Trust
Family Action	Is a national charity which provides practical, emotional and financial support to families who are experiencing poverty, disadvantage and social isolation across England. They work with over 45,000 families through around 120 community-based services.
Family Mosaic	A housing association that provides affordable homes to rent and buy (in Hackney and across London, Essex and the South-East of England), as well as care and support services to their residents, such as training, employment and access to learning.
Centre for Mental Health	Centre for Mental Health is a national independent charity whose mission is to inform policy and practice in mental health, based on high-quality evidence, presented impartially**,** and often collaboratively. It doesn't provide support services itself but acts as a link between the research world and health/social care providers.
Hackney Homes	A not-for-profit organisation that is responsible for managing Hackney Council's council homes. This involves collecting council housing rent, and repairing and maintaining council homes. It will cease to exist when the management of Hackney Council's housing stock is returned to the Council at the end of the Council's contract with Hackney Homes on the 31 March

	2016
City and Hackney Mind	The leading provider of voluntary sector mental health services in the City of London and in Hackney. It is a registered charity, providing a range of services including advocacy and advice, counselling and psychotherapy, and education and employment services.
IRIE Mind	I.R.I.E. stands for Integration, Respect, Inclusion and Empowerment. It is also a word that expresses positivity in the Afro-Caribbean culture. I.R.I.E. Mind centre for recovery and social inclusion targets marginalised, at-risk and disengaged service users in Hackney. It is run by City and Hackney Mind and based at the Homerton Hospital site. Most of its users have a long history of severe and enduring mental health problems and multiple traumas, and they struggle with substance and alcohol misuse. The centre seeks to help its users to improve their mental and physical wellbeing.
Bikur Cholim	A community organisation serving the Charedi Jewish community in the north of Hackney.
Personalisation	A social care approach defined by DoH as every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings
Supporting People	Supporting People programme was introduced in April 2003 and brought together a number of uncoordinated funding streams to ensure that services were commissioned in line with local need rather than funding opportunity. It provides housing related support to enable people who need that support to remain safe and independent in the community.
Choice Based Lettings	Hackney Choice is a choice based lettings scheme which gives applicants on the housing waiting/transfer list more choice and control over where they live. It allows applicants to apply for available properties which are advertised, rather than wait to be allocated a home.
Employment and Support Allowance	Is the state benefit which replaced Incapacity Benefit. You can claim it if you're ill or disabled and if offers financial support if you're unable to work and personalised help so that you can work of you're able to.
Long Term Conditions	Is a condition that cannot, at present, be cured but can be controlled by medication and other therapies e.g. diabetes, heart disease or chronic obstructive pulmonary disease.