**Camden Joint Strategic Needs Assessment**

**Chapter 18: Mental Health (Updated 21 October 2013)**

Source: [**http://www.camden.gov.uk/ccm/content/social-care-and-health/health-in-camden/joint-strategic-needs-assessment-2012/chapter-18--mental-health.en?page=1**](http://www.camden.gov.uk/ccm/content/social-care-and-health/health-in-camden/joint-strategic-needs-assessment-2012/chapter-18--mental-health.en?page=1)

**Key messages**

**•**Mental illness includes common conditions such as depression, anxiety disorders and obsessive compulsive disorder which can be highly disabling, and also less common but very severe and enduring mental illnesses such as schizophrenia and dementia.

• Mental illness affects 17% of adult and 10% of children at any one time and 1 in 4 of us at some time in our lives.

• Mental and physical health are inextricably linked and each can affect the outcome of the other, particularly in some key physical health conditions such as obesity, substance misuse, smoking, cancer and cardio-vascular disease.

• Nearly a third of all people with long-term physical conditions have a co-morbid mental illness (usually depression or anxiety) and this association is particularly strong for cardio-vascular disease, diabetes, chronic obstructive pulmonary disease (COPD) and musculoskeletal disorders.

• People with serious mental illness have a life expectancy at least 5-10 years lower than the general population, due to poor physical health.

• There are 3,171 adults diagnosed with serious mental illness (SMI) registered with Camden GPs, 28,331 adults who have at one-time been diagnosed with depression, anxiety or both and 813 people with dementia.

• Camden has the 3rd highest SMI prevalence and 7th highest depression prevalence in London.

• Approximately 2,310 children aged 5-16 have some type of mental disorder.

• People from a low socio economic status, women, Black Minority Ethnic groups and people with long term conditions or disabilities are more likely to suffer from mental illness. In addition certain vulnerable groups including looked after children, carers, the homeless population and offenders are at higher risk of mental illness than the general population.

• Mental health and wellbeing are also influenced by housing, education, health, employment, social inclusion, community safety, racism and harassment.

• There is widespread under-diagnosis and under-treatment of mental illness across the population.

• The impact of the economic downturn and simultaneous reforms to welfare benefits may result in increased mental health need in coming years.

• Camden’s population is set to age, increasing the need for dementia services

**What is the issue?**

Mental illness includes a number of different conditions which are often considered as one. It spans common conditions such as depression, anxiety disorders, obsessional compulsive disorder and post-traumatic stress disorder, all of which can be highly disabling, but often respond well to treatment, to less common but very severe and often enduringmental illnesses such as schizophrenia and dementia. Mental illness affects 17% of adults and 10% of children at any one time, and one in four of us at some time in our lives. The burden of this morbidity is high: the degree of disability imposed by depression is 50% higher than that for angina, asthma, arthritis or diabetes[1]. On this basis (excluding premature death) mental illness accounts for nearly 40% of morbidity in the UK, compared to 6% for cardiovascular disease and 2% for diabetes[1]. Whereas physical illness tends to impact more with increasing age, mental illness often begins in childhood and impacts heavily on the working age population. Up to the age of 65, mental illness accounts for nearly as much morbidity as all physical illnesses put together. The social exclusion experienced by people with mental health problems often contributes to this low quality of life.

Mental and physical health are inextricably linked and each can affect the outcome of the other, particularly for some key health conditions such as obesity, substance misuse, smoking, cancer and cardio-vascular disease. Nearly a third of all people with long-term physical conditions have a co-morbid mental illness (usually depression or anxiety). This association is particularly strong for cardio-vascular disease, diabetes, chronic obstructive pulmonary disease (COPD) and musculoskeletal disorder[2]. Mental illness can intensify the effects of a physical illness and considerably raise the cost of physical health care. Rates of hospitalisation and death for those with mental health problems are up to three times higher than for others.

Having a mental illness also impacts heavily on physical health and mortality. People with serious mental illness (SMI) have a life expectancy as much as 20 years less than the general population. They are estimated to be twice as likely to die from coronary heart disease and four times as likely to die from respiratory disease. Rates of smoking amongst people with SMI are at least double that of the general population and people with mental health conditions consume 42% of all tobacco in England[3]. Depression has the same effect on life-expectancy as smoking and a much greater effect than obesity[2].

Mental ill health has large personal, social and economic costs and can impact on every aspect of life, including physical health, employment, offending and risk behaviour. Risk factors for mental illness include deprivation, low income, domestic violence, unemployment, poor housing and poor education. The stigma attached to mental ill-health and the social barriers that surround it amplify its direct effects.

There is increasing national emphasis on the central role of mental wellbeing in both physical and mental health. Mental wellbeing is more than the absence of mental ill health; features of mental wellbeing include high life satisfaction, mastery and a sense of control, having a purpose in life, a sense of belonging and positive relationships with others. Good mental wellbeing builds resilience, is protective against emotional and behavioural problems and is associated with a broad range of positive outcomes such as better physical and mental health and life expectancy, improved educational performance, employment outcomes and social integration[4]. There is considerable evidence that wellbeing and resilience can be improved through interventions at individual, family and community levels and at all stages of the life-course[5] .

**How important is this issue in Camden?**

**Children and Young People**Based on national prevalence data it is estimated that approximately 2,310 children aged 5-16 have some type of mental disorder (table 1) [6]. In 2012/13 there were a total of 1,886 cases seen by Camden’s community child and adolescent mental health services (CAMHS). These figures suggest that local services have made good progress in reaching a significant number (up to 80%) of Camden’s estimated population of children with mental health needs.  However, it should be noted that the figures may include some double counting as individualised data is collected on an anonymised basis.
 **Table 1: Estimated prevalence of mental disorders in young people**

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Common mental health problems**28,331 adults registered with a Camden GP have at one time been diagnosed with depression, anxiety or both (14% of the adult population) [7]. Approximately 10,000 people have been diagnosed with depression, 10,000 with anxiety and depression, and 8,000 with anxiety. From QOF data (which records only diagnoses of depression) Camden has the 7th highest rate of depression in London. Estimates from National Psychiatric Morbidity data predict that up to 36,607 people in Camden will have a common mental health problem at any one time.

**Serious mental illness**3,358 adults (18 and over) recorded on QOF registers are living with a serious mental illness (SMI) (1.3% of the population). The crude prevalence of SMI in Camden is higher than both England and London (table 2) and the third highest rate of SMI in London. Poor physical health is common for people with a serious mental illness. People living with a serious mental illness have a significantly higher prevalence of all long term physical conditions (except for atrial fibrillation) than Camden’s general population aged 18[8] .

**Personality Disorder**Personality disorders are mental health conditions that affect how people manage their feelings and how they relate to other people. Mild personality disorders that do not seriously interfere with a person's ability to function socially are common. Severe disorders are rare and affect less than 2% of the population.
No QoF or GP extracted data is available for prevalence of personality disorders, but by extrapolating from national data we estimate that there are 1,230 people living with a severe personality disorder in Camden.

**Dementia**There were 813 people aged 65+ with a diagnosis of dementia registered with Camden GPs in 2011/12[9] . This is a lower crude rate than England and similar to London. Dementia is strongly correlated with age. Camden and London’s young population explains the relatively low crude prevalence of dementia. Recent research found that the prevalence of dementia in people age 65+ is 6.5% (this is lower than previous estimates) [10]. If this percentage were applied to Camden’s 65+ population it would suggest an estimated number of cases of dementia registered with GPs in Camden of about 1,300, giving a diagnosis rate of about 63%. **Table 2: QOF Prevalence for Serious Mental Illness, Depression and Dementia, registered population, Camden, London and England 2011/12**

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**Source: Health and Social Care Information Centre,** [**http://www.hscic.gov.uk/qof**](http://www.hscic.gov.uk/qof)

**Suicide and Death from Undetermined Injury**Camden’s suicide rate has decreased substantially over the last decade in both men and women, and is now similar to London and national averages (figure 1). The ratio of female to male suicides is slightly higher than the national average, and this is especially true of women over the age of 65. There were 52 deaths recorded with cause as suicide or injury undetermined in Camden for all persons during the 3 year period 2009-11 (an average of 17 deaths a year).  This gives Camden the 7th highest rate of mortality from suicide or injury undetermined in London and is similar to that in London and England, despite the higher prevalence of mental illness and significant levels of risk factors in the local population. Although the absolute number ofsuicides amongst under 18 year olds is very small, there have been individual cases where there is a possibility that these may have been linked to loss of contact with services, highlighting the need for effective transition arrangements between child and adolescent and adult mental health services.
 **Figure 1: Age-standardised rate of mortality from suicide or injury of undetermined intent per 100,000 population, Camden, London and England, 1993-95 to 2009-11 (three year rolling average).**

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**Which population groups are most at risk?**

**Age**For children and young people, risk increases with age; 7.7% of children aged 5-10 have a mental disorder and 11.5% of young people aged 11-16. Early mental health problems are an important risk factor for adult mental illness: Half of all lifetime mental health problems have already developed by age 14[11] .

In adults, mental health conditions are most common in the working age population, peaking in middle age. Non-organic psychotic disorders do not generally appear before puberty and are most common amongst the 45-54 age group. Onset after this age is rare. Mean age of onset is earlier in men than in women.

Rates of common mental illness peak at age 40 - 54 and then drop in later life. Even taking into account the lower prevalence of common mental health conditions in older adults, there is known to be significant under-diagnosis and under-treatment of neurotic disorders in older age groups, and particularly of depression.

Depression often co-occurs with other serious conditions more common in older adults such as heart disease, diabetes, cancer and stroke, and is mistakenly viewed as a normal consequence of these problems. The symptoms of depression are also sometimes mistakenly viewed as a normal part of ageing.

**Gender**More men experience serious mental illness than women, especially those under the age of 65. New diagnoses of serious mental illness are almost twice as common in men as women. Rates of common mental illness are higher in women, although there is commonly recognised under-diagnosis of anxiety and particularly depression in men.  This pattern is reversed for child and adolescent mental health, mainly due to the over-representation of boys with conduct disorders and ADHD.

**Ethnicity**Nationally, women from black and Asian ethnic groups have high rates of common mental illness, and rates are particularly high amongst South Asian women (up to 35%). This situation is replicated locally, but both Asian women and Asian men are under-represented locally in diagnosis and treatment. Black and Asian residents also show a lower diagnosed prevalence of anxiety disorders[7]. Men of Irish descent are also under-represented in diagnosis and treatment of common mental health problems whilst Irish men are over-represented in local suicide figures.

Locally, men from Black communities have the highest rates of diagnosed serious mental illness, at 4.8% compared to a borough average prevalence of 1.6%8 and are over-represented in Community Mental Health Team caseloads and admissions relative to the general population. Black populations are also more likely to access mental health services through crisis or emergency services and are more likely to be receiving compulsory treatment, although there is evidence that individuals and families will often have tried to access help earlier. Nearly 20% of assertive outreach contacts are with Black African clients (three times the proportion in the population). Whilst the admission rate locally for white ethnic groups is 1.4 times higher than the England average for all ethnic groups, the admission rate for black ethnic groups is 4.9 times higher than the England average for all ethnic groups, compared to the London average for Black ethnicities of 2.6 times the England average . Although over-representation of Black communities in acute and emergency mental health services is a national issue, there is an even greater issue locally. In contrast, Asian communities are under-represented in both admissions and community mental health teams.

**Socioeconomic status**Nationally, there is a social gradient to mental illness. Rates of mental illness for the poorest are nearly double those of the richest fifth by income1. This is born out locally for those with serious mental illness, but to a much lesser extent for common mental health problems[7]. This suggests under-diagnosis of common mental health problems in those from lower socio-economic backgrounds.

**Physical health**Many people with long-term physical conditions have poor mental health, which can lead to significantly poorer health outcomes and reduced quality of life. Research suggests that people with long-term conditions are two to three times more likely to experience mental illness than the general population[13] .

**Sexual Orientation**Lesbian, Gay and Bisexual people are at higher risk of mental health conditions, suicidal ideation, alcohol and substance misuse, and deliberate self-harm than heterosexual people, with rates between 1.5 and 2 times general population rates.

**Vulnerable groups**70 per cent of people accessing homelessness services have a mental health problem, although the causal relationship is complex.

**Offenders**90% of offenders have substance misuse problems, mental health problems or both and 9% have a serious mental illness. Personality disorder affects many people in society, most of whom do not commit offences, but for some, it significantly contributes to offending and risk related behaviours. In the offending population – although estimates vary – it is probably present in at least 50% of the population[14]. Recently released prisoners have a greatly increased risk of suicide. Men are eight times and women 36 times more likely to die by suicide within 1 year of release from prison than would be expected in their respective sex groups in the general population[15].

**Young offenders**Research from the Mental Health Foundation (2002) shows that the prevalence of mental health problems for those in the criminal justice system is between 21% and 85%, the highest incidence being for those in custody (an estimated 95% of imprisoned young offenders have a mental health disorder). Mental health conditions in young offenders are often neither recognised nor treated.

**Looked after children and children on the child protection register**
These children are already vulnerable to mental health problems by the time they come into the care system. They are more likely to come from families where social and environmental risks (such as familial mental health problems, alcohol and drug misuse, domestic violence and abuse/neglect) are present, and where the opportunities for secure and stable early attachments to a primary caregiver are often poor. The care experience itself can then exacerbate this vulnerability. National estimates (DCSF 2009) suggest that 60% of looked after children have problems with mental health and emotional wellbeing.  For Camden this would equate to an estimate of 155 looked after children.

**Complex Families and mental health**A significant proportion of parents will have a mental illness during some of the time that they are caring for children.  The impact of parental mental ill health on child development and family functioning is well documented:
• Children of parents with mental health problems are at increased risk of developing mental health problems and conduct disorders
• Inter-parental conflict and violence is associated with parental mental health problems and has a powerful and lasting negative effect on child development
• Families affected by parental mental health difficulties are at increased risk of poverty
• It is estimated that children of parents with mental health problems account for between a third and a half of all children receiving services from young carers’ projects

Due to the high risk factors associated with parental mental ill health it has been identified as one of the local filters for Camden’s work on complex families.

**Carers**Carers of people with physical and mental problems are more likely to report high levels of neurotic symptoms than those caring for people with physical problems or old age, 28% compared with 14% [16].   Isolation from family and friends is a problem for all carers, but caring for someone with a mental illness can increase this isolation as a result of the stigma of mental health caring. Both can lead to depression and anxiety.

**Drug and Alcohol Misuse**It is estimated that up to half of people diagnosed with a mental health condition also misuse substances[17]. The relationship between mental health and substance misuse is complex and varies from individual to individual: A mental health condition can lead to drug or alcohol misuse as a form of self-medication, the use of alcohol or drugs can exacerbate an existing mental health condition, or can trigger mental health problems[15].

## Future trends and/or factors likely to impact

Forecast population growth will lead to proportional increased need in all types of mental health conditions for children and adults. The biggest change will be as a result of an ageing population and the increased demand on dementia services. Population predictions to 2021 suggest an accelerated growth in the number of older people: a 21% increase in adults aged over 65 years (+ 4,500 people) and a 32% increase in adults aged over 85 (+1000 people),  of whom 1 in 14 over 65 and 1 in 6 over 85 can be expected to have a form of dementia. It is estimated that overall numbers of people with dementia living in the borough by 2021 will increase by 25% (from 1300 to 1725), that the number aged over 85 with dementia will increase by 40% (from 699 to 979), and that the number from BMER groups will double (from 186 to 372).

Evidence from previous economic downturns suggests that across the population there will be short term and long term health effects. In the past, these have included an increase in mental health problems, including depression, and possibly lower levels of wellbeing as well as more suicides and attempted suicides. At the same time as the downturn, the government has implemented a welfare reform package, which removes the safety net from those most at risk of unemployment, job insecurity, low income, debt and poor quality housing. Since these impacts are all significant social determinants of mental health, mental health inequalities are likely to widen[18]. These austerity measures are set to continue and increase at least to 2016. The extent to which this leads to increased need and demand for services within the borough will also be determined by the possibility of migration in or out of the borough of those most affected by the economic climate and welfare changes.

## What is being done to address the issue in Camden?

**The National Setting**
Historically, and nationally, there has been chronic underinvestment in mental health services and a perception that treatments are of limited effect. In fact, there are effective treatments available for a range of mental illnesses, and unlike some physical long-term conditions, much mental illness is curable or can be managed successfully long-term in the community. For example, the combination of modern anti-psychotic medication along with recovery based services has enabled the majority of those with a serious mental illness to avoid hospitalisation and to stabilise their condition in a community setting. Evidenced based psychological therapies for depression and anxiety are inexpensive and have recovery rates of around 50%. It is relatively rare for those with serious mental illness to go untreated, but for people with common mental illness, those in treatment are a minority. According to the 2007 National Psychiatric Morbidity Survey, which covered a random sample of households, only 24% of people with depression and anxiety disorders were in any form of treatment. Of these 14% simply got medication and only the remaining 10% got any form of counselling or therapy. Only 2% were getting CBT which is the main NICE-recommended therapy. In the past year only 3% had seen a psychiatrist and 2% a psychologist.

Despite having relatively good services locally (and in particular since the introduction of IAPT services in 2008), there are still large numbers of people with untreated mental illness in the borough.

**The Local Setting**

**Mental Health Strategy Review**
The major re-organisation of the NHS following the implementation of the Health and Social care bill in April 2013 has led to changes in commissioning responsibilities. In particular, some services previously commissioned locally (such as forensic and Tier 4 CAMHS provision) are now commissioned at a national level. Local commissioning is now led by Camden Clinical Commissioning Group (CCG). There has also been a re-organisation within the Mental Health Foundation Trust based on models of care clusters, and changes to the role of primary care.

Within this context, Camden CCG are currently leading a mental health strategy review developing local vision and models for services in the following areas:

• Services for people with personality disorder
• Improved transition from child and adolescent to adult mental health services
• Alcohol services
• Common mental health problems

A key feature of the programme is the engagement of service users and carers in order to develop greater understanding of experience and needs. Case studies and other engagement events are being undertaken that will give a qualitative description of patient and carer’s lifetime journeys through mental health services in order to help develop more responsive services.

**Child and Adolescent Mental Health**
Camden has a tradition of delivering high quality CAMH services. During 2012/13 a strategic review of community CAMH services was undertaken in order to:

• Gain a greater understanding of the needs of children and young people in Camden in relation to psychological wellbeing and  mental health
• Assess capacity of current services to meet identified needs
• Identify unmet needs and facilitate service development or redesign accordingly
• Ascertain whether current services still represent value for money

The review was informed by comprehensive assessment of current needs and service models, benchmarking against national datasets and extensive consultation with a wide variety of stakeholders including children and young people, their families, schools and health and social care providers and commissioners.

The review found that Community CAMH services in Camden are comprehensive and responsive.  CAMHS provides an extensive range of highly integrated services which span the tiers of need and cover the multiplicity of children’s services.  The reach of local CAMH services into the target population is significant.  During the course of the review some specific areas were identified as requiring further development and/or review, and these will be used to update the service model, consolidate provision and identify opportunities for further investment.

On-going service improvements were developed in response to emerging findings from the review.  As a result, significant progress has been made in relation to a number of key service areas:

**CAMHS in primary schools**

Local CAMHS teams have undergone significant remodelling to provide increased support to Camden’s maintained primary schools; all maintained primary schools in Camden are now offered half a day a fortnight (or 1 day month) of CAMHS outreach to meet the school’s identified needs

**Children & Young People’s Increasing Access to Psychological Therapies**

C&YP IAPT will extend training to staff and service managers in CAMHS and embed evidence based practice across services

**Assertive outreach team (AOT)**

A virtual AOT has been established to provide intensive in-reach / outreach to young people at risk of, or admitted to Tier 4 services . The number of  CAMHS Tier 4 admissions in 2012/13 reduced by 32% from 2010/11 (from 31 admissions in 10/11 to 21 admissions in 12/13)

**Kaleidoscope**

Jointly commissioned by CAMHS and the Young People’s Pathway, Kaleidoscope is a 7 bed unit which provides a step down from, or alternative to, Tier 4 admission

**Parental mental health**

Significant additional investment in parental mental health services has been made during 2012/13.  This has both increased the overall capacity of existing specialist services to support parents with mental health needs across the borough and enabled the development of new support services where there are identified gaps:−

- Specialist support for vulnerable young parents including parents whose children have been removed
- Integrated adult mental health assessment and support in the MALT
- In addition, a review of parental mental health services has been undertaken with a view to streamlining pathways to support.  The recommendations of this review are currently being considered.

Every Camden Child, Camden’s children’s health joint commissioning plan (2012-15) sets out Camden’s aspirations for community based health services for children and young people across all levels of need.  The plan aims to significantly improve outcomes for children and young people in Camden through delivering the “right care, at the right time, in the right place”.  For child and adolescent mental health, the plan identifies two key work streams for the next three years:

**1) Minding the Gap (improving outcomes for young people transitioning to adulthood)**
During 2013/14 options will be developed to improve support to meet the needs of vulnerable young people aged 16-25 in relation to mental health, substance misuse, sexual health.  The proposal (subject to approval of the full business case) is to improve the way that preventative and treatment services are delivered locally by age-aligning of commissioning and provision of mental health and substance misuse services for young people up to the age of 25. This will increase capacity to meet identified needs and provide continuity of care for vulnerable young people that require a service post-18, whilst preparing them for adulthood.
Secondly, the development of an innovative community hub which integrates health services for young people with advice and support on employment, training, housing and benefits as well as positive activities and opportunities for the development of innovative social enterprises will increase reach to non help seeking young people and can bridge those requiring a higher level clinical intervention.

**2) Mental health promotion**
In response to feedback from children, young people and parents, a mental health promotion programme has been developed to raise awareness of mental health issues; promote emotional resilience; reduce stigma; and promote help seeking as positive.  The programme has been co-produced with Camden young people and includes:
• Redevelopment of Camden’s urlife.org.uk website to include interactive information on mental health and substance misuse as well as sexual health;
• Further promotion of mental health awareness in schools (through PSHE and roll out of the Brighter Moods: Brighter Minds programme);
• Development of a ‘charter mark’ for schools based on the Department of Health’s You’re Welcome criteria for young people friendly health services;
• The development of the Camden Couch street marketing campaign which takes information on mental health and local services to the places where young people congregate and ‘hang out’; and
• An increase in CAMHS community outreach services in non-stigmatising, universal settings, specifically GP practices and secondary schools

**Adult Mental Health**
A comprehensive adult mental health commissioning plan for 3 years was approved in April 2012. The plan mirrors the national strategy set out in “No Health without Mental Health” and focuses on wellbeing and the prevention of common and serious mental disorders, recovery and rehabilitation, integrated approaches to physical and mental health, high quality, safe and timely care, and reducing stigma.  It builds on the progress of recent years which has been made by investing in early intervention, assertive outreach, crisis and memory services, with integrated care by multi-disciplinary teams, and regular engagement with service users. Accommodation pathways have also been much improved over the last few years, together resulting in a 30% cut in inpatient bed numbers in 2011-12. This has ensured that more people with mental health problems receive support when they need it most, that services are personalised and maximise independence, has made it possible to decommission inpatient, continuing care and out-of-area forensic beds and has reduced suicides.

Camden’s IAPT service was among the first national pilots of IAPT in 2008 and is now a well-developed service able to effectively implement NICE guidelines for depression and anxiety. In common with most other localities, Camden IAPT service is working towards a national target of providing therapy to 15% of those with depression and anxiety by March 2015, with a target recovery rate of 50%. This year, the service is on target to see just under 9% of this population and achieve a recovery rate of 40%.

**Recent local developments in adult mental health care**
Last year the IAPT service developed to include a service to people with long term physical conditions and medically unexplained symptoms as part of an integrated care pilot, for which the Camden IAPT service is a pathfinder site.
• An increase in the capacity of the memory service and in crisis dementia nursing has been agreed and a local project is working on developing a model for a dementia-friendly community in the Kilburn area.
• A specialist smoking cessation service for people with serious mental illness has been developed and is seeing early success in achieving quitters from among this group.
• Public health has used data extraction from GP data bases to produce data profiles for serious mental illness, dementia and depression and anxiety. This has provided accurate local data on prevalence, co-morbidity, lifestyle and local variation to support commissioners and services in planning and development.
• Camden and Islington have recently commissioned jointly a new mental health employment service that delivers the whole pathway of training and employment support services for people with mental health needs. This ranges from services engaging people in activities that increase their employability up to providing support to attain paid employment, and job retention support for those in work.

Other key areas of the mental health plan are building on recent successes as well as improved liaison and greater service collaboration. These include:

• Implementation of a 5 year dementia plan
• Improving the physical health care of people with mental illness. A physical care group has been set up within the Mental Health Foundation Trust to address these issues amongst their patients.
• Redesigning day opportunities (including employment services)
• Development of a structured and standardised pathway for people with Personality Disorder who are in crisis to improve the consistency, co-ordination and coherence of case management. This includes the commissioning of a new crisis house.
• A greater emphasis on early intervention, prevention and the promotion of mental wellbeing.
• A joint proposal is currently being developed to develop and refresh the suicide prevention pathway in Camden and Islington.

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