Mental Health Needs Assessment for Enfield

Dr Jonathan Campion
Director for Public Mental Health (South London & Maudsley NHS Foundation Trust)
Visiting Professor of Population Mental Health (UCL)
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Introduction

Mental health conditions and self-harm account for almost one third of the burden of disease in the UK (as measured by Years Lived with Disability) (WHO, 2014) and affect people of all ages. The reasons for such a large impact include (Campion, 2013):

- Almost a quarter of the population are affected by mental health conditions each year
- Majority of lifetime mental health conditions arise before adulthood
- Broad range of impacts including on education, employment, health risk behaviour (e.g. 42% adult tobacco consumption is by people with mental health conditions), physical health and 10-20 year reduced life expectancy
- Only a minority receive any treatment

Mental wellbeing has a similar broad range of impacts across health and other sectors (Campion et al, 2012) yet a significant proportion of the population has poor mental wellbeing. People with higher levels of mental wellbeing have better general health, use health services less, live longer, have better educational outcomes, are more likely to have a healthy lifestyle and are more productive at work, take less time off sick, have higher income, and have stronger social relationships.

Effective public mental health interventions exist to (Campion & Fitch, 2013):

- Treat mental health conditions
- Prevent associated impacts such as premature death
- Prevent mental disorder from arising
- Promote mental wellbeing including as part of recovery from mental health conditions

However, only a minority of people with mental health conditions in the UK receive treatment (Green et al, 2005; McManus et al, 2009) while far fewer receive effective interventions to prevent health conditions and promote mental wellbeing. While it is vital that people with mental health conditions have access to treatment, such interventions have a relatively small impact on reducing burden of mental disorder (Andrews et al, 2004). Therefore, interventions to prevent mental disorder and promote mental wellbeing are also important to sustainably reduce burden of mental disorder.

This implementation gap results in a broad range of impacts and associated economic costs even in the short term.
Background and methodology

Joint Strategic Needs Assessments (JSNAs) should provide information about local levels of health and social care needs as well as information about broader determinants (DH, 2012). JSNAs thereby inform actions which local authorities, local NHS and other partners need to take to improve the health and wellbeing of their population (DH, 2012).

However, mental health is poorly covered in JSNAs; a review of child and adolescent mental health in JSNAs assessed content and quality of data intelligence of 145 JSNAs (Olivia & Lavis, 2013) found that two thirds of JSNAs had no section which specifically addressed child and adolescent mental health needs while one third of JSNAs did not include an estimated or actual level of need for child and adolescent mental health services in their area. A further audit of 23 JSNAs covering a population of six million people found that public mental health intelligence was usually inadequately and inconsistently covered often only in passing (Campion et al, in press).

In 2012, public mental health commissioning guidance was published which was endorsed by ADPH, RSPH and LGA (Campion & Fitch, 2012) and updated in 2013. It different public mental health intelligence which was also highlighted in the Mental Health Challenge (Campion, 2013):

- Local level of risk and protective factors
- Local numbers from higher risk groups
- Local levels of well-being and mental disorder
- Proportion receiving effective PMH interventions
- Outcomes of PMH interventions
- Economics including spend and economic impact of public mental health interventions

This was further developed by identification of all public mental health intelligence sources using the HSCIC Indicator Portal, public mental health commissioning guidance (Campion & Fitch, 2013) and Internet searches. Various types of analysis were done including estimating prevalence and costs of different mental disorder which informed the PHE and NHSE fingertips resource.

Mental health is a key component of any needs assessment. The objectives of this Mental Health Needs Assessment are to:

- Understand the mental health and wellbeing needs of the population in Enfield
- Identify the services that are currently in place to treat mental health conditions and prevent associated impacts, prevent mental health conditions, and promote mental wellbeing
- Establish the extent to which existing services meet this need

This mental health needs assessment includes a range of research methods, specifically the following:

- Review of existing strategies and policy documents
- Review of publically available population mental health relevant data and benchmarking against other London boroughs, England and deprivation. Some data
was available at Barnet Enfield and Haringey Mental Health Trust (BEH-MHT) level although often data could not be broken down to Enfield patients

- Collection of additional local population mental health relevant data not available from public data sets from a wide range of local organisations
- Estimation of local costs of mental health conditions, public mental health expenditure and potential economics savings from improved coverage of particular public mental health interventions
National and local policy context

The cross-government mental health strategy “No health without mental health” (HMG, 2011) set out long-term ambitions for the transformation of mental health care “…and more importantly, for a broad change in the way people with mental health problems are supported in society as a whole”.

The strategy included six objectives:

1. More people will have good mental health: More people of all ages and backgrounds will have better wellbeing and good mental health. Fewer people will develop mental health conditions – by starting well, developing well, working well, living well and ageing well

2. More people with mental health conditions will recover: More people who develop mental health conditions will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live

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

4. More people will have a positive experience of care and support: Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people’s human rights are protected

5. Fewer people will suffer avoidable harm: People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service

6. Fewer people will experience stigma and discrimination: Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health conditions will decrease

The CCG Planning Guidance (NHSE, 2014) includes the Mental Health Crisis Care Concordat (CCC) and describes the actions required of commissioners and providers to ensure that those experiencing a mental health crisis are properly supported. This includes the need to ensure that there is enough capacity to prevent CYP (or vulnerable adults), undergoing mental health assessments in police cells.

The Care Act 20141 is another significant national strategy, enshrines the new statutory principle of individual wellbeing as the driving force behind the Act, and makes it the responsibility of local authorities to promote wellbeing when carrying out any of their care and support functions (LGA, 2015)2. A number of significant changes included as part of this legislation are (LGA, 2015)3:

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2 http://www.local.gov.uk/care-support-reform/-/journal_content/56/10180/6527719/ARTICLE
3 http://www.local.gov.uk/care-support-reform/-/journal_content/56/10180/6527719/ARTICLE
- Principle of wellbeing: Local authorities must promote wellbeing when carrying out any of their care and support functions in respect of a person, and that person should be enabled to participate as fully as possible in decisions at every stage in their care.

- Assessment, including carers: Local authorities must undertake an assessment for any adult, including a carer (see below), who appears to have any level of needs for care and support, irrespective of whether the local authority thinks the individual has eligible needs.

- National Eligibility Criteria: The Care Act introduces a national eligibility threshold for adults with care and support needs which consists of three criteria, all of which must be met for a person’s needs to be eligible. The eligibility threshold has been set at a level which is intended to allow local authorities to maintain their existing access to care and support.

- Care planning and review: If the local authority has a duty to meet a person’s needs, it must help the person decide how their needs are to be met by preparing a care and support plan, or support plan for carers. The plan must describe what needs the person has and which needs the local authority is to meet.

- Deferred payments: From April 2015, a new scheme will mean that people should not have to sell their homes in their lifetime to pay for residential care. Termed ‘deferred payments’, this arrangement must be offered by all local authorities to people who meet certain eligibility criteria governing the scheme.

- Funding reforms: From April 2015 intermediate care for up to six weeks and re-enablement requiring minor aids and adaptations up to the value of £1,000 must continue to be arranged by the local authority free of charge – in line with NHS funded intermediate care.

More recently documents such ‘Closing the Gap: Priorities for essential change in mental health’ (DH, 2014) and NHS England’s Five Year Forward View (NHSE, 2015) affirmed an ambition to realise a parity of esteem between mental and physical health.

‘Closing the Gap’ (DH, 2014) sets out how changes in local service planning and delivery will make a difference over two or three years, to the lives of people with mental health conditions. The document sets out 25 detailed targets under the following main headings:

- Increasing access to mental health services
- Integrating physical and mental health care
- Starting early to promote mental wellbeing and prevent mental health conditions
- Improving the quality of life of people with mental health conditions
- Mental health is everybody’s business

The Mental Health Crisis Care Concordat (DH, 2014) is a national agreement between services and agencies involved in the care and support of people in crisis. The core principles are:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovery and staying well / preventing future crises
The Five Year Forward View (NHS England, 2015) sets out a plan to realise parity of esteem by 2020 which “will require further investment” and involve:

- New waiting time standards for psychological therapies, such that 95 rather than 75 per cent of people referred start treatment within six weeks and those experiencing a first episode psychosis do so within a fortnight
- Expanded access standards to cover a comprehensive range of mental health services, including children’s services, eating disorders, and those with bipolar conditions
- New commissioning approaches to help ensure the above happens
- Extra staff to coordinate such care

It clearly sets out how national bodies will work together between now and 2021 to improve mental health and support rapid access evidence-based treatment. So far, the taskforce has undertaken a wide consultation to understand what people want to see change which has identified the following three key themes:

- Prevention of mental health conditions and tackling stigma
- Access: Timely access to effective, good quality evidence-based mental health treatment and therapies in response to need, in the least restrictive setting
- Quality including:
  - Having the right information to make meaningful decisions about treatment
  - Wider diversity and skill mix in NHS staff, including the need for peer support and more staff with psychological support skills
  - Importance of care planning
  - Need for patients to have more control over their care and to access support that would work best for them as an individual

**National child and adolescent policy context**

**Future in Mind**

In 2014, NHS England set up a working group to examine child and adolescent mental health. The following recommendations were published in a document entitled ‘Future in Mind’ (NHSE, 2015):

- Ensure the support and intervention for young people being planned in the Mental Health Crisis Care Concordat is implemented
- Implement clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care
- Include appropriate mental health and behavioural assessment in admission gateways for inpatient care for young people with learning disabilities and/or challenging behaviour
- Promote implementation of best practice in transition, including ending arbitrary cut-off dates based on a particular age.

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4 The Five Year Forward View Mental Health Taskforce: public engagement findings
The Government’s wide-ranging report on children and adolescent mental health, *Future in Mind, March 2015* stipulates that each CCG area is required to produce a Transformation Plan.

**Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report**

A NHS England Tier 4 review (NHSE, 2014a) highlighted gaps in provision of mental health treatment for children and young people, and NHS England is exploring a range of options for future commissioning and more collaborative work. The CAMHS transformation planning framework makes specific reference to this, so that current Tier 4 resource could be directed towards other services such as day care / community care.

**Liaison Psychiatry Services in Accident and Emergency**

The national development of all age liaison mental health services in Accident and Emergency (A & E) Departments, with targeted investment over 2015-16, should improve access to appropriate mental health support in A&E for children and young people experiencing mental health crisis. It is mandatory that that the views and experience of children and young people are taken fully into account as urgent and crisis care services are transformed and improved. In particular they should be involved on the co-production of further access and waiting time standards.

**CAMHS Payment by Results (PbR)**

CAMHS is facing a process of significant service change in the next few years, as we prepare for the introduction of CAMHS Payment by Results (PbR), which will bring us in line with adult mental health services and the wider NHS, where PbR is already established. Department of Health preparatory work on CAMHS PbR is exploring the use of case complexity factors as part of a CAMHS PbR care clustering process. This aims to ensure that more complex cases would attract higher tariffs, reflecting the increased time needed for case formulation and treatment alongside multidisciplinary and interagency liaison.

**NICE guidelines**

There are NICE guidelines on psychosis and schizophrenia in CYP (NICE, 2013a), self-harm (NICE, 2013b) and antisocial behaviour and conduct disorders in CYP (NICE, 2013c).

**Local policy context**

**2015-2020 Enfield Joint Commissioning Strategy for the emotional wellbeing and mental health of children and young people**

This sets out the way in which comprehensive and integrated Child and Adolescent Mental Health Services (CAMH services) will be commissioned to improve outcomes. Services will be commissioned by schools, colleges, academies, Enfield Council and NHS Enfield Clinical Commissioning Group. The intention is to adopt a whole systems approach, built around the need of children and young people and to break down the barriers between services and develop, deliver and commission a range of high quality and accessible mental health support based on the THRIVE model.
As part of the development of the joint commissioning strategy there has been ongoing work with the Enfield CAMHS young peoples’ engagement and parents’ engagement groups, which are becoming increasingly important in the way we develop and monitor services, and a web based survey of children and young people and parents and all users of Enfield CAMHS

Clinical strategy
The BEH Clinical Strategy was developed in 2013 and set the direction for the Trust’s development during the period 2013-18. It set out a number of key proposals for future service development based on the principles of promoting recovery, working closely with stakeholders in primary care and the third sector, and developing stepped care, in which problems are managed in different settings according to their level of complexity and severity. It also set out our commitments to improving quality and delivering a more responsive service to primary care – commitments which have been delivered.

Enablement strategy
In the two years since the Clinical Strategy was first developed, ‘Enablement’ established as a way to describe the approach to delivering the 2013-18 strategy. In April 2015, BEH-MHT launched the Enablement Programme following consultation with patient and carers’ representatives, local authorities, CCG’s, local GPs, local Healthwatch bodies, other partner organisations and staff. Enablement can be defined as a strengths-based model of care, founded on the principles of self-help and independence, focusing on keeping patients well and preventing the need for higher-level care if possible. The overarching aim of the Programme is to enable people to identify and work towards their own wellbeing, community, social and employment goals. There are a range of pilots, training, workforce reviews and community initiatives currently underway including

- Supporting frequent repeat inpatients with care planning through Barnet Network
- Courses for staff and service users in Recovery Houses about use of Wellness Recovery Action Plan (WRAP)
- Cluster 11 and 12 project (enduring disability from psychotic illness) (Barnet) assisting transition from CPA to other forms of support
- Barnet Assessment Service to divert people to the Network instead of onward referral to other parts of secondary care
- Implementation of Acceptance and Commitment Therapy model to Haringey Complex Care team
- CAMHS transition project which is using an enablement approach to facilitate transition
- Human resources policy and process review to support employment of service users
- Staff training on enablement with Middlesex University
- Apprenticeship scheme including for peer-support
- Extending enablement to different secondary care services

All of this work is designed to help implement recovery – or enablement – ideas and practice into the day-to-day work of individual teams, and to use the skills and resources of everyone involved (including service-users) to develop innovative ways of promoting recovery environments.
Results

1. Population details
2. Child and adolescent mental health conditions
   - Estimated levels of different mental health conditions and proportion receiving treatment
   - Treatment for child and adolescent mental disorder by tier
   - Complexity
   - Training
   - Expenditure, costs and potential savings
3. Adult mental health conditions
4. Secondary care for people with mental health conditions
5. Social care for people with mental health conditions
6. Economics of mental health conditions
   - National and local costs of mental health conditions
   - Expenditure on mental health conditions
   - Potential economic savings from improved coverage of treatment
7. Risk factors for mental health conditions
   - Inequalities and deprivation
   - Household factors – homelessness, fuel poverty, debt
   - Pregnancy – maternal smoking, birth weight
   - Parental factors – estimated number with mental health conditions / proportion receiving treatment, parental unemployment
   - Child risk factors – underweight/ obese, child poverty, children in need, abuse, bullying, domestic violence, school absence and exclusion, screen time
   - Child higher risk groups – looked after children, special education needs, young carers, NEETs, young offenders,
   - Adult risk factors – physical inactivity, obesity, lack of educational qualification, unemployment, economic inactivity, benefit claimants, work stress, social isolation, crime and violence
   - Higher risk groups – long term physical conditions, learning disability, carers, LGBT, offenders, BME groups, refugees, older people
   - Economics of prevention of mental health conditions
8. Levels of wellbeing
9. Protective factors for wellbeing
   - Breast feeding
   - Wellbeing promotion of parents and young children
   - Early education provision
   - Education achievement
   - School based mental health promotion
   - Physical activity in adults, good health, employment including for mental disorder, housing, safety, social contact, control, volunteering, cultural activities
   - Economics of mental wellbeing promotion
1) Population details for Enfield

The most recent population estimate for Enfield is 324,574 (166,815 female, 157,759 male) (ONS, 2015) which makes it the fourth largest London borough.

Population by age group
In Enfield, the proportion of the population which is (ONS, 2015):

- Under 18 (25.2%) was higher than London (22.5%) or England 21.3%
- Aged 18-64 years (61.9%) was lower than London (66.0%) but higher than England (61.1%)
- Over 64 (12.8%) was higher than London (11.5%) but lower than England 17.6%

Population projections
The population of Enfield

- All ages is forecast to grow by 9% between 2014 and 2020, 15% by 2025 and 21% by 2030 (PANSI, 2014)
- Aged 18-64 is forecast to grow by 8% between 2014 and 2020, 13% by 2025 and 17% by 2030 (PANSI, 2014)
- Aged 65 and over is forecast to grow by 12% between 2014 and 2020, 24% by 2025 and 39% by 2030 (POPPI, 2014)

By 2030, population increases will be different for different age groups (PANSI, 2014; POPPI, 2014):

- Age 18-24: 11% increase
- Age 25-34: 4% increase
- Age 35-44: 23% increase
- Age 45-54: 15% increase
- Age 55-64: 40% increase
- Age 65-69: 18% increase
- Age 70-74: 32% increase
- Age 75-79: 34% increase
- Age 80-84: 66% increase
- Age 85-90: 63% increase
- Age 90 and over: 109% increase

Population turnover
The turnover of a population in an area can have a significant impact on provision of services. A high turnover may indicate a lack of social cohesion in the area. Population turnover per 1,000 residents in Enfield (111.5) was 5th lowest of London boroughs (range 92.6-207.4), lower than London region (207.4) but higher than England (90.7) (2014) (ONS, 2014).
2) Child and adolescent mental health conditions

This section covers different child and adolescent mental health conditions and includes:
- Estimated levels, numbers affected and proportion receiving treatment for different mental health conditions
- Different levels (tiers) of treatment
- Economic savings from particular treatments

It links to section 7 on risk factors and higher risk groups.

2.1 Estimated levels of child and adolescent mental health conditions and treatment coverage

The estimated proportion of 5-16 year olds with any mental health condition in Enfield (9.9%) was 7th highest of London boroughs (range 7.1-10.8%) and higher than London region (9.3%) or England (9.3%) (Green et al, 2005; ONS, 2011). This implies there are an estimated 5,194 people aged 5-16 in Enfield with a mental and behavioural disorder based on local population size (ONS, 2015).

**Conduct disorder**

The estimated proportion of 5-16 year olds with conduct disorder in Enfield (6.1%) was 7th highest of London boroughs (range 4.0-6.8%) and higher than London region (5.7%) or England (5.6%) (2014) (Green et al, 2005). This implies there are an estimated 3,200 individuals aged 5-16 in Enfield with conduct disorder.

School days missed and exclusions are associated with conduct disorder (section 7.6). Proportion of half days missed in Enfield by primary school pupils (4.3%) was 6th highest of London boroughs and for secondary school pupils (5.1%) 3rd highest of London boroughs (2014/15) (DfE, 2015). Fixed period school exclusion rate in Enfield compared to other London boroughs (2013/14) (DfE, 2014)
- Primary school (1.2%) and secondary school (8.7%) pupils were 3rd highest
- Due to persistent disruptive behaviour (0.90%) was 2nd highest
- Exclusion rates have been increasing. For instance, number of primary school fixed term exclusions has increased from 185 in 2009/10 to 417 in 2014/15

**Numbers receiving treatment**

- Parenting interventions are first line recommended treatment for conduct disorder (NICE, 2013). No information was available about number of parents of children with conduct disorder receiving parenting interventions in Enfield
- Proportion of CAMHS presentations in 2013/14 which were conduct disorder was 23.3% to generic CAMHS (94 individuals) (CORC) and 12.5% to Adolescent team
- There is a Better Care Fund proposal that has been agreed for implementation in 2015/16 to fund an Intensive Behaviour Support Service which supports families where there is a risk of admission to a residential/in patient units (overlap with conduct disorder)
Emotional disorder
The estimated proportion of 5-16 year olds with emotional disorder in Enfield (3.9%) was 7th highest of London boroughs (range 2.8-4.3%) and higher than London region (3.6%) or England (3.6%) (2014) (Green et al, 2005). This implies there are an estimated 2,046 individuals aged 5-16 in Enfield with emotional disorder.

Information on numbers receiving treatment
- Child and Young People’s IAPT services which see 16 and 17 year olds (no information provided on numbers seen)
- Proportion of CAMHS presentations which were emotional disorder in 2013/14 was 69.3% to Enfield generic (282 individuals) (CORC) and 80.8% to Adolescent team

Hyperkinetic disorder
The estimated proportion of 5-16 year olds with hyperkinetic disorder in Enfield (1.7%) was 7th highest of London boroughs (range 1.1-1.8%) and higher than London region (1.6%) or England (1.5%) (2014) (Green et al, 2005). This implies there are an estimated 892 individuals aged 5-16 in Enfield with hyperkinetic disorder. Estimated number of 16-24 year olds with hyperkinetic disorder in Enfield (5,111) was 7th highest of London boroughs and based on national estimate of 13.8% (McManus et al, 2009).

Information on numbers receiving treatment
- Parenting interventions are first line recommended treatment for hyperkinetic disorder. No information was available about number of parents of children with hyperkinetic disorder receiving parenting interventions in Enfield
- Proportion of CAMHS presentations in 2013/14 which were hyperkinetic disorder was 9.8% to Enfield generic CAMHS (40 individuals) (CORC) and 3.8% to Adolescent team

For adults, there were 144 secondary care contacts for adults with ADHD in 2014/15, (locally provided figures).

Psychosis
No estimates exist for numbers of under 18’s with psychosis. During 2013/14, 0.2% presentations to generic Enfield CAMHS were psychotic disorder (one individual) (CORC). However, a review found that 9% of presentations (135 individuals) to Enfield CAMHS were young people experiencing hallucinations and delusions (Earle et al).

Eating disorder
Estimated numbers with eating disorder:
- Anorexia nervosa (AN)
  - Estimated rate of new cases each year (annual incidence) of anorexia nervosa was 19/100,000 in females and 2/100,000 in males although the highest rate was in 13-19 year old females at 50.8/100,000 (NICE, 2004). In Enfield, this would equate to 8 females aged 13-19
  - Estimated proportion with AN (prevalence) in 16 year olds was 7/1000 for females and 1/1000 for males (NICE, 2004). In Enfield, this would equate to 29 female and 4 male 16 year olds
• Estimated proportion with AN (prevalence) among young females (0.37%) which would equate to 70 women aged 16-24 in Enfield (Smink et al, 2012)

• Bulimia: Estimated prevalence of bulimia nervosa was 0.5-1.0% of young women which equates to 94-188 women aged 16-24 in Enfield (NICE, 2004; Smink et al, 2012)

• Estimated prevalence of eating disorder for 10-19 year olds was 31 per 100,000 for males and 120 per 100,000 for females which equates to 6 males and 23 females aged 10-19 in Enfield (from Enfield CAMHS strategy quoting CORC, 2014)

• Proportion of 16-24 year olds screening for with a possible eating disorder in the past year (based on a score of 2 or more on the SCOFF scale and using national scores of 6.1% for males and 20.3% of females) in Enfield (4,850) was 6th highest of London boroughs (based on a score of 2 or more on the SCOFF scale and using national scores of 6.1% for males and 20.3% of females) in Enfield (from Enfield CAMHS strategy quoting CORC, 2014)

During 2013/14, 1.7% presentations to generic Enfield CAMHS were eating disorder (7 individuals) (CORC). The Royal Free Hospital Eating Disorder Service (EDS) provides a specialist eating disorder service for Enfield children and young people. It is a service commissioned in collaboration with other North Central London CCG’s that offers intensive community support, and outreach clinics in borough as an alternative to inpatient admission. During 2014/15 in Enfield, the Royal Free CAMHS Eating Disorder Service received 31 referrals of which 29 were accepted (waiting times 0-3 weeks 69.0%, 4-6 weeks 20.7%, 7-9 weeks 10.3%. There were seven admissions.

Autistic spectrum disorder (ASD)

Estimated number of under-18 year olds with ASD in Enfield based on national rates (1.6%) was 1,312 with an estimated 480 individuals aged 5-10 with ASD (ChiMat). Proportion of primary, secondary and special school pupils identified as having ASD in Enfield (1.14%) was 16th highest of London boroughs (range 0.30-2.51%), similar to London region (1.15%) but higher than England (1.08%) (2015) (DfE, 2015). Proportion of Enfield CAMHS presentations in 2013/14 with ASD was 6.6% (27 individuals) (CORC).

NICE (2011) outlines interventions for ASD. The Enfield CAMHS strategy highlights that a multi-agency pathway is in place for children with autism aged under-6 although stated that provision for older children in particular needed to be improved. Findings indicate that there is a short fall in psychology provision, resulting in increased waiting times for assessment. It is proposed to use funding from the Transformation Plan for a waiting list initiative in 2015/16 and for an additional psychologist from recurrent funding thereafter. In addition it is proposed to fund a nurse prescriber to improve the skill mix of the team.
Alcohol use disorder
Estimated levels of alcohol of alcohol use disorder

  - Were regular drinkers (1.8%) was 6th lowest of London boroughs (range 1.0-8.6%) and lower than London region (3.1%) and England (6.2%)
  - Have been drunk in the past four weeks (8.4%) was mid-range for London boroughs (range 2.6-24.5%), similar to London region (8.9%) but lower than England (14.6%)
- 9% of 11-16 year olds regularly used alcohol which equates to 2,191 11-16 year olds in Enfield (Green et al, 2005)
- Fixed period exclusion rate due to drugs/alcohol use in Enfield (0.088%) (49 individuals) was 13th highest of London boroughs (range 0.03-0.17%) and higher than London region (0.08%) or England (0.1%) (2013/14) (DfE, 2014)
- Drinking rates are much higher for conduct disorder (19%), emotional disorder (13%) and hyperkinetic disorder (13%) compared to no disorder (9%) (Green et al, 2005) so early intervention for these disorders including with parenting programmes will have a significant impacts in almost half of estimated cases

Admission rate for alcohol specific conditions per 100,000 aged under 18 years in Enfield (19.2) was 7th lowest of London boroughs (range 13.9 to 49.3) and lower than London region (26.6) or England (40.1) (2011/12–2013/14) (HSCIC, 2014). No further information was provided about numbers receiving interventions for alcohol.

Drug use disorder
Estimated levels of alcohol of drug use disorder

  - Have ever tried cannabis (6.8%) was 4th lowest of London boroughs (range 5.6-18.6%) and lower than London region (10.9%) or England (10.7%)
  - Have taken cannabis in the last month (3.2%) was 4th lowest of London boroughs (range 1.8-8.5%) and lower than London region (5.0%) or England (4.6%)
  - Took drugs excluding cannabis in the last month (0.7%) (CI 0.2-1.2) was 10th lowest of London boroughs (range 1.0% to 8.6%) and lower than London region (1.0%) and England (0.9%)
- 8% of 11-16 year olds had taken drugs at some time which equates to 1,947 11-16 year olds in Enfield (Green et al, 2005)
- Rates of any drug misuse are much higher for conduct disorder (28%), hyperkinetic disorder (23%) and emotional disorder (20%) compared to no disorder (8%) (Green et al, 2005) so early intervention for these disorders including with parenting programmes will have a significant impacts in almost half of estimated cases

During 2013/14, 0.2% presentations to generic Enfield CAMHS were substance misuse (one individual) (CORC). Admission rate for substance misuse per 100,000 aged 15-24 years in Enfield (43.9) was 3rd lowest of London boroughs (range 39.4-118.7) and lower than London region (65.2) or England (81.3) (2010/11–2013/14) (HSCIC, 2014).
Tobacco smoking

- Were regular smokers (2.0%) was 4th lowest of London boroughs (range 1.3-6.7%) and lower than London region (3.4%) or England (5.5%)
- Tried other tobacco products in Enfield (4.2%) was 2nd lowest of London boroughs (range 3.4-14.2%) and lower than London region (6.1%) or England (8.2%)
- Tried e-cigarettes in Enfield (10.5%) was 8th lowest of London boroughs (range 7.2-16.6%) and lower than London region (12.0%) or England (18.4%)
- Smoking rates are several times higher for conduct disorder (30%), emotional disorder (19%) and hyperkinetic disorder (15%) compared to no disorder (6%) (Green et al, 2005) so early intervention for these disorders including with parenting programmes will have a significant impact in almost half of estimated cases

No information was provided about local smoking cessation or prevention including for those with mental health conditions.

Self-harm
The last national psychiatric morbidity survey found that 7% of 11-16 year olds had reported self-harm which equates to 1,704 11-16 year olds in Enfield (from Green et al, 2005). However, rates of self-harm are several times higher for emotional disorder (28%), conduct disorder (21%) and hyperkinetic disorder (18%) (Green et al, 2005) so early intervention for these disorders including with parenting programmes will have a significant impact on self-harm in almost half of estimated cases.

During 2013/14, 4.9% presentations to generic Enfield CAMHS had self-harmed (20 individuals) (CORC) while a further 12% (181 individuals) had attempted suicide (Earle et al). Enfield CAMHS provides an urgent assessment service for children and young people admitted to paediatric wards (North Middlesex & Barnet Hospitals) with presentations of Deliberate Self Harm (DSH). They completed 89 DSH assessments between August 2014 and July 2015. From 2016/17 provision will be extended to become a whole service response to crisis, including for example children and young people presenting at A&E, or at risk of exclusion from school. This will ensure fit with the proposed implementation of a THRIVE type model.

Admission rate in Enfield for (HSCIC, 2014):

- Self-harm per 100,000 aged 10-24 years (156.2) was 9th lowest of London boroughs (range 116.3-338.5) and lower than London region (204.8) or England (352.3) (2010/11 - 2012/13). Admissions for self-harm in Enfield increased from 57 in 2012/13 to 81 in 2013/14, 58 in 2014/15 and 78 in 2015/16 (local data)
- Unintentional and deliberate injuries per 10,000 aged 0-14 years in Enfield (84.3) was 15th lowest of London boroughs (range 64.4-122.9) and similar to London region (86.8) but lower than England (112.2) (2013/14)
- Unintentional and deliberate injuries per 10,000 aged 15-24 years in Enfield (86.9) was 8th lowest of London boroughs (range 70.0-133.1) and lower than London region (101.5) or England (136.7) (2013/14)
2.2 Treatment for child and adolescent mental disorder by tier

A section 75 agreement supports the joint commissioning of children’s services, and the CCG and Council work in partnership to both commission and performance manage CAMHs. Schools and public health colleagues are engaged in this process. Provision of treatment of child and adolescent mental disorder can be divided into four separate levels or tiers. However, Future in Mind promotes the use of more integrated models of care such as the THRIVE model which brings services together to focus on the needs of children and young people, in the context of a system which is struggling to meet increase demand and complexity of need, whilst refocussing on building resilience, personalisation of evidence based and outcome driven care, support for vulnerable groups, and value based service delivery. The CCG and Enfield Council recognise the advantages of THRIVE and that any model will need to build on the Single Point of Entry into children’s services in Enfield which already co-ordinates access to Early Help. Work is currently being undertaken to improve the co-ordination of CAMHS provision within the Single Point of Entry so that access to the most appropriate service is simplified.

The next section outlines the available CAMHS services by different tier.

**Tier 1 universal services**
- Estimated number requiring tier 1 CAMHS in Enfield was 12,060
- Health visitors: No information was provided about numbers seen
- Preschool: No information was provided about numbers referred or seen
- Schools including school nurses and counsellors: No information was provided about numbers referred or seen
- General practitioners and primary care services: No information was provided

**Tier 2: Targeted services such as youth offending teams, primary mental health workers, and school and youth counselling (including social care and education)**
Mental health professionals working singularly rather than as part of a multi-disciplinary team (such as CAMHS professionals based in schools, or paediatric psychologists in acute care settings).
Estimated number requiring tier 2 CAMHS in Enfield was 5,628

School based tier 2 services
- Social and Emotional Wellbeing and Mental Health (SEMH) Provider Group and Future in Mind Head Teacher group has been set up to work with schools, co-ordinate training, and respond to needs
- Health and Emotional Wellbeing Service (HEWS): During the first year of delivery in 2014, fourteen schools bought into the service. Currently this is primarily an early intervention service and HEWS workers facilitate referral into higher levels of CAMH services where necessary. Three new schools have bought in to the service for 2015/16 academic year. A HEWS (CAMHS) worker spends either a day or half day per week in each school providing:
  - Direct assessment and intervention service for children young people and families
  - Consultation to staff
  - Training for staff
  No information about number receiving interventions
- Educational Psychology Service (no information about number receiving interventions)
Educational Psychologists (EPs) carry out assessments and interventions with children and young people aged up to 25 years across the whole spectrum of developmental difficulties, including problems of emotional and social development and behaviour and some more severe mental health problems. EPs advise schools and parents about referral to Tier 3 CAMH services as appropriate.

EPs assess and support children with symptoms of ASD and ADHD both prior to formal diagnosis and after screening/assessment by Tier 3 CAMH services.

EPs work with schools in a range of ways to promote children’s emotional well-being, for example, supporting and promoting nurture groups, liaising with teaching and pastoral staff in schools and with agencies such as Place To Be and the Behaviour Support Service (BSS) where appropriate and contributing to pastoral support plan meetings for children at risk of permanent exclusion. Some schools are developing approaches based on Cognitive Behavioural Therapy (CBT) in conjunction with EPs to improve the well-being of all pupils.

Currently EPs are instrumental in developing the capacity of families and schools to support and educate children with autism via projects developed by the EPs in conjunction with other agencies (MAPS – Making a Positive Start, ASRAP – Autism Resource Allocation Panel and PLANS - Positive Learning and Nurturing Schools).

EPs provide projects to support whole classes or groups of children to improve their well-being and self-esteem: for example, anger management groups, solution focused work with whole classes, the Tree of Life project (which promotes positive sense of ethnic and national aspects of identity).

EPs also provide training for the staff of schools and early years settings to promote awareness of factors affecting children’s emotional development e.g. on Attachment Theory.

Under the new Children and Families Act 2014, statements of special educational needs are being replaced by Education, Health and Care Plans (EHC plans). EPs will be instrumental in the process of converting some statements to EHC plans as well as continuing to provide psychological advice for new EHC plans.

- Place2be worked with 10 schools during 2013/14 and included the following elements
  - Place2Talk: Universal self-referral service run in the lunch hour open to any child in the school. During 2013/14, this involved 3,114 children
  - Referral and assessment using Strengths and Difficulties Questionnaire
  - One-to-one Counselling: Weekly sessions delivered to children for a school term or over the full academic year. During 2013/14, there were 416 referrals, 153 assessments (before counselling), 11 children seen for short term counselling and 148 children seen for long term counselling
  - Therapeutic group work (supporting small groups of six children affected by a similar issue – e.g. bullying, transition, low self-esteem)
  - Parent Partnership work: Up to 5 sessions for parents/carers whose children are being seen by Place2Be: During 2013/14, there were 610 sessions with parents
  - Practical advice, guidance and sign-posting for families
  - Multi-agency work involving onwards referrals and joined up support: During 2013/14, 74 children were referred or signposted elsewhere and there were sessions with social services (19), CAMHS (11). Ed Psych (7), Multi-agency (44) and Other (67)
  - Safeguarding: Early identification and child protection
Place2Think: Consultation for staff to think around the needs and behaviour of children in their care. During 2013/14, there were 1,492 sessions

Assistance with whole class work e.g. PSHE lessons, Circle Time, Citizenship

Specialist training and CPD opportunities: building skills and capacity to support children’s emotional wellbeing more effectively

Place2talk: In the spring term 2014, saw 1,830 different children in 3,048 visits. There were 309 individual sessions and 889 group sessions. An evaluation showed mixed feedback about the sessions

- Nurture groups Operate in 26 schools supporting children with their readiness to learn and building resilience to manage the transition to secondary school. An estimated 280 children are supported per year
- Early Years Social Inclusion (EYSI) team work with a large number of primary schools and have established 2 approaches to working with young children facing difficulties in settling in and or making progress in schools. Tiger Teams focus on developing gross and fine motor skills and LASS groups that support children with language and communication skills. Await number receiving interventions

Other tier 2 services although there was lack of information about numbers being seen:

- IAPT Service provides individual and group services for 16 years and over (9 trainees). IAPT practitioners provide stress and wellbeing training in local colleges. The work is being expanded to Sixth Form Colleges
- Web based services including The Big White Wall
- Behaviour Support Service has a role in supporting families and children and young people who are not attending schools
- Pupil Referral Units are well placed to support young people with emotional and behavioural difficulties. In complex cases, BSS are involved along with EPS and CAMH services.
- Change and Challenge (Troubled Families) programme is targeted for families. The Change and Challenge Team has clinical psychologist and therapists
- Family and Adolescent Support Hub (FASH) is aimed at children and young people who are on the edge of coming into local authority care. FASH is funded through the Innovation Fund referenced in Future in Mind, and has clinical psychologists and therapists working in the teams.
- CAMHS in the Youth Offending Services (YOS): A dedicated Tier 2 CAMHS clinician works with young people at risk of or involved in offending. The clinician is based at the YOS as part of the multi-agency team, and can facilitate access to the full range of CAMH services
- CAMHS in Social Care: A dedicated Tier 3 clinician works with social workers, to support children, young people and their families. These are families that have been identified as needing additional support
- Services provided for children and young people with milder problems - often provided by primary mental health workers (as outreach from Tier 3 CAMHS) who may work with the child or young person directly or indirectly by supporting professionals working in universal services
- Services to specific groups of children and young people at increased risk of developing mental health conditions: See section 7.8 of the report covering higher risk groups:
  - Looked after children (LAC) (see section 7.8.1):
Estimate 166 LAC in Enfield with a mental health condition based on 45.3% prevalence (Ford et al, 2007). There were an estimated 20.5% with conduct disorder, 11.4% with anxiety disorders, 12.0% with emotional disorder, 8.3% with ADHD, 13% with neurodevelopment problems, 3% with autism (Ford et al, 2007) and 25% who ate excessively (Tarren-Sweeten, 2006).

Enfield HEART provides a mental health service that offers assessment (including for Court), consultation to the professional network and direct therapeutic work with looked after children and young people in order to: ensure mental health needs are addressed, contribute to care planning and reduce placement breakdowns. On 31.3.15 HEART had 97 open CAMHS & EPS cases involving looked after children and young people compared with 82 on 31.3.14. 95 CAMHS referrals were received by HEART in the 12 months to 31.3.15 (compared with 74 in the year to 31.3.14) and a range of interventions offered (consultation, mental health assessment, psychodynamic psychotherapy, cognitive behavioural therapy, family therapy etc.). The average waiting time from referral to first contact was just over two weeks (actual figure, 2.08 weeks) which is slightly more than the 2013/14 figure of 1.8 weeks, reflecting the significant increase in referrals.

Looked after children leaving care: A local service audit showed that 56% (72/128) of young adults in Enfield leaving care service were estimated to have mental health needs.

- Young carers (see section 7.8.3)
- Enfield Parenting Support Service provides research-based, accessible services for all vulnerable children and their families in Enfield through driving the use of the Early Help Form across all sectors including statutory voluntary and community groups. The Community Parent Support Service and the 16/17 Young Person’s Homeless Service directly empower parents to achieve the best outcomes for children, young people, families and communities. No information was provided about numbers from different groups receiving such services.

- Parenting interventions are NICE recommended first line interventions for conduct disorder (NICE, 2013) and hyperkinetic disorder (NICE, 2009) which are estimated to affect 4,092 individuals aged 5-16 in Enfield (see earlier section). No information was provided about parenting interventions.

Tier 3 specialist CAMHS

Multi-disciplinary teams of child and adolescent mental health professionals provide a range of interventions. Access to the specialist team is often via referral from a GP but referrals may also be accepted from schools and other agencies, and in some cases self-referral. Tier 3 CAMHS services in Enfield comprise of:

- Two multidisciplinary teams (north and south)
- SAFE team which is for adolescents and families in crisis with acute mental health problems
- Alliance team which is an enhanced tier 3 crisis support team (three mental health nurses)
- SCAN team is for children and adolescents with both neurodevelopmental disorder and mental health needs who attend special schools
- CAMHS Child Development Team (CDT) provides assessment and diagnostic services for children under 6 with neuro–developmental problems, physical disability, learning disability and life-limiting conditions.
Enfield Parent and Infant Project (EPIP) is part of a wider Parent Infant Mental Health Service. EPIP is a small specialist service providing therapeutic assessment and support to parents and their babies up to the age of 18 months where there are issues and difficulties around relationships and attachment, as a result of parental mental ill health and/or complex social difficulties.

Estimated number of under-17 year olds in Enfield who require tier 3 CAMHS (1,485) was 3rd highest of London boroughs (2012) (from Kurtz, 1996 although significant concerns about data quality). During 2014/15, Enfield CAMHS accepted 1,504 referrals. The following information for 2014/15 was provided by Enfield CAMHS:

- **Tier 3 referrals**
  - Total Enfield CAMHS Tier 3 and Adolescent Team: 2,125 referrals of which 1,504 accepted (71%) (70% of referrals aged 0-14 years)
  - Enfield CAMHS Tier 3 team: 1,813 referrals of which 1,235 were accepted (68% acceptance)
  - Enfield CAMHS Adolescent teams: 312 referrals of which 269 were accepted (71% acceptance)
  - Enfield Parent Infant Partnership (EPIP): 54 referrals of which 52 were accepted (96% acceptance)
  - Source of referrals (2014/15): Primary care (42% / 893 referrals), education (17%), child health (16%), other (10%), social services (6%), internal referral (3%), A&E (2%), self-referral (1%)

- **Waiting times and attendance for initial appointments**
  - 89.2% of cases were seen within 13-week referral to appointment target
  - Initial appointments: 1,448 attendances with Tier 3 and Adolescent 739 cancelling or not attending (33.8%), 27 attendances with EPIP with 8 cancelling or not attending (22.9%)
  - Average wait for an initial appointment was 7.6 weeks in the generic teams, 2.5 weeks for the Adolescent teams and 3.8 weeks for EPIP

- **Caseload**
  - CAMHS (968), HEART (96), Children Centre Teams (26), SCAN (103), CDT (103), SAFE Adolescent team (238), Alliance Adolescent Team (8): Total 1,542
  - EPIP (44)

- **Contacts**
  - Community contacts by CAMHS were 15,281 with no contacts in CAMHS Tier 4 Acute or HDU
  - Follow up appointments: 13,301 attendances with Tier 3 and Adolescent 4,569 cancelling or not attending (25.6%), 249 attendances with EPIP with 56 cancelling or not attending (18.4%)
  - Telephone contacts: 794 with Tier 3 and Adolescent Teams and 14 with EPIP

- **Ethnicity of contacts**: 43% White, 30% Not Known, 13% Black, 8% Mixed, 4% Indian, 2% Other

- **Discharges**: 2,194 from CAMHS Team and 16 from EPIP

- **Proportion of problems presenting to Enfield CAMHS**

- **Multi-systemic therapy team for 11-17 year olds** aims to keep children out of the care system by working alongside the main caregivers and family support system (provided by Brandon Centre)

- **Community mental health teams**:
  - Proportion of under 18’s in adult CMHT’s: No information was provided
Specialist CAMHS can include teams with specific remits to provide for particular groups of children and young people including CAMHS learning disability teams, community forensic CAMHS, adolescent substance misuse teams, crisis/home treatment teams working intensively to prevent admission to hospital, and paediatric liaison teams providing CAMHS input to children and young people in acute care settings. No information was provided about such services.

**Staffing for Tier 3 CAMHS in Enfield**

- **Enfield CAMHS Tier 3 team**
  - Divided into North, South, HEART, Children’s Centres, SCAN and CDT
  - Clinical staff were 2.8 Consultants, 3.9 Clinical Psychologists, 3.9 Child and Adolescent Psychotherapists, 6.7 Family Therapists and 1.7 CAMHS Practitioners

- **Enfield CAMHS Adolescent teams**
  - Divided into SAFE Adolescent Service and Alliance Adolescent Team
  - Clinical staff were 2.8 Registered Nurses, 1.5 Consultants, 2.5 Clinical Psychologists, 0.6 Child and Adolescent Psychotherapists and 0.7 CAMHS Practitioners

- **Enfield Parent Infant Partnership (EPIP):** 0.6 CAMHS practitioner and 0.4 Parent Infant Psychotherapist

**Tier 4 highly specialised CAMHS**

Tier 4 includes day and inpatient services, some highly specialist outpatient services, and increasingly services such as crisis/home treatment services which provide an alternative to admission. Such services are often provided on a regional or supra-regional basis. There are also a small number of highly specialised services including medium secure adolescent units, services for gender dysphoria, CAMHS services for children and young people who are deaf; and highly specialist obsessive compulsive disorder services. These services will have been commissioned on a national basis. The Beacon Centre is commissioned by NHS England and provided by Barnet Enfield & Haringey Mental Health Trust to provide a twelve bed Tier 4 in-patient Acute Adolescent Unit.

- Estimated number of under-17 year olds in Enfield who require Tier 4 CAMHS (65) was 2nd highest of London boroughs (2012) (from Kurtz, 1996 - significant concerns about data quality)
- Admission rate for mental disorder per 100,000 aged 0-17 years in Enfield (90.2) was 13th highest of London boroughs (range 32.7-391.6) and lower than London region (101.9) but similar to England (87.2) (2013/14) (HSCIC, 2014)
- During 2014/15, there were 22 admissions/readmission and 1,325 overnight bed days of Enfield young people in Tier 4 inpatient services (locally provided data)

Several tier 4 external contracts include:

- Tavistock & Portman NHS Foundation Trust. Enfield has a small contract to provide outpatient Tier 3 CAMH services to Enfield children & young people according to need. This has been useful if parents are employed in Enfield in related professions, or are seeking a second opinion
- Royal Free NHS Hospital Eating Disorder Service is commissioned across NCL and provides a specialist community eating disorder service for Enfield children and young people (section 2.1)
- Brandon Centre is commissioned to provide multi systemic therapy to children, young people and families on the edge of care
- South London and Maudsley Trust: For second opinions, recommended by a CAMHS consultant or senior clinician, on complex neuro-developmental disorders, including autism
Multi-Disciplinary Panels related to CAMHS: There are a number of multi-disciplinary panels related to CAMHS; the adoption panel, complex issues, the early support resource allocation panel

2.3 Complexity
CAMHS clinicians, professionals from external agencies and researchers agree that complexity is multifactorial and multiplicative and is not fully explained by simply counting up numbers of complexity factors in a given situation (Earle et al). Factors found to contribute to complexity in local CAMHS cases included factors relating to the:
- Child
- Family context
- Clinician
- Nuanced aspects of the clinical presentation
- Functioning of the professional network and level of service provision
- Amount of time needed to assess, treat, and manage interagency liaison
- Unexpected / risky events

Data collected in the BEH-MHT survey and 2013/14 CORC found that children and young people attending BEH CAMHS presented with severe and co-morbid difficulties including self-harm, suicide, trauma and early onset psychosis. Managing risk, which may be unclear or rapidly changing, was a complex challenge. Enfield data indicated a large number of cases with suicidal thoughts and higher numbers of past suicide attempts.

Proportion of young people with:
- Different presenting problems to generic Enfield CAMHS during 2013/14 (CORC)
  - 0.2% experienced hallucinations and delusions
  - 1.7% experienced eating disorder
  - 6.6% had autistic spectrum disorder
  - 4.9% had self-harmed
  - 2.9% had learning disability
  - 95% had more than one presenting problem
- At risk
  - 42% were clinician rates low risk in Enfield CAMHS, 40% as medium risk and 12 as high risk
  - 21% posed a risk to others
- Risk factors for mental health conditions (see section 7)
  - 28% in Enfield CAMHS have experienced child abuse
  - 7% in Enfield CAMHS were subject to a Child Protection Plan (compared to 7.6% nationally)
  - 70% had family relationship difficulties
  - 16% had experienced bereavement
  - 6.8% had a serious physical health issue
  - 19% in Enfield CAMHS were rated as living in financial difficulty
- Higher risk groups (see section 7.8)
- 10% in Enfield CAMHS were classed as ‘Children in Need’
- 19% in Enfield CAMHS had limited attendance at school, employment or training with 9% attendance at school, employment or training
- 10% were recorded as young carers

Living situation
- 47% in Enfield CAMHS were living with both parent
- 9% in Enfield CAMHS were living other situations including foster placements, institutions and independently
- 25% in Enfield CAMHS had a family member with a mental health condition
- Complexity: 31.4% were rated as slightly complex, 31.4% as moderately complex and 30.1% as definitely complex
- Medication: 78.4% were not prescribed any medication in Enfield CAMHS

Engagement
- 11% of carers in Enfield CAMHS had counterproductive attitude while 12% had an attitude which was indifferent
- Just under half were difficult to engage
- 6.7% if families required a interpreter

- 27.5% of cases were involved with social services. 3.5% of cases were involved in youth offending services, 7.5% of services involved liaison with 3rd sector organisations, 14.6% of cases involved child health agencies (including paediatrics, school nurses and speech and language therapists) and 42% of cases involved work with educational services (including schools, pupil referral units and educational psychologists)
- Complexity is likely to inform case clustering in the future introduction of CAMHS Payment by Results (PbR)

2.4 Training to promote mental health literacy
Could include:
- CAMHS providing ‘core skills’ training to the CYP workforce in social care, education and health – prioritising those that work with vulnerable groups
- CYP IAPT provides staff training for (CAMHS strategy)
  - Cognitive behavioural therapy (CBT) for anxiety disorders and depression
  - Parenting training for behavioural and conduct disorders (3 to 10 year olds)
  - Systemic family practice for conduct disorder (over 10 years), depression and self-harm, and eating disorders
  - Interpersonal psychotherapy for adolescents for depression
- Educational programmes to increase mental health literacy

2.5 Priorities for investment (Enfield CAMHS strategy 2015/16)
- Early identification and intervention: It is a priority for the CCG and Enfield Council to strengthen early identification and intervention, and ensure that there is a common understanding and ability to recognise mental health problems among volunteers and professionals working with young people. Addressing this is partly a training and workforce issue but consideration will also need to be given to re-profiling investment
• Creating a platform for future development: Address performance issues identified in the strategy, IT infrastructure and funding for backfill to support implementation of the plan, and additional funding for extra capacity to develop particular work streams including the work with the voluntary sector and the work on peer support and engagement

• Early identification and intervention: LBE are working with partners including the CCG on the development of an Early Years Help model which will incorporate the Early Years Foundation Stage with the Healthy Child Programme, and ensure an ongoing emphasis on building resilience

• Perinatal mental health services, and Parent and Infant Mental have been identified as areas where there is a strong evidence base and care pathways and provision needs to be strengthened. All partners and commissioners support the draft NCL Perinatal Strategy and Enfield CCG is awaiting the perinatal mental health allocations to implement the NCL Draft Strategy recommendations about need to invest in specialist support (see section 3.M). Parent and Infant Project as part of a wider Parent Infant Mental Health Service. Enfield has worked with the EPC (Enfield Parents & Children) in securing a grant from PIP UK to develop the PIP further in Enfield, based on the commitment of the CCG and the LBE to provide match funding. Funding for this service is identified as a priority in the plan.

• Schools: Implementation of a THRIVE type model should ensure that services are more responsive to need. Encouraging schools to continue to invest in mental health services is also an important part of the Transformation Plan, and work to develop a co-ordinated offer is advanced:
  o A training programme has been agreed and includes level one training for all staff and specialist training to develop ‘mental health champions
  o The Future in Mind Head Teachers Group is keen on piloting a Contact Point in schools
  o We want to expand the HEWS (Health and Emotional Wellbeing in Schools) project

• Eating disorders (see section 2.1)

• CYP IAPT (see section 2.1)

• Vulnerable children and young people including look after children and criminal justice entrants (see section 7)

• Autism (see section 2.1)

2.7 CAMHS workforce
Using CAMHS workforce as a benchmark for investment levels, based on 2012 National CAMHS benchmarking, Enfield would require a total CAMHS workforce of 40.75 wte staff to reach the national mean, or 37.35 wte staff to reach the national median (Enfield CAMHS strategy). Using recently updated Royal College of Psychiatrists guidance on workforce, capacity and functions of CAMHS in the UK, for Enfield to achieve a 5 star service would require a clinical workforce of 49.1 WTE. The current Enfield clinical workforce at September 2015 is 36.4 wte, excluding trainees.

2.8 Economics of child and adolescent mental health conditions
During 2015/16, the CCG and Enfield council is investing £4.67m into CAMHs, including the NHS share of complex care placements. This will increase to £5.46m with new Transformation funds of £0.59m plus CYP funding of £96,500. NHS Enfield CCG is currently investing £0.27m a year in the Royal Free Hospital Eating Disorder service.

Expenditure rate per head of population aged under 18 in NHS Enfield CCG on (2012/13) (DH, 2014):
- CAMHS (£46.5) was 12th highest of London boroughs (range £10.8-£183.8) and lower than England (£61.3)
- CAMHS primary care prescribing (£1.7) was 4th lowest of London boroughs (range £1.4-£5.7) and lower than England (£4.6) (significant concern about data quality)
- CAMHS secondary care (£40.9) was 5th highest of London boroughs (range 0-£153.7) and higher than England (£27.7) (significant concern about data quality)
- CAMHS community care (£2.0) was low for London boroughs (range 0-£102.0) and lower than England (£17.0) (significant concern about data quality)

Proportion of mental health expenditure rate on CAMHS in NHS Enfield CCG (6.3%) was 9th highest of London boroughs (range 1.7% to 10.5%) and similar to England (6.2%) (2012/13) (DH, 2014) (see table on next page).

Better Care Fund proposal has been agreed for implementation in 2015/16 to fund an Intensive Behaviour Support Service.

Economic costs of child and adolescent mental disorder
- Mental health problems in children and young people are associated with excess costs estimated as being between £11,030 and £59,130 annually per child. These costs fall to a variety of agencies (e.g. education, social services and youth justice) and also include the direct costs to the family of the child's illness.
- Estimated annual costs of crime by adults who had childhood conduct disorder or sub-threshold conduct disorder in Enfield was £339.3m (based on SCMH, 2009)

Potential savings from parenting interventions for conduct disorder
Estimated minimum net savings arising from parenting interventions provided to every parent of a child/adolescent with conduct disorder in Enfield would be £29.7m total savings (criminal justice £24.0m, NHS £4.1m, education £1.4m) (based on Knapp et al, 2011).
Table 2.1: Total CAMHS expenditure increased from £4.7m in 2014/15 to £5.5m in 2015/16 (see locally provided data below).

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Council Investment in Mental Health Services

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Future In Mind Transformation Funding

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CYP IAPT

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Schools Investment

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</thead>
</table>

<table>
<thead>
<tr>
<th>Total Schools</th>
<th>-</th>
<th>95,680</th>
</tr>
</thead>
</table>

| Total                     | 4,703,431  | 5,456,312  |
3) Adult mental health conditions

This section covers estimated levels and treatment coverage for mental health conditions including:
- Common mental disorder
- Severe mental illness and psychosis
- Dementia
- Personality disorder
- Eating disorder
- Alcohol use disorder
- Drug use disorder
- Smoking
- Long term mental health conditions
- Complex needs
- Self-harm
- Suicide
- Parental mental health conditions

A) Common mental disorders

A.1 Estimated levels of any common mental disorder

The estimated proportion of adult population aged 16-74 with a common mental disorder in NHS Enfield CCG (15.6%) was 12th lowest of London boroughs (range 13.7-21.6%), lower than London region (16.4%) but the same as England (15.6%) (2014/15) (NHSE, 2015). This implies there are 36,106 people in Enfield with a common mental disorder aged 16-74 (ONS, 2015). Prevalence of common mental disorder was correlated with deprivation with Enfield lower than expected for its level of deprivation (figure 3.1).

Figure 3.1: Estimated proportion of adult population aged 16-74 with a common mental disorder (2014/15) vs socioeconomic deprivation score


5 The score of the Index of Multiple Deprivation, 2010, is used here. These figures combine values of many indicators into a single score that indicates the overall level of deprivation in each LSOA. A higher number indicates a higher level of deprivation.
Another source of estimated prevalence of common mental disorder is an independent survey of GP patients run on behalf of NHS England and sent out to over a million people across the UK. This found that the proportion of people who reported feeling moderately or extremely anxious or depressed in NHS Enfield CCG (11.2%) was 14th lowest of London boroughs (range 9.1 to 15.1%) and similar to London region (11.7%) but slightly lower than England (12.4%) (2014/15) (NHSE, 2015).

A.2 Estimated prevalence of different common mental disorder

Mixed anxiety and depressive disorder
The estimated prevalence of mixed anxiety and depressive disorder among the 16-74 population in Enfield (8.0%) was mid-range of London boroughs and lower than London region (8.5%) or England (8.9%) (PHE, 2014). This would suggest that 18,516 people in Enfield had mixed anxiety and depressive disorder (ONS, 2015). In 2021, the prevalence of mixed anxiety and depressive disorder in Enfield is estimated to fall slightly to 7.9% (PHE, 2014) (although note concern about data quality).

Generalised anxiety disorder
The estimated prevalence of generalised anxiety disorder among the 16-74 population in Enfield (5.0%) was 10th lowest of London boroughs and lower than London region (5.3%) but higher than England (4.5%) (PHE, 2014). This would suggest that 11,572 people in Enfield had generalised anxiety disorder (ONS, 2015). In 2021, the prevalence of mixed anxiety and depressive disorder is estimated to fall slightly to 5.1% (PHE, 2014) (although note concern about data quality).

Depressive episode
The estimated prevalence of depressive episodes among the 16-74 population in Enfield (3.3%) was 11th lowest of London boroughs and lower than London region (3.5%) but higher than England (2.5%) (PHE, 2014). This would suggest that 7,638 people in Enfield had depressive episodes (ONS, 2015). In 2021, the prevalence of depressive episodes is estimated to rise to slightly fall to 3.4% (PHE, 2014) (although note concern about data quality).

Phobias
The estimated prevalence of all phobias in Enfield (2.0%) was 12th lowest of London boroughs, similar to London region (2.2%) and higher than England (1.8%) (PHE, 2014). This would suggest that 4,629 people in Enfield had phobias (ONS, 2015). In 2021, the prevalence of phobias is estimated to slightly fall to 2.0% (PHE, 2014) (although note concern about data quality).

Obsessive compulsive disorder
The estimated prevalence of obsessive compulsive disorder in Enfield (1.5%) was 13th lowest of London boroughs, lower than London region (1.6%) and higher than England (1.1%) (PHE, 2014). This would suggest that 3,472 people in Enfield had obsessive compulsive disorders (ONS, 2015). In 2021, the prevalence of obsessive compulsive disorder is estimated to slightly fall to 1.4% (PHE, 2014) (although note concern about data quality).

Panic disorder
The prevalence of panic disorder in Enfield (0.81%) was 12th highest of London boroughs, similar to London region (0.86%) and higher than England (0.65%) (PHE, 2014). This would suggest that 1,875 people in Enfield had panic disorder (ONS, 2015). In 2021, the prevalence of panic disorder is estimated to slightly fall to 0.82% (PHE, 2014) (although note concern about data quality).
Post-traumatic stress disorder
The prevalence of post-traumatic stress disorder in Enfield (3.0%) was 10th lowest of London boroughs (range 2.8-3.0%) and similar to London region (3.0%) and England (3.0%) (PHE, 2014). This would suggest that 6,944 people in Enfield had post-traumatic stress disorder (ONS, 2015).

Level of anxiety and depression in social care users
The proportion of social care users with anxiety and depression in Enfield (61.2%) was highest of London boroughs (range 47.3-61.2%) and higher than London region (54.4%) or and England (52.8%) (2013/14) (HSCIC, 2014).

Level of anxiety and depression in older people
Estimated numbers of people aged 65 and over estimated to have depression in Enfield was 3,604 (POPPI, 2014).

Higher risk groups and common mental disorder
Estimated number of depressed mothers in Enfield
- 613 pregnant mothers and 1061 new mothers one year after birth (based on systematic review prevalence rates from Gavin et al, 2005 and latest birth rates ONS, 2015)
- 605 women (based on NICE benchmark figures of 12% who may require support for mental health problems during pregnancy or in the postnatal period) (2012) (PHE, 2014)

Proportion of social care service users who were moderately or extremely anxious or depressed in Enfield (61.2%) was highest of London boroughs (range 47.3-61.2%) and higher than London region (54.4%) or England (52.8%) (2013/14) (HSCIC, 2014)

A.3 Primary care coverage of people with common mental disorder
The proportion of people on the primary care depression register in NHS Enfield CCG (4.8%) was 12th lowest of London boroughs (range 3.6-7.5%) and lower than London region (5.3%) or England (7.3%) (2014/15) (HSCIC, 2015).

Given that the estimated proportion of adult population aged 16-74 with a common mental disorder in NHS Enfield CCG is 15.6% (see section A.1), this implies that 30.8% of people with common mental disorder in Enfield were on the primary care depression register in 2014/15.

The proportion of new cases on the primary care depression register in NHS Enfield CCG (0.9%) was mid-range for London boroughs (range 0.6-1.2%), same as London region (0.9%) but lower than England (1.2%) (2014/15) (HSCIC, 2015).

Variations should reflect the level of need, which in turn is associated with the level of deprivation (McManus et al, 2009). However, figure 3.2 below shows that there was no clear relationship between the level of deprivation and the proportion of people on the primary care depression register.
Variation in proportion on primary care depression register across GP practices in Enfield

Although the proportion of the adult population on the primary care depression register in Enfield was 4.8%, the rate across different practices varied from 0.33% to 11.1%. In figure 3.3 below, those in orange are not significantly different from the England average (HSCIC, 2015).
Proportion of people on the primary care depression register at practice level was not correlated with socioeconomic deprivation score which implies that other factors account for variation in the proportion of people on primary care depression registers in different practices.

**A.4 Primary care outcomes for people with common mental disorder**

**Assessment of depression (QOF DEP001)**

Appropriate assessment for in patients with depression is essential to decide on interventions and improve the quality of care. A biopsychosocial assessment as close as possible to the time of diagnosis enables a discussion with the patient about relevant treatment and options, guided by the stepped care model of depression described in NICE clinical guideline 90 (NICE, 2009).
The proportion of adults with a new diagnosis of depression who had a bio-psychosocial assessment upon diagnosis in NHS Enfield CCG (78.3%) was 4th highest of London boroughs (range 48.4-83.5%) and higher than England (75.8%) (2013/14) (HSCIC, 2014).

Review of depression (QOF DEP002)
The rationale for such follow-up measurement is derived from the recognition that depression is often a chronic disease, yet treatment is often episodic and short-lived. The proportion of newly diagnosed adults with depression with a review within 10-56 days after diagnosis in NHS Enfield CCG (68.5%) was 4th highest of London boroughs (48.7-75.1%) and higher than England (63.8%) (2014/15) (HSCIC, 2015).

Exception rates for depression
Exception reporting allows GP practices to pursue the quality improvement agenda and not be penalised, where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect. The proportion of people on the depression register excluded from quality measures (exception rate) in NHS Enfield CCG (17.4%) was 2nd lowest of London boroughs (range 14.6-34.4%) and lower than England (24.5%) (2014/15) (HSCIC, 2015). However, the rate between practices in Enfield varied from 0–75.0%.

A.5 Antidepressant treatment for common mental disorder
Antidepressants are an effective treatment option for common mental disorder. The rate of primary care antidepressant prescribing per STAR-PU in NHS Enfield CCG (0.8) was 15th highest of London boroughs (range 0.5-1.1) and the same as London (0.8) but lower than England (1.3) (2014/15) (NHSBSA, 2015). Figure 3.4 highlights that the rate at which antidepressants are prescribed is not significantly associated with deprivation.

Figure 3.4: Antidepressant prescribing: Average daily quantities (ADQs) per STAR-PU (2014/15) vs socio-economic deprivation score

Source: DCLG (2010), NHSBSA
The proportion of first choice antidepressants of the total number of prescription items in NHS Enfield CCG (68.9%) was mid-range for London boroughs (range 62.7-76.4) and similar to London region (70.0%) and England (69.2%) (2014/15) (NHSBSA, 2015).

A.6 Hypnotic prescribing
Hypnotic prescribing rate in NHS Enfield CCG (0.91) was mid-range for London boroughs (range 0.50 -1.42), similar to London region (0.87) but lower than England (1.08) (2014/15) (NHSBSA, 2015).

A.7 IAPT for common mental disorder
Psychological treatment is effective for the treatment of common mental disorder. The Improving Access to Psychological Therapies (IAPT) programme is a large-scale initiative that aims to increase significantly the availability of NICE recommended psychological treatments for common mental disorder within NHS commissioned services in England.

This section on IAPT covers:
- Referral rate including for BME groups
- Waiting time
- Proportion referred who enter treatment
- Completion of treatment
- Recovery rate
- Internet based psychological therapy

IAPT referrals
The IAPT referral rate per 100,000 population in NHS Enfield CCG (703) was 10th lowest of London boroughs (range 360-1,364) and lower than London region (821) or England (839) (Q4 2014/15) (HSCIC, 2015). Figure 3.5 below shows the referral rate in Enfield was lower than England although the gap has reduced

Figure 3.5: IAPT referral rate (quarterly) per 100,000 population aged 18+

Source: HSCIC (2015)
The IAPT referral rate in NHS Enfield CCG per 100,000 population for:

- Depression (69) was 16th highest of London boroughs (range 2-326) and lower than London region (93) or England (87) (Q3 2014/15) (HSCIC, 2015)
- Mixed anxiety and depression (40) was 11th lowest of London boroughs (range 2-186) and lower than London region (72) or England (122) (Q4 2014/15) (HSCIC, 2015)

During 2014/15, there were 4,970 referrals to IAPT services in NHS Enfield CCG (HSCIC, 2015) which represents 13.8% of the 36,106 people estimated to have a common mental disorder (from section 3.A.1). However, many of these referrals were the 11,110 people on the GP depression register.

**IAPT referral rate for BME groups**

The proportion of referrals to IAPT which were from Black and minority ethnic (BME) groups in NHS Enfield CCG (51.5%) was 14th highest of London boroughs (range 10-7-96.9%), similar to London (50.5%) and higher than England (16.4%) (Q4 2014/15) (HSCIC, 2015). Proportion of the population which was non-white in Enfield was 39% (ONS, 2011).

**IAPT referral rates for younger people**

An interview with an IAPT practitioner working in the borough revealed a number of interesting observations about the local service (Rainbow, 2014). Firstly, it was observed that most young clients (16-20 year olds) were referred by GPs or attended appointments made by their parents. Common issues seen among this age group were anxiety, low self-esteem, low mood, lack of motivation, pressure from university work, and a sense of not being able to keep up with their peers. It was also noted that younger clients in the Edmonton area were often reluctant to meet with practitioners in person, preferring to use the telephone service. The practitioner believed that this could be because young clients found travelling stressful or expensive. It was observed that conditions such as post-traumatic stress disorder and obsessive compulsive disorder were rarely seen among this age group and tend to be presented by people over the age of 20.

**IAPT waiting times**

Proportion of people waiting less than 28 days for first treatment in Enfield CCG (74.5%) was 13th lowest of London boroughs (range 42.9-97.0%) and similar to England (74.9%) March, 2015) (HSCIC, 2015).
Figure 3.6: Proportion of IAPT referrals waiting less than 28 days for first treatment

Source: HSCIC (2015)

However, in the last year, IAPT waiting times in NHS Enfield CCG have been at least the same as national rates as highlighted by the figure above.

Proportion of IAPT referrals entering treatment

During Q4 2014/15, the rate per 100,000 population entering treatment in NHS Enfield CCG (323) was lower than any London borough (range 323-932), London (579) or England (564) (HSCIC, 2015). The figure below highlights that the rate per 100,000 population entering treatment in NHS Enfield CCG has been consistently lower than national rates since Q2 in 2013/14 (HSCIC, 2015).

Figure 3.7: Rate of entry into IAPT

Source: HSCIC (2015)
The number entering treatment in Enfield during 2014/15 was 2,955 (HSCIC, 2015) which represents 8.2% of the 36,106 people estimated to have a common mental disorder (from section 3A.1). The proportion of people with anxiety/ depression entering IAPT in March 2015 in Enfield CCG (8.0%) was the lowest of any London borough (8-28.3%) with Enfield consistently lower than England since April 2013 (HSCIC, 2015).

Completion of IAPT
The number completing treatment in Enfield during 2014/15 was 1,745 (HSCIC, 2015) which represents 4.8% of the 36,106 people estimated to have a common mental disorder.

Completion rate for IAPT treatment per 100,000 population in Enfield CCG (221) was the 7th lowest of London boroughs (range 51-494) and lower than London region (274) or England (298) (Q4 2014/15) (HSCIC, 2015). Figure 3.8 below shows that the completion rate of IAPT in Enfield CCG has been consistently lower than the national rate for the past 2 years.

Figure 3.8: IAPT treatment completion rate per 100,000 population aged 18+ (quarterly)

![Graph showing IAPT treatment completion rate per 100,000 population aged 18+ (quarterly)](image)

Source: HSCIC (2015)

Proportion of patients entering IAPT who finished a course of treatment in NHS Enfield CCG (78.0%) was highest of London boroughs (range 0.6-78.0%) and higher than London region (34.0%) or England (39.8%) (Q3 2014/15)(HSCIC, 2015).

Levels of IAPT recovery
Proportion of those who completed IAPT treatment and were recorded as “reliable improvement” in Enfield (59.4%) was mid-range for London boroughs (range 42.7-66.7%), similar to London region (57.3%) but lower than England (61.6%) (2014/15 Q4) (HSCIC, 2015). However, the proportion of those completing IAPT treatment who were ‘moving to recovery’ in Enfield (48.6%) was 6th highest of London boroughs (range 23.1-68.6%) and higher than either London region (41.9%) or England (45.2%) (March 2015) (HSCIC, 2015).
Non-attendance of IAPT appointments

Proportion of IAPT appointments where patients did not attend and gave no advance warning in NHS Enfield CCG (10.3%) was mid-range for London boroughs (range 5.1-16.3%), similar to London region (10.8) and lower than England (11.9%) (Q3 2014/15) (HSCIC, 2015).

Internet based psychological therapy

The following internet based psychological therapies were provided in Enfield

- CBT through Big White Wall: Between April and December 2015, 9 CBT clients and 9 counselling clients registered for therapy
- Computerised CBT (Silvercloud): 70 licences used from July (start of contract) to December, with numbers increasing month on month as more staff are trained to use the programme and GPs become aware of the direct referral option
- Instant messaging/livechat CBT with IESO Digital Health: From April 2015 to end of January 2016, 169 referrals and 57 people entering treatment. Over 30% of referrals were in January alone, following an extensive marketing drive in west Enfield

Group based psychological therapy

- Perinatal: From June 2015 to Feb 2016, 146 women attended monthly stress and wellbeing groups in conjunction with local maternity services
- School based: 39 workshops were conducted for 500 pupils in 2015/16

A.8 Secondary care for common mental disorder

Data for 2009/10-2011/12 showed that the directly standardised rate (DSR) per 100,000 population for admissions to hospital for unipolar depressive disorders in Enfield (30.9) was 13th lowest of London boroughs (range 16.8-76.2) and lower than either London region (37.0) or England (32.1) (HES, 2013).

However, data for 2012/13 showed that emergency admission rates per 100,000 population for neuroses (includes neurotic, stress related and somatoform disorders) in Enfield (10.4) was 3rd lowest of London boroughs (7.8-49.7) and lower than England (21.7) (HES, 2015) although this data was subject to wide confidence intervals.

B) Severe mental illness and psychosis

SMI comprises a number of conditions including schizophrenia, bipolar affective disorder and other psychoses. This section covers:

- Estimated prevalence and incidence
- Primary care
  - Coverage on SMI register
  - Prescribing of anti-psychotic medication
  - Outcomes of physical health issues
- Premature mortality
- Secondary care including:
  - Early intervention psychosis services
  - Psychological therapies
  - Emergency admission
- Assertive outreach teams  
  (Crisis resolution and home treatment teams covered in secondary care)

B.1 Estimated prevalence of SMI

*Estimated prevalence of psychotic disorder*

Proportion of the population aged over 16 in 2012 estimated to have a psychotic disorder in Enfield (0.46%) (1,145 individuals) was mid-range for London boroughs (range 0.27-0.77%), lower than London region (0.51%) although higher than England (0.40%) (PHE, 2012) (some concerns over quality of this data).

B.2 Primary care coverage for people with SMI

Proportion of adults on the primary care SMI register (people diagnosed with schizophrenia, bipolar disorder or other psychoses or on lithium therapy) in NHS Enfield CCG (1.01%) (3,247 individuals) was mid-range for London boroughs (range 0.65-1.51%), similar to London region (1.07%) and higher than England (0.88%) (2014/15) (HSCIC, 2015). The proportion of people on the SMI register is correlated with level of deprivation as shown in figure 3.9 with NHS Enfield CCG as expected for deprivation level.

**Figure 3.9: Proportion of people on primary care SMI register (%) vs socioeconomic deprivation**

![Figure 3.9](image)


The proportion of estimated people with psychosis who are on the SMI register in Enfield (2.21) was 13th highest of London boroughs (range 1.67-3.10) and similar to England (2.22) (2014/15).

However, there was a wide variation in the proportion on the SMI register across GP practices in Enfield (range 0.22-2.63%) (HSCIC, 2015) which would suggest that some practices are not detecting SMI.
Primary care prescribing of antipsychotic medication

The rate of GP prescribing of drugs for psychoses and related disorders (quarterly items per 1000 population) in NHS Enfield CCG (41.8) was 9th highest of London boroughs (range 24.0-71.4), higher than London (38.9) but lower than England (45.4) (2014/15 Q4) (HSCIC, 2015).
Figure 3.11: Primary care prescribing rate of drugs for psychoses and related disorders vs socioeconomic deprivation (IMD)


B.3 Comprehensive care plan
The proportion of patients with SMI who had a primary care comprehensive care plan in NHS Enfield CCG (82.9%) was 10th highest of London boroughs (range 73.5-85.1%) and higher London (80.5%) or England (77.2%) (2014/15) (HSCIC, 2015).

B.4 Primary care coverage of physical health of people with SMI
Those with SMI are at significantly higher risk of a range of physical health conditions and associated premature mortality. People with schizophrenia have a mortality of between two and three times that of the general population and most of the excess deaths are from diseases that are the major causes of death in the general population, including cardiovascular diseases. A number of primary care QOF measures incentivise GP physical health checks.

Blood pressure and SMI (QOF MH003)
Proportion of patients on the SMI register who had a record of a blood pressure check in the last 12 months in NHS Enfield CCG (85.6%) was 5th highest of London boroughs (range 75.9-86.5%), similar to London region (83.1%) and slightly higher than England (81.5%) (2014/15) (HSCIC, 2015).

Cholesterol check and SMI (QOF MH004) (but measure now retired)
Proportion of adults on the SMI register who had a record of a cholesterol check over the last 12 months in NHS Enfield CCG (69.6%) was mid-range for London boroughs (range 60.1-73.6%), similar to London region (69.3%) and slightly higher than England (68.0%) (2013/14) (HSCIC, 2014).

HbA1c/glucose and SMI (QOF MH005) (but measure now retired)
The relative risk of developing diabetes mellitus is two to three times higher in people with schizophrenia than in the general population. The proportion of adults in the SMI register who had a record of a blood glucose or HbA1c check in NHS Enfield CCG (74.7%) was 8th highest of London boroughs (range 68.7-79.2%) and similar to London region (74.8%) and England (74.9%) (2013/14) (HSCIC, 2014).
**BMI and SMI (QOF MH006) (but measure now retired)**

Proportion on the SMI register who had a record of a BMI check in the preceding 12 months in NHS Enfield CCG (81.1%) was mid-range for London boroughs (range 77.1-85.3%), similar to London region (81.5%) and slightly higher than England (78.8%) (2013/14) (HSCIC, 2014).

**Alcohol consumption and SMI (QOF MH007)**

The proportion of patients on the SMI register who had an alcohol consumption check in NHS Enfield CCG (86.2%) was 6th highest of London boroughs (range 78.4-88.7%), similar to London region (83.7%) and slightly higher than England (80.3%) (2014/15) (HSCIC, 2015).

**Cervical screening and SMI (QOF MH008)**

A recent report by the Disability Rights Commission based on the primary care records of 1.7 million primary care patients found that women with schizophrenia were less likely to have had a cervical sample taken in the previous five years (63%) compared with the general population (73%).

Proportion of female patients on the SMI register who had a record of a cervical screening test in NHS Enfield CCG (70.9%) was mid-range for London boroughs (range 62.8-74.4%) and similar to London region (70.6%) and England (71.6%) (2014/15) (HSCIC, 2015).

**Lithium check (QOF MH009)**

It is important to check thyroid and renal function regularly in patients taking lithium due to increased risk of hypothyroidism, hypercalcaemia and abnormal renal function. Overt hypothyroidism has been found in between eight per cent and 15% of people on lithium. The proportion of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months in NHS Enfield CCG (93.8%) was 11th highest of London boroughs (range 85.3-97.4%), similar to London region (92.4%) and slightly lower than England (93.4%) (2014/15) (HSCIC, 2015).

**Lithium levels (QOF MH010)**

Lithium monitoring is essential due to the narrow therapeutic range of serum lithium and the potential toxicity from intercurrent illness, declining renal function or co-prescription of drugs, for example thiazide diuretics or non-steroidal anti-inflammatory drugs (NSAIDS), which may reduce lithium excretion. The proportion of patients on lithium therapy that had a their levels within therapeutic range in the preceding four months was in NHS Enfield CCG (74.3%) was 11th lowest of London boroughs (range 63.4-86.1%) and lower than London region (77.3%) or England (82.6%) (2014/15) (HSCIC, 2015).

**Smoking status (QOF SMOKE002)**

The proportion of patients with a variety of long term physical health conditions\(^6\) including SMI with a record of their smoking status over the preceding 12 months (SMOK002) in NHS Enfield CCG (93.2%) was similar to London boroughs (range 90.0- 95.7%), London region (93.1%) and England (93.2%) (2014/15) (HSCIC, 2015).

**Record of smoking cessation intervention (QOF SMOKE005)**

Smoking is the single largest cause of preventable death in people with SMI and effective interventions exist to support smoking cessation. The proportion of smokers on with different physical long term conditions including SMI who were offered cessation support and treatment

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\(^6\) Conditions include: coronary heart disease, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses
within the preceding 12 months in NHS Enfield CCG (94.5%) was mid-range for London boroughs (range 90.2-97.8%) and similar to London region (94.8%) and England (94.1%) (2014/15) (HSCIC, 2015). However, no data was provided about local smoking cessation support for people with SMI.

**Exception rate for SMI checks**

The exception rate for SMI checks in NHS Enfield CCG (6.2%) was 2nd lowest of London boroughs (range 6.0-12.8%) and lower than England (11.1%) (2014/15) (HSCIC, 2015).

**Table 3.1: Summary of primary care coverage of physical health screening for people with SMI**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Enfield</th>
<th>London</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with SMI with blood pressure check: % with record in preceding 12 months (MH003)</td>
<td>85.6%</td>
<td>83.1%</td>
<td>81.5%</td>
</tr>
<tr>
<td>Patients with SMI with cholesterol check: % with record in preceding 12 months (MH004)</td>
<td>69.6%</td>
<td>69.3%</td>
<td>68.0%</td>
</tr>
<tr>
<td>Patients with SMI with blood glucose or HbA1c check: % with record in preceding 12 months (MH005)</td>
<td>74.7%</td>
<td>74.9%</td>
<td>74.9%</td>
</tr>
<tr>
<td>Patients with SMI with BMI check: % with record in preceding 12 months (MH006)</td>
<td>81.1%</td>
<td>81.5%</td>
<td>78.8%</td>
</tr>
<tr>
<td>Patients with SMI with alcohol consumption check: % with record in preceding 12 months (MH007)</td>
<td>86.2%</td>
<td>83.7%</td>
<td>80.3%</td>
</tr>
<tr>
<td>Female patients with SMI who had cervical screening test: % tested in preceding 5 years (MH008)</td>
<td>70.9%</td>
<td>70.6%</td>
<td>71.6%</td>
</tr>
<tr>
<td>Patients on lithium therapy with record of serum creatinine and TSH: % with record in the preceding 9 months (MH009)</td>
<td>93.8%</td>
<td>92.4%</td>
<td>93.4%</td>
</tr>
<tr>
<td>Patients on lithium therapy with levels in therapeutic range: % within preceding 4 months (MH010)</td>
<td>74.3%</td>
<td>77.3%</td>
<td>82.6%</td>
</tr>
<tr>
<td>Smoking status recorded in people with variety of long term physical conditions and SMI in the last 12 months (SMOK002)</td>
<td>93.2%</td>
<td>93.1%</td>
<td>93.2%</td>
</tr>
<tr>
<td>Proportion of smokers with variety of long term physical conditions and SMI offered cessation support and treatment within preceding 12 months (SMOK005)</td>
<td>94.5%</td>
<td>94.8%</td>
<td>94.1%</td>
</tr>
<tr>
<td>Exceptions from SMI checks: % of people on SMI registers exempt from checks</td>
<td>6.2%</td>
<td>NA</td>
<td>11.1%</td>
</tr>
</tbody>
</table>

**Source:** HSCIC (2014) and HSCIC (2015)
B.5 Secondary care coverage for people with psychosis

**Early Intervention Psychosis (EIP) Services**

The estimated rate per 100,000 population of adults aged 16-64 who develop a first episode of psychosis each year (annual incidence) in Enfield (37.2) was 16th lowest of London boroughs (range 21.4-71.9), lower than London region (40.6) but higher than England (24.2) (Psymaptic, 2014). Applying local population estimates (ONS, 2015) implies 78 people aged 16-64 develop a first episode of psychosis each year in Enfield.

Early Intervention Psychosis services see people with a first episode psychosis. The age range of people seen by Early Interventions Psychosis services by BET, the provider for Enfield is now up the age of 60 years and this service is available to people with psychosis and their carers for a maximum of three years.

**Early Intervention Psychosis (EIP) Services – new cases of First Episode Psychosis seen**

The quarterly rate per 100,000 population at which new cases of psychosis are being seen by Early Intervention Psychosis Services (EIPS) in NHS Enfield CCG (17.5) was the lowest of London boroughs (range 17.5-57.0) and lower than London region (30.5) or England (24.0) (Q4 2014/15) (NHSE, 2015) (note this indicator is published as a cumulative figure, therefore the data for Q1-Q3 are pro-rated up to show the forecast out-turn for the year-end position based on the in-year data). The figure below shows that rate of new cases of FEP being seen by EIP services in Enfield has fallen from 22.8 in 2013/14 Q1 to 17.5 in 2014/15 Q4 show little variation in rate being seen in the last 5 quarters.

This would imply that 47.0% of estimated new cases of psychosis were seen by Early Intervention Psychosis services in Enfield which is lower than 59.4% in England. Rate of referral for First Episode Psychosis varies by practice and so referral rates could be increased by targeted education interventions for low referring practices.

**Figure 3.12: Rate (annual) of new cases of psychosis seen by Early Intervention Psychosis teams per 100,000 population in NHS Enfield CCG**

![Graph showing rate of new cases of psychosis seen by EIP services in Enfield CCG](image)
Early Intervention Psychosis (EIP) Services – caseload

The Early Intervention Psychosis Teams caseload per 100,000 population in NHS Enfield CCG (45.9) was 5th lowest of London boroughs (range 1.8-129.7) and lower than London region (62.1) or England (37.5) (2014/15 Q2) (NHSE, 2015) (this is an end-of-quarter snapshot compared to the cumulative annual figure for new cases of psychosis above).

However, this has fallen from a rate of 48.9 per 100,000 in NHS Enfield CCG in 2013/14 Q1 to 41.7 per 100,000 in 2014/15 Q4 [note this data is subject to wide confidence intervals].

Figure 3.13: Rate of people being treated by Early Intervention Psychosis teams per 100,000 population in NHS Enfield CCG

Source: NHSE (2015)


- Contacts per patient on caseload (33.6) was mid-range of London trusts and lower than the mean nationally (38.3)
- Average waiting time for routine appointments (weeks) (2.0) was joint lowest of London trusts and same as the median nationally
- DNA rate (12.6%) was 3rd lowest of London trusts and just below the upper quartile nationally (13.0%)
- Proportion of referrals accepted as a proportion of all referrals received (68.7%) was 3rd lowest of London trusts and below the lower quartile nationally
- Proportion of all community cluster 10 patients under the EIT (81.9%) was 4th highest of London trusts and above the upper quartile nationally

Psychological therapy for psychosis

Proportion of psychosis care spells receiving psychological therapy in NHS Enfield CCG (9.9%) was 4th highest of London CCG’s (range 0.2-14.3%) and higher than London region (5.2%) or England (3.4%) (2013/14) (HES, 2014).
Report of the second round of the National Audit of Schizophrenia (NAS2) 2014 for which interviewed 56 service users at BEH-MHT found that although availability and uptake of Psychological Therapies was above average for CBT (table 3.2) and about average for Family Interventions (table 2), it was still well below what should be provided. More recent locally provided data showed that current numbers receiving CBT from EIPS (28), CSRT (55), RET (61) and CRT (8).

**Table 3.2: Provision of CBT for people with psychosis (National Audit of Schizophrenia, 2014)**

<table>
<thead>
<tr>
<th>Proportion of service users</th>
<th>National</th>
<th>BEH-MHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offered CBT</td>
<td>39%</td>
<td>53%</td>
</tr>
<tr>
<td>Taking up CBT</td>
<td>19%</td>
<td>28%</td>
</tr>
<tr>
<td>Reporting they had received CBT</td>
<td>18%</td>
<td>27%</td>
</tr>
</tbody>
</table>

Report of the second round of the National Audit of Schizophrenia (NAS2) 2014 for which interviewed 56 service users at BEH-MHT found that though availability and uptake of Family Interventions was about average for (table 3.3), it was still well below what should be provided.

**Table 3.3: Provision of family therapy for people with psychosis (National Audit of Schizophrenia, 2014)**

<table>
<thead>
<tr>
<th>Proportion of service users</th>
<th>National</th>
<th>BEH-MHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offered family intervention</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td>Taking up family intervention</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td>Reporting they had received family intervention</td>
<td>12%</td>
<td>16%</td>
</tr>
</tbody>
</table>

During 2014/15 in Enfield for psychosis, there were (locally provided figures)
- 2,887 secondary care contacts with Early Intervention Psychosis services
- 4,546 secondary care contacts with Community Rehabilitation
- 15,593 secondary care contacts with Support and Recovery Teams
- 6,701 secondary care contacts with Wellbeing Teams

**Emergency admissions for psychosis**

Emergency admission rate for schizophrenia per 100,000 population in Enfield (113.0) was 15th highest of London boroughs (range 31.0-233.0) and higher than London region (103.0) or England (57.0) (2009/10–2011/12) (HES, 2013)

**B.6 Premature mortality in people with SMI**

Nationally, there is an excess of over 40,000 deaths among SMI patients which could be reduced if SMI patients received the same healthcare interventions as the general population (HSCIC, 2013).
The excess mortality rate for under-75 in adults with serious mental illness is expressed as the percentage of deaths based on the general population and mental health mortality rates. A methodological limitation of this indicator is that it only accounts for those adults recorded in secondary mental health services:

- Excess mortality rate for under 75 adults with serious mental illness in Enfield (284.6) was 13th lowest of London boroughs (range 230.9-489.8) and lower than England (347.2) (2012/13) (HSCIC, 2014)
- Premature mortality rate for under 75 adults with serious mental illness in Enfield (868) was 11th highest of London boroughs (range 496-1,748) and lower than England (1,319) (2012/13) (HSCIC, 2014)
- Neither were associated with socioeconomic deprivation

Report of the second round of the National Audit of Schizophrenia (NAS2) (2014) for which interviewed 56 service users at BEH-MHT found that monitoring of physical health risk factors was below average and thus well below what should be provided. It was particularly poor for monitoring of glucose control and lipids.

**B.7 Economics of psychosis**

- Psychosis annual estimated cost in Enfield: £69.4m (from Kirkbride et al, 2012)
- Early intervention for first episode psychosis
  - Net savings of £18 for each £ spent (Knapp et al, 2011)
  - Estimated net savings over usual care if all people estimated to develop first episode psychosis in Enfield received care from early intervention psychosis services: £3.0m
  - Intervention cost saving to NHS by end of first year
  - 47.0% of estimated new cases of psychosis were seen by Early Intervention Psychosis services in Enfield
- Early intervention for the stage which precedes psychosis (Clinical High Risk State)
  - Net savings of £10 for each £ spent (Knapp et al, 2011)
  - Estimated net savings if all people estimated to develop Clinical High Risk State (CHRS) in Enfield received care from early detection services: £5.4m
  - The intervention is cost saving to the NHS by the end of the second year although currently, there are no CHRS services in Enfield
- Family therapy: Estimated savings to NHS over 3 years if all people in Enfield (from Knapp et al, 2014)
  - On the SMI register (see section 3.B.1) received family therapy: £13.6m
  - Estimated to have psychotic disorder in previous year (see section 3.B.2) received family therapy: £4.8m
- CBT: Estimated savings to NHS over 3 years if all people in Enfield (from Knapp et al, 2014)
  - On the SMI register received CBT: £3.2m
  - Estimated to have psychotic disorder in previous year received CBT: £1.1m
C) Dementia

C.1 Estimated prevalence

Estimated numbers of people with dementia in Enfield (NHSE, 2015)
- Total: 3,022
- Mild: 1,659
- Moderate: 985
- Severe: 378
- In care homes: 515

Projected numbers of people with dementia in Enfield in (POPPI, 2014) in:
- 2020: 3,464
- 2025: 4,022
- 2030: 4,697

C.2 Primary care

Proportion in Enfield on the primary care dementia register (HSCIC, 2015):
- Aged over 64 (4.61%) (1,901 individuals) was 12th highest of London boroughs (range 3.79-5.23%) and higher than London region (4.44%) or England (4.44%) (September, 2015).
- Population (0.59%) (1,888 individuals) was 8th highest of London boroughs (range 0.29-0.77%) and higher than London region (0.49%) but lower than England (0.74%) (2014/15). Within Enfield, the proportion on the dementia register varied from 0.1% to 1.5% (see below)
- Dementia diagnosis rate in Enfield: 62.4%

Figure 3.14: Proportion on primary care dementia register in different GP practices within Enfield

Source: HSCIC, 2015
- Dementia whose care was reviewed in last 12 months (DEM002) (79.5%) (1,499 individuals) was 13\textsuperscript{th} highest of London boroughs (63.3-84.6%) and higher than London region (77.9%) or England (77.0%)
- New dementia diagnosis and blood test recorded 6 months before or after entering onto the dementia register (DEM003) (78.1%) (325 individuals) was 10\textsuperscript{th} highest of London boroughs (range 63.3-84.4%) and higher than London region (74.8%) or England (74.4%)

C.3 Secondary care for dementia

\textit{Secondary care community services}

- 1,888 referrals made to memory services of which 1,505 were from primary care and 378 from internal referrals from other CMHT
- 1,846 referrals accepted to memory services of which 1,475 were from primary care and 366 from internal referrals from other CMHT

During 2014/15 in Enfield for dementia/ cognitive impairment, there were (locally provided figures)
- 6,552 contacts with Community Mental Health Teams
- 9,706 contacts with Day Services
- 2,734 contacts with Memory Treatment Clinic
- 19 contacts with Occupational Therapy
- 715 contacts with Psychology
- 2,626 Occupied Bed Days (OBD) for Acute Inpatients
- 14,721 OBD’s for continuing care

\textit{Secondary care inpatient services}

Admissions (2013/14) (HSCIC, 2014)
- Age standardised rate of people with a mention of Alzheimer's disease using inpatient hospital services per 100,000 resident population in NHS Enfield CCG for people:
  - Over age 20 (176.6) (303 individuals) was 13\textsuperscript{th} highest of London boroughs (range 94.6-331.8) and higher than London region (164.4) or England (146.2)
  - Over age 65 (702.3) (299 individuals) was 12\textsuperscript{th} highest of London boroughs (range 371.5-1,329.6) and higher than London region (649.0) or England (574.5)
- Age standardised rate of people with a mention of vascular dementia using inpatient hospital services per 100,000 resident population in NHS Enfield CCG for people:
  - Over age 20 (99.5) (170 individuals) was 8\textsuperscript{th} lowest of London boroughs (range 76.6-259.9) and higher than London region (129.7) or England (127.5)
  - Over age 65 (391.7) (166 individuals) was 7\textsuperscript{th} highest of London boroughs (range 298.2-1,038.0) and higher than London region (514.1) or England (505.2)
- Age standardised rate of people with a mention of unspecified dementia using inpatient hospital services per 100,000 resident population in NHS Enfield CCG for people
  - Over age 20 (424.1) (729 individuals) was 13\textsuperscript{th} highest of London boroughs (range 245.4-587.1) and higher than London region (394.2) or England (336.1)
Over age 65 (1,658.1) (704 individuals) was 14th highest of London boroughs (range 971.8-2,311.8) and higher than London region (1,558.7) or England (1,327.3)

Emergency admissions (2013/14) (HSCIC, 2014)
- Age standardised rate of emergency admissions of people with a mention of dementia per 100,000 resident population in NHS Enfield CCG for people:
  - Over age 20 (870) (1,487 individuals) was 11th lowest of London boroughs (range 543-1,376), lower than London region (937) but higher than England (779)
  - Over age 65 (3,425) (1,499 individuals) was 11th lowest of London boroughs (range 2,127-5,361) and lower than London region (3,685) or England (3,046)
- Proportion of emergency admission for people with dementia that were short stay in NHS Enfield CCG for people:
  - Over age 20 (21.8%) (324 individuals) was 8th lowest of London boroughs (range 18.0-37.7) and lower than London region (27.3) or England (25.5)
  - Over age 65 (21.7%) (1,499 individuals) was 8th lowest of London boroughs (range 17.4-37.4%) and lower than London region (27.1%) or England (25.4%)

Ratio of inpatient service use for people with dementia to recorded diagnoses in NHS Enfield CCG for people (74.5) was mid-range for London boroughs (54.3-96.4), similar to London region (74.9) but higher than England (65.1) (2013/14) (HSCIC, 2014).

C.4 Risk factors for dementia
Note opportunities for prevention re smoking, physical inactivity, excess weight, alcohol related conditions, social isolation. The proportion of people in Enfield with:
- Hypertension (13.3%) was 4th highest of London boroughs (range 7.9–14.1%), higher than London region (11.1%) but lower than England (13.7%) (2013/14) (HSCIC, 2014)
- Stroke (1.2%) was joint 4th highest of London boroughs (range 0.8–1.6%), higher than London region (1.1%) but lower than England (1.7%) (2013/14) (HSCIC, 2014)
- Coronary Heart Disease (2.5%) was joint 8th highest of London boroughs (range 1.4–3.0%) and higher than London region (2.1%) or England (3.3%) (2013/14) (HSCIC, 2014)
- Diabetes (7.0%) was joint 6th highest of London boroughs (range 2.6–8.5%) and higher than London region (6.0%) or England (6.2%) (2013/14) (HSCIC, 2014)
- Smokers (13.6%) was 8th lowest of London boroughs (range 11.2–22.2%) and lower than London region (17.1%) or England (18.0%) (2014) (IHS, 2014)

D) Personality Disorder
Personality disorders are longstanding, ingrained distortions of personality that interfere with the ability to make and sustain relationships and include antisocial personality disorder (ASPD) and borderline personality disorder (BPD).

D.1 Estimated prevalence
According to previous adult national surveys, the prevalence of any personality disorder in 16-74 year olds was 4.4% (Singleton et al, 2001), of Anti-Social Personality Disorder (ASPD) 0.3% and Borderline Personality Disorder (BPD) 0.4% (McManus et al, 2009).
Applying the national prevalence to local ONS mid-year population estimates for Enfield (ONS, 2015), the number of 16-74 year olds in Enfield with:

- Any personality disorder: 10,184
- Antisocial personality disorder: 694
- Borderline Personality Disorder: 926

D.2 Treatment
During 2015/16, there were 3,182 secondary care contacts with people with personality disorder in Enfield (locally provided figures).

E) Eating disorder
E.1 Estimated prevalence
The estimated prevalence of eating disorder in adults in Enfield (7.0%) was similar to London region (6.7%) and England (6.7%) (McManus et al, 2009). This would suggest that 17,433 people aged 16 and over in Enfield had an eating disorder (ONS, 2015).

E.2 Treatment
There were 77 referrals and 547 attendances to secondary care for eating disorders in Enfield during 2014/15 (locally provided data).

Mean length of stay (excluding leave and unadjusted for outliers) in BEH-MHT for eating disorders (97) was near mean (100) for trusts nationally and mid-range for London trusts (2014/15) (NHS Benchmarking Network, 2015).

F) Alcohol use disorder
Alcohol is one of the largest avoidable risks for disease and death. Alcohol misuse also results in annual economic costs of £20-55 billion in England (NICE, 2010).

F.1 Impact of alcohol
- Alcohol-specific mortality (directly standardised rate per 100,000 population) in Enfield (7.5) was 11th lowest of London boroughs (range 4.6-14.8%) and lower than London region (9.0%) or England (11.9%) (2011-13) (LAPE, 2014)
- Alcohol-related mortality (directly standardised rate per 100,000 population) in Enfield (33.1) was 5th lowest of London boroughs (range 25.4-53.9) and lower than London region (38.9) or England (45.3) (2011-13) (LAPE, 2014)
- 12.0% of Enfield CPP assessments identified alcohol misuse (2014/15) (DfE, 2015)

F.2 Estimated prevalence
The estimated proportion of people above age 15 with different types of alcohol consumption in Enfield were as follows for different levels of drinking (LAPE, 2014):
- Binge drinkers: 12.2% (30,636 people) 10th lowest of London boroughs (range 7.5% to 25.3%)
- Higher risk drinkers: 6.6% (16,574 people) 8th lowest of London boroughs (range 5.3% to 8.9%)
Increasing risk drinkers: 17.5% (43,945 people) 3rd lowest of London boroughs (range 16.8% to 21.7%)
Lower risk drinkers: 75.9% (190,596) people) 3rd highest of London boroughs (range 69.4% to 76.7%)
Abstainers: 22.3% (55,999 people) 14th highest of London boroughs (range 14.3-35.1%)

F.3 Treatment
Primary care treatment for alcohol use disorder
During 2014/15 in Enfield, no treatment was recorded as occurring in primary care (NDTMS, 2016). Two pregnant women received treatment.

Secondary care treatment for alcohol use disorder
Secondary care can be provided either in the community or in hospital
During 2014/15, 339 people were in treatment for alcohol (333 in the community, 7 inpatients and 12 in residential rehabilitation) (NDTMS, 2016). A further 195 people received treatment for alcohol and non-opiate misuse (232 in the community, 4 inpatients and 11 in residential rehabilitation). The majority were self-referrals.
Rate of adults in specialist alcohol misuse services per 1000 population in Enfield (1.6) (equivalent to 354 adults) was 11th lowest of London boroughs (range 0.7-3.4) and lower than London region (2.0) or England (2.3) (2013/14) (NDTMS, 2015)
Proportion waiting more than three weeks for treatment in Enfield (4.0%) was low for London boroughs (range 0-10.8%) and lower than London region (1.7%) and England (4.8%) (2014/15) (NDTMS, 2015)
Proportion who successfully completed alcohol treatment in Enfield (44.4%) (157 individuals) was 9th highest of London boroughs (range 29.5-54.6%) and higher than London region (40.2%) or England (42.5%) (2013) (NDTMS, 2014). During 2014/15, proportion who successfully completed treatment in Enfield (34%) (116 individuals) was mid-range for London borough range (21.9-56.4%) and higher than London region (25.3%) but lower than England (39%)

Alcohol admissions (2013/14) (LAPE, 2014)
Alcohol-specific admission rate (directly standardised per 100,000 population) in Enfield (231) was 2nd lowest of London boroughs (range 217-607) and lower than London region (346) or England (374). The rate in Enfield has gradually increased from 165 in 2008/9
Alcohol-related hospital admission rate (directly standardised per 100,000 population) in Enfield
  - Broad (1,214) was 13th lowest of London boroughs (range 857-1,635) and lower than London region (1,281) or England (1,253)
  - Narrow (331) was 4th lowest of London boroughs (range 253-520) and lower than London region (394) or England (444)
• Admission episode rate for alcohol-related conditions (directly standardised per 100,000 population) in Enfield:
  o Broad (2,277) was mid-range for London boroughs (range 1,589-3,155) and lower than London region (2,179) or England (2,111)
  o Narrow (572) was 11th highest of London boroughs (range 433-801) and lower than London region (541) or England (645)

• Admission episodes for alcohol-related mental and behavioural disorders (directly standardised per 100,000 population) in Enfield:
  o Broad (238) was 3rd lowest London boroughs (range 194-933) and lower than London region (402) or England (394)
  o Narrow (43) was lowest of London boroughs (range 43-144) and lower than London region (83) or England (87)

• Admission episodes for alcohol-related intentional self-poisoning (narrow) (directly standardised per 100,000 population) in Enfield (12.2) was 2nd lowest of London boroughs (range 11.2-42.5) and lower than London region (23.0) or England (58.6)

Figure 3.15: Rate of alcohol specific admissions in Enfield per 100,000 population

Source: LAPE (2014)

F.4 Concurrent intervention from mental health services and alcohol misuse
Research suggests that between 22% and 44% of adult psychiatric inpatients also have problematic drug or alcohol use, with up to half being drug dependent (Menezes et al, 1996; Graham et al, 2001). The prevalence of co-existing mental health and substance use problems (termed ‘dual diagnosis’) may affect between 30 and 70 per cent of those presenting to health and social care settings (Crome et al, 2009).
Proportion receiving concurrent treatment from mental health services and substance misuse services for alcohol misuse in Enfield (31% / 104 patients) was mid-range for London boroughs (9.3-55.6%), lower than London region (28.8%) but higher than England (20%) (2014/15) (NDTMS, 2015).

F.5 Economic costs of alcohol misuse and potential economic savings from brief intervention
The total costs of alcohol misuse in Enfield based on national, inflation adjusted Department of Health data can be estimated in 2009/10 prices at around £138.2m, comprising: £18.0m in NHS costs, £43.1m in output losses and £77.2m from the costs of crime (from Knapp et al, 2011).

Estimated net savings if all increasing risk, higher risk and binge drinkers in Enfield received screening and brief interventions in primary care (from Knapp et al, 2011):
- Total net savings: £18.7m
- Crime net savings: £9.6m
- Productivity net savings: £5.5m
- NHS net savings: £3.6m

F.6 Alcohol strategic development and locally identified opportunities
Outcomes for Government’s Alcohol Strategy (2012) include:
- Change in behaviour so people think it is not acceptable to drink in ways that could cause harm to themselves or others
- Reduction in alcohol related violent crime
- Reduction in the number of adults drinking above recommended levels
- Reduction in the number of people ‘binge drinking’
- Reduction in the number of alcohol related deaths
- Reduction in the numbers of 11-15 year olds drinking alcohol and the amounts consumed
- Reduction in alcohol related presentations to hospital and primary care

An Enfield DAAT Strategy Development Away Day in 2013 highlighted that:
- Drug and alcohol treatment system does not operate within isolation
- The treatment system works within a partnership framework to ensure the needs of patients are met through a holistic approach
- The policy landscape has shifted and there is a greater understanding that recovery is the goal of the treatment journey
- Understanding that sustained recovery is achieved through patients accessing a wide range of services to meet their needs including access to volunteering and mentoring opportunities, meaningful activities, education and training
- Addressing unemployment and job retention is key to addressing recovery through partnership working with Enfield JobCentre Plus (JCP) and soon be to established Welfare & Support Hub (WASH)
- Pathways need to have a more recovery focus including access to housing related support including the Substance Misuse Rent Deposit Scheme (SMURDs) and floating support schemes
- Primary care and its important role in screening and early identification of harmful or hazardous drinkers through use of IBAs as well as addressing physical health issues, offering vaccinations for BBVs, conducting health checks and dietary advice
• Arrangements for referring patients to Adult safeguarding and the MASH need to be better understood particularly for patients who are co-morbid substance misuse and mental health
• There needs to be increased partnership working regarding domestic violence and perpetrator violence and pathways to MARAC
• Need for capacity building through training and regular updates through mainstream services including GP surgeries, Pharmacies, Family centres, JCP and housing options to support early identification

Current DAAT priorities include:
• Increasing the number of illicit drug users engaging in treatment to achieve a drug free life
• Increasing the number of harmful drinkers with accessing specialist treatment
• Helping more drug and alcohol users who achieve a life free from dependency to obtain employment, education and training
• Continuing to develop criminal justice partnership arrangements to ensure we have the maximum possible impact on crime reduction
• Reducing the impact that alcohol and illicit drug use has on our primary care and acute hospital settings by improving access to community treatment in more appropriate settings
• Improving our transitional arrangements for young people affected by substance misuse to ensure they have seamless integrated support from Children’s to Adult’s services
• Continuing to develop the Hidden Harm Service offering support to parents with a substance misuse issue as well as children affected by parental substance misuse issue
• Ensuring a co-ordinated approach to supporting patients with severe and enduring mental health issues with co-morbid substance misuse through partnership working with the Enfield Dual Diagnosis Service and Mental Health Services
• Improving pathways with IAPT services to ensure that patients with a substance misuse issue, who are stable or working towards abstinence with mild to moderate anxiety or depression have access to CBT initiatives

Opportunities identified by Enfield public health:
• Consult with community and key partners to develop a robust, effective and achievable adult and young people’s substance misuse strategy
• This may include developing new services to identify harmful drinkers much earlier in order to help more people achieve positive health improvements
• Provide attractive services so that a much higher proportion of other drug users (especially cannabis and cocaine) and harmful drinkers engage in treatment so that we can reduce crime to our best ability
• Expand family intervention and support services to reduce the number of children in need of safeguarding and increase educational attainment and school attendance
• Improve our local health promotion programme to ensure that all of the community develop a knowledge of the risks of harmful drinking and illicit drug use
• Support our schools to develop the best Personal, Social and Health Education programmes for all children up until they reach school leaving age
• Improving data sharing with A&E services to identify alcohol related violence and working with partners to reduce drug and alcohol related crime
G) Drug use disorder

G.1 Local impact
Impacts include 12.8% of Enfield Child Protection Plan assessments identified drug misuse (2014/15) (DfE, 2015).

G.2 Estimated numbers affected
Numbers of adults aged 16-59 in Enfield using different types of drugs in the past year based on national estimates (HO, 2015):

- Illegal drug use (8.6%): 16,855
- Cannabis use (6.7%): 13,131
- Class A drug use (3.2%): 6,272
- Powder cocaine (2.3%): 4,507

Estimated numbers of 16-24 year olds in Enfield using different types of drugs in the past year based on national estimates (HO, 2015):

- Illegal drug use (19.4%): 7,119
- Cannabis use (16.3%): 5,982
- Class A drug use (7.6%): 2,789
- Ecstasy (5.4%): 1,982
- Powder cocaine (4.8%): 1,762

Estimated prevalence of opiate and/or crack cocaine use per 1000 population n Enfield (7.4) was 14th lowest of London boroughs (range 4.0-18.5) and lower than London region (9.6) or England (8.4) (2011/12) (Hay et al, 2013). This equates to 1,581 individuals aged 15-64 in Enfield.

G.3 Treatment

Primary care treatment for drug use disorder
During 2014/15, 78 people with opiate use in Enfield received treatment received primary care although none were recorded as receiving treatment for non-opiate use (NDTMS, 2016). However, there may be under-reporting.

Secondary care services for drug use disorder

- Secondary care can be provided either in the community or in hospital
- During 2014/15 in Enfield, 487 people received treatment for opiate use from specialist substance misuse services in the community, 9 from residential rehabilitation and 7 people from inpatient care (NDTMS, 2016). A further 230 people received treatment for non-opiate use in community care, 11 from residential rehabilitation and 11 people from inpatient care
- Rate of adults in specialist drug misuse services per 1000 population in Enfield (4.4) (equivalent to 979 adults) was mid-range of London boroughs (2.4-9.5) and lower than London region (5.1) or England (5.0) (2013/14) (NDTMS, 2015). In 2014/15, the number of adults in specialist drug misuse services was similar (992)
• Waiting times: Proportion waiting more than three weeks for treatment in Enfield (1.7%) was low as for most London boroughs (range 0-2.7%) and similar to London region (0.9%) and England (2.0%) (2013/14) (NDTMS, 2014)

• Offenders: Proportion entering prison with substance dependence issues who were previously not known to community treatment in Enfield (63.4%) was 3rd highest of London boroughs (range 36.1-69.8%) and higher than London region (57.1%) or England (46.9%) (2012/2013) (NDTMS, 2014)

• Outcomes
The Treatment Outcome Profile (TOPs) tracks patient’s progress through their treatment journey in a number of different areas and used as a clinical tool with the patient encouraging discussions and engagement. At regular intervals throughout the patient’s treatment journey it looks at reductions in substance use and injecting behaviour as well as abstinence rates, securing housing and work. Current evidence from national data suggests that opiate users who stop using illicit opiates within the first 6 months of treatment are almost five times more likely to complete treatment successfully compared to those who do not. During 2014/15 (NDTMS, 2016), data for Enfield shows that:
  o 50% of opiate (equivalent to 47 patients) and cannabis users (50 patients) and 65% of cocaine users (equivalent to 20 patients) stopped using illicit drugs six months after starting treatment
  o 66% (21 patients) who reported a housing need at the beginning of their treatment no longer reported a housing need at treatment completion
  o 23% (65 patients) were working 10 or more days in the months prior to their successful treatment completion

Proportion experiencing successful outcomes from treatment in Enfield for:
  o Opiate use (10.0%) (50 individuals) was mid-range for London boroughs (range 4.2-14.8%) and slightly higher than London region (9.0%) or England (7.8%) (2013) (NDTMS, 2014). In 2014/15 this was 47 individuals (NDTMS, 2016)
  o Non-opiate use (47.2%) (266 individuals) was 4th highest of London boroughs (range 20.4-60.2%) and higher than London region (37.2%) or England (37.7%) (2013) (NDTMS, 2014). In 2014/15 this had reduced to 109 individuals (NDTMS, 2016)

• Hospital admission rate for 15-24 year olds due to substance misuse (directly standardised per 100,000 population) in Enfield (43.9) (equivalent to 30 adults) was 3rd lowest of London boroughs (range 39.4-118.7) and lower than London region (65.2) or England (81.3) (2011/12-2013/14) (HES, 2014)

G.4 Proportion receiving concurrent intervention from drug misuse and mental health services
Proportion receiving concurrent treatment from drug misuse and mental health services in Enfield (28.7% / 278 patients) was 13th highest of London boroughs (range 12.3-46.8%) and similar to London region (28.3%) (2014/15) (NDTMS, 2015).

G.5 Drug strategic development and locally identified opportunities
Government drug strategy (2010) highlights:
• Taking recovery beyond the treatment system
• Tackling drug misusing offenders
• Improved physical and mental health especially reducing HIV, Hep B and Hep C
• Education, training and employment
• Whole family system approach
• Break intergenerational cycles of drugs misuse
  o Medications in recovery, re-orienting drug dependence treatment’ (Strang, 2012)
  o Building recovery in communities (NTA 2012)

Locally identified opportunities for prevention and reducing drug use in the community
• Public campaigns to highlight issues around drug misuse and signposting for help
• Working in partnership with community organisations to address specific issues in relation to substance misuse where there may be cultural or language barriers
• Ensuring that there is a co-ordinated approach when Crack House Closures are implemented to ensure wraparound support for patients
• Collaborative working with ASB Teams and the Police with regard to screening operations, targeting of hotspots and use of intelligence led policing and better use of CCTV
• Supporting co-ordinated outreach work where necessary
• Utilising Schools to ensure prevention messages are relayed to young people and parents
• Working in partnership with colleges and universities through education and awareness campaigns at open days and Fresher’s Fayres
• Explore joint working with opportunities with community and faith groups through family based approach
• Working proactively with Youth Services to reach young people who are not engaged with targeted provision but may be ‘at risk’ and therefore require support and intervention
• Continue to work jointly with Children’s Care training and development teams to ensure substance misuse module is mandatory for all social workers given the prevalence of drug and alcohol issues being identified as a factor within Child Protection and Children in Need plans
• Promoting treatment services as a whole to the community not just Young Peoples or Adult Services

H) Smoking

H.1 Impact of smoking
Smoking is the single largest cause of long term physical illness and premature death including for people with mental health conditions.

Smoking related death rate (directly standardised per 100,000 population) in Enfield (256.1) was 12th lowest of London boroughs (range 186.6-384.0) and slightly lower than London region (275.9) and England (288.7) (2011-2013) (APHO, 2014).

Smoking attributable hospital admissions (directly standardised per 100,000 population) in Enfield (1,764) was 12th lowest of London boroughs (range 1,192-2,534) and higher than London region (1,606) or England (1,645) (2013-14) (HSCIC, 2014).
Cost per capita of smoking attributable hospital admission in Enfield (£41.1) was 9th highest of London boroughs and similar to London region (£39.1) and England (£38.0) (2011/12) (HSCIC, 2014).

**H.2 Prevalence of smoking**
The proportion of adults who smoke in Enfield 13.6% was 8th lowest of London boroughs (range 11.2-22.2%) and lower than London region (17.0%) or England (18.0%) (IHS, 2014). Based on the ONS mid-year population estimate (ONS, 2015), this implies there are 32,990 smokers in Enfield.

However, the proportion of primary care population recorded as smokers in Enfield (18.9%) (equating to 47,781 smokers) was higher than the IHS figure above, 13th highest of London boroughs (range 13.1-22.0%) and slightly higher than London region (17.8%) or England (18.4%) (2014-2015) (HSCIC, 2015).

Smoking rates are substantially higher among those with mental health conditions who consume 42% of all tobacco in England (McManus et al, 2010; Campion et al, 2014). Smoking is the single largest cause of preventable death in this group who therefore require targeted support. The estimated number of smokers with different mental health conditions in Enfield was (McManus et al, 2010):

- Common mental disorder: 11,554
- Psychosis: 458
- Alcohol dependence (higher risk drinkers): 7,624
- Drug dependence: 4,328
- Total: 23,964

**H.3 Smokers cessation intervention provision**
Proportion of smokers who had record of offer of support and treatment from primary care in the previous two years in Enfield (86.5%) was mid-range for London boroughs (range 81.1-93.8%) and similar to London region (86.5%) and England (85.8%) (2014/15) (HSCIC, 2015).

Proportion of all smokers setting a quit date with stop smoking services in Enfield (6.8%) was 11th highest of London boroughs (range 3.2-35.1%) and higher than London region (6.2%) or England (5.6%) (2014/15) (HSCIC, 2015).

Smoking cessation has at least the same impact on anxiety and depressive symptoms as antidepressants (Taylor et al, 2014) as well as being the most preventable cause of death in people with mental health conditions. Despite more than 42% of tobacco consumption being by people with mental health conditions, there was no information on provision of smoking cessation for this group. BEH MHT has started with forensics which is being evaluated before any further roll out. No information was provided about numbers receiving smoking cessation intervention in secondary care.

**H.4 Outcomes of smoking cessation interventions**
In 2014/15, proportion of all smokers achieving a 4 week quit from stop smoking services in Enfield (4.1%) was 7th highest of London boroughs (range 1.5-16.9%) and higher than London region (3.1%) or England (2.8%) (2014/15) (HSCIC, 2015). This equates to 1,603 smokers. However, proportion of all smokers achieving a CO validated 4 week quit from stop smoking services in Enfield (1.1%) was 3rd lowest of London boroughs (0.7-16.7%) and lower than London region (2.0%) or England (2.0%) (2014/15) (HSCIC, 2015).
Cost per NHS Stop Smoking Service quitter in Enfield (£145) was 2nd lowest of London boroughs (range £98-974) and lower than London region (£417) or England (£420) (2014/15) (HSCIC, 2015).

The draft Healthy Workplace Action Plan (2015) for Enfield plans to increase internal staff communication of stop-smoking initiatives, e.g. quit-smoking article, promotion of stop-smoking strategies and initiatives.

I) Long term mental health conditions
The proportion who reported a long-term mental health condition in Enfield (4.0%) was 12th lowest of London boroughs (range 2.8-6.5%) and lower than London region (4.5%) and England (5.1%) (2014/15) (GP Patient Survey, 2015). Figure 3.16 below shows that the proportion of those who report having a long term mental health condition is correlated with deprivation.

Figure 3.16: % reporting a long-term mental health problem vs socioeconomic deprivation score


J) Complex needs
During 2014/15 in Enfield, there were (locally provided figures)

- 9,864 secondary care contacts with Severe and Complex Non-Psychotic Complex Needs services
- 1,558 secondary care contacts with Severe and Complex Non-Psychotic Dual Diagnosis services

K) Self harm
Rates of self-harm are higher in people with mental health conditions. Self-harm is also an important risk factor affecting around half of people who die by suicide (see section 2.1 on adolescent self-harm).

Estimated proportion of the population in Enfield who during their lifetime (from McManus et al, 2009):

- 10.6% (25,713) adults attempt suicide
- 8.6% (20,862) adults self-harm
Admissions (directly age-sex standardised rate per 100,000 population) in Enfield for:

- Self-harm in 10-24 year olds (201.1) (125 individuals) was 12th lowest of London boroughs (range 119.1-416.6) and lower than London region (228.0) or England (412.1) (2013-14) (HES, 2015)
- Emergency admissions for self-harm (82.8) was 5th lowest of London boroughs (range 60.9-171.9) and lower than England (203.2) (2013-14) (HES, 2015) (not associated with deprivation) (2013-14) (HES, 2015)
- Admission episodes for alcohol-related intentional self-poisoning (narrow) (directly standardised per 100,000 population) in Enfield (12.2) was 2nd lowest of London boroughs (range 11.2-42.5) and lower than London region (23.0) or England (58.6) (2013/14) (LAPE, 2014)

Mental health promotion, prevention and early intervention are important to reduce self-harm. However, the effective assessment and management of self-harm by NHS services where people do present with self-harm, particularly in Accident & Emergency represents a huge opportunity to future suicide risk (NICE, 2013b).

L) Suicide

The presence of a mental health condition is an important risk factor for suicide since the majority of people who committed suicide had a mental health condition at the time of death (Cavanagh et al, 2003; Phillips, 2010) although only a minority received any treatment (McManus et al, 2009). Among the most common mental health conditions linked with suicide are common mental disorders, schizophrenia, and substance misuse (Bertolote & Fleischmann, 2002). Therefore, improving coverage of treatment of mental health conditions is a key way to reduce suicide.

L.1 Suicide rates

The mortality rate from suicide and undetermined injury (standardised per 100,000 population) in Enfield (5.5) was 5th lowest of London boroughs (range 4.5-9.9) and lower than London region (7.0) or England (8.8) rate (2012-14) (ONS, 2015). Rate was not associated with socioeconomic deprivation.
Figure 3.17: Mortality rate from suicide and injury undermined in Enfield (standardised rate for 100,000) in Enfield

Source: ONS (2015)

Years of life lost due to suicide (age standardised per 100,000 population) in Enfield (18.5) was 3rd lowest of London boroughs (range 17.2-32.2) and lower than London region (24.0) or England (31.4) rate (2011-13) (ONS, 2014).

Enfield Lock was identified as a suicide hot spot although 16 people had suicided on rail tracks in Enfield since 2007.

L.2 Suicide prevention

As previously mentioned, since the majority of suicides are by people with mental health conditions most of who receive no treatment (Green et al, 2005; McManus et al, 2009), improving coverage of treatment of mental health conditions is a key way to reduce suicide.

The government’s suicide prevention strategy identifies six areas of focus (DH, 2015):

- Reduce the risk of suicide in key high-risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

The top five changes mental health service providers could make to reduce suicide were to (NCISH, 2013):

- Provide specialist community services such as crisis resolution/home treatment, assertive outreach and services for patients with dual diagnosis
- Implement National Institute for Health and clinical Excellence (NICE) guidance on depression

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- Share information with criminal justice agencies
- Ensure physical safety and reduce absconding on in-patient wards
- Create a learning culture based on multi-disciplinary review

Further areas which offer opportunities to reduce suicide include:
- Early intervention psychosis services are associated with reduced suicide as are services to address crisis including CRHT’s
- Psychosocial assessments of people who have suicidal thoughts or have self-harmed are themselves helpful in preventing further suicidal behaviour (Kapur et al, 2013)
- Cognitive Behavioural Therapy/Dialectal Behavioural Therapy reduce the risk of repeat self-harm (O’Connor et al, 2013)
- Reducing access to means (through installation of physical barriers) can avert suicides at hotspots
- Targeting higher risk groups included unemployed (HMG, 2014) and young/middle aged men (Preventing Suicide in England National Strategy, 2012)
- Self-harm (see previous section K)

L.3 Local suicide prevention work
NCI evidence suggested that only 28% of suicides in a local population are in contact with mental health services within a year of their death and it was suggested that instead of developing a suicide prevention action policy in isolation, the Trust should look to the commissioners and the Directors of Public Health to lead a LSAP to which the Trust would contribute.

Suicide prevention work by public health
Enfield Public Health had done some work to identify what services were available in the borough and found that the services being offered matched most of the requirements set out in a Manchester University study. Some gaps were identified including contact with young people.

Suicide prevention work by BEH-MHT
A workshop was convened the aims of which were to provide greater clarity about current local suicide prevention plans of the three boroughs and BEH-MHT, to get an update on the Tri-borough Crisis Concordat status, to identify if there were any gaps against the priorities in the national strategy, and to discuss actions and priorities for taking improvement plans forward in the Trust and the three boroughs.

In 2015, BEH-MHT produced a Clinical Quality Review Group report which highlighted that:
1. There was no comprehensive Local Suicide Action Plan (LSAP) in the BEH areas and further consideration needs to be given to this
2. BEH-MHT remained of the view that a Trust suicide strategy or action plan should not be developed independently of the LSAP, or of other Trust quality strategies or measures.
3. The ‘Zero Tolerance of Suicide’ approach advocated by Mersey Care was of interest and exemplified how a Trust can organise around a specific high profile initiative with likely benefits for staff engagement and service quality. However there was as yet no evidence that this had impacted on suicide rates
4. BEH-MHT was responding to recommendations of the National Confidential Inquiry (NCI) and National Preventing Suicide strategy through a range of services and measures. More recent work from the NCI was of interest but did not make specific recommendations although it draws attention to clinically recognises risks associated with organisational instability and change, and loss of continuity of care.

5. The NCI recommendations drew attention to major risk factors for suicide such as economic pressure, housing, debt and unemployment, which have risen in recent years. BEH-MHT recognised the impact of these and the resulting increase in risk, which can only be partly mitigated by measures available to the Trust or indeed the local health economy.

6. While national policy focuses on suicide prevention, a key issue for the Trust was the impact of completed suicide on staff and carers, and BEH-MHT would continue to develop approaches to mitigate this impact.

A Barnet, Enfield & Haringey Tri-Borough Suicide Prevention Workshop on 7/09/2015 highlighted that BEH-MHT did not have a specific suicide prevention policy or an action plan for suicide prevention but the separate plans for risk management / risk assessment at the Trust probably fulfilled many actions recommended for a Mental Health Trust.

**Work with British Transport Police**

There was a joint partnership between British Transport Police (BTP), BEH-MHT, Papryus (prevention of young suicide) and Maytree. NHS staff were embedded within the BTP Public Protection Unit (PPU) in order to develop an integrated service. Objectives include to:

- Actively reduce and prevent future railway suicides
- Actively reduce and prevent incidents on the rail network that result in disruption of the railway
- Together assess risks, classify incidents and decide appropriate and proportionate follow up actions
- NHS staff to provide the interface between health and social care agencies and BTP in order to ensure proportionate information is shared in order to achieve the best patient outcome
- Reduce the time BTP staff spend related to Section 136 Mental Health Act assessments
- Contact the health provider of every individual that comes to our attention
- Jointly initiate Suicide Prevention Plans for vulnerable people who come to attention on the rail network
- Pro-active engagement for high-risk persons and locations
- Raise the profile of deaths and incidents on the rail network

Possible local actions identified included:

- Hot spots: Mental Wellbeing Partnership Board subgroup had met over a year ago and identified local hotspots had been identified and it was suggested that some helpline numbers could be put on signposts around the hotspots
- Tap-it was launched by Enfield and Southward Councils in January 2014 with the help of £60,000 funding from the Mayor’s Office for Policing and Crime (MOPAC), as part of their London Crime Prevention Fund. It is a personal safety app designed to help people who find themselves in vulnerable situations although there was information regarding impact. However, Enfield Mental Health Users group (EMU) consulted with service users and suicide
prevention specialists who felt the app was not applicable to suicide prevention and could have detrimental effects.

M) Parental mental health conditions

M.1 Estimated number of parents with mental health condition

Parental mental health conditions have a broad range of impacts including on the family and children. Children of parents with a mental health condition are at increased risk of mental health conditions (see section 7.4.1). Therefore, treatment of parental mental health conditions is therefore important to prevent associated impacts including mental health conditions in their children.

The estimated numbers of parents with different mental health conditions in Enfield are as follows assuming that prevalence levels for adult population are the same as for parents (see sections 3):

- Common mental disorder (15.6%): 11,538 parents
- Psychosis (0.46%): 340 parents
- Personality disorder (4.4%): 3,254 parents
- Eating disorder (7.0%): 5,177 parents
- Binge drinkers (12.2%): 9,024 parents
- Higher risk drinkers (6.6%): 4,882 parents
- Drug dependent (0.74%): 547 parents

The proportion of households with dependent children where at least one person has a long term health problem or disability in Enfield (6.1%) was 5th highest of London boroughs (range 1.6–7.5%) and higher than London region (5.0%) or England (4.6%) (ONS, 2011). This equates to 7,318 households in Enfield.

No information was available about the proportion of 20,309 parents with common mental disorder, psychosis, personality disorder and eating disorder receiving treatment. BEH-MHT had no mother and baby unit (NHS Benchmarking, 2015). The Enfield Schools and children’s services safeguarding children self-assessment (Enfield, 2014) found that little information was held about the crossover between parental and child mental health.

Regarding drug and alcohol misuse, the rate per 100,000 population at which parents in Enfield were in treatment for (2011/12) (NDTMS, 2013):

- Drug problems (96.6) (68 parents) was 12th lowest of London boroughs (range 35.0-137.9) and lower than London region (104.1) or England (110.4)
- Alcohol problems (78.1) (55 parents) was 6th lowest of London boroughs (range 38.4-178.0) and lower than London region (108.2) or England (147.2)
M.2 Estimated number of new mothers with mental health condition and proportion receiving treatment

During the previous year, there were 4,824 births in Enfield (ONS, 2015)

Estimated number of women who required mental health support during pregnancy or the postnatal period in Enfield (605) was 7th highest of London boroughs (2012) (from 12% NICE benchmarking rate). Estimated economic cost of perinatal depression, anxiety and psychosis for each one year cohort of births in Enfield was £40.7m (from Bauer et al, 2014).

Estimated numbers of mothers in Enfield who were depressed during pregnancy (613) almost doubles one year after birth (1061) (based on systematic review prevalence rates from Gavin et al, 2005 and latest birth rates ONS, 2015).

Applying national rates of perinatal mental disorder to new mothers in Enfield would suggest that there would be (JCPMH, 2012):

- Postpartum psychosis: 9.6 women
- Chronic serious mental illness: 9.6 women
- Severe depressive illness: 144.6 women
- Mild moderate depressive illness and anxiety states: 482-724 women
- PTSD: 144.6 women
- Adjustment disorders and distress: 724-1446 women

Only a minority of women with perinatal mental disorder receive treatment due to a combination of poor awareness among mothers, stigma and insufficient training of primary care practitioners (CMH, 2015). Local information provided about local treatment and support for new mothers did not include how many received treatment/support from different services or associated outcomes:

- Primary care
- Health Visitors: All (in post before September 2015) are trained in Perinatal Mental Health, have undertaken the Institute of Health Visiting training and there are two specific HVs trained in more depth to support HVs with their clients
- Strengthening Families, Strengthening Communities parenting programme provided through ECYPS (Enfield Children and Young Peoples Service)
- Parent Infant Partnership have a project through CCTS
- BEH Samaritans
- Children’s Centres
- Peer support group in Muswell Hill (note review of effectiveness of peer support by Rainbow, 2014)
- Mother and baby unit (need to go to Homerton hospital)
4) Secondary care for adults with mental health conditions

This section will cover the following:
- Access to secondary mental health care
- A&E attendance for mental health conditions
- Hospital admissions
- Bed availability, occupancy and length of stay
- Delayed transfers of care
- Discharges
- Detention under the Mental Health Act (MHA)
- Care Programme Approach (CPA)
- Crisis care
- Community secondary care
- Liaison
- Balance between community and inpatient care
- Information on secondary care by cluster
- Service quality indicators
- Workforce

A) Access to secondary mental health services

A.1 Rate of access
Rate of access to secondary mental health services per 100,000 population in NHS Enfield CCG (1,807) was 15th lowest of London boroughs (range 1,226-3,192) and lower than London region (1,978) or England (2,214) (2014/15 Q4) (HSCIC, 2015) (crude rate). Rate of access per 100,000 population in Enfield reduced from 2,060 in 2013/14 Q1 to 1,807 in 2014/15 Q4 (HSCIC, 2015).
Figure 4.1: Rate of people in contact with secondary mental health services per 100,000 in Enfield (quarter snap shots)

Source: HSCIC (2015)

Figure 4.2 below highlights that rate of contact with secondary services was associated with deprivation although Enfield had a lower rate than would be expected for level of deprivation.

Figure 4.2: Rate of contact with secondary mental health services per 100,000 population vs socioeconomic deprivation


Proportion of people in contact with mental health services who are from black and minority ethnic groups in NHS Enfield CCG (21.0%) was 9th lowest of London boroughs (range 6.3-51.9%) compared to London region (29.3%) and England (8.6%) (2012/13) (HSCIC, 2014).
B) A&E attendance for mental health conditions

Crisis resolution teams treat people with serious mental health conditions when they experience an acute psychiatric crisis. However, many crisis episodes result in contact with police services or attendance at hospital A&E departments. Mental health conditions are also associated with physical health problems, which may also result in hospital visits.

Attendance rate at A&E for psychiatric disorders per 100,000 population in NHS Enfield CCG (17.3) was lowest of London boroughs (range 17.3-640.3) and lower than London region (215.8) or England (243.5) (2012/13) (HSCIC, 2013). Attendance rate at A&E for psychiatric disorders was not associated with deprivation.

C) Hospital admission for mental health conditions

C.1 Rate of admissions

Admission rate per 100,000 population in NHS Enfield CCG (72.0) was 14th lowest of London boroughs (range 27.6-157.2), lower than London region (86.1) but higher than England (69.8) (HSCIC, 2015). Over the last six quarters, admission rate per 100,000 population in Enfield had risen from 59.9 in 2013/14 Q1 to 72.0 in 2014/15 Q2 (HSCIC, 2015).

Figure 4.3: Mental health admission rate per 100,000 population in NHS Enfield CCG

Source: HSCIC (2015)

Admission rate per 100,000 population in BEH-MHT for (2014/15) (NHS Benchmarking Network, 2015):

- Adults (313) was 3rd highest of London trusts and just above the upper quartile (299) for trusts nationally
- Older adult (162) was mid-range for London trusts and just above the lower quartile (146) for trusts nationally
C.2 Hospital admission for people already engaged with secondary mental health services

The proportion of mental health service users who were inpatients in a psychiatric hospital in NHS Enfield CCG (5.5%) was 2nd highest of London boroughs (range 1.8-5.6%) and higher than London region (3.4%) or England (2.5%) (Q2 2014/15) (HSCIC, 2014). The admission rate for mental health service users has been increasing over the previous 18 months (HSCIC, 2015) (see below).

Figure 4.4: Proportion of mental health service users who were admitted to a psychiatric hospital in NHS Enfield CCG

Source: HSCIC (2015)

Proportion of mental health service users who were inpatients in a psychiatric hospital in BEH-MHT (3.7%) was 3rd highest of London comparator trusts (range 2.0-4.2%) and higher than London commissioning region (3.3%) or England (2.5) (2014/15 Q4) (HSCIC, 2015). Rates have varied between 3.5% and 3.7% over the last five quarters.

C.3 Emergency admissions and readmissions

Proportion of admissions which were emergency in (2014/15 Q2) (HSCIC, 2015)

- NHS Enfield CCG (47.8%) was 3rd lowest of London boroughs (range 30.8-92.9%) and lower than England (73.5%)
- BEH-MHT (48.6%) was 2nd lowest of London comparator trusts (range 37.3-90.6%) and lower than London commissioning region (66.9%) or England (73.5%)

Proportion of admissions which were emergency re-admissions in BEH-NHT:

- In 2014/15 Q2 (5.4%) was 3rd lowest of London comparator trusts (range 3.2-15.8%) and lower than London commissioning region (8.0%) or England (9.3%) (HSCIC, 2015)
- For adults in 2014/15 (2.1%) was lowest of London trusts and below the lower quartile nationally (NHS Benchmarking Network, 2015)
• For older adults in 2014/15 (1.1%) was 2nd lowest of London trusts and below the lower quartile nationally (NHS Benchmarking Network, 2015)

C.4 Bed availability
Acute beds per 100,000 population for BEH-MHT (2014/15) (NHS Benchmarking Network, 2015) for:
• Adults (25.0) was above the upper quartile (23.8) for trusts nationally but 3rd lowest of London trusts
• Older adults (19) was below the lower quartile (37) for trusts nationally and 2nd lowest of London trusts

• Number (22) compared to 75 for the BEH-MHT
• Occupied bed days (114) compared to 477 for the BEH-MHT
• Note that the Carnal Farrer had forecast 2,336 bed days required for adult acute external placements in 2013/14
• Trust wider external placements

Table 4.1: Number of external placements and associated Occupied Bed Days in BEH-MHT from 2014-2016 (locally provided data)

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C.5 Bed occupancy
Bed occupancy (excluding leave) for BEH-MHT (2014/15) (NHS Benchmarking Network, 2015) for:
• Acute adult and older adult (100%) was highest for trusts within London and nationally
• Long term complex care (97.1%) was 3rd highest for trusts nationally and 2nd highest for London trusts
• Psychiatric Intensive Care Units (97.8%) higher than upper quartile (91.8%) for trusts nationally and highest for London trusts
• Medium secure (96.7%) was above upper quartile (95.2%) for trusts nationally and mid-range for London trusts
- Low secure (93.7%) was below upper quartile (95.4%) for trusts nationally and mid-range for London trusts
- Eating disorders (74.9%) was below lower quartile (79.2%) for trusts nationally and 2\textsuperscript{nd} lowest of four London trusts

Occupied bed days (excluding leave) per 100,000 population for BEH-MHT (2014/15) (NHS Benchmarking Network, 2015):
- Adults (9,156) was above the upper quartile (8,233) for trusts nationally and mid-range for London trusts
- Older adults (7.005) was below the lower quartile (11,091) for trusts nationally and 2\textsuperscript{nd} lowest for London trusts

C.6 Length of stay
Mean length of stay in days (excluding leave and unadjusted for outliers) for BEH-MHT (2014/15) (NHS Benchmarking Network, 2015):
- Adults (26.0) was close to the lower quartile (26.3) for trusts nationally and lowest of London trusts
- Older adults (32) was lowest of all trusts with national lower quartile (58)
- Long term complex care (177) was below lower quartile (321) for trusts nationally and lowest for London trusts
- Psychiatric Intensive Care Units (49) was near mean for trusts nationally and mid-range for London trusts
- Medium secure (248) was below lower quartile (337) for trusts nationally and 2\textsuperscript{nd} lowest for London trusts
- Low secure (256) was below lower quartile (265) for trusts nationally and joint lowest for London trusts
- Eating disorders (97) was near mean (100) for trusts nationally and mid-range for London trusts

C.7 Delayed transfers of care due to NHS and social care
Proportion of transfers of care which were delayed in BEH-MHT for (2014/15) (NHS Benchmarking Network, 2015):
- Adults (5.6%) was close to the upper quartile (5.8%) for trusts nationally (2014/15) but mid-range for London trusts
- Older adults (27.9%) was highest of all trusts and much higher than London trusts

Days of delayed transfer of care per 1000 beds in BEH-MHT due to (2014/15 Q4) (HSCIC, 2015):
- NHS (21.1) was 3\textsuperscript{rd} highest of London comparator trusts (range 8.3-25.8) and higher than London commissioning region (19.1) but lower than England (24.8). However, annual figures for 2014/15 for BEH-MHT (29.8) was close to the lower quartile (29.8) for trusts nationally (NHS Benchmarking Network, 2015)
- Social care (19.3) was mid-range of London comparator trusts (range 8.1-23.3) and higher than London commissioning region (16.8) but lower than England (21.9)
Days of delayed transfer of care for older adults for BEH-MHT (35.7) which was 2\textsuperscript{nd} lowest of London trusts but close to the mean (41.0) for trusts nationally (2014/15 (NHS Benchmarking Network, 2015).

D) Discharges

Mental health discharge rate for NHS Enfield CCG (75.1) was 14\textsuperscript{th} lowest of London boroughs (range 35.5 to 153.5) but higher than England (69.8) (HSCIC, 2015). Discharge rate increased from 59.0 in 2013/14 Q1 to 75.1 in 2014/15 Q2.

Figure 4.5: Mental health discharge rate from hospital (quarterly) per 100,000 population in NHS Enfield CCG

Source: HSCIC (2014)

Delayed discharge

Days of delayed discharge per 1000 mental health bed days in (2014/15 Q2) (HSCIC, 2015):

- NHS Enfield CCG (19.0) was 13\textsuperscript{th} lowest of London boroughs (range 1.2 to 149.7) and lower than London region (32.2) or England (28.3)
- BEH-MHT (34.2) was 4\textsuperscript{th} lowest of London comparator trusts (range 3.3-76.7) and lower than London commissioning region (34.0) or England (28.3)

Days of delayed transfer of al care due to NHS per 1000 bed days in BEH-MHT (21.1) was 3\textsuperscript{rd} highest of London comparator trusts (range 8.3-25.8) and higher than London commissioning region (19.1) but lower than England (24.8) (2014/15 Q4) (HSCIC, 2015).

Follow up after discharge

Rate of follow for patients on CPA within 7 days after discharge in NHS Enfield CCG (99.4%) was high for London boroughs (range 91.7-100%) and higher than England (97.0%) (2015/16 Q1) (HSCIC, 2015).
E) Detention under the Mental Health Act

Under the Mental Health Act (MHA), a patient can be formally detained in hospital for his or her own safety, or that of other people on account of a mental health condition.

E.1 Detention under the Mental Health Act

The quarterly rate per 100,000 population at which people were subject to the Mental Health Act in NHS Enfield CCG (73.0) was 8th highest of London boroughs (range 13.2-103.1) and higher than London region (54.6) or England (39.5) (2014/15 Q4) (HSCIC, 2015). Over the last 18 months, there was an initial reduction in detention rate from 88.5 in 2013/14 Q1 to 60.7 in 2013/14 Q3 which has increased over time to 73.0 in 2014/15 Q4.

Figure 4.6: Rate of detention under the Mental Health Act per 100,000 population in NHS Enfield CCG

Source: HSCIC (2015)

Rate of detention under the Mental Health Act was correlated with deprivation with the rate of detention in NHS Enfield CCG slightly lower than would be expected against deprivation as shown in figure 4.7 below.
Figure 4.7: Annual rate of detention under Mental Health Act per 100,000 population (2012/13) vs socioeconomic deprivation


E.2 Detention under the Mental Health Act on Admission

Rate of detention under the Mental Health Act on admission per 100,000 in Enfield CCG (18.8) was 11th lowest of London boroughs (range 10.3-47.7) and similar to England (17.7) (Q2 2014/15) (HSCIC, 2015). This rate for Enfield has been stable over the last level which was more similar to the England average as is shown in figure 4.8 below.

Source: HSCIC (2015)
Proportion of admissions which were MHA detentions in BEH-MHT during:

- 2014/15 Q2 (33.8%) was 3rd highest of London comparator trusts (range 11.4-38.1%) and higher than London commissioning region (29.3%) or England (25.4%) (HSCIC, 2015). Rates varied between 28.4% and 33.8% over the last three quarters
- 2014/15 (35.6%) was mid-range for London trusts and above the mean nationally (32.9%) (NHS Benchmarking Network, 2015)

F) Care Programme Approach

The Care Programme Approach (CPA) has four main elements including assessment, care plan, care co-ordination and review7. CPA requires health and social services to combine their assessments to make sure everybody needing CPA receives properly assessed, planned and coordinated care. It should also ensure that patients get regular contact with a care co-ordinator.

F.1 Proportion of people on CPA

Rate at which people were on CPA per 100,000 of population in NHS Enfield CCG (566) was 9th highest of London boroughs (range 288-761) and higher than London region (494) or England (460) (Q4 2014/15) (HSCIC, 2015). Rate of people on CPA was not associated with associated with deprivation.

Figure 4.9: Rate of people on Care Programme Approach per 100,000 population in NHS Enfield CCG


F.2 Proportion of people in contact with mental health services on CPA

Proportion of people using adult and older adult NHS funded secondary mental health services who were on CPA in NHS Enfield CCG (31.3%) was 8th highest of London boroughs (range 17.5-38.9%) and higher than London region (25.0%) or England (20.8%) (Q4 2014/15) (HSCIC, 2015). Although the

The proportion of people in contact with mental health services on CPA increased during 2014/15, it is now slightly lower than 2 years ago.

**Figure 4.10: % of people in contact with mental health services who are on CPA in NHS Enfield CCG**

Proportion of people on CPA in BEH-MHT (29.0%) was 2nd highest of London comparator trusts (range 17.2-31.8%) and higher than London commissioning region (23.9%) or England (20.8%) (2014/15 Q4) (HSCIC, 2015). Rates have been between 28.3 and 30.6 over the last five quarters.

**F.3 Proportion of people on CPA with a review**
Proportion of people on CPA for more than 12 months who had a review in (Q4 2014/15) (HSCIC, 2015):

- NHS Enfield CCG (94.8%) was 15th lowest of London boroughs (range 81.7-98.5%) and similar to London region (94.1%) and higher than England (80.4%)
- BEH-MHT (93.8%) was 3rd lowest of London Mental Health Trusts (range 82.4-97.8%), similar to London Commissioning region (94.2%) and higher than England (80.4%)

**F.4 Proportion of people on CPA with HoNOS recorded**
Proportion of people on CPA with HoNOS recorded in (Q4 2014/15) (HSCIC, 2015):

- NHS Enfield CCG (93.4%) was mid-range for London boroughs (range 83.5-99.1%), similar to London region (93.0%) but higher than England (84.0%)
- BEH-MHT (91.9%) was 4th lowest of London Mental Health Trusts (range 84.1-98.6%), similar to London Commissioning region (92.7%) but higher than England (84.0%)

**F.5 CPA and employment**
The proportion of those on CPA in employment in (2014/15 Q4) (HSCIC, 2015):

- NHS Enfield CCG (3.9%) was 5th lowest of London boroughs (range 2.9-10.6%) and lower than London region (5.7%) or England (6.9%). The chart below highlights little change over the
last 18 months. Proportion on CPA in employment was not correlated with socioeconomic deprivation.

- BEH-MHT (4.2%) was lowest of London comparator trusts (range 4.2-9.8%) and lower than London commissioning region (5.7%) or England (6.9%)

**Figure 4.11: % of people aged 18-69 on CPA in employment in NHS Enfield CCG**

![Graph showing % of people aged 18-69 on CPA in employment in NHS Enfield CCG](image)

**Source:** HSCIC (2015)

Proportion of people in contact with mental health services with employment status recorded in BEH-MHT (37.0%) was 4th lowest of London comparator trusts (range 26.7-81.3%), lower than London commissioning region (47.3%) but similar to England (36.6%) (2014/15 Q4) (HSCIC, 2015).

**F.6 Proportion on CPA in settled accommodation**

The proportion of people on CPA in settled accommodation in (Q4 2014/15) (HSCIC, 2015):

- NHS Enfield CCG (66.7%) was 5th lowest of London boroughs (range 56.9-92.0%), lower than London region (77.8%) but higher than England (60.7%)
- BEH-MHT (68.0%) was 2nd lowest of London comparator trusts (range 64.2-91.5%). lower than London commissioning region (78.0%) but higher than England (60.7%)
Proportion of people in contact with mental health services with accommodation status recorded in BEH-MHT (36.9%) was 3rd lowest of London comparator trusts (range 26.3-81.3%) and lower than London commissioning region (47.4%) or England (40.6%) (2014/15 Q4) (HSCIC, 2015).

G) Crisis care

The proportion of people in contact with mental health services with a crisis plan in place in NHS Enfield CCG (37.8%) was 7th highest of London boroughs (range 8.0-45.2%) and higher than London region (26.4%) or England (17.6%) (Q4 2014/15) (HSCIC, 2015). However, the proportion with crisis plans in place in Enfield had reduced over the last three quarters.
The proportion of people in contact with mental health services with a crisis plan in place in BEH-MHT (37.8%) was 3rd highest of London Mental Health Trusts (range 11.4-47.0%) and higher than London Commissioning region (25.2%) or England (17.6%) (Q4 2014/15) (HSCIC, 2015).

**Crisis Resolution Home Treatment services**

Crisis resolution home treatment (CRHT) teams provide intensive support for people in mental health crises in their own home. It is designed to provide prompt and effective home treatment, including medication, in order to prevent hospital admissions and give support to informal carers. An admission has been gate kept if the service user was assessed before admission and if they were involved in the decision-making process, which resulted in admission.

The proportion of admissions which were gate kept by Crisis Resolution Home Treatment teams in Enfield (100%) was joint highest of London boroughs (92.0-100%) compared to England (98.1%) (Q4 2014/15) (NHSE, 2015).

Crisis Resolution and Home Treatment team face to face contact per 100,000 population in BEH trust (8,748) was highest of London trusts and higher than the upper quartile nationally (4,697) (2014/15) (NHS Benchmarking Network, 2015).

During 2014/15 in Enfield for crisis and emergency, there were (locally provided figures)

- 2,400 contacts with Triage
- 14,160 contacts with Crisis Resolution Home Treatment teams
- 14 contacts with Day Therapy
- 16,344 Occupied Bed Days (OBD)
- 1,778 OBDs for PICU
- 120 OBD’s for external placements
- 3,572 OBD’s for Recovery Houses

Report of the second round of the National Audit of Schizophrenia (NAS2) 2014 for which interviewed 56 service users at BEH-MHT found that a below average proportion reported knowing how to get help in a crisis. A review led by the CQC (DH, 2014) collated people’s experiences of seeking help from crisis care services, the effectiveness of care provided, the response they received from staff and if the care given met their needs at the time of acute emotional distress. It highlighted the opportunity to improve home treatment team capacity enabling the teams to be in a position to respond quickly. There were inconsistencies in the quality of crisis care, with some service users expressing dissatisfaction around clinical practice, accessibility and lack of safety during crisis (CQC, 2015). As part of the local commissioners and BEH operational management CQC action plan to inspect and improve crisis care, a survey of 89 service user across BEH-MHT was carried out regarding their experiences of crisis care (Bhandari & Irvaniipour, 2015). This highlighted the importance of better community mental health services, being listened to, psychological therapy, good quality inpatient care, and medication reviews. Findings included:

- Large number of service users reported good examples of care in acute wards across BEH-MHT inpatient settings, where the recovery pathway and clinical staff were praised
- 76% had contact with mental health services prior to their most recent mental health crisis with 56% using the CRHTT during their most recent contact
• Review of medication was reported by 25% as something that may have helped prevent a crisis
• Under use of community services including the voluntary sector, charity organisations, liaison and IAPT services
• Lack of awareness of A&E psychiatric liaison services with 53% not being aware of this service
• GPs supported at least 50% of individuals in crises but only referred 12% to mental health services which could improve with mental health training for GP’s

H) Community secondary mental health care

Community mental health team caseload
Community mental health team caseload per 100,000 population in BEH trust for people (2014/15) (NHS Benchmarking Network, 2015):
• Aged 16-64 (1,865) was 2nd highest of London trusts and above the upper quartile nationally (1,810)
• Aged above 64 (2,925) was mid-range for London trusts and close to the mean nationally (2,800)

Community mental health team contact
Community mental health team face to face contact per 100,000 population in BEH-MHT for people (2014/15) (NHS Benchmarking Network, 2015):
• Aged 16-64 (42,805) was mid-range for London trusts and below the upper quartile nationally (43,955)
• Aged above 64 (53,882) was 3rd highest of London trusts and above the upper quartile nationally (46,838)

Assertive Outreach Services
Assertive Outreach services are specialist teams set up to work with adults with mental illness or personality disorder who “find it difficult to work with services, have been admitted to hospital a number of times and may have other problems such as violence, self-harm, homelessness or substance abuse.”

Rate of people accessing Assertive Outreach Services per 100,000 population in NHS Enfield CCG (18.8) was 5th lowest of London boroughs (range 1.9-112.1) and lower than London region (46.2) or England (21.5) (Q2 2014/15) (HSCIC, 2015). Figure 4.14 below shows the rate for Enfield has been consistent (HSCIC, 2015).

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8 http://www.nhs.uk/NHSEngland/AboutNHSservices/mental-health-services-explained/Documents/Assertive%20Outreach-Factsheet.pdf
Figure 4.14: Rate of people receiving assertive outreach services in Enfield per 100,000 population (end of quarter snapshot)

Source: HSCIC (2015)

Day care
The rate of contacts and day-care attendances per 100,000 population in NHS Enfield CCG (15,689) was 10th highest of London boroughs (range 9,256-19,957) and higher than London region (14,025) or England (12,490) (Q2 2014/15) (HSCIC, 2015). This has been consistently above the England average over the past year (HSCIC, 2015).

Figure 4.15: Rate of contacts and day care attendances (quarterly) per 100,000 population in Enfield CCG

Source: HSCIC (2015)
The rate of contacts and day care attendances is correlated with deprivation with Enfield close to expected levels (HSCIC, 2014).

**Figure 4.16: Rate of contacts and day care attendances (quarterly) per 100,000 population vs socioeconomic deprivation**

![Graph showing rate of contacts and day care attendances](image)

**Source:** HSCIC (2014), DCLG (2010)

**Recovery houses**

No information was provided about the number of bed days in recovery houses and bed and breakfasts.

**I) Liaison**

The work of liaison services focus on two areas

- Accident & Emergency: Patients are not usually admitted and have explicit mental health conditions
- Already inpatients

Previous research (RAID) highlighted that liaison input for people who were already inpatients resulted in economic savings. However, increases in patients presenting at A&E over the past two years has resulted in activity primarily focused on patients presenting to A&E. Possible reasons include closure of drop in centres.

An audit of 576 patients seen by BEH-MHT liaison services between December 2014 and January 2015 found that 10% were referred to the Crisis team and 5.2% were admitted.

Opportunities exist to address Medically Unexplained Symptoms (MUS)
J) Balance between community and inpatient care
- Community care (86.9%) was between the national mean (86.0%) and median (87.0%)
- Hospital care (13.1%) was between the national mean (14.0%) and median (13.0%)
- Proportion of service users under the care of community teams (96.7%) was similar to nationally (mean 98.0%)
- Proportion of service users in hospital (3.3%) was higher than nationally (mean 2.0%)

K) Information on secondary mental health care use by cluster
Diagnostic coding
Proportion in contact with mental health services with a diagnosis recorded in (2014/15 Q4) (HSCIC, 2015):
- NHS Enfield CCG (26.8%) was 9th lowest of London boroughs (range 15.7-59.6%) and lower than London region (35.0%) or England (16.4%)
- BEH-MHT (27.6%) was 3rd lowest of London comparator trusts (range 17.7-48.7%) and lower than London commissioning region (34.0%) but higher than England (16.4%)

Clustering
Proportion assigned to a mental cluster in
- NHS Enfield CCG (76.9%) was 14th lowest of London boroughs (range 55.0-92.1%) and similar to London region (77.1%) but higher than England (69.0%) (2013/14 Q1) (HSCIC, 2014)
- BEH-MHT (67.6%) was 4th highest of London comparator trusts (range 27.6-79.8%) and higher than London commissioning region (55.3%) or England (59.0%) (2014/15 Q4) (HSCIC, 2015)

In-patient cluster assignment
- Clusters 1-2 (0.9%) was at the upper quartile level nationally (0.9%) and 2nd highest of London trusts
- Clusters 1-4 (5.3%) was below the mean level nationally (7.6%) and 3rd highest of London trusts
- Clusters 1-8 (non-psychosis diagnoses) (20.0%) was below the mean nationally (23.1%) and 2nd highest of London trusts
- Clusters 10-16 (psychosis) (58.1%) was above the mean nationally (55.3%) but lowest of London trusts
- Cluster 17 (psychosis and affective disorder difficult to engage) (4.7%) was at below the mean nationally (6.2%) and 3rd lowest of London trusts
- Clusters 18-21 (organic disorders) (17.2%) was below the upper quartile level nationally (17.8%) and 2nd highest of London trusts
Community cluster assignment

- Clusters 1-8 (non-psychosis diagnoses) (32.9%) was below the mean nationally (35.6%) and mid-range for London trusts
- Clusters 10-16 (psychosis) (53.1%) was higher than the upper quartile nationally (37.3%) and 3rd highest of London trusts
- Cluster 17 (psychosis and affective disorder difficult to engage) (0.8%) was below the lower quartile nationally (1.0%) and lowest of London trusts
- Clusters 18-21 (organic disorders) (13.2%) was below the lower quartile level nationally (22.3%) and 2nd lowest of London trusts

Community cluster contact

- Clusters 1-8 (non-psychosis diagnoses) (34.0%) was below the mean nationally (37.0%) and highest for London trusts
- Clusters 10-16 (psychosis) (55.3%) was above the upper quartile nationally (48.1%) but 3rd lowest of London trusts
- Cluster 17 (psychosis and affective disorder difficult to engage) (1.9%) was below the lower quartile nationally (2.6%) and lowest of London trusts
- Clusters 18-21 (organic disorders) (8.7%) was below the lower quartile level nationally (9.9%) but 2nd highest of London trusts

L) Secondary mental health care quality indicators
Patient experience in BEH-MHT of (NHSE, 2013)

- Access and waiting (7.18) was mid-range for London comparator trusts (range 6.49-8.10) and close to England (7.24)
- Safe and high quality care (6.87) was mid-range for London comparator trusts (range 6.37-7.63) and close to England (6.74)
- Better information and more choice (6.48) was mid-range for London comparator trusts (range 5.99-6.67) and close to England (6.54)
- Building close relationships (7.83) was 2nd lowest of London comparator trusts (range 7.75-8.43) and lower than England (8.11)

Satisfaction in BEH-MHT

- Community team patient satisfaction score (62.0%) was lowest of London or other trusts (lower quartile nationally 67.0%)
- Staff satisfaction score (75.0%) was 2nd lowest of London trust but just below the mean nationally 76.0%) (2014/15) (NHS Staff, 2015)


- Serious Incidents per 100,000 occupied bed days (excluding leave) and face to face contacts (18) was mid-range for London trusts and just above the lower quartile nationally (16)
- Ligature Incidents per 100,000 occupied bed days (excluding leave) (9) was lowest of London trusts and trusts nationally (lower quartile 84) (2014/15)
Incidents of physical violence to patients per 100,000 occupied bed days (excluding leave) (44) was lowest of London trusts and below lower quartile nationally (44)

Incidents of physical violence to staff per 100,000 occupied bed days (excluding leave) (84) was 2nd lowest of London trusts and below lower quartile nationally (117)

Complaints

- Complaints per 100,000 occupied bed days (excluding leave) and face to face contacts in BEH-MHT (61) was mid-range for London trusts and just below the mean nationally (65) (2014/15) (NHS Benchmarking Network, 2015)

Staff training and experience (NHSE, 2014): Proportion of staff in the last year in BEH-MHT:

- Receiving job relevant training, learning or development (79.4%) was lowest of London comparator trusts (range 79.4-84.5%) but close to England (81.7%)
- Receiving health and safety training (55.7%) was lowest of London comparator trusts (range 55.7-80.2%) and lower than England (73.7%)
- Witnessing potentially harmful errors, near misses or incidents 28.7%) was mid-range for London comparator trusts (range 25.7-35.6%) and higher than England (26.9%)

**M) Workforce**


- Balance of workforce: Proportion of workforce working in
  - Community services (52.2%) was lower than nationally (mean 54.2%)
  - Hospital services (47.8%) was higher than nationally (mean 45.8%)

- Rate of provision of consultant psychiatrists per 10 beds in BEH-MHT compared to other trusts
  - Acute adult (0.5) was at mean level nationally and mid-range for London trusts
  - Older adult (0.5) was at mean level nationally and 2nd highest of London trusts
  - PICU (0.6) was below mean level nationally and 2nd lowest of London trusts
  - Eating disorders (1.0) was at upper quartile level nationally and highest of London trusts
  - Low secure (0.6) was below mean level nationally (0.7) and 2nd highest of London trusts
  - Medium secure (0.6) was at lower quartile level nationally and 2nd lowest of London trusts

- Rate of provision of qualified nurses per 10 beds in BEH-MHT compared to other trusts
  - Acute adult (9.5) was higher than upper quartile nationally (8.3) and highest for London trusts
  - Older adult (6.3) was below lower quartile nationally and mid-range for London trusts
  - PICU (9.5) was below lower quartile nationally and 3rd lowest of London trusts
  - Eating disorders (6.8) was below lower quartile nationally and 2nd lowest of London trusts
  - Low secure (11.0) was above upper quartile nationally and highest of London trusts
  - Medium secure (7.6) was at lower quartile level nationally (7.7) and 3rd lowest of London trusts
• Rate of provision of PICU therapists per 10 beds in BEH-MHT (0.4) was at lower quartile level nationally and mid-range of London trusts

• Vacancy rates for acute adult workforce as % of WTE in BEH-MHT (32.1%) was highest of any trust nationally or within London with mean level 13.3% nationally
5) Social care for people with mental health conditions

Proportion of social care service users who were moderately or extremely anxious or depressed in Enfield (61.2%) was highest of London boroughs (range 47.3-61.2%) and higher than London region (54.4%) or England (52.8%) (2013/14) (HSCIC, 2014) (see section 3A.2).

5.1) Level of social care mental health clients

The rate at which mental health clients received social care per 100,000 population in Enfield (262) was 14th lowest of London boroughs (range 81-1,017) and lower than London region (385) or England (384) (2013/14) (HSCIC, 2014). The rate was not associated with deprivation as would be expected if this was related to need.

Figure 5.1: Rate of social care mental health clients receiving services during the year per 100,000 population (2013/14) versus socioeconomic deprivation

Source: HSCIC (2014)

5.2) New Social Care Assessments for mental health clients

Rate of new social care assessment for mental health clients aged 18-64 per 100,000 population in Enfield (133) was 16th lowest of London boroughs (range 2-1,917) and lower than London region (332) or England (265) (2013/14) (HSCIC, 2014).

5.3) Residential and nursing care for mental health clients

Proportion of social care mental health clients aged 18-64 in residential and nursing care per 100,000 population Enfield (20.1) was 13th lowest of London boroughs (range 2.8–108.5) and lower than London region (29.7) or England (31.9) (2013/14) (HSCIC, 2014).
5.4) Home and day care for mental health clients
By contrast, the rate of social care mental health clients aged 18-64 receiving home care per 100,000 population in Enfield (98.1) was 4th highest of London boroughs (range 0-229.6) and lower than London region (46.1) or England (42.2) (2013/14) (HSCIC, 2014).

Rate of mental health clients aged 18-64 receiving day care or day services per 100,000 population in Enfield (15.1) was low compared to other London boroughs (range 0-178.9) and lower than London region (43.2) or England (34) (2013/14) (HSCIC, 2014).

5.5) Direct payments for mental health clients
The proportion of social care mental health clients in Enfield receiving (2013/14) (HSCIC, 2014):
- Direct payments (13.4%) was 13th highest of London boroughs (range 0.8-85.7%) and higher than London region (10.7%) or England (10.7%)
- Direct payments or a personal budgets (59.8%) was 12th highest of London boroughs (range 3.8-100%) and higher than London region (34.5%) or England (28.4%)

5.6) Satisfaction with social care
Proportion of social care service users in Enfield who (2013/14) (HSCIC, 2014):
- Were extremely or very satisfied with their support (59.8%) was mid-range for London boroughs (range 53.1-76.6%) and similar to London region (60.3%) but lower than England (64.8%)
- Say services mad them feel safe and secure (86.6%) was 2nd highest of London boroughs (range 53.9-87.4%) and higher than London region (76.8%) or England (79.1%)
Third sector care for adults with mental health conditions

A number of third sector organisations provide support for people with mental health conditions:

1) Ebony People’s Association (EPA) provides culturally sensitive services to black minority ethnic people with mental health issues although the charity has recently expanded to people of all ethnicities. It offers a family-centred service designed to bridge the gap between the community and mental health services. EPA works with London Metropolitan University and Middlesex University, taking on social workers as part of their compulsory work placements (see section 9.8). In addition to this, EPA is currently designing a ‘volunteer champion’ project which will see a group of service users become ambassadors for the charity. The project will start with six champions who will be trained to run programmes and activities for other users and work as peer supporters. It is hoped that the project will benefit the volunteer champions by giving them employment and aiding their recovery, while also providing a useful resource for other users.

2) Richmond Fellowship is a national charity with an office in Enfield. Its employment advisors accept referrals from secondary mental health services and work with clients on a one-to-one basis with the aim of moving them into employment (see section 9.8)

3) Enfield Saheli is a Voluntary organisation which provides Advocacy, Advice and Support to women who are isolated, vulnerable and going through emotional and mental distress
   - Provides emotional and practical support to women in Enfield who are going through Domestic Abuse and other distresses
   - Work not only with clients but also other organisations to raise awareness about the issues faced by women.
   - Services
     - Multi-lingual counselling
     - Outreach work in clients homes
     - Therapeutic Weekly Drop-in (Fridays) includes Exercise classes, Art Therapy, Walking Club, Sewing, Arts and Craft Classes, Spiritual Healing & Meditation Awareness / Educational Workshops, topics which assist women during their recovery, i.e. literacy skills, social skills, assertiveness, healthy lunch, etc.
     - Welfare benefits Advice to maximise client’s income
     - Activities – Weekly Yoga classes
     - IT Classes – to develop additional skills, self-esteem and confidence for vulnerable women to eventually get into paid employment.
     - Domestic Violence Advocacy Service raises awareness of domestic abuse amongst communities in Enfield in addition to providing support to women who are experiencing physical, emotional or financial abuse. During current financial year, support to 85 women fleeing domestic abuse
○ Keep Well Keep Safe Project – Supports women to overcome isolation and integrate into the mainstream community
○ Mental Health Service - Ongoing Therapeutic Support is provided to minimise the risk of women having a relapse, reducing pressure on hospitals and GPs.
○ Women’s Support Group – each month
○ Numbers accessing
  ➢ 140 service users who have mild to moderate mental Health needs
  ➢ 53 service users are either diagnosed with schizophrenia, dementia, bipolar affective disorder, anxiety attacks, Alzheimer’s, paranoia, personality disorder

4) Wellbeing Connect Services: In the past year 80 had accessed advocacy services, 25 received information and advice, 14 monthly support meeting and 30 children and young people

5) Enfield Carers Centre supports different types of carers. Key statistics during 2014/15 included 1,329 new carer referrals, 1,115 carers had respite breaks, 860 carers used the emergency card scheme, 522 carers attended training and/or workshop sessions and 117 carers received counselling. The carers GP liaison project funded by Enfield CCG identified nearly 200 new carers this year (see section 7.10.4)

6) Enfield Children and Young Persons Services is a voluntary organisation which provides advice and support to voluntary and community organisations working with children and young people aged 0-25 years (section 9.8)

7) Enfield MIND: Affiliated to National Mind, Mind in Enfield is a third sector organisation which has been delivering mental health services for adults for over two decades. The following include services it currently delivers:
   • Multi-cultural counselling: Mind in Enfield engage counsellors who use a variety of approaches including, integrative, psychodynamic, gestalt, transactional analysis, person centred, psychosynthesis, existentialist. The service is BACP accredited and referrals, including self-referrals, come from a variety of sources. During 2015 to 2016, 274 referrals were received and 207 attended counselling following assessment with 72% satisfaction rate on different measures
   • Advocacy, information and advice: Case workers provide housing advice, homelessness, housing disrepair, over crowdedness and discrimination. Anyone wishing to access the service for the first time has to be referred from another agency such as community mental health team. Clients who have used the service previously can telephone and make an appointment to see a caseworker. Telephone advice is in operation on a daily basis; welfare benefits advice is provided at Chase Farm Hospital and Park Avenue Mental Health Resource Centre. Advocacy work is carried out at North London Forensic Service and Chase Farm Hospital. In exceptional circumstances a home visit service can happen. Between April 2015 to December 2015, 171 clients were supported
   • Psycho-social Support (Drop-In) and Well-being Service: This service is delivered by engaging clients in a variety of appropriate, physical and cognitive activities designed to integrate the mind body and soul. Such activities include: yoga, relaxation, tai-chi, gardening, cookery, creative writing art, sorting activities. Personal development courses are also provided as part of the psycho-social support and well-being service delivery
6) Economics of mental health conditions

6.1) Cost of mental health conditions
The estimated annual economic cost of mental health conditions to the national economy is more than £105 billion (CMH, 2010). This figure includes £21.3 billion in health and social care costs and £30.3 billion in lost economic output, including lost working days, higher staff turnover and lower productivity.

The cost to the UK of depression and anxiety disorders in 2007 was £7.5 billion and £8.9 billion, respectively, when taking into account the cost of services and lost earnings (McCrone et al, 2008). Assuming treatment and support arrangements, employment patterns and the proportion of mental health needs that are recognised and treated remains the same, this figure is projected to rise to £8.3 billion and £9.7 billion, respectively by 2026.

According to the Labour Force Survey, stress, depression and anxiety accounted for 15.2 million days lost (12%) which was second to only musculoskeletal conditions (ONS, 2014).

The economic costs of mental health conditions in London are around £26 billion each year (Knapp et al, 2014): £7.5 billion is spent on treatment each year with the largest costs outside the health sector.

Local economic cost of mental health conditions
Estimated costs of child and adolescent conduct disorder in Enfield

- Estimated annual costs of crime by adults who had childhood conduct disorder or sub-threshold conduct disorder in Enfield was £339.3m (based on SCMH, 2009)
- Estimated life time cost of a one year cohort of children and adolescents with conduct disorder in Enfield: £480m (based on Friedli and Parsonage, 2007)

Estimated annual costs of different adult mental health conditions in Enfield (using national costs):

- Depression: £44.8m (based on McCrone et al, 2008)
- Anxiety disorder: £53.3m (based on McCrone et al, 2008)
- Psychosis: £69.4m (based on Kirkbride et al, 2012)
- Dementia: £85.5 (based on Knapp & Prince, 2007)
- Personality disorder: £47.3m (based on McCrone et al, 2008)
- Alcohol misuse: £138.2m (from Knapp et al, 2011)
- Smoking: £68.9m (Nash & Featherstone, 2010)
- Class A drug use: £87.4m (Gordon et al, 2006)
- Medically unexplained symptoms: £104.1m (Bermingham et al, 2010)
- Total costs of adult mental disorder in Enfield: £698.9m

Annual estimated Enfield costs of:

- Mental disorder to employers in Enfield: £142m (based on NICE, 2009)
• Unemployment costs due to mental disorder in Enfield: £185.5m (based on McCrone et al, 2008)

Costs for each one year cohort in Enfield of perinatal depression, anxiety and psychosis: £40.7m (from Bauer et al, 2014).

6.2 NHS expenditure on mental health conditions in Enfield

The proportion of overall CCG expenditure on mental health in NHS Enfield CCG (13.8%) was 13th highest of London boroughs (range 8.6-20.9%) and higher than England (12.7%) (NHSE, 2015) (some concerns about data quality). This measure was correlated with deprivation and the chart below highlights Enfield CCG close to expected rate. Enfield CCG was 6th highest for other local authorities at third more deprived decile (range £9.3-£19.2).

**Figure 6.1: % of all CCG expenditure categorised as mental health (2013/14) vs socioeconomic deprivation**

Source: NHSE, (2015)

**Primary care prescribing expenditure on mental health conditions**

Primary care expenditure on CAMHS prescribing in NHS Enfield CCG (£1.7 per person) was 4th lowest of London boroughs (range £1.4-5.7) and lower than England (£4.6 per person) (2012/13) (DH, 2014) (significant concerns about data quality) (see section 2.5).

Primary care expenditure on prescribing for mental health conditions in NHS Enfield CCG (£7.48 per person) was 9th lowest of London boroughs (range £3.18-10.20) and lower than England (£12.3 per person) (2013/14) (NHSE, 2015). Expenditure was not associated with deprivation (see figure 6.2 below) although Enfield was lowest of other local authorities at third more deprived decile (range £7.48-£20.87).
Figure 6.2: Primary care prescribing expenditure on mental health: rate (£) per person (2013/14) vs socioeconomic deprivation

Source: NHSE, (2015)

Primary care expenditure rate for antidepressants (net ingredient cost £ per 1000 STAR-PU\(^9\)) in NHS Enfield CCG (£35.6) was 6\(^{th}\) highest of London boroughs (range £22.3-£54.9) but lower than England rate (54.7) (2014/15 Q4) (HSCIC, 2015). Rate of prescribing was not associated with deprivation as would be expected if prescribing was associated with level of need. However, it was associated with proportion on the primary care depression register although cost of antidepressant prescribing in Enfield was higher than expected.

Figure 6.3: Cost of primary care prescribing for antidepressant drugs: Net Ingredient Cost (£) per 1,000 STAR-PU (quarterly) in NHS Enfield CCG (2014/15 Q4) (HSCIC, 2015) vs proportion on depression register (2014/15) (HSCIC, 2015)

Source: HSCIC (2015)

\(^9\) Specific Therapeutic Group Age-sex weightings Related Prescribing Units
Primary care expenditure on prescribing for hypnotics and anxiolytics per 1000 STAR-PU in NHS Enfield CCG (92.4) was 14th lowest of London boroughs (range £50.2-139.9) and lower than England (137.5) (2014/15 Q4) (HSCIC, 2015).

Primary care expenditure on prescribing for psychoses and related disorders per 1000 STAR-PU in NHS Enfield CCG (639) was 13th lowest of London boroughs (range £419-877) and lower than England rate (677) (2014/15 Q4) (HSCIC, 2015). Expenditure on prescribing for anti-psychotic medication was associated with socioeconomic deprivation although was lower than expected in NHS Enfield CCG.

**Figure 6.4: Primary care expenditure on prescribing for psychoses and related disorders per 1000 STAR-PU in NHS Enfield CCG vs socioeconomic deprivation**

![Graph showing the relationship between primary care expenditure on prescribing for psychoses and related disorders and socioeconomic deprivation in NHS Enfield CCG.]


**Expenditure on specialist mental health services**

Per person expenditure on specialist mental health services in NHS Enfield CCG (£136.2) was 15th highest of London boroughs (range £81.3-£272.3) but lower than England (£151.1) (2013/14) (NHSE, 2015). Per person expenditure on specialist mental health services was associated with deprivation with Enfield close to expected rates.
Figure 6.5: Specialist mental health services expenditure rate (£) per person (2013/14) vs socioeconomic deprivation


Cost per bed in BEH-MHT (2014/15) (Benchmarking Network, 2015) for

- Acute adults (£105,372) was 2nd lowest of London trusts and below the lower quartile nationally (£112,024)
- Older adults (£98,964) was 2nd lowest of London trusts and below the lower quartile nationally (£113,857)

One of the main contributors to costs per bed is the staffing model in place and intensity of medical, nursing and therapy input to wards. The size of wards can also be a factor in costs due to economies of scale achieved in larger environments and therefore providers who operate smaller wards may find they report higher costs than peers with the same number of beds spread over a smaller number of wards. Cost per occupied bed day (excluding leave) in BEH-MHT (2014/15) (Benchmarking Network, 2015) for:

- Acute adult (£296) was 2nd lowest of London trusts and below the lower quartile nationally (£330)
- Older adult (£271) was lowest of London trusts and below the lower quartile nationally (£359)

Cost for each of the following in BEH-MHT (2014/15) (Benchmarking Network, 2015) for

- Acute adult admission (£8,651) was lowest of London trusts and below the lower quartile nationally (£9,337)
- Older adult (£271) was lowest of London trusts and below the lower quartile nationally (£359)
- Patient on the generic CMHT caseload (£1,656) was lowest of London trusts and below the lower quartile nationally (£1,960)


- Community care (56.4%) was higher than the mean nationally (51.7%)
- Hospital care (43.6%) was lower than the mean nationally (48.3%)

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6.3 Social care expenditure on mental health conditions in Enfield

Total social care long term expenditure (gross) on adults with mental health needs in Enfield for adults (2014/15) (HSCIC, 2015):

- Aged 18-64 (£3.9m) included home care (£2.4m), residential care (£0.9m) and direct payments (£0.4m)
- Aged 65 and over (£1.6m) included residential care (£0.8m), nursing (£0.1m), direct payments (£0.2m)

Total social care short term expenditure (gross) on adults with mental health needs in Enfield for adults (2014/15) (HSCIC, 2015):

- Aged 18-64 (£0.8m)
- Aged 65 and over (£0.1m)

Unit costs of long term residential and nursing care for adults requiring mental health support in Enfield (2014/15) (HSCIC, 2015):

- Aged 18-64 (£915.2) compared to London (£895.9) and England (£750.3)
- Aged 65 and over (£663.1) compared to London (£569.0) and England (£489.3)

Unit costs of long term residential and nursing care for adults requiring support with memory and cognition in Enfield (2014/15) (HSCIC, 2015):

- Aged 18-64 (£576.9) compared to London (£903.3) and England (£698.1)
- Aged 65 and over (£777.9) compared to London (£692.4) and England (£516.6)

6.4 Potential economic savings from improved coverage of treatment

The last mental health strategy included estimated economic savings of different public mental health interventions (Knapp et al, 2011). The following outlines potential economic savings of treatment of mental health conditions in Enfield

**Conduct disorder**

Estimated net savings if parents of all children and adolescents estimated to have conduct disorder in Enfield received parenting interventions (Knapp et al, 2011) (see section 2.5):

- Total net savings: £29.7m
- Crime related net savings: £24.0m
- NHS net savings: £4.1m
- Education net savings: £1.4m

**First episode psychosis**

Estimated net savings over standard care if all people estimated to develop first episode psychosis in Enfield each year received care from Early Intervention Psychosis services (from Knapp et al, 2011):

- Total net savings: £3.0m
- NHS net savings: £1.2m
- Productivity net savings: £1.4m
- Intangible net savings: £0.25m
The intervention is cost savings to the NHS by the end of the first year. Currently, 47.0% of estimated new cases of psychosis are seen by Early Intervention Psychosis services in Enfield.

**Pre-psychosis**
Estimated net savings if all people estimated to develop a Clinical High Risk State (CHRS) in Enfield each year received care from early detection services (from Knapp et al, 2011):
- Total net savings: £5.4m
- NHS net savings: £1.8m
- Productivity net savings: £3.4m

The intervention is cost savings to the NHS by the end of the second year. Currently, there are no CHRS services in Enfield.

**Schizophrenia: Family therapy**
Estimated savings to NHS over 3 years if all people in Enfield (from Knapp et al, 2014)
- On the SMI register (see section 3.B.1) received family therapy: £13.6m
- Estimated to have psychotic disorder in previous year (see section 3.B.2) received family therapy: £4.8m

**Schizophrenia: CBT**
Estimated savings to NHS over 3 years if all people in Enfield (from Knapp et al, 2014)
- On the SMI register received CBT: £3.2m
- Estimated to have psychotic disorder in previous year received CBT: £1.1m

**Increasing risk drinkers: Brief interventions**
Estimated net savings if all increasing risk, higher risk and binge drinkers in Enfield received screening and brief interventions in primary care (from Knapp et al, 2011):
- Total net savings: £18.7m
- Crime net savings: £9.6m
- Productivity net savings: £5.5m
- NHS net savings: £3.6m
7) Risk factors for mental health conditions

This section covers important risk factors for mental health conditions as well as level of intervention to address such factors:

- Inequalities and deprivation
- Household factors – homelessness, fuel poverty, debt
- Pregnancy – maternal smoking, birth weight
- Parental factors – estimated number with mental health conditions / proportion receiving treatment, parental unemployment
- Child risk factors – underweight/ obese, child poverty, children in need, abuse, bullying, domestic violence, school absence and exclusion, screen time
- Child higher risk groups – looked after children, special education needs, young carers, NEETs, young offenders
- Adult risk factors – physical inactivity, obesity, lack of educational qualification, unemployment, economic inactivity, benefit claimants, work stress, social isolation, crime and violence
- Higher risk groups – long term physical conditions, learning disability, carers, LGBT, offenders, black and minority ethnic groups (BME) and refugees
- Economics of prevention of mental health conditions

Since the majority of lifetime mental health conditions arise before adulthood (Kessler et al, 2007) and 25-50% of adult mental illness may be preventable with appropriate interventions in childhood, interventions to address risk factors during pregnancy and childhood are important particularly by targeting parents, families, preschools and schools.

7.1) Inequalities and deprivation

Deprivation is associated with increased risk of mental health conditions which then result in a range of further inequalities (Campion et al, 2013). Whilst deprivation scores can be a good indicator of need for mental health care, they tend to underestimate population needs in the most deprived areas (Tulloch & Priebe, 2010).

Nationally, Enfield is the 64th most deprived of the 326 local authorities in England. Overall Index of Multiple Deprivation (IMD) score which is a measure of deprivation in Enfield (26.1) was 14th highest of London boroughs (range 10.1-42.9) and higher than England (21.7) (DCLG, 2010). However, Enfield has 177 LSOA’s which vary in deprivation score from 4.62 to 58.93 (DCLG, 2010). Most of the deprivation is concentrated along the eastern and southern corridors of the borough, resulting in significant inequalities across Enfield as a whole.

Proportion living in 20% most deprived areas in Enfield (27.7%) was 13th highest of London boroughs (range 0-83.8%), the same as London region (27.7%) and higher than England (20.4%) (DCLG, 2013).
Proportion of older people living in 20% most deprived areas in Enfield (21.9%) was 14\textsuperscript{th} lowest of London boroughs (range 10.8-49.7%) and higher than England (16.2%) (DCLG, 2011) (see section 7.5.2 for deprivation and children).

- Males (7.7) was 9\textsuperscript{th} highest of London boroughs (range 2.4 to 14.3)
- Females (4.3) was 13\textsuperscript{th} lowest of London boroughs (range 0.6 to 8.9)

Reduction of inequalities requires action on six policy objectives (Marmot et al, 2010):
1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

Information on local programmes to address inequality was not provided.

7.2) Household factors

Homelessness
Homelessness is associated with increased risk of mental health conditions. Among the homeless, prevalence of common mental health problems is over twice as high and of psychosis 4-15 times as high compared to the general population with 10-20% of the homeless population fulfilling the criteria for dual diagnosis (Crisis, 2009). A previous study found that 67% of 16-25 year olds sleeping rough in London had a mental disorder (Vasilou, 2006).

Statutory homelessness per 1000 households in Enfield (5.0) was 15\textsuperscript{th} highest of London boroughs (range 0.8 to 12.5) and the same as London region (5.0) but higher than England (2.3) (2013/14) (DCLG, 2015).

The rate of households in temporary accommodation per 1000 households in Enfield (17.8) was 8\textsuperscript{th} highest of London boroughs (range 1.3 to 29.7) and higher than London region (12.8 and England (2.6) (2013/14) (DCLG, 2015).

No information was provided about local work.

Fuel poverty
Fuel poverty refers to a household that cannot afford to heat its home to an adequate standard of warmth and meet its other energy needs in order to maintain health and wellbeing. Fuel poverty is associated with increased risk of common mental disorder (Harris et al, 2010).

Proportion of households in fuel poverty in Enfield (10.6%) was 10\textsuperscript{th} highest of London boroughs (range 3.9-14.9%) and similar to London region (9.8%) and England (10.4%) (DECC, 2013). This equates to 12,711 households in Enfield (ONS, 2012). Associated excess winter death rate in Enfield
(26.1) was 2nd highest of London boroughs (range 7.4-27.0) and higher than London region (18.0) or England (17.4) (2010-2013) (PHE, 2015).

Interventions in Enfield

- Citizens Advice Bureau reported that of the 137 people who came for Energy Best Deal appointments (which are specifically for people in fuel poverty) in 2015, 11 had declared mental health problems
- 95 households had a Smart Homes grant approved for energy efficiency measures (predominantly solid wall insulation) of which 87 installations had been completed. However, no information was provided about the mental health of applications

Debt

Debt increases the risk of mental illness and mental illness increases the risk of getting into debt (Fitch et al, 2014). Debt is important in mediate the impact of socioeconomic deprivation on risk of mental health conditions. Debt advice is cost effective and results in net savings of £4 for each £ spent (Knapp et al, 2011).

No information was provided about provision of debt advice including for people with people with mental health conditions.

7.3) Pregnancy factors

Maternal smoking

Smoking in pregnancy is associated with increased risk of childhood mental health conditions (Murray et al, 2010; Brion et al, 2010).

Proportion of women who smoke at time of delivery in NHS Enfield CCG (6.7%) was 7th highest of London boroughs (range 1.6-9.8%) and higher than London region (5.2%) or England (5.2%) (2014/15 Q4) (HSCIC, 2015). During the previous year, there were 4,824 births in Enfield (ONS, 2015) which would approximate to 323 mothers smoking at time of delivery.

During 2014/15 (HSCIC, 2015), number of pregnant smokers in Enfield who:

- Set a quit date (115) was 2nd highest of London boroughs and equivalent to 35.6% of the estimated pregnant smokers
- Self-reported quit rate was 80% (92 quits) which was the highest of London boroughs. However, CO validated quit rate was 10% (11 quits)
- Lost to follow up: 23 (20%)

Low birth weight

Low birth weight is associated with increased risk of mental disorder (Abel et al, 2010). Proportion of babies recorded as having a low birthweight (less than 2,500g) in 2014 in Enfield (2.7%) was 8th lowest of London boroughs (range 2.1-5.0%) and lower than London region (3.2%) or England (2.9%) (ONS, 2015).
7.4 Parental factors

In Enfield in 2011, there were (ONS, 2013)

- 20,214 families with one dependent child aged 0-18
- 15,697 families with two dependent children aged 0-18:
- 8,113 families with three or more dependent children aged 0-18

Proportion of households which have lone parents with dependent children in Enfield (11.8%) was 2nd highest of London boroughs (range 2.1-14.4%) and higher than London region (8.5%) or England (7.1%) (2011) (ONS, 2014). There were 14,085 lone parent households with dependent children in Enfield (ONS, 2014).

Therefore, in 2011 in Enfield, there were 73,963 parents with dependent children aged 0-18.

7.4.1 Parental mental health conditions

Children of parents with a mental health condition are at increased risk of mental health conditions.

- Poor maternal health is associated 5 fold increased risk of child mental health problem (Meltzer et al, 2003)
- Children of depressed parents are at 2–3 fold increased risk of developing depression (Weissman et al, 2006)
- Parents of children with emotional disorder are (Green et al, 2005):
  - More than twice as likely to have an emotional disorder (51%) compared to parents of children without an emotional disorder (23%)
  - More likely to have a severe emotional disorder (18%) compared to parents of children without an emotional disorder (4%)
- Parents of children with conduct disorder were more likely to have an emotional disorder (48%) themselves compared to 23% of parents of children without a conduct disorder

Therefore, treatment of parental mental health conditions is therefore important to prevent associated impacts including mental health conditions in their children.

The estimated numbers of parents with different mental health conditions in Enfield was estimated in section 3M which highlighted that no information was available about the proportion of 20,309 parents with common mental disorder, psychosis, personality disorder and eating disorder receiving treatment. BEH-MHT had no mother and baby unit (NHS Benchmarking, 2015). The Enfield Schools and children’s services safeguarding children self-assessment (Enfield, 2014) found that little information was held about the crossover between parental and child mental health.

Section 3M also highlighted the estimated number of new mothers with different mental health conditions in Enfield included mild to moderate common mental disorder (482-724), PTSD (155), adjustment disorder/ distress (724-1446), severe depressive illnes (145), psychosis (9.6), chronic SMI (9.6) (JCPMH, 2012). However, only a minority of women with perinatal mental disorder receive treatment due to a combination of poor awareness among mothers, stigma and insufficient training of primary care practitioners (CMH, 2015). Local information provided about local treatment and support for new mothers did not include how many received treatment/support from different services or associated outcomes (see section 3M).
Enfield is currently developing a Parent and Infant Project in Enfield CAMHS as part of a wider Parent Infant Mental Health Service. Enfield has worked with the EPC (Enfield Parents & Children) in securing a grant from PIP UK to develop the PIP further in Enfield, based on the commitment of the CCG and the LBE to provide match funding.

7.4.2 Teenage pregnancy
Proportion of deliveries to mothers under the age of 18 in Enfield (0.9%) was 2nd highest of London boroughs (range 0.2-1.0%), higher than London region (0.5%) and similar to England (1.0%) (2013/14 HES, 2014). This equates to 43 births in Enfield (ONS, 2015).

Under 18 birth rate per 1000 in Enfield (8.0) was 3rd highest of London boroughs (range 1.8-10.0) and higher than London region (5.1) or England (7.8) (2013) (ONS, 2014).

Family Nurse Partnership (FNP) support first time mothers aged 19 and under at conception who are at higher risk of mental health conditions including care leavers, no school qualifications, low social support. In Enfield, FNP supports 72 young mothers. Enfield FNP reported that 30% of young parents self-report as suffering from depression and anxiety.

7.4.3 Parental unemployment
The last child and adolescent psychiatric morbidity survey found that 20% of children without a working parent had a mental disorder compared to 9% of children with one parent working and 8% of children with both parents working (Green et al, 2005).

The proportion of households with dependent children where there was no adults in employment in Enfield (8.5%) was 2nd highest of London boroughs (range 0.9-10.4%) and higher than London region (5.7%) or England (4.2%) (ONS, 2011). This equates to 10,169 households in Enfield.

No information was provided about work targeting the mental health of unemployed or their families.

7.5) Child risk factors
Child adversity accounts for 30% of adult mental health conditions (Kessler et al, 2011) and is therefore important to address to prevent such conditions from arising. Several of the factors in this section constitute adversity and are particularly important to address to prevent mental health conditions and poor wellbeing.

7.5.1 Underweight and overweight children
Proportion of children who were underweight (2013/14) (HSCIC, 2014)
- In reception year in Enfield (1.32%) was mid-range for London boroughs (range 0.43-2.95%), lower than London region (1.47%) but higher than England (0.95%)
- In year 6 in Enfield (1.26%) was 13th lowest of London boroughs (range 0.76-2.86%), lower than London region (1.67%) but higher than England (1.36%)
Proportion of children who were obese (2013/14) (HSCIC, 2014)

- In reception year in Enfield (12.2%) was 9th highest of London boroughs (range 6.0-14.4%) and higher than London region (10.8%) or England (9.5%)
- In year 6 in Enfield (24.6%) was 9th highest of London boroughs (range 11.1-26.7%) and higher than London region (22.4%) or England (19.1%)

Childhood obesity rates are at their highest in the east of the Borough, particularly in the south-east of the Borough.

Locally provided data could include:

- Proportion of school meals complying with the national school food standards
- Universal free school meals
- Trading standards engaging with fast food outlets to provide healthier options

7.5.2 Child poverty

Rates of mental health conditions in children and adolescents from lowest quintile for household income are three higher than for those in the highest quintile (Green et al, 2005). The proportion of dependent children under 16 living in poverty in Enfield (29.6%) was 6th highest of London boroughs (range 8.8-37.9%) and higher than London region (23.7%) or England (19.2%) (HMRC, 2012).

Proportion of young people presenting to CAMHS in Enfield who were living in financial difficulty was 19% (Earle et al).

Most of the deprivation is concentrated along the eastern and southern corridors of the borough, resulting in significant inequalities across Enfield as a whole. Changes in benefit rules are having an anecdotal impact on the population profile and on the increase in complexity of children and young people seen by CAMHs. Edmonton Green was the joint 5th highest ward in London in 2014 for child poverty with 43% of children in the ward living in poverty and Edmonton parliamentary constituency had the 6th highest child poverty percentage in England with 43% of children living in poverty in 2014. Enfield is now the 7th highest local authority in the country for child poverty at 37%.

7.5.3 Children in need

A child in need is one who has been referred to children’s social care services, and who has been assessed, usually through an initial assessment, to be in need of social care services. A child can have more than one episode of need throughout the year but episodes should not overlap. If a child has more than one episode, then each is counted in the figures.

Rate of ‘children in need’ per 10,000 people aged under 18 in Enfield (560) (4,533 children) was 11th lowest of London boroughs (range 339-1,159) and lower than London region (685) or England (679) (2013/14) (DfE, 2015). Proportion of children in need for more than 2 years in Enfield (36.4%) was 11th highest of London boroughs (range 12.2-43.0%) and higher than London region (33.0%) or England (31.6%) (2013/14) (DfE, 2015).

Rate of new cases of children in need per 10,000 people aged under 18 in Enfield (2013/14) (DfE, 2015):

- Identified during the year (319.8) was 15th lowest of London boroughs (range 120.6-648.6) and lower than London region (362.2) or England (371.7)
• Referred during the year (347) was 7th lowest of London boroughs (range 169-881) and lower than London region (467) or England (572)

Proportion of children in need referrals with completed initial assessment during the year in Enfield (42.6%) was mid-range for London boroughs (range 0.5-95.2%), similar to London region (40.6%) but lower than England (46.9%) (2013/14) (DfE, 2015).

Proportion of children in need as a result of abuse, neglect or family dysfunction in Enfield (48.8%) was 6th lowest of London boroughs (range 39.9-82.9%) and lower than London region (57.3%) or England (65.8%) (2014) (DfE, 2015).

7.5.4 Child abuse
Young people aged 11–17 years who experienced severe maltreatment by a parent or guardian were 6.4 times more likely to have current suicide ideation and 4.6 times more likely to have self-harm thoughts than those who were not severely maltreated (Radford/NSPCC, 2011). Young adults aged 18–24 years who experienced severe maltreatment by a parent or guardian adult were 3.9 times more likely to have current self-harming thoughts than those who were not severely maltreated.

Estimated numbers of 11-24 year olds who have experienced different types of abuse
Numbers of young people in Enfield estimated to have experienced (from national survey by Radford/NSPCC, 2011):
  • Severe maltreatment: 3,847 individuals aged 11-17 and 4,083 individuals aged 18-24
  • Severe physical violence at the hands of an adult: 1,981 individuals aged 11-17 and 3,238 individuals aged 18-24
  • Emotional abuse during childhood: 1,952 individuals aged 11-17
  • Severe neglect during childhood: 3,819 individuals aged 11-17

Repeated sexual abuse/intercourse in England during childhood and adolescence is associated with even higher rates of adult mental disorder (Jonas et al, 2011):
  • Depressive episode (OR 6.2)
  • Post-traumatic stress disorder (OR 6.9)
  • Probable psychosis (OR 15.3)
  • Alcohol dependence (OR 5.2)
  • Eating disorder (OR 11.7)
  • Attempted suicide (OR 9.4) (Bebbington et al, 2009)

Estimated numbers who have experienced sexual abuse in Enfield:
  • Non-consensual sexual intercourse before age 16: 1,517 under-18 year olds (Bebbington et al, 2011)
  • Non-consensual sexual intercourse and touching before age 16: 6,724 under-18 year olds (Bebbington et al, 2011)
  • Contact sexual abuse during past year: 546 individuals aged 11-17 (Radford/NSPCC, 2011)
Interventions to address and prevent abuse

1) Child Protection Plans (CPP)

- Rate of children who were the subject of a CPP per 10,000 people at the end of the year in Enfield (25.2) was 2nd lowest of London boroughs (range 0-57.8) and lower than London region (37.2) or England (42.0) (2013/14) (DfE, 2015). The number of children who were the subject of a child protection plan during the year in Enfield was 257 with 12 due to sexual abuse (2013/14)
- Rate of children who were the subject of a new CPP per 10,000 people during the year in Enfield (31.8) (257 individuals) was 6th lowest of London boroughs (range 22.4-75.2) and lower than London region (43.0) or England (52.0) (2013/14)
- During 2014/15, the number of children who became the subject of a CPP in Enfield had increased to 342 with 44% due to neglect, 8.2% due to physical abuse, 2.3% due to sexual abuse and 44.7% due to emotional abuse (DfE, 2015)
- Proportion of Enfield CPP assessments where factors were identified included domestic violence (46.5%), mental health (29.2%), learning disability (17.3%), physical disability or illness alcohol misuse (12.0%), drug misuse (12.8%), physical disability or illness (12.5%), young carer (4.4%), gangs (2.9%) and child sexual exploitation (2.5%) (2014/15) (DfE, 2015)
- Proportion of children who became the subject of a CPP for a second or subsequent time in Enfield (10.5%) was 10th lowest of London boroughs (range 6.3-20.5%) and lower than London region (13.1%) or England (15.8) (2014)
- Proportion of children under CPP who were reviewed within the required timescales in Enfield (100%) was joint highest of London boroughs (range 88.3-100%) and higher than London region (97.2%) or England (94.6%) (2014)
- Proportion of young people in CAMHS in Enfield who were subject to a CPP was 7% which equates to 111 individuals (Earle et al)

2) Local CAMHS
Proportion of young people in Enfield CAMHS who had experienced child abuse was 28% which equates to 444 individuals (Earle et al).

3) Other interventions including

- School based programmes to detect and prevent abuse: No information provided
- Parenting interventions reduce risk of abuse: Strengthening Families Strengthening Communities parenting course at SPOE was completed by 104 parents between April to July 2014

A review of the child sexual assault pathway for London (Goddard et al, 2015) found variation and significant gaps in medical aftercare and long-term emotional support (especially for those under 13 years), as well as issues with the prosecution process. Recommendations include the establishment of five Child Houses in London and an enhanced paediatric service at the Havens (sexual assault referral centres). The Child Houses are a child friendly building where children and young people will be able to access medical examination, sexual health aftercare, counselling, therapy and advocacy. These houses also aim to provide early interviews with police and crown prosecution services. Children or young people only having to tell their story once and complete their court cross-
examination soon after disclosure, instead of waiting for court appearances up to a year or two later. The vision includes partnerships to maximise opportunities for CAMHS, third sector and school, working with paediatricians, the police and the judicial system.

The pragmatic first steps are the establishment of CSA hubs in each sector to support children and young people following child sexual abuse, exploitation or FGM. These hubs will build on the best of the existing services, creating shared care pathways, ensuring robust peer review and creating centres of expertise for medical assessment and treatment. They will see all children and young people assessed and offered brief intervention following CSA/CSE/FGM, with onward referrals as existing criteria allow. The hubs will strengthen links with existing third sector services, offering clinical supervision for complex case management.

**Safeguarding expenditure**

Expenditure rate per 10,000 0-17 year olds in Enfield on (2013/2014) (DfE, 2015):

- Safeguarding children and young people’s services (£1.46m) was 5th lowest of London boroughs (range £1.04-£11.07m) and lower than London region (£2.38m) or England (£1.76m)
- Expenditure rate on local authority children and young people’s services (excluding education) (£6.9m) was 7th lowest of London boroughs (range £5.5m-£41.2m) and lower than London region (£9.2m) or England. However, expenditure rate was not associated with rate of children in need or estimated prevalence of any mental disorder

**Bullying**

Bullying is also associated with elevated rates of anxiety, depression and self-harm in adulthood (Copeland, et al 2013).

  - Were bullied others (48.1%) was 6th lowest of London boroughs (range 42.6-55.2%) and lower than London region (50.0%) or England (55.0%)
  - Had bullied others (9.9%) was 10th lowest of London boroughs (range 7.2-14.0%) and lower than London region (11.0%) or England (10.1%)
- Cyber-bullying: Estimated numbers of 10-17 year olds experiencing cyber-bullying in Enfield was 5,276 individuals (from McAfee and Anti-Bullying Alliance, 2013)
- Interventions
  - No information was provided about school based bullying prevention programmes
  - School-based interventions to reduce bullying: result in £14 saved for each pound spent (Knapp et al, 2011). If all children aged 5-16 in Enfield received school based bullying prevention programmes, net savings would be £56.7m (see section 7.11)

**Context of local assessment of child and young people’s needs in Enfield**

In 2012, Enfield Council commissioned a report to assess the needs of children and young people living in households where there was domestic abuse, substance abuse, and/or at least one parent or carer with mental ill health, and to identify what services were being delivered to them and their families (Enfield, 2014). The key findings from the report included:
A large proportion of Child Protection Plans featured domestic violence, substance or alcohol misuse and mental health issues (see previous page on CPP’s) although a significant proportion had issues presenting in combination.

Majority of children presenting to social care were living in poverty, in single parent families, in receipt of benefits/ free school meals and had poor academic attainment/attendance records.

Most presentations were from the east of the Borough where the most deprived wards are and where most service provision exists.

There was a wide variety of domestic violence provision in Enfield although little work was done with children of victims. The west of Enfield was significantly under-represented in service provision, and little integrated work was done for those presenting with additional mental health or substance or alcohol misuse issues.

There was strong adult mental health, children’s mental health, and LAC mental health provision in Enfield, with good links into third sector partners. However, little information was held about the crossover between parental and child mental health, and more work was required around transition services for young people as a result of different thresholds between services.

There was good provision for both adult and young people’s substance misuse, and the introduction of the Hidden Harm service was strengthening the crossover between the two into all services, and into partner services. However, following the move of adult services to a Payment by Results model, service users with mental health issues were excluded, meaning there was little scope to access integrated treatment.

There were many examples of good practice of children and young people and their families being included in service design, and their views being sought to shape services.

The recommendations in the report were taken forward through the Enfield Safeguarding Improvement Plan and the following improvements made:

- Implemented the Single Point of Entry in October 2012 including additional funding secured through Change & Challenge programme for additional domestic violence resource
- Commissioning Domestic Violence service for families with children under 5 operating from Children’s Centre
- Partnership project with DAAT for Hidden Harm
- Range of services available to prevent offending and re-offending
- Providers asked for feedback on a 6 monthly basis as part of the commissioning process to establish what differences they have made
- Unity Peace Conference held as a result of young people wanting to address gang and post code war issues

Enfield Council works successfully in collaboration with a wide range of partners including the Metropolitan Police, NHS Enfield, Enfield Community Services (ECS) (provider arm of NHS Enfield), Job Centre Plus, the private and voluntary sectors, the local CCG, head teachers and college principles, and college and school governor representatives. The well-established partnership working arrangements have clear lines of responsibility and accountability.
The priorities for children’s services are set out in the Council’s Business Plan, the Health & Well-Being Strategy and the Schools and Children’s Services Department Plan. Safeguarding is a key priority and principle that informs and underpins all work. The Commissioning and Community Engagement division has overall responsibility for the Children and Young People's Involvement Strategy and the Participation Team acts as the strategic lead for involvement and parent engagement in the borough. The Enfield Youth Parliament has just been re-elected and the successful Parent Engagement Panels are being further developed and rolled out across the borough.

The Enfield Safeguarding Children Board brings together the main organisations working with children, young people and families in Enfield. A review of the Business plan in March 2014 showed that in most key areas progress had been made. It was felt also that new and emerging themes needed to be incorporated into the plan moving forward to reflect the priorities in the Borough as well as those arising nationally from Serious Case Reviews and Independent Management Reviews. These now form the basis of individual work plans for each of the sub groups and include:

- Domestic Violence
- Sexual Exploitation and trafficking
- Missing children
- Private fostering
- Working closely with other Boards on joint initiatives such as mental health
- Improving collaboration with neighbouring LSCBs for example running learning events with Haringey on Sudden Infant Death Syndrome
- Female genital Mutilation – task and finish group in place and working closely with Public Health
- Developing further the work of the Young Peoples Board

**Single Point of Entry service (SPOE)** (Enfield, 2014)

SPOE provides a single point of entry in Enfield to enable accessing support and provision for children, young people and their families who are experiencing often complex and multiple needs but are not at immediate risk and require a multi-agency response (Enfield, 2014). Early help forms requiring multi-agency response and the Police referral forms (Merlin) are submitted through to the SPOE for screening and risk assessment. The core members of the SPOE are Parent Support, Education Welfare, Social Care, Police and Health. Other agencies who have a regular weekly presence in the SPOE are the Youth Support Service, YISP, Children’s Centres, CAMHS, COMPASS (substance misuse service), Probation, a Gangs worker and St Christopher’s Young Runaway’s Project. More recently the SPOE has forged links with the Voluntary and Community sector with a representative from this service area with an “umbrella view” of available services attending on a weekly basis to advise and broker support packages within the third sector. The SPOE has secured funding for a full time Domestic Violence Advisor (see section E.5 below). All agencies in the SPOE have signed up to an Information Sharing Protocol. In 2013-2014, Children’s Services:

- Received 312 per month although has since increased
- Responded to 2,857 referrals, 778 of which were Multi Agency referrals and 1773 were for single agency targeted support
- Carried out 1,255 initial, 985 core assessments and 1,220 Child & Family Assessments
• Completed 79% of initial assessments in 10 working days, 80.9% of core assessments in 35 working days and 62.9% of Child & Family Assessments in 35 working days
• Completed 567 Section 47 enquiries
• Held 85.7% of initial child protection conferences within 15 working days of the decision to go to conference
• Had 204 children and young people subject to a child protection plan at year end
• Held 228 review children protection conferences (98% on time)
• Looked after 299 children and young people at year end
• Held 7.4% of looked after children reviews within timescales
• Made 11 Special Guardianship Orders
• Enabled 20 adoptions to take place

Impacts of SPOE on parental outcomes and engagement (Enfield, 2014)
• From the parenting contract/orders being formalised between schools, families and the Community Parent Support Service include:
  o Improved attendance by parents at behaviour panels - approximately 90% of all young people seen at behaviour panel were supported through single or multi-agency interventions and avoid permanent exclusions
  o Increased parental involvement in understanding their roles and responsibilities to improve their child’s behaviour both in and out of school
  o Increased parental ability and confidence to find solutions and deal with their family challenges effectively
  o Improved relationships between parents and professionals (particularly schools) to build on their families’ strengths
  o A rise in their child’s achievement and attendance at school.
• Strengthening Families Strengthening Communities parenting course was completed by 104 parents the between April to July 2014. Parents reported that the course had increased their confidence in their ability to manage their anger and that they were more likely to ask their children for their opinions about a range of topics, including gangs

Troubled families programme
At the end of Phase One of the government’s Troubled Families Programme known in Enfield as the Change and Challenge Programme, 1,142 families had been identified and 775 families have been ‘turned around’ (locally provided data). Phase Two will extend to the programme to include up to 2,760 families until 2020 and focus on:
• Parents and children involved in crime and antisocial behaviour
• Children who do not attend school regularly
• Children identified as in need (4,533 under 18 year olds in Enfield) or subject to a Child Protection Plan (257 children)
• At the end of Phase One
• Unemployed adults or young people at risk of unemployment
• Families affected by domestic violence and abuse
• Parents and children with a range of health problems
**7.5.5 Domestic violence**

Children who live with domestic violence are at increased risk of behavioural problems and emotional trauma, and mental health conditions in adult life (Holt et al, 2008; Hegarty 2011). Victims of domestic violence are also at increased risk of mental health conditions. See section 7.9.8 for levels of domestic violence and associated interventions.

**7.6) School factors**

Enfield has 96 schools comprising 69 primary schools (including two academies and three free schools), 18 secondary schools (including five academies and one free school), three all through combined primary and secondary schools, 6 special schools. There is also one pupil referral unit and eight independent schools.

Proportion of children taking free school meals in Enfield (19.5%) was 16th lowest of London boroughs (range 8.6-40.2%), similar to London region (19.2%) and higher than England (15.2%) (2015) (DfE, 2015).

**School absences and exclusions**

Days missed are associated with conduct disorder (see section 2.1) as well as other child illness and parental factors. Proportion of half days missed by (2014/15) (DfE, 2015):

- Primary school pupils in Enfield (4.3%) was 6th highest of London boroughs (range 3.4-5.1%) and higher than London region (4.1%) or England (3.9%)
- Secondary school pupils in Enfield (5.1%) was 3rd highest of London boroughs (range 4.1-5.4%) and higher than London region (4.7%) but similar to England (5.0%)

School exclusions are associated with conduct disorder. Fixed period exclusion rate for pupils in Enfield (2013/14) (DfE, 2014):

- In primary schools (1.2%) was 3rd highest of London boroughs (range 0.2-3.4%) and higher than London region (0.7%) or England (1.0%)
- In secondary school (8.7%) was 3rd highest of London boroughs (range 2.4-12.4%) and higher than London region (5.9%) or England (6.6%)
- Due to persistent disruptive behaviour (0.9%) was 2nd highest of London boroughs (range 0.2-1.5%) and higher than London region (0.5%) but similar to England (0.9%)
- Due to drugs/alcohol use (0.09%) (49 individuals) was 13th highest of London boroughs (range 0.03-0.17%) and higher than London region (0.08%) or England (0.1%)

Exclusion rates have been increasing. For instance, number of primary school fixed term exclusions has increased from 185 in 2009/10 to 417 in 2014/15. There is a Better Care Fund proposal that has been agreed for implementation in 2015/16 to fund an Intensive Behaviour Support Service.

Permanent exclusion rate from secondary schools in Enfield (0.22%) was 8th highest of London boroughs (range 0.0-0.30%) and higher than London region (0.16%) or England (0.12%) (2012/13) (DfE, 2014).
School based interventions to prevent mental health conditions

- Schools and colleges in Enfield do not have a training programme/contract for stress/mental health support. Although Enfield local authority has a training programme for managing stress, schools cannot access this.
- Information was provided about schools based mental health programmes in section 2.2
- School-based social and emotional learning programmes to prevent conduct disorder result in £84 net savings for each pound spent (Knapp et al, 2011). If such programmes were provided to all 10 year olds in Enfield (ONS, 2015), net savings would be £27.1m after five years and £42.7m after ten years (see section 7.11)

7.7) Screen time and sleep deprivation

Screen time is now the main waking activity of children (Sigman, 2014), associated with poor wellbeing (Sigman, 2012) and displaces many other activities which promote good physical and mental health. Evidence suggests a “dose-response” relationship, where each additional hour of viewing increases the likelihood of experiencing socio-emotional problems’ (PHE, 2014)

- Levels of screen time (Ofcom, 2012): Numbers of hours per day in front of a screen were 3-4 hours for 4 year olds, 4 hours for aged 5-7, 4.5 hours by ages 8-11 and 6.5 hours for teenagers
- Internet: 12-15 year olds are spending as much time on the internet as they do watching TV which amounts to an estimated 17 hours a week on each activity
- Texts: 12-15 year olds send an average of 193 texts every week

US Department of Health issued recommended limits for screen time’ as one of its national ‘health improvement priorities’ and a key ‘disease prevention objective’ (US DHHS, 2014). Advice/information to parents could include:

- No screens in children’s bedroom
- No screen time for under 2’s and above that age a maximum of two hours per day
- Advice to parents of younger children to choose screen material with a slower pace, less novelty and more of a single narrative quality
- Monitor and control the time their children spend on hand-held computer games/media

Sufficient sleep is an important protective factor for wellbeing particularly during childhood. However, more than one in four 14 and 15-year-old girls (28%), and just over a fifth of boys of the same age (22%) do not think they sleep enough to concentrate on their studies (Balding and Regis, 2012). This could be improved through appropriate information to students and parents regarding sleep hygiene which could be liked to information about screen time.
7.8) Child higher risk groups

Particular groups of children and adolescents are at higher risk of mental health conditions and poor wellbeing (Campion & Fitch, 2013). Appropriate information is required to enable appropriate targeting for these groups to preventing of inequalities.

7.8.1 Looked after children (LAC)

Looked-after children (LAC) have 5-fold increased risk of mental health conditions (Ford et al, 2007)

- Rates of LAC (per 100,000) in Enfield (43.9) was 13th lowest of London boroughs (range 21.7-104.7) and lower than London region (52.0) or England (60.0) in (2014/15) (DfE, 2015). In March 2015, this had increased 360 children with 226 LAC placed in Enfield by other local authorities.

- Reasons for children starting to be looked after in Enfield included abuse or neglect (48%), absent parenting (19%), socially unacceptable behaviour (11%), family dysfunction (9%), family acute stress (9%) and parents illness or disability (4%) (2014/15) (DfE, 2015).

- Placement: Proportion of LAC in Enfield in (2013/14) (DfE, 2014)
  - Foster placement (73.3%) (220 children) was mid-range for London boroughs (range 60.0-82.9%) and similar to London region (53.6%) or England (59.8%).
  - Secure unit children's homes/ hostels (6.7%) was 5th lowest of London boroughs (range 0-22.6%) and lower than London region (10.9%) or England (9.2%).

- Leaking care per 10,000 population aged under 18 (22.6) was 7th lowest of London boroughs (range 12.6-52.3) and lower than London region (31.1) or England (26.8) (2014/2015) (DfE, 2015).

- Missing from care: Ten looked after children five of whom were out of borough placements were reported as missing between April and June 2015 (Enfield, 2015).

Assessment of looked after children

- Proportion of LAC who an annual assessment in Enfield (87.5%) was 4th lowest of London boroughs (range 58.3-100%) and lower than London region (92.2%) or England (88.4%) (2014) (DfE, 2014).

- Proportion of LAC who had emotional and behavioural assessment (90.0%) was 8th highest of London boroughs (range 32.0-100%) and higher than London region (78.0) or England (68.0) (2014) (DfE, 2014).

Educational outcomes for looked-after children (2012/13) (DfE, 2013)

- Proportion of LAC who achieved 5+GCSE’s E*-C or equivalent in Enfield (41.7%)% was highest of London boroughs and higher than London region (20.8%) or England or (15.3%)

Mental health of looked-after children

- Average mental ill-health score for LAC in Enfield (13.9) was 14th highest of London boroughs (range 10.5-15.6), higher than London region (13.4) but same as England (13.9) (2013/14) (DfE, 2014). A score of 14-16 may reflect clinically significant problems while a score of over 16 reflects high risk of clinically significant problems. A score was obtained for 90% of eligible children of whom 36% reached the level of “concern”. SDQ score was weakly negatively correlated with deprivation.
During 2012/13, proportion of LAC whose emotional and behavioural health was considered ‘of concern’ in Enfield (32.0%) (45 children) was 13th lowest of London boroughs (range 16.0-77.0%) and lower than London region (34.0%) or England (38.0) (DfE, 2014)

Intervention: For a child with low scores (i.e. low cause for concern), the social worker was informed. For a child with high scores, a brief summary was written and the social worker was invited to consult with CAMHS HEART. Where a high score was obtained, the young person was already appropriately linked to CAMHS in most cases

A local service audit showed that 56% (72/128) of young adults in the Enfield leaving care service were estimated to have mental health needs

Locally provided services (see section 2.2)

HEART provides a mental health service that offers assessment (including for Court), consultation to the professional network and direct therapeutic work with looked after children and young people in order to: ensure mental health needs are addressed, contribute to care planning and reduce placement breakdowns. In March 2015, there were 360 LAC of whom 166 would be estimated to have a mental health conditions (from Ford et al, 2007). On 31.3.15, HEART had 97 open CAMHS & EPS cases involving looked after children and young people compared with 82 on 31.3.14. 95 CAMHS referrals were received by HEART in the 12 months to 31.3.15 (compared with 74 in the year to 31.3.14) and a range of interventions offered (consultation, mental health assessment, psychodynamic psychotherapy, CBT family therapy etc.). The average waiting time from referral to first contact was just over two weeks (actual figure, 2.08 weeks) which is slightly more than the 2013/14 figure of 1.8 weeks, reflecting the significant increase in referrals.

The “In-Step” Fostering Scheme provides rapid and accessible therapeutic support to foster placements where there is a risk of placement breakdown. 25 placements received this support between April 2014 and April 2015, either individually or as part of a group, from the IN-STEP CAMHS Practitioner (with support from the Child Psychiatrist). Three groups for 9 foster carers were facilitated between September 2014 and April 2015; evaluation from the carers indicated positive impacts on, for example, their understanding of their young people, their relationships with them, their ability to manage challenge and the overall stability of the placements.

Expenditure on looked after children

Expenditure rate per 10,000 0-17 year olds on looked after children in Enfield (£2.4m) was 7th lowest of London boroughs (range £1.8-£6.7m) and lower than London region (£3.5m) or England (£3.1m) (2013/14) (DfE, 2014)

In 2015, the Enfield was awarded £2.1m to set up a Family Adolescent and Support Hub to work with young people identified as being in, on the edge of, or returning from care

A Better Care Fund proposal under consideration for 2016/17 to fund CAMHS provision for children and young people leaving care

7.8.2 Children with special education needs (SEN)
Children with special educational need have higher rates of mental disorder (Parry-Langdon, 2008). Proportion of school age pupils with special educational need in Enfield (13.8%) was 9th lowest of
London boroughs (range 10.3-20.6%) and lower than London region (15.6%) or England (15.4%) (DfE, 2015).

Proportion of school age pupils in Enfield with (DfE, 2015):

- Statement (2.3%) was 4th lowest of London boroughs (range 0.3-4.0%) and lower than London region (2.8%) or England (2.8%)
- Statements of SEN where primary need is social, emotional and mental health in Enfield (2.7%) was 6th highest of London boroughs (range 0.3-3.0%) and higher than London region (2.1%) or England (2.0%)
- Learning disability in Enfield (3.24%) was 4th lowest of London boroughs (range 0.2-5.8%) and lower than London region (4.1%) or England (5.0%)
- Speech, language or communication needs in Enfield (3.0%) was 16th lowest of London boroughs (range 0.3-4.7%) and lower than London region (3.1%) but higher than England (2.3%)

Proportion of children known to schools with per 1000 pupils in Enfield with (2013/14) (DfE, 2014):

- Moderate learning difficulties (8.3) was 7th lowest of London boroughs (range 0-24.4) and lower than London region (12.3) or England (15.6)
- Severe learning difficulties (2.37) was 10th lowest of London boroughs (range 1.05-6.34) and lower than London region (3.03) or England (3.73)

Planned expenditure per 100,000 pupils in Enfield on (2013/14) (DfE, 2014):

- Special schools (£10.4m) was 13th lowest of London boroughs (range 0-£29.3m) and lower than England (£12.4m)
- Pupil referral units (£2.0m) was 9th lowest of London boroughs (range 0-£13.4m) and lower than England (£2.6m)

### 7.8.3 Young carers

Proportion of under-15 year olds who provided (ONS, 2011):

- Unpaid care in Enfield (0.92%) (equivalent to 675 individuals with ONS, 2015) was 6th lowest of London boroughs (range 0.69-1.30) and lower than London region (1.07%) or England (1.11)
- More than 20 hours unpaid care per week in Enfield (0.21%) (equivalent to 154 individuals with ONS, 2015) was 12th lowest of London boroughs (range 0.11-0.35) and similar to London region (0.22%) or England (0.21%)

Proportion of 16-24 year olds who provided (ONS, 2011):

- Unpaid care in Enfield (5.5%) (equivalent to 2,018 individuals with ONS, 2015) was mid-range for London boroughs (range 3.4-6.6%), similar to London region (5.4%) and higher than England (4.8%)
- More than 20 hours unpaid care per week in Enfield (1.6%) (equivalent to 587 individuals with ONS, 2015) was 14th highest of London boroughs (range 0.7-2.1%) and similar to London region (1.5%) but higher than England (1.3%)
Locally provided data

- 400 known Young Carers in Enfield although actual number probably nearer 1,000
- Ethnicity of Young Carers: White British (32%), Black British (16%) with 30% ‘Black African’, ‘African/Caribbean’, ‘Asian’ or ‘Turkish/Turkish Cypriot’.
- Average age of Enfield Young Carers is 12
- 52% of Enfield’s Young Carers are female, and 48% male.
- DAZU in Enfield provided a service to young carers (see box X)

Table 7.1: Counselling services for young carers provided by Dazu Young Carers Project in past year

<table>
<thead>
<tr>
<th>Metric</th>
<th>No.</th>
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<tbody>
<tr>
<td>No. of young carers (individual) receiving counselling during the period</td>
<td>34</td>
</tr>
<tr>
<td>% young carers (individual) receiving counselling during the period</td>
<td>10%</td>
</tr>
<tr>
<td>No. counselling sessions provided during the period</td>
<td>192</td>
</tr>
<tr>
<td>No. young carers reporting improved outcomes as a result of counselling during the period</td>
<td>34</td>
</tr>
<tr>
<td>% young carers reporting improved outcomes as a result of counselling during the period</td>
<td>100%</td>
</tr>
<tr>
<td>No. young carers satisfied with counselling service during the period</td>
<td>33</td>
</tr>
<tr>
<td>% young carers satisfied with counselling service during the period</td>
<td>97%</td>
</tr>
</tbody>
</table>

Table 7.2 Counselling services for your carers funded by London borough Enfield

<table>
<thead>
<tr>
<th>Metric</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of young carers (individual) receiving counselling during the period</td>
<td>51</td>
</tr>
<tr>
<td>% young carers (individual) receiving counselling during the period</td>
<td>15.4%</td>
</tr>
<tr>
<td>No. counselling sessions provided during the period</td>
<td>262</td>
</tr>
<tr>
<td>No. young carers reporting improved outcomes as a result of counselling during the period</td>
<td>51</td>
</tr>
<tr>
<td>% young carers reporting improved outcomes as a result of counselling during the period</td>
<td>100%</td>
</tr>
<tr>
<td>No. young carers satisfied with counselling service during the period</td>
<td>50</td>
</tr>
<tr>
<td>% young carers satisfied with counselling service during the period</td>
<td>98%</td>
</tr>
</tbody>
</table>
7.8.4 Not in education, employment or training (NEET)
Proportion of 16-18 year olds not in education, employment or training in Enfield (3.1%) was 14th lowest of London boroughs (range 1.5-5.7%) and lower than London region (3.4%) or England (4.7%) (2014) (DfE, 2015). No information was provided about local interventions targeting this group.

7.8.5 Young offenders
Young offenders have 3-fold increased risk of mental health conditions and suicide (Lader et al, 2000)
- Men aged 15-17 in custody have 18-fold increased risk of suicide (Fazel et al, 2005)
- Women under age 25 have 40-fold increased risk of suicide (Fazel & Benning, 2009)

A large proportion of adolescent offending is associated with mental health conditions and could be prevented through provision of NICE recommended treatment particularly for conduct disorder. Mental health support for offenders would also reduce subsequent re-offending.

Levels of youth justice engagement
Rate of 10-18 year olds in the youth justice system per 1000 population in Enfield (9.1) was 7th highest of London boroughs (range 4.5-12.4) and higher than London region (7.5) or England (7.0) (2013/14) (MoJ, 2015).

Rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population in Enfield (472) (155 individuals) was 11th highest of London boroughs (range 180-707) and higher than London region (426) or England (409) (2014) (MoJ, 2015). Rates have been decreasing both nationally and in Enfield since 2010.

Figure 7.1: First time entrant rate to the youth justice system in Enfield per100,000 aged 10-17
Local interventions

The Youth and Family Support Service was established in 2013 and comprises six Operational Delivery Units which are co-located:

- Youth Offending Unit (YOU)
- Youth Development and Support Unit (YDSU)
- Parenting Support Unit (PSU)
- Change and Challenge Unit (Troubled Families)
- Family and Adolescent Support Unit (FASH)
- Strategy, SRE (Sex and Relationships Education) and Operational Support Unit (SSOSU)

The Enfield CAMHS strategy aims to ensure that young people in the youth offending system have ready access to mainstream services with additional funding provided for CAMHS psychologist and school nurse sessions to facilitate access and provide training. The Brandon Centre is commissioned to work with nominated young people, some of whom are offenders or are at risk of offending. Enfield YOS is part of the Resettlement Network and this provides some additionality to the current team.

Several partnerships include with Youth Development Unit, Community Parenting Support, Adolescent Support Unit, Change and Challenge Unit, Engaging with NEET’s, and with two resettlement consortia (including Enfield) to address the needs of sentenced young people. The statutory caseload increased from 177 in September 2014 to 209 in February 2015. No information about proportion receiving treatment for mental health conditions.

Rate of proven re-offending after 12 months in Enfield has increased from 32.5% (April 2011 – March 2012 cohort) to 37.4% (April 2012 to March 2013 – latest period). This rise of 4.9% compares to a rise of 2.4% in London and a decrease of 0.6% in the family.

Gangs

Gang-affiliation is associated with mental disorder. Poor mental health can attract young people to gangs and be a barrier to gang desistance (PHE, 2015). Equally, involvement in or association with, gang-related activities can damage mental health and worsen existing problems. Targeted mental health support for vulnerable young people is therefore a multiagency interest and important to prevent gang-related violence.

At the point of arrest of young people (mainly 10 to 18-year olds), almost 40% of those who were gang members had signs of severe behavioural problems before the age of 12, compared with 13% of general youth justice entrants (Khan et al, 2013). Around a quarter had a suspected mental health diagnosis and over a quarter were suffering sleeping or eating problems (compared with less than 10% for general entrants). One in three female and one in ten male gang members were considered at risk of suicide or self-harm.

A report on Enfield YOS (Sutton, 2015) provided details of young people sentenced to custody and/or released on supervision between April 2012 and December 2014. The majority of primary offences were for robbery and 70% were associated with gangs. However, no information was provided about the mental health of those sentenced.
Youth justice expenditure
Expenditure rate per 10,000 0-17 year olds on youth justice in Enfield (£0.34m) was 8th highest of London boroughs (range 0-£0.76m) but lower than London region (£0.31m) or England (£0.29m) (2013/14) (DfE, 2014). However, expenditure rate was not correlated with estimated prevalence of conduct disorder or entry rate into youth justice system.

7.8.6 Traveller children
The proportion of school children who are Gypsy/Roma in Enfield (0.16%) was mid-range for London boroughs (range 0-0.41%), similar to London region (0.14%) and lower than England (0.30%) (2015/16) (DfE, 2015).

7.8.7 Asylum seeking children
The number of asylum seeking children who were looked after in Enfield (35) was 3rd highest of London boroughs (range 0-360), similar to London region (0.14%) and lower than England (0.30%) (2014) (DfE, 2015).

7.9) Adult risk factors

7.9.1 Physical inactivity
People with lower levels of regular physical activity have lower levels of positive wellbeing compared to people with moderate and higher levels of physical activity (Pasco et al, 2011).

Level of physical inactivity

- Physical inactivity rate in Enfield (30.0%) was 10th highest of London boroughs (range 15.7-39.3%) and higher than London region (27.0%) or England (27.7%) (Active People Survey, 2015)
- Proportion with a mean sedentary time in the last week over 7 hours per day in Enfield (70.9%) was 10th highest of London boroughs (range 61.0-77.8%) and similar to London region (69.8%) and England (70.1%) (2014/15) (WAY Survey, 2015)

Regarding interventions, to address physical inactivity, a GP Exercise Referral Service had a number of referral criteria including low level anxiety/depression although no information was provided about numbers receiving such interventions or associated outcomes (see section 9.8 for other interventions).

7.9.2 Excess weight and obesity
Obesity is a risk factor for a number of physical health problems, which in turn can increase the risk of mental health conditions. Moreover, obesity has been found to be risk factor for different mental health conditions and low self-esteem (Collingwood, 2007).

Proportion of adults in Enfield who were (Active People Survey, 2014):
- Obese (26.0%) was 2nd highest of London boroughs (range 13.0-32.2%) and higher than London region (20.2%) or England (24.0%)
- Overweight or obese (64.8%) was 4th highest of London boroughs (range 46.0-68.4%), higher than London region (58.4%) but similar to England (64.6%)

The total population with a BMI of 30 or more (obese) is set to rise between 2014 and 2030 (Projecting Older People Population Information System, 2014).

### 7.9.3 Lack of educational qualification

Lack of education is associated with increased risk of developing a mental health condition. The proportion of adults with no qualifications or level one qualifications in Enfield (35.8%) was 4th highest of London boroughs (range 11.0-43.1%) and higher than London region (28.3%) or England (35.8%) (ONS, 2011). This equates to 86,894 adults in Enfield with no or level one qualification. No information was provided about numbers attending adult learning.

### 7.9.4 Unemployment, economic inactivity and benefit claimants

Unemployment is associated with higher rates of mental health conditions and suicide (Evans-Lacko et al, 2013; Stuckler et al, 2009).

The unemployment rate (aged 16+) in Enfield (8.3%) (13,200 people) was 6th highest of London boroughs (range 4.5-10.8%) and higher than London region (7.0%) or England (6.2%) (2014) (ONS, 2015).

The proportion of long-term unemployed (claiming job seekers allowance for over 12 months) in Enfield (0.85%) (1,760 people) was 6th highest of London boroughs (range 0.27-1.12%) and higher than London region (0.68%) or England (0.61%) (2014) (ONS, 2015).

#### Economic inactivity

The proportion of people aged 16-64 who were economically inactive in Enfield (24.2%) (50,000 people) was higher than London region (22.7%) or England (22.5%) (2014/15) (ONS, 2016).

#### Benefit claimants

The proportion of the population who were benefits claimants in Enfield (2.4%) (5,071 people) was higher than London (2.1%) or England (2.0%) (2014/15) (ONS, 2016).

The rate of benefit claimant for alcoholism per 100,000 population in Enfield (63.9) (130 people) was 6th lowest of London boroughs (range 48.9 – 222.2) and lower than London region (117.1) or England (131.0) (2014) (PHE, 2015).

Local information about targeted mental health interventions for unemployed people with mental health conditions is highlighted in section 9.8.

### 7.9.5 Work related stress

Enfield CCG and providers have occupational health contracts that include counselling/therapy although GPs do not have this type of programme in place.

The previous mental health strategy highlighted that (Knapp et al, 2011):

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10 Level 1 qualifications = 1-4 O Levels/CSE/GCSEs (any grades), Entry Level, Foundation Diploma, NVQ level 1, Foundation GNVQ, Basic/Essential Skills
• Early detection of depression at work and provision of eight sessions of psychological therapy results in net savings of £5 for each £ spent due to reduced work absence
• Mental health promotion at work results in £10 net savings mainly to the employer for each £ spent after one year. If every adult in employment in Enfield (154,200) (ONS, 2015) received a simple set of interventions to promote their wellbeing, net savings to local employers within one year would be £107.2m with £34.1m from reduced absenteeism and £85.5m through reduced presentism

The draft Healthy Workplace Action Plan (2015) planned to disseminate a CBT Stress Survey for managers and staff with results to be fed back for evaluation by the HWWG and to lead to amendment of HHASC Stress Action Plan.

7.9.6 Social isolation and loneliness (also see section 9E on social contact)
Loneliness is associated with poor mental and physical health (Mushtaq et al, 2014). Proportion of households in Enfield occupied by a (ONS, 2011):
• Single person (10.8%) (33,359 households) was 9th lowest of London boroughs (range 8.0-34.4%) and lower than London region (12.8%) or England (12.8%)
• Single person aged over 65 in Enfield (3.9%) (12,108 households) was 16th lowest of London boroughs (range 2.3-7.3%) and the same as London region (3.9%) but lower than England (5.2%)

Local information about interventions to reduce social isolation in Enfield is highlighted in section 9.11.

7.9.7 Community instability
Level of population turnover (internal migration) per 1000 resident population in Enfield (111.5) was 5th lowest of London boroughs (range 92.6-207.4), lower than London region (144.9) but higher than England (90.7) (ONS, 2015).

7.9.8 Crime and violence
• Violent crime (PHE, 2015)
  o Violent crime rates per 1,000 residents in Enfield (16.4) (5,272 violent crimes) was 11th lowest of London boroughs (range 10.9-90.9) and lower than London region (19.4) but higher than England (13.5) (2014/15)
  o Hospital admission rate for violent crime (directly standardised per 100,000 residents) in Enfield (34.6) (363 admissions) was 7th lowest of London boroughs (range 17.0-85.7) and lower than London region (51.3) or England (52.4) (2011/12-2013/14) (PHE, 2015)
• Sexual offence rate per 1,000 residents in Enfield (1.29) (412 offences) was 11th lowest of London boroughs (range 0.88-6.84) and lower than London region (1.56) or England (1.40) (2014/15) (PHE, 2015)
• Domestic abuse rate per 1,000 of the population recorded by police in Enfield (20) was the same as every London borough and London region and similar to England (19.4) (ONS, 2015) (poor quality data and under-reporting)
• Proportion of Enfield Child Protection Plan assessments where domestic violence was identified (46.5%) (2014/15) (DfE, 2015)
• Referral rate for abuse of people with learning disability in Enfield (28.7) was 3rd lowest of London boroughs (range 0–256.0) and lower than London region (111.5) or England (109.3) (2012/13) (HSCIC, 2014)

Intervention to address violence
• Domestic violence: Numbers of staff in Enfield who support victims of domestic violence was as follows although no information was available about numbers seen or associated outcomes:
  o Coordinator for domestic violence work within the Community Safety Team
  o One domestic violence worker within the Single Point of Entry (SPOE)
  o One domestic violence worker within the primary care IRIS project providing training for GP practices to conduct routine enquiry about DV (about half of the practices currently take part in Enfield).
  o Several domestic violence workers employed by SOLACE Women’s Aid
  o Two domestic violence workers within Family and Adolescent Support Unit (FASH) (for 2015/16 only)
  o MOPAC have also commissioned additional IDVAs from Victim Support who have a pan-London contract
• For adult perpetrators of domestic violence, referrals can be made by agencies to the Domestic Violence Intervention Project (DVIP) which also takes self-referrals (http://www.dvip.org/). Perpetrators can also phone the Respect phoneline, which is the UK helpline for anyone who is concerned about their own or someone else’s behaviour towards their partner (www.respectphoneline.org.uk). No data was held for numbers referred or attending programmes
• Multi Agency Risk Conferences (MARAC) are convened by Detective Inspector of Police Community Safety Unit and co-chaired by Domestic Violence Coordinator for the borough (Enfield, 2014). During the 12-months to December 2015, there were 696 referrals to the MARAC (involving 773 children) which is a significant long-term rise compared to 2013 figures. Referrals from the police have risen steadily since the end of 2013 and presently form over half of all referrals with 390 referrals during the same period. 55% of MARAC referrals in the past 12-months have been from black and/or ethnic minority communities, which is slightly over-representative of the population of Enfield. There has been an increase in referrals during 2014 as a result of revising police processes to ensure the referral of police repeat victims (3 police calls or more in a 12 month period) which has enabled the MARAC to support more repeat victims and ensure victims do not slip through the net
• Psychosexual interventions: There are a number of specialist services that offer psychosexual interventions that can be accessed by residents in Enfield including the North London Rape Crisis Service, Rape Crisis London, the National Rape/Sexual Abuse Helpline and counselling available through other voluntary and statutory organisations.

7.9.9 Environmental noise
Rates of complaints about noise per 1000 population in Enfield (10.7) was 13th lowest of London boroughs (range 2.7–76.9) and lower than London region (17.4) but higher than England (7.4) (2013/14) (CIEH, 2014).
7.10) Adult higher risk groups
Particular groups are at several fold increased risk of developing mental health conditions and therefore need targeted intervention to prevent such conditions arising.

7.10.1 Long term physical conditions
Long term physical conditions are associated with increased risk of mental health conditions. For instance, one long term physical condition is associated with 2-3 fold increased risk of depression while two or more long term conditions is associated with seven fold increased risk of depression (NICE, 2009). Opportunities exist to improve detection and treatment of associated mental health conditions which lead to improved outcomes of physical health. Furthermore, such groups at increased risk benefit from interventions to prevent associated mental health conditions.

Levels of long term conditions
The proportion on primary care registers for different long-term physical conditions in Enfield (2014/15) (HSCIC, 2015):

- Asthma: 4.9% (15,643 people) was 11th highest of London boroughs (range 3.6–5.7%), higher than London region (4.7%) but lower than England (6.0%)
- Chronic obstructive pulmonary disease: 1.1% (3,400 people) was joint 3rd lowest of London boroughs (range 0.8 – 1.9%) and lower than London region (1.1%) or England (1.8%). In 2011/12, the estimated proportion of detected COPD in Enfield (30.1%) was 12th lowest of London boroughs (range 21.4–45.2%) and lower than England (57.1%)
- Coronary heart disease: 2.4% (7,656 people) was 9th highest of London boroughs (range 1.3–2.9%), higher than London region (2.1%) but lower than England (3.2%)

Proportion of people with long term illness, disability or medical conditions diagnosed by a doctor in Enfield (11.3%) was 8th lowest of London boroughs (range 9.2–16.4%) but lower than London region (12.6%) or England (14.1%) (2014/15) (WAY, 2015).

More broadly, the proportion of the population whose day-to-day activities were limited by their health or disability in Enfield (15.4%) was 4th highest of London boroughs (range 11.2-17.3%) and higher than London region (14.2%) but lower than England (17.6%) (ONS, 2011).

Level of support for long term conditions
- Proportion of people with long term conditions visiting their GP in the last 6 months who felt they had enough support from local services in NHS Enfield CCG (57.4%) was mid-range for London boroughs (range 53.7–61.6%), similar to London region (57.6%) but lower than England (63.3%) (2014/15) (PHE, 2015)
- Proportion of people receiving an NHS Health Check in Enfield (21.8%) was 9th lowest of London boroughs (range 10.3–43.3%) and lower than London region (26.3%) or England (22.9%) (2013/14 Q1 – 2015/16 Q2) (PHE, 2015)
- No information about mental health screening of people with long term physical conditions or targeted interventions to promote their mental health

7.10.2 Learning disability
Adults with learning disabilities are at three-fold higher risk of schizophrenia and at double the risk of depression compared with adults in the general population (Smiley, 2005).
Current and future number of people with Learning Disability in Enfield
Number with learning disability in Enfield is predicted to increase from 5,862 in 2014 to 6,335 by 2020 while number with Downs Syndrome is predicted to increase from 128 in 2014 to 141 by 2020 (PAMSI and POPPI).

Proportion with Learning Disability known to primary care and local authorities
Proportion of adults with learning disability in Enfield
- Registered with primary care in Enfield 0.36% (1,154 adults) was 10th highest for London boroughs (range 0.07–0.50%), same as London region (0.34%) and lower than England (0.44%) (2014/15) (HSCIC, 2015)
- Known to local authority in Enfield (0.44%/ 865 adults) was 2nd highest of London boroughs (range 0.21–0.66%), higher than London region (0.35%) and similar to England (0.43%) (2013/14) (HSCIC, 2014)

Number with learning Disability receiving services
During 2013/14, there were 870 adults with learning disability in Enfield who received services provided or commissioned by the local authority (NASCIC, 2015):
- Community based services: 730
- Residential care: 130
- Nursing care: 10

Outcomes for adults with learning disability
- Primary care outcomes: Proportion of adults with learning disability receiving GP health checks in Enfield (53.6%) was 11th highest of London boroughs (range 12.9-75.3%) and higher London region (49.5%) or England (44.2%) (2013/14) (HSCIC, 2014). The Enfield learning disability highlighted that 80 people with learning disability had died since 2008 and that the commissioning strategy was examining the factors contributing to these deaths
- Employment outcomes for people with learning disability (2013/14) (HSCIC, 2014)
  - Rates of employment in Enfield (17.3%) was 3rd highest of London boroughs (range 1.5-22.5%) and higher than London region (8.8%) or England (6.7%) (weakly negatively correlated with deprivation)
  - Gap in employment rates between people with learning disability compared to overall employment in Enfield (48.3%) was lowest of London boroughs (range 48.3-75.0%) and lower than London region (60.9%) or England (65.0%)
- Accommodation for people with learning disability (2013/14) (HSCIC, 2014)
  - Proportion living in stable and appropriate accommodation in Enfield (79.8%) was 2nd highest of London boroughs (range 47.6-85.3%) and higher than London regions (68.6%) or England (74.9%)
  - Proportion living in non-settled stable accommodation in Enfield (19.1%) was 8th lowest of London boroughs (range 0-42.0%) and lower than London region (24.1%) or England (21.7%)
  - Proportion living in accommodation whose status was unknown to the local authority in Enfield (116%) was low for London boroughs (range 0-36.1%) and lower than London region (7.3%) or England (3.4%)
• Rate of referrals of abuse per 1000 with learning disability in Enfield (28.7) was 3\textsuperscript{rd} lowest of London boroughs (range 0-256.0.\%) and lower than London region (111.5) or England (109.3) (2012/13) (HSCIC, 2014)

• Use of community services by people with learning disability: Proportion of adults with learning disability using community services in Enfield (80.3\%) was 7\textsuperscript{th} highest of London boroughs (range 30.0-90.8\%) and higher than London region (69.0\%) or England (75.4\%) (2013/14) (HSCIC, 2014)

• Direct payments: Proportion of adults with learning disability receiving direct payments in Enfield (25.3\%) (185 people) was 10\textsuperscript{th} lowest of London boroughs (range 12.1-100\%) and lower than London region (32.2\%) or England (30.5\%) (2013/14) (HSCIC, 2014)

• Social support: Rate of adults with learning disability supported by social services throughout the year per 100,000 population in Enfield (405.1) was 3\textsuperscript{rd} highest of London boroughs (range 199.9-502.5), higher than London region (325.5) but lower than England (414) (2013/14) (HSCIC, 2014)

Estimated number of people with learning disability who have mental health conditions

• People with learning disability are at several fold increased risk of mental health conditions (JCPMH, 2013)

• Estimated number of people with learning disability with different mental health conditions in Enfield in 2014 (Enfield learning disability needs assessment, 2015 from JCPMH, 2013)
  o Depression 234
  o Generalised anxiety disorder 362
  o Phobia 362
  o Agoraphobia 88
  o Obsessive compulsive disorder 147
  o Schizophrenia 176
  o Bipolar affective disorder 88
  o Autistic spectrum disorder 616
  o Challenging behaviour 91

Service coverage for treatment of mental health conditions for people with learning disability

• Enfield has an Integrated Learning Disabilities Service (ILDS), a jointly commissioned service which includes staff from Enfield Council and the NHS organisations providing expertise in health and social care through partnership arrangements. The service seeks to support people to be independent and to maintain their health and wellbeing. Around 900 people are supported each year, a figure which is forecast to increase through growth in the population and a rise in the number of young people coming through transition in Enfield

• The ILDS service includes an ‘Equals’ team which deals specifically with employment, training and volunteering opportunities for people with disabilities. The ILDS also includes a carers’ assessment worker who is responsible for providing advice to the ILDS workforce and undertaking Carers Assessments as per the Care Act 201

• Community Intervention Service (CIS)
  o Provides ‘nurse led’ preventative/crisis intervention support in the community
Facilitates timely discharge for people with learning disabilities who are at risk of falling into crisis; being admitted to assessment and treatment services

Targets those with complex needs and behaviour that can prove challenging at times who are at greater risk of falling into crisis especially where there are other factors such as carer fatigue, transition, bereavement and safeguarding issues

- Hospital settings: Enfield has two hospitals within the borough, Chase Farm and North Middlesex. Chase Farm Hospital includes the Seacole Assessment and Treatment Unit, which offers specialist multi-disciplinary assessment and treatment to people with learning disabilities, including emergency accommodation
- No local information was provided about proportion of 2,073 people with learning disability and mental health conditions in Enfield receiving treatment for such conditions

Proportion of gross current expenditure in Enfield for adults with learning disabilities for (2013/14) (HSCIC, 2014):

- Nursing and Residential Care (35.2%) was 3.4% less than England and 7.1% less than the comparator group average
- Day and Domiciliary Care (60.1%) was 4.1% more than England and 10.3% more than the comparator group average
- Assessment and Care Management (4.7%) was 0.7% less than England and 3.2% less than the comparator group average

Services for people with learning disabilities in Enfield can be improved in the following way (Enfield learning disability needs assessment, 2015):

- Improve proportion of people learning disability known to social care and health services
- Improve proportion of people learning disability known to primary care, health promotion/screening and community based secondary care
- Whole system approach and pooled budgets
- Working proactively to enhance skills and positive behaviour
- Improve coverage of community mental health team
- Reduce risk of placement breakdowns

7.10.3 Carers
Carers are important for the recovery of people with mental and physical health conditions although are at higher risk of developing a mental health condition.

The pressures of caring can take a toll on carers’ physical and mental health: 54% of carers have suffered depression because of their caring role; carers also felt more anxious (77%) and more stressed (83%) because of their caring role (Carers UK, 2015). Furthermore, impacts extend onto physical health and social health with 61% of carers said that they were worried about the impact of caring on their relationships with friends and family. Therefore, support for carers can prevent such problems arising.
Local level of carers

Proportion of people providing unpaid care in Enfield (1.98%) (6,194 people) was 10th highest of London boroughs (range 0.75–2.42%), higher than London region (1.82%) but lower than England (2.37%) (ONS, 2011).

Carer outcomes

- Carer-reported quality of life in Enfield (8.1) was 5th highest of London boroughs (range 6.5–9.0), higher than London region (7.7) but the same as England (8.1) (2012/13) (HSCIC, 2013)
- Assessments for carers looking after an adult with a mental health condition per 100,000 population in Enfield (6.3) was 3rd lowest of London boroughs (range 0-295.8) and lower than London region (65.4) or England (64.3) (2013/14) (HSCIC, 2014)
- Carers receiving services or advice or information as % of mental health clients receiving community services in Enfield (4.1) was 4th lowest of London boroughs (0-100) and lower than London region (20.5) or England (19.5) (2013/14) (HSCIC, 2014)
- Carer inclusion: Proportion of carers who report that they have been included or consulted in discussion about the person they care for in Enfield (72.7%) was 3rd highest of London boroughs (55.4-76.5%) and higher than London region (65.9%) but similar to England (72.9) (2013/14) (HSCIC, 2014).
- Carer social contact: Proportion of carers who had as much social contact as they would like in Enfield (36.9%) was 11th highest of London boroughs (20.5-51.4%) and similar to London region (35.5%) or England (38.5%) (2014/15) (HSCIC, 2015)
- Carer satisfaction: Overall satisfaction of carers with social services in Enfield (41.8%) was 8th highest of London boroughs (25.5-52.4%) and higher than London region (35.3%) but lower than England (42.7%) (2012/13) (HSCIC, 2013)

Locally, Enfield Carers Centre supports different types of carers (including older carers, working carers, former carers, parent carers, young adult carers (16-25), and Black & Minority Ethnic carers). During 2014/15, there were:

- 1,329 new carer referrals
- 1,115 carers had respite breaks
- 860 carers used the emergency card scheme
- 522 carers attended training and/or workshop sessions
- 117 carers received counselling

The carers GP liaison project funded by Enfield CCG

- Identified nearly 200 new carers this year
- 1 out of every 10 patients at a GP practice is a carer
- 47 of the 49 Enfield GP practices are actively engaging with Enfield Carers Centre
- 9 Carers Champions now exist at GP practices throughout the borough
- 76 carers attended ECC’s quarterly GP & Health Forums

7.10.4 Lesbian, gay and bi-gender people

Lesbian, gay, or bi-gender people are at increased risk of mental health conditions (Chakraborty et al, 2011). A study of 21-25 year olds (Fergusson, 2005) found a 5 fold increased risk of depression in
gay men and 1.7 fold increase in gay women and 12 -fold increased risk of suicide attempts in young gay men compared with heterosexual young men

The proportion of the population self-reporting as lesbian, gay, or bisexual in the East in London (2.6%) was higher than the UK (1.6%) (ONS, 2014). Based on an adult population of 242,575 (ONS, 2015) this equates to 6,307 adults in Enfield.

No information was provided about the number of lesbian, gay or bi-gender people receiving intervention to treat or prevent mental health conditions.

7.10.5 Offenders
Offenders experience poorer mental and physical health than the general population. Offenders including people on remand and recently discharged from custody are at increased risk of mental health conditions and suicide.

Proportion of offenders who re-offend in Enfield (25.4%) was 14th of London boroughs (range 21.0-31.9%) and similar to London (26.5%) and England (25.9%) (MoJ, 2013).

No local information was provided about the number of offenders receiving intervention to treat or prevent mental health conditions.

7.10.6 Black and Minority Ethnic groups (BME)
Certain BME groups are at higher risk of mental health conditions.

Proportion of the Enfield population which is (ONS, 2011):
- White (61.0%) which was mid-range for London boroughs (29.0-87.7%) and similar to London region (59.8%) but lower than England (85.4%)
- Asian or Asian British (11.2%) which was 14th lowest of London boroughs (4.9-43.5%) and lower than London region (18.5%) but higher than England (7.8%)
- Black or Black British (17.2%) which was 12th highest of London boroughs (1.5-27.2%) and higher than London region (13.3%) or England (3.5%)
- Mixed/ multiple ethnic group in Enfield (5.5%) was 11th highest of London boroughs (2.1-7.6%) and similar to London region (5.0%) but higher than England (2.3%)

Section 3.47 IAPT figures highlighted that the proportion of referrals to IAPT which were from Black and minority ethnic (BME) groups in NHS Enfield CCG (51.5%) was 14th highest of London boroughs, similar to London (50.5) and higher than England (16.4%) (Q4 2014/15) (HSCIC, 2015). No other information was provided about the number of people from BME groups receiving intervention to treat or prevent mental health conditions.

7.10.7 Refugees
For refugees resettled in western countries (Fazel et al, 2005a):
- 9% of adult refugees had post-traumatic stress disorder (PTSD) compared with 3% of adults in England (McManus et al, 2009)
- 5% had major depression compared to 2.1% in the UK (NICE, 2004)
- 44% of those diagnosed with PTSD also had major depression
11% of children had PTSD

As a proxy measure for refugees, the rate of new migrant GP registrations (per 1,000 resident population) in Enfield (16.7) was 8th lowest of London boroughs (4.8-48.7) and lower than London region (26.4) or England (11.7) in 2014 (Migration Indicators Tool, 2015).

### 7.10.8 Older people groups

Proportion of people aged over 64 who are supported throughout the year in Enfield (11.5%) was 15th of London boroughs (range 5.5-17.2%) and higher than London region (11.0%) or England (9.8%) (2013/14) (HSCIC, 2014).

 Permanent admissions of people aged over 64 to residential and nursing care per 100,000 population in Enfield (440) (180 individuals) was mid-range for London boroughs (190-763) and similar to London region (454) but lower than England (651) (2013/14) (HSCIC, 2014)

Proportion of people aged over 64 in Enfield (2013/14) (HSCIC, 2014)

- Still at home 91 days after discharge from hospital (82.0%) was 7th lowest of London boroughs (71.6-100%) and lower than London region (88.1%) but similar to England (82.5%) (weakly correlated with deprivation)
- Offered re-ablement services following discharge from hospital (3.9%) was 14th lowest of London boroughs (1.2-25.8%) and lower than London region (5.0%) but higher than England (3.3%)

### 7.11 Economics of prevention of mental health conditions

**Expenditure on interventions to prevent mental health conditions**

Public mental health is not one of the prescribed statutory functions of Enfield public health and Enfield does not currently fund any public mental health work. However, Enfield public health contributes strategically through the partnership board and local authority colleagues.

Expenditure on different areas relevant to prevention of mental health conditions highlighted in the previous section include

- **Children services:** Expenditure rate on local authority children and young people’s services (excluding education) per 10,000 0-17 year olds in Enfield (£6.9m) was 7th lowest of London boroughs (range £5.5m-£41.2m) and lower than London region (£9.2m) or England (£7.8m) (2013/14) (DfE, 2015). However, expenditure rate was not associated with rate of children in need or estimated prevalence of any mental disorder
- **Safeguarding:** Expenditure rate on safeguarding children and young people’s services per 10,000 0-17 year olds in Enfield (£1.46m) was 5th lowest of London boroughs (range £1.04-£11.07m) and lower than London region (£2.38m) or England (£1.76m) (2013/2014) (DfE, 2015)
- **Youth justice:** Expenditure rate per 10,000 0-17 year olds on youth justice in Enfield (£0.34m) was 8th highest of London boroughs (range 0-£0.76m) but lower than London region (£0.31m) or England (£0.29m) (2013/14) (DfE, 2014). However, expenditure rate was
not correlated with estimated prevalence of conduct disorder or entry rate into youth justice system

- Special schools and pupil referral units: Planned expenditure per 100,000 pupils in Enfield on (2013/14) (DfE, 2014):
  - Special schools (£10.4m) was 13th lowest of London boroughs (range £0-£29.3m) and lower England (£12.4m)
  - Pupil referral units (£2.0m) was 9th lowest of London boroughs (range £0-£13.4m) and lower than England (£2.6m)

- Looked after children
  - Expenditure rate per 10,000 0-17 year olds on looked after children in Enfield (£2.4m) was 7th lowest of London boroughs (range £1.8-£6.7m) and lower than London region (£3.5m) or England (£3.1m) (2013/14) (DfE, 2014)
  - In 2015, the Enfield was awarded £2.1m to set up a Family Adolescent and Support Hub to work with young people identified as being in, on the edge of, or returning from care

Potential savings from addressing risk factors for mental health conditions

The last mental health strategy included estimated economic savings of different public mental health interventions (Knapp et al, 2011). The following outlines potential economic savings arising from interventions to prevent mental health conditions in Enfield

- Parenting interventions for conduct disorder: NICE (2013) recommends parenting intervention as first line treatment for the estimated 5,194 (6.1%) children and adolescents with conduct disorders in Enfield. Such interventions also prevent adult mental disorder and result in net savings of £8 for each £ spent. Estimated minimum net savings arising from parenting interventions provided to every parent of a child/adolescent with conduct disorder in Enfield would be £29.7m (criminal justice £24.0m, NHS £4.1m, education £1.4m) (based on Knapp et al, 2011)

- School-based social and emotional learning programmes to prevent conduct disorder result in £84 net savings for each pound spent (Knapp et al, 2011). If such programmes were provided to all 10 year olds in Enfield (ONS, 2015), net savings would be:
  - £0.03m after one year (£0.2m to NHS, £0.1m to education, £0.2m to criminal justice vs £0.6m for cost of intervention)
  - £27.1m after five years (£3.2m to NHS, £0.6m to education, £23.9m to criminal justice vs £0.6m for cost of intervention)
  - £42.7m after ten years (£4.9m to NHS, £0.8m to education, £37.5m to criminal justice vs £0.6m for cost of intervention)

- School-based interventions to reduce bullying result in £14 saved for each pound spent (Knapp et al, 2011). Given that the cost of the intervention is just £15.50 per pupil per year, it offers good value for money even if repeated annually. The economic case is even stronger if allowance is made for other benefits of reduced bullying, such as improved psychological wellbeing. If all children aged 5-16 years received school based bullying prevention programmes in Enfield, minimum net savings of £56.7m

- Suicide prevention through GP training results in net savings of £44 for every £1 invested (Knapp et al, 2011). If all GP’s in Enfield received such an intervention, estimated savings would be:
- £3.4m after one year
- £6.2m after five years
- £7.6m after ten years

- Work based mental health promotion: If every adult in employment in Enfield (154,200) (ONS, 2015) received a simple set of interventions to promote their wellbeing, net savings to local employers within one year would be £107.2m with £34.1m from reduced absenteeism and £85.5m through reduced presentism (Knapp et al, 2011)
8) Levels of mental wellbeing

Mental wellbeing is associated with a wide range of improved outcomes in health, education and employment, as well as reduced crime and antisocial behaviour.

- Low life satisfaction score (15.0%) (CI 12.7-17.2) was mid-range for London boroughs (10.7-19.1%) and similar to London region (15.5%) and England (13.7%)
- Low worthwhile score (NA)
- Low happiness score (NA)

The mean score of the 14 WEMWBS wellbeing measures in Enfield (48.4) was similar to other London boroughs (range 46.7-48.9), London region (47.8) and England (47.6) (2014/2015) (WAY, 2015).

Wellbeing for higher risk groups
- Quality of life for adults using social care in Enfield (18.4) was similar to other London boroughs (range 17.8-20.1), London region (18.5) and England (19.0) (2013/14) (HSCIC, 2014)
- Carer-reported quality of life in Enfield (8.1) was 5th highest of London boroughs (range 6.5-9.0), higher than London region (7.7) but the same as England (8.1) (2012/13) (HSCIC, 2013)
- Health related quality of life for older people in Enfield (0.71) was mid-range for other London boroughs (range 0.65-0.77) and similar to London region (0.72) and England (0.73) (2012/2013) (NHSE, 2013)
9) Protective factors for mental wellbeing

A range of factors promote mental wellbeing (Campion et al, 2012). Information about the local level of such factors as well as relevant interventions to promote them is an important part of a mental health needs assessment.

This section covers important protective factors for mental wellbeing as well as level of intervention to address such factors:

- Breastfeeding
- Wellbeing promotion of parents and young children
- Early education place provision
- Level of development in early years foundation stage
- Schools
- Physical activity in adults
- Good health
- Employment
- Housing
- Safety
- Social contact
- Volunteering
- Control
- Economics of mental health promotion

9.1) Breast feeding

Proportion of mothers breastfeeding within 48 hours of birth in Enfield (86.7%) was mid-range for London boroughs (range 73.3-92.9%), similar to London region (86.1%) and higher than England (74.3%) (2014/2015) (NHSE, 2015). Figures were unavailable for Enfield for proportion of children who were breastfed at 6-8 weeks after birth. Locally provided interventions include the health visiting service in Enfield offers support to all new mothers with breastfeeding advice and has breastfeeding peer supporters who work alongside the Health Visitor service within Children’s Centres.

9.2) Wellbeing promotion of parents and young children

Following information on local provision:

- Family support services to Enfield families with children aged under 5 years are delivered by 23 children’s centres operating across twelve clusters and two family centres. ‘Time to talk’ weekly drop in sessions in Children Centres were highly rated by 37 parents who attended during first quarter of 2015/16
- Enfield Parenting Support Service provides high quality, research based, accessible services for all vulnerable children and their families in Enfield (see section 2.2)
- Family Nurse Partnership support first time mothers aged 19 and under at conception (see section 7.4.2)
Other organisations highlighted as contributing to child and adolescent resilience included Family Nurse Partnership, (section 7.4.2), young carers (section 7.8.3), Place2Be (section 2.3, Solace, Greek Cypriot Women’s Centre, and Enfield Parents and Children.

9.3) Early education place provision
Number of 2 year olds benefiting from funded early education in 2015 in Enfield (1,450) was almost double the number in 2014 (DfE, 2015).

9.4) Level of development in early years foundation stage
Proportion of children achieving a good level of development at the end of reception in Enfield (2013/14) (DfE, 2014):
- 57.5% was 7th lowest of London boroughs (range 52.5-75.3%) and lower than London region (62.2%) or England (60.4%)
- with free school meal status (49.1%) was 13th lowest of London boroughs (range 36.1-68.1%) and lower than London region (52.3%) but higher than England (44.8%)

9.5) Schools
9.5.1 Educational attainment
Proportion achieving 5+A*-C grade GCSE’s in Enfield (59.7%) was 12th lowest of London boroughs (range 51.3-74.4%) and lower than London region (61.4%) but higher than England (56.8%) (2013/2014) (DfE, 2014). Achievement was not correlated with deprivation.

In 2014/15, proportion achieving 5+A*-C grade GCSE’s in Enfield (DfE, 2015):
- 53.6% was lower than London (59.6%) but similar to England (52.8%)
- Eligible for Free School Meals (41.5%) was lower than London (46.5%) but higher than England (33.7%)

Attainment of a Level 2 qualification by the age of 19 in Enfield (87.1%) was similar to London (86.8%) and England (85.4%) (2014) (DfE, 2015).

No local information was available on proportion continuing into formal education, apprenticeships or employment with training.

9.5.2 School grants
Dedicated school grant per pupil in 2015/16 in Enfield (£5,187) was lower than London (£5,394) or statistical neighbours (£5,203) and was 7.5% less than previous year (EFA, 2015).

9.5.3 School based mental health promotion
Section 2.2 outlines several local projects including:
- Voluntary sector including for young carers (section 7.8.3)
- Place2Be (section 2.2)
- Early Years Social Inclusion (EYSI) team (section 2.2)
- Nurture groups and LASS groups (section 2.2)
- Health and Emotional Wellbeing Service (HEWS) (section 2.2)
9.6) Physical activity in adults

People with high levels of regular physical activity have higher levels of positive emotions such as interest, excitement, enthusiasm and alertness compared to people with moderate and low levels of physical activity.

Levels of physical activity

- Proportion of adults that engaged in recommended levels of physical activity in Enfield (53.7%) was 9th lowest of London boroughs (46.4-71.2%) and lower than England (57.0%) (2014) (Active People Survey, 2015)
- Proportion of the population that used outdoor space for exercise in Enfield (13.8%) was 14th highest of London boroughs (0.3-24.6%) which was higher than London region (11.8%) but lower than England (17.1%) (2013/14) (Nature England, 2015)

Regarding local intervention, health trainers saw over 800 clients so far this financial year with an associated 29.4% increase in wellbeing although no information was available on what proportion had mental health conditions (locally provided data).

9.7) Good health

The proportion of the population reporting general health as excellent in Enfield (31.2%) was 4th highest of London boroughs (range 24.1-33.3%) and higher than London (27.7%) or England (29.5%) (2014/15) (WAY, 2015).


- Females (62.7) was 12th lowest of London boroughs (range 55.5-71.2) and higher than London (63.8) or England (63.9)
- Males (62.4) was 11th lowest of London boroughs (range 53.6-69.7) and lower than London (63.4) or England (63.3)

9.8) Employment

Work is generally good for both physical and mental health and wellbeing.

The proportion of the adult population in employment in Enfield (44.8%) was 10th highest of London boroughs (range 20.8-82.1%) and higher than London region (39.5%) or England (37.7%) (2014 Q4) (ONS, 2015).

Enfield draft Healthy Workplace Action Plan (2015) outlines the following actions to promote mental health and wellbeing in the workplace:

- Disseminate the CBT Stress Survey for managers and staff with results to be fed back for evaluation by the HWWG and to lead to amendment of HHASC Stress Action Plan
- Improve staff recognition and normalisation of issues of mental health in the workplace, e.g. mental health PAR objectives for managers, the creation of a forum to allow for the expression and addressing of staff concerns about workplace stress and the diversification of Enfield Health Trainer service to develop a peer-support service for Council staff.
• Plan and deliver a health fair for Enfield Council staff, to encompass all Council sites, as well as the NHS presence at Enfield Civic Centre. Fair to cover a holistic approach to health and wellbeing matters - perhaps using the Healthy Workplace Charter standards as a guide
• Increase internal staff communication of stop-smoking initiatives, e.g. quit-smoking article, promotion of stop-smoking strategies and initiatives.

Work based mental health promotion could deliver estimated economic savings of £107.2m within one year to local employers if every adult in employment in Enfield received a simple set of interventions to promote their wellbeing (Knapp et al, 2011) (section 9.15).

**Employment for people with mental health conditions**

People with mental health conditions have lower rates of employment than those without. However, employment is an important part of recovery.

Levels of employment for people with mental health conditions
• Proportion of people with mental health conditions in employment in Enfield (44.8%) was 10th highest of London boroughs and higher than London (39.5%) or England (37.7%) (2014 Q4) (HSCIC, 2014) (concerns over data quality). However, the rate has been increasing over the last few years
• Gap in employment rate for those with mental health conditions and overall employment rate in Enfield (28.1%) was 10th lowest of London boroughs (range -0.4-69.0%) and lower than England (36.0%) (2014 Q4) (HSCIC, 2014) (PHE data quality red)
• Proportion of those on CPA in employment in (2014/15 Q4) (HSCIC, 2015) (see section 3.F.5):
  o NHS Enfield CCG (3.9%) was 5th lowest of London boroughs (range 2.9-10.6%) and lower than London region (5.7%) or England (6.9%)
  o BEH-MHT (4.2%) was lowest of London comparator trusts (range 4.2-9.8%) and lower than London commissioning region (5.7%) or England (6.9%)

Supported employment involves placing clients in competitive jobs without any extended preparation and is more effective than pre-vocational training for finding competitive employment (Kinoshita et al, 2013). The Individual Placement Support (IPS) model is a particular form of supported employment involving an employment specialist working closely with their client to understand their individual strengths and weakness and find a good job match for their abilities and skills and is the most effective way to support people with more severe mental illness gain employment. It was successfully introduced in the London boroughs of Kingston and Merton and resulted in significant increases in proportion in mainstream work or educational activity at 6 months and 12 months and such intervention is also important for Early Intervention Psychosis services (see Rainbow, 2015).

Peer support can increase stability in work, education and training, and increase self-worth and confidence (Rainbow, 2014). Some studies suggest that peer support also result in economic savings (Trachtenberg et al, 2013). CBT and Motivational Interviewing can also support return to employment. Peer support can also be beneficial to the peer supporter by increasing their self-esteem and giving them employment.
Local employment interventions for people with mental health conditions

- In 2013/14 a mental health and employment programme was implemented across the borough following a pilot in Edmonton (Rainbow, 2014)
  - Enhanced jobs brokerage support has been provided through the Council’s specialist service JOBSnet. Advisors at the centre have been trained in mental health to provide a service to people with a range of mental health issues many who were already on medication. If they were not in contact with services, JOBSnet staff referred them to GPs and IAPT. The JOBSnet service is also currently being marketed in GP surgeries.
  - A mental health training programme for staff at Jobcentre Plus, the Work Programme and volunteer-involving organisations was positively evaluated in Edmonton although had not been delivered to staff in the Work Programme or volunteer involving organisations (except EVA)
  - An initial draft of an employment pathway for people experiencing common mental health problems had been developed but had not been implemented
  - An employability group had been run across three mental health services in Haringey East, Haringey West and Enfield groups although had not been as well-attended as initially hoped
  - Engagement with employers to support staff and improve chances of job retention: Some groundwork has taken place but this element of the programme is still in its early stages

- Enfield Children and Young Persons Services is a voluntary organisation which provides advice and support to voluntary and community organisations working with children and young people aged 0-25 years. In the past, ECYPS has found work experience placements for vulnerable young people experiencing difficulties such as mental health issues, learning disabilities or trouble holding down educational or work opportunities. The scheme was funded by the Fair Share Trust to incentivise employers to take on a young person and give them advice, information and training from within their workplace (Rainbow, 2014)

- Richmond Fellowship is a national charity with an office in Enfield. Its employment advisors accept referrals from secondary mental health services and work with clients on a one-to-one basis with the aim of moving them into employment. The advisors offer (Rainbow, 2014):
  - A person-centred approach which identifies individuals’ skills, values and interests
  - Employment preparation courses, assertiveness training and help to develop IT skills
  - Support in job searching, CV preparation, completing job applications, and preparing for interviews
  - Advice on disclosure of mental health issues to employers and, where appropriate, ongoing support for an individual and their employer in the workplace

- Ebony People’s Association (EPA) is a charity based in Edmonton and provides culturally sensitive services to black minority ethnic people with mental health issues. EPA works
with London Metropolitan University and Middlesex University, taking on social workers as part of their compulsory work placements

- **Peer support**
  - Peer support training provided by Enfield Mental Health Users group: 14 people have received training in three cohorts with seven service users moving into employment
  - The N18 project is a joint project with OrganicLea and EMU offering a mental health supported food growing and training scheme. It is funded by HSF and Catalyst. It is linked to Peer Mentoring in the Community.
- **BEH-MHT** currently employs 8 apprentices under the Admin and Clerical apprenticeship scheme (locally provided information)

Gaps in local provision in Enfield included (Rainbow, 2014):

- Staff involved with the Work Programme and voluntary organisations have not been trained in mental health
- Mental health and employment pathway is incomplete
- IAPT employment groups not as well-attended as initially hoped and did not link in well with JOBSnet although IAPT reports that employment workers now work very closely with JOBSnet
- Long waiting times for face-to-face IAPT counselling and below-standard recovery rate
- Lack of employer support within the borough
- More emphasis on learning disabilities than mental health in Enfield council
- Clients worried about losing their benefits if gaining paid employment or voluntary work
- Services under-used by young adults

**Employment for people with learning disability**

- Employment rate for people with learning disability in Enfield (17.3%) was 3rd highest of London boroughs (range 1.5-22.5%) and higher than London region (8.8%) or England (6.7%) (2013/14) (HSCIC, 2014) (weakly negatively correlated with deprivation)
- Gap in employment rates between people with learning disability compared to overall employment in Enfield (48.3%) was lowest of London boroughs (range 48.3-75.0%) and lower than London region (60.9%) or England (65.0%) (2013/14) (HSCIC, 2014)
- Enfield Council is working with Equals to support young people with learning disabilities to complete work placements within the Council (Rainbow, 2014). This will involve running a pilot with a cohort of five individuals. The Council's Human Resources department hopes to make use of trial days where the individual can come in for half a day, meet their proposed manager and decide whether the placement seems right for them before committing. It is also hoped that the cohort will be able to complete an ‘away day’ with current apprentices so that they do not feel segregated and can learn more about the apprenticeship scheme. Previous apprentice away days have involved building a sensory garden for people with sensory disabilities and cultivating a community garden.
9.9) Housing

Housing has an important effect on mental health.

Overcrowding

The proportion of households with an occupancy rating of -1 or less in Enfield (11.4%) was mid-range for London boroughs (range 4.0-25.4%), similar to London region (11.6%) and higher than England (4.8%) (ONS, 2011). An occupancy rating of -1 implies that a household has one fewer bedrooms than the standard requirement.

Maintaining stable and appropriate accommodation and providing social care in this environment promotes personalisation and quality of life, prevents the need to readmit people into hospital or more costly residential care and ensures a positive experience of social care (PHE, 2015).

The proportion of people on CPA in settled accommodation in (Q4 2014/15) (HSCIC, 2015) (see section 4.H.6):

- NHS Enfield CCG (66.7%) was 5th lowest of London boroughs (range 56.9-92.0%) and lower than London region (77.8%) or England (60.7%)
- BEH-MHT (68.0%) was 2nd lowest of London comparator trusts (range 64.2-91.5%) and lower than London commissioning region (78.0%) but higher than England (60.7%)

Proportion of people in contact with mental health services with accommodation status recorded in BEH-MHT (36.9%) was 3rd lowest of London comparator trusts (range 26.3-81.3%) and lower than London commissioning region (47.4%) or England (40.6%) (2014/15 Q4) (HSCIC, 2015).

Enfield Mental Health Users group is working with 14 services users in supported hosing to establish supported networks and develop skills prior to them moving into independent living.

9.10) Safety

Safety is fundamental to mental health and wellbeing.

The proportion of those using social care services who felt services made them feel safe and secure in Enfield (86.6%) was 2nd highest of London boroughs (range 53.9-87.4%) and higher than London region (76.8%) or England (79.1%) (2013/14) (HSCIC, 2014).

9.11) Social contact

Social contact is important for good mental health.

Proportion who had as much social contact as they would like in Enfield who were:

- Adult social care users (39.2%) was 14th lowest of London boroughs (range 35.4-50.0%) and lower than London region (40.7%) or England (44.5%) (2013/14) (HSCIC, 2014)
- Adult carers (36.9%) was 11th lowest of London boroughs (range 35.4-51.4%) and similar to London region (35.5%) and England (38.5%) (2014/15) (HSCIC, 2015)
A numbers of organisations provide opportunities to promote social contact including for people with mental health conditions. Social contact is also promoted through volunteering and cultural activities provided by several organisations outlined below.

1) Library
   - Health Initiatives across Enfield Library and Museum Service: As well as information and books, the service contributes to health and wellbeing via various different initiatives and programmes
   - Online Sports bookings: Advertised across the borough, customers can book sports courses in the library
   - Carers Ticket: Alongside carers ticket, outreach to the Enfield Carers Centre on a monthly basis to promote, ticket use and home library service
   - Employment support: Work clubs (two hours of free internet and job-related printing), job advisors and National Careers Services in Enfield libraries
   - Books on prescription: Displays at six main libraries and promotion to practise manager at Ordnance Unity Centre and MIND
     o Self-help books for common mental health conditions (collections at six Libraries)
     o Books on Prescription: Dementia (collections at six Libraries)
     o Various other events at different libraries across Enfield throughout the year
   - Home Library Service: 250 isolated and potentially vulnerable residents visited once every 4 weeks with a collection of books. Referrals to Social Services are made should we be concerned about the resident’s welfare

2) Enfield Saheli is a voluntary organisation which provides Advocacy, Advice and Support to women who are isolated, vulnerable and going through emotional and mental distress (see section 5)

3) Wellbeing Connect Services: In the past year, 80 had accessed advocacy services, 25 info and advice, 14 monthly support meeting and 30 children and young people

4) BEH-MHT plans to employ six Peer Support Community Engagement Workers from April 2016 who will be based in the Trust Assessment Centres (two in Enfield)

5) Volunteering (see below)

6) Enfield MIND (see section 5): Psycho-social Support (Drop-In) and Well-being Service: This service is delivered by engaging clients in a variety of appropriate, physical and cognitive activities designed integrate the mind body and soul. Such activities include: yoga, relaxation, tai-chi, gardening, cookery, cookery, creative writing art, sorting activities. Personal development courses are also provided as part of the psycho-social support and well-being service delivery

7) Enfield Mental Health Users group holds a weekly over 65 group which supports 16 over 65s with long term mental health issues and memory loss who have been identified as being at risk of social isolation. It receive referrals from the Hawthorns ward Chase Farm and the memory clinics

9.12) Volunteering
   - Enfield Volunteer Action provides volunteering opportunities through the Volunteer Centre
   - Ebony People’s Association (EPA) (see 9.12)
• Enfield Mental Health Users group has 66 current and potential volunteers with 12 ex volunteers 5 of whom gained employment and left due to this
• Enfield Time Bank [http://www.enfieldtimebank.org.uk](http://www.enfieldtimebank.org.uk)

9.13) Control

Being in control is associated with good mental health. Proportion who use services who felt they had control over their daily life in Enfield (69.2%) was mid-range London boroughs (range 61.3-87.0%) and lower than London region (72.4%) or England (76.8%), and weakly negatively correlated with deprivation (2013/14) (HSCIC, 2014).

9.14) Cultural activities

No information was provided

9.15) Economics of mental health promotion

**Expenditure on interventions to promote mental health**

- Expenditure rate on local authority children and young people’s services (excluding education) per 10,000 0-17 year olds in Enfield (£6.9m) was 7th lowest of London boroughs (range £5.5m-£41.2m) and lower than London region (£9.2m) or England (£7.8m) (2013/14) (DfE, 2015). However, expenditure rate was not associated with rate of children in need or estimated prevalence of any mental disorder.
- Expenditure rate on Sure Start Children Centres and early years per 10,000 0-17 year olds in Enfield (£0.78m) was 13th lowest of London boroughs (range £0.50-£17.18m) and lower than London region (£1.14m) or England (£0.92m) (2013/14) (DfE, 2015)

**Potential savings from mental health promotion**

Savings from mental health promotion are greatest during childhood and adolescence. Cost effective interventions to promote mental wellbeing during adulthood include:

- School-based social and emotional learning programmes to prevent conduct disorder result in £84 net savings for each pound spent (Knapp et al, 2011). If such programmes were provided to all 10 year olds in Enfield (ONS, 2015), net savings would be:
  - £0.03m after one year (£0.2m to NHS, £0.1m to education, £0.2m to criminal justice vs £0.6m for cost of intervention)
  - £27.1m after five years (£3.2m to NHS, £0.6m to education, £23.9m to criminal justice vs £0.6m for cost of intervention)
  - £42.7m after ten years (£4.9m to NHS, £0.8m to education, £37.5m to criminal justice vs £0.6m for cost of intervention)
- Work based mental health promotion: If every adult in employment in Enfield (154,200) (ONS, 2015) received a simple set of interventions to promote their wellbeing, net savings to local employers within one year would be £107.2m with £34.1m from reduced absenteeism and £85.5m through reduced presentism (Knapp et al, 2011)
- Targeted promotion interventions include supported housing for men with enduring mental illness which can save £11,000–£20,000 each year per person (CSED, 2008).
Summary

This mental health needs assessment for Enfield includes primary care, secondary care, social care, public health and other sectors. Key findings are outlined in each section of the report.

1) Population details

In Enfield, the proportion of the population which is (ONS, 2015):
- Under 18 (25.2%) was higher than London (22.5%) or England 21.3%
- Aged 18-64 years (61.9%) was lower than London (66.0%) but higher than England (61.1%)
- Over 64 (12.8%) was higher than London (11.5%) but lower than England 17.6%

The population of Enfield is forecast to grow by 9% between 2014 and 2020, 15% by 2025 and 21% by 2030 (PANSI, 2014)

2) Child and adolescent mental health conditions

Since the majority of lifetime mental health conditions arise before adulthood, appropriate coverage of treatment during childhood and adolescence results in improved outcomes and prevention of a broad range of outcomes across the life course.

Estimated levels of child and adolescent mental disorder and proportion receiving treatment
- Only a minority of the estimated children and adolescents with different mental health conditions in Enfield received any treatment which reflects the national picture
- Estimated proportion of 5-16 year olds with any mental health condition in Enfield (9.9%) was 7th highest of London boroughs (range 7.1-10.8%) and higher than London region (9.3%) or England (9.3) (Green et al, 2011). This is equivalent to 5,194 individuals
- Conduct disorder: Estimated proportion of 5-16 year olds with conduct disorder in Enfield (6.1%) was 7th highest of London boroughs and equivalent to 3,200 individuals 94 of who were see by generic CAMHS
- Emotional disorder: Estimated proportion of 5-16 year olds with emotional disorder in Enfield (3.9%) was equivalent to 2,046 individuals 282 of who were seen by generic CAMHS
- Hyperkinetic disorder: Estimated proportion of 5-16 year olds with emotional disorder in Enfield (1.7%) was equivalent to 892 individuals 40 of who were seen by generic CAMHS
- Psychosis: During 2013/14, 0.2% presentations to generic Enfield CAMHS were psychotic disorder (one individual) (CORC). However, a review found that 9% of presentations (135 individuals) to Enfield CAMHS were young people experiencing hallucinations and delusions (Earle et al)
- Eating disorder: Estimated 29 individuals aged 10-19 with eating disorder in Enfield (CORC, 2014) although among 16-24 year old women, estimated 70 with anorexia and 188 with bulimia (Smink et al, 2012). However, estimated 4,850 individuals aged 16-24
year olds in Enfield screen for possible eating disorder (using eating disorders screening tool and PHE, 2013). During 2013/14, generic Enfield CAMHS saw 7 individuals with eating disorder (1.7% presentations) (CORC). During 2014/15 in Enfield, the Royal Free CAMHS Eating Disorder Service accepted 29 referrals

- Autistic spectrum disorder (ASD): Estimated number with ASD in Enfield was 1,312 based on 1.6% national prevalence rates with an estimated 480 individuals aged 5-10 with ASD. Proportion of all school pupils identified as having ASD in Enfield was 1.14%. Proportion of Enfield CAMHS presentations in 2013/14 with ASD was 6.6% (27 individuals) (CORC)

- Alcohol use disorder: Proportion of 15 year olds in Enfield who had been drunk in the past four weeks (8.4%) was mid-range for London boroughs (WAY, 2015). Admission rate for alcohol specific conditions in under 18 years in Enfield was 7th lowest of London boroughs and lower than London region (26.6) or England (40.1) (HSCIC, 2014). Drinking rates are much higher for conduct disorder (19%), emotional disorder (13%) and hyperkinetic disorder (13%) compared to no disorder (9%) (Green et al, 2005) so early intervention for these disorders including with parenting programmes will have a significant impacts in almost half of estimated cases. However, no further information was provided on about other interventions

- Drug use disorder: Proportion of 15 year olds in Enfield who had taken cannabis in the last month (3.2%) was 4th lowest of London boroughs and lower than London region (5.0%) or England (4.6%) (WAY, 2015). Admission rate for substance misuse per 100,000 aged 15-24 years in Enfield (43.9) was 3rd lowest of London boroughs and lower than London region (65.2) or England (81.3) (HSCIC, 2014). Rates of any drug misuse are much higher for conduct disorder (28%), hyperkinetic disorder (23%) and emotional disorder (20%) compared to no disorder (8%) (Green et al, 2005) so early intervention for these disorders including with parenting programmes will have a significant impacts in almost half of estimated cases. However, no further information was provided on about other interventions

- Tobacco smoking: Proportion of 15 year olds in Enfield who were regular smokers (2.0%) was 4th lowest of London boroughs and lower than London region (3.4%) or England (5.5%) (WAY, 2015). No information was provided about local smoking cessation or prevention. Smoking rates are several times higher for conduct disorder (30%), emotional disorder (19%) and hyperkinetic disorder (15%) compared to no disorder (6%) (Green et al, 2005) so early intervention for these disorders including with parenting programmes will have a significant impacts in almost half of estimated cases

- Self-harm: The last national psychiatric morbidity survey found that 7% of 11-16 year olds had reported self-harm which equates to 1,704 individuals aged 11-16 in Enfield. During 2013/14, 4.9% presentations to generic Enfield CAMHS had self-harmed (20 individuals) (CORC) Proportion of Enfield CAMHS presentations with self-harm while a further 12% (181 individuals) had attempted suicide (Earle et al). Admission rate for self-harm in Enfield for 10-24 year olds was 9th lowest of London boroughs and lower than London region (204.8) or England (352.3) (HSCIC, 2014). However, admissions for self-harm in Enfield increased from 57 in 2012/13 to 81 in 2013/14, 58 in 2014/15 and 78 in 2015/16 (local data). However, rates of self-harm are several times higher for emotional disorder (28%), conduct disorder (21%) and hyperkinetic disorder (18%)
(Green et al, 2005) so early intervention for these disorders including with parenting programmes will have a significant impact on self-harm in almost half of estimated cases.

Treatment for child and adolescent mental disorder by tier
- **Tier 1 universal services:**
  - Estimated number requiring tier 1 CAMHS In Enfield was 12,060
  - No information about numbers seen provided health visitors, preschool, schools or primary care
- **Tier 2:**
  - Estimated number requiring tier 2 CAMHS In Enfield was 5,628
  - School based services
    - Health and Emotional Wellbeing Service (HEWS): During the first year in 2014, fourteen schools the service although no information on numbers seen
    - Education psychologists although no information about number seen
    - Place2be worked with 10 schools and during 2013/14 provided self-referral service (3,114 children), one-to-one counselling (153 assessments, 11 short term counselling and 148 long term counselling), therapeutic group work, parent partnership work (610 sessions), multi-agency work with 74 children being referred elsewhere, work with staff to think about the mental health needs of their students (1,492 sessions), training
    - Nuture groups operate in 26 schools supporting children with readiness to learn and building resilience to manage the transition to secondary school. An estimated 280 children are supported per year
    - Early Years Social Inclusion (EYSI) team work with a large number of primary schools but no information on number seen
  - Several other services exist although lack of information for most services about numbers being seen or associated outcomes
    - Web based services including The Big White Wall
    - IAPT Service provides individual and group services for 16 years and over (nine trainees)
    - Behaviour Support Service for families and children not attending schools
    - Pupil Referral Units
    - Change and Challenge (Troubled Families) targeted at families
    - Family and Adolescent Support Hub (FASH) is aimed at children and young people who are on the edge of coming into local authority care
    - CAMHS in the Youth Offending Services (YOS) has a dedicated Tier 2 CAMHS clinician works with young people at risk of or involved in offending
    - CAMHS in Social Care: A dedicated Tier 3 clinician works with social workers, to support children, young people and their families
    - Services provided for children and young people with milder problems - often provided by primary mental health workers (as outreach from Tier 3 CAMHS)
  - Looked after children (LAC): Estimated 166 LAC with mental health conditions. Enfield HEART provides a mental health service that offers assessment for LAC and on 31.3.15 had 97 open CAMHS & EPS cases involving LAC
Enfield Parenting Support Service provides services for vulnerable children and their families in Enfield although no information about numbers receiving services

Lack of information on parenting interventions for 4,092 individuals aged 5-16 with conduct and hyperkinetic disorder in Enfield

- Tier 3 Multi-disciplinary teams of child and adolescent mental health professionals
  - Estimated number of under-17 year olds in Enfield who require tier 3 CAMHS (1,485) was 3rd highest of London boroughs (2012)
  - During 2014/15, Enfield CAMHS accepted 1,504 referrals and had a caseload of 1,542
  - 89.2% of cases were seen within 13-week referral to appointment target although 33.8% of initial appointments did not attend

- Tier 4 includes day and inpatient services, some highly specialist outpatient services, and services such as crisis/home treatment services which provide an alternative to admission.
  - Admission rate for mental disorder per 100,000 aged 0-17 years in Enfield (90.2) was 13th highest of London boroughs, lower than London (101.9) but similar to England (87.2)

- Economics of child and adolescent mental health conditions
  - Estimated annual costs of crime by adults who had childhood conduct disorder or sub-threshold conduct disorder in Enfield was £339.3m
  - Estimated minimum net savings arising from parenting interventions provided to every parent of a child/adolescent with conduct disorder in Enfield would be £29.7m (criminal justice £24.0m, NHS £4.1m, education £1.4m) (from Knapp et al, 2011)

3) Adult mental health conditions

Common mental disorder

- Proportion of adults estimated to have a common mental disorder in Enfield CCG (15.6%) was 12th lowest of London boroughs (range 13.7-21.6%), lower than London region (16.4%) but the same as England (15.6%) (2014/15) (NHSE, 2015). This equates to 36,106 adults in Enfield

- Proportion of social care service users who were moderately or extremely anxious or depressed in Enfield (61.2%) was highest of London boroughs (range 47.3-61.2%) and higher than London region (54.4%) or England (52.8%) (2013/14) (HSCIC, 2014)

- Estimated annual costs due to depression and anxiety in Enfield: £98.1m

- Primary care (2014/15) (HSCIC, 2015)
  - Depression register
    - Proportion of people on primary care depression register in NHS Enfield CCG (4.8%) was 12th lowest of London boroughs and lower than London region (5.3%) or England (7.3%) although proportion varied from 0.33% to 11.1% between different Enfield GP practices
    - 30.8% of those estimated to have common mental disorder in Enfield were on the primary care depression register
Assessment: Proportion with a new diagnosis of depression who had bio-psychosocial assessment upon diagnosis in NHS Enfield CCG (78.3%) was 4th highest of London boroughs (range 48.4-83.5%) and higher than England (75.8%) (2013/14) (HSCIC, 2014)

Review of depression: Proportion of newly diagnosed adults with depression with a review within 10-56 days after diagnosis in NHS Enfield CCG (68.5%) was 4th highest of London boroughs (range 48.7-75.1%) and higher than England (63.8%) (2014/15)

Exception rate from depression register in NHS Enfield CCG (17.4%) was 2nd lowest of London boroughs (range 14.6-34.4%) and lower than England (24.5%) (2014/15). However, the rate between practices in Enfield varied from 0–75.0%

- Primary care prescribing (2014/15) NHSBSA, 2015
  
  o Antidepressant prescribing
    
    ➢ Rate of primary care antidepressant prescribing per STAR-PU in NHS Enfield CCG (0.8) was mid-range for London boroughs (range 0.5-1.1) and the same as London (0.8)
    
    ➢ Proportion of first choice antidepressants of the total number of prescription items in NHS Enfield CCG (68.9%) was mid-range for London boroughs

  o Hypnotic prescribing rate in NHS Enfield CCG (0.91) was mid-range for London boroughs

- IAPT (psychological therapies) (HSCIC, 2015)
  
  o Referrals
    
    ➢ IAPT referral rate per 100,000 population in NHS Enfield CCG (703) was 10th lowest of London boroughs (range 360-1,364) and lower than London region (821) or England (839) (Q4 2014/15)
    
    ➢ During 2014/15, 13.8% of people estimated to have a common mental disorder were referred to IAPT services in NHS Enfield CCG
    
    ➢ Proportion of referrals to IAPT from BME groups in Enfield CCG (51.5%) was 14th highest of London boroughs (range 10-7-96.9%), similar to London (50.5%) and higher than England (16.4%) (Q4 2014/15)

  o IAPT waiting times: Proportion of people waiting less than 28 days for first treatment in Enfield CCG (74.5%) was 13th lowest of London boroughs (range 42.9-97.0%) and similar to England (74.9%) (March, 2015)

  o IAPT entry: During Q4 2014/15, the rate per 100,000 population entering treatment in NHS Enfield CCG (323) was lower than any London borough (range 323-932), London (579) or England (564)

  o IAPT completion rate for IAPT treatment per 100,000 population in Enfield CCG (221) was 7th lowest of London boroughs (range 51-494) and lower than London region (274) or England (298) (Q4 2014/15). Proportion of people estimated to have common mental disorder completing treatment in Enfield during 2014/15 was 4.8%

  o IAPT recovery rates:
    
    ➢ Proportion of those who completed IAPT treatment and were recorded as “reliable improvement” in Enfield (59.4%) was mid-range for London boroughs
    
    ➢ Proportion of those completing IAPT treatment who were ‘moving to recovery’ in Enfield (48.6%) was 6th highest of London boroughs (range 23.1-68.6%)

  o Rates of non-attendance for IAPT appointments in NHS Enfield CCG (10.3%) was mid-range for London boroughs (range 5.1-16.3%), similar to London region (10.8) and lower than England (11.9%) (Q3 2014/15)
In the previous year, IAPT had run group interventions for 146 women after birth and 500 school pupils in 39 workshops and internet based psychological therapies were provided to 146 individuals. No information was available about associated outcomes

- Hospital admission rate for unipolar depression in Enfield (30.9) was 13th lowest of London boroughs (range 16.8-76.2) and lower than either London region (37.0) or England (32.1) (2009/10-2011/12) (HES, 2013)
- Emergency admission rate for neuroses in Enfield (10.4) was 3rd lowest of London boroughs (7.8-49.7) and lower than England (21.7) (2012/13) (HES, 2015)

**Psychosis**

- Estimated proportion of the population aged over 16 with a psychotic disorder in Enfield (0.46%) (1,145 individuals) was mid-range London boroughs (range 0.27-0.77%), lower than London region (0.51%) but higher than England (0.40%) (PHE, 2012)
- Primary care: Proportion on primary care SMI register in NHS Enfield CCG (1.01%) was mid-range for London boroughs (range 0.65-1.51%), similar to London region (1.07%) and higher than England (0.88%) (2014/15) (HSCIC, 2015). However, there was a wide variation in the proportion on the SMI register across GP practices in Enfield (range 0.22-2.63%)
- Primary care prescribing rate of drugs for psychoses and related disorders in NHS Enfield CCG (41.8) was 9th highest of London boroughs (range 24.0-71.4), higher than London (38.9) but lower than England (45.4) (2014/15 Q4) (HSCIC, 2015)
- Secondary care
  - Early intervention psychosis services:
    - Estimated annual rate per 100,000 adults aged 16-64 for developing a first episode psychosis (FEP) in Enfield (37.2) was 16th lowest of London boroughs (range 21.4-71.9), lower than London region (40.6) but higher than England (24.2) (Psymaptic, 2014)
    - Rate at which new cases of FEP were seen by Early Intervention Psychosis Services (EIPS) in NHS Enfield CCG (17.5) was the lowest of London boroughs (range 17.5-57.0) and lower than London region (30.5) or England (24.0) (Q4 2014/15) (NHSE, 2015). The rate of FEP being seen by EIP services in Enfield has fallen from 22.8 in 2013/14 Q1 to 17.5 in 2014/15 Q4
    - 47.0% of estimated new cases of psychosis were seen by Early Intervention Psychosis services in Enfield which was lower than 59.4% in England. Since the rate of referral for First Episode Psychosis varies by practice and so referral rates could be increased by targeted education interventions for low referring practices
    - Proportion of referrals accepted as a proportion of all referrals received (68.7%) was 3rd lowest of London trusts and below the lower quartile nationally (2014/15)
Early Intervention Psychosis Teams caseload per 100,000 population in NHS Enfield CCG (45.9) was 5th lowest of London boroughs (range 1.8-129.7) and lower than London region (62.1) or England (37.5) (2014/15 Q2)

- Psychological therapy for psychosis
  - Proportion of psychosis care spells receiving psychological therapy in NHS Enfield CCG (9.9%) was 4th highest of London CCG’s (range 0.2-14.3%) and higher than London region (5.2%) or England (3.4%) (2013/14) (HES, 2014)
  - Report of the second round of the National Audit of Schizophrenia (NAS2) (2014) interviewed 56 service users at BEH-MHT and found that although availability and uptake of Psychological Therapies was above average for CBT and about average for Family Interventions, it was still well below what should be provided

- Assertive outreach (section 4): Rate of people accessing Assertive Outreach Services per 100,000 population in NHS Enfield CCG (18.8) was 5th lowest of London boroughs
- Emergency admission rate for schizophrenia per 100,000 population in Enfield (113.0) was 15th highest of London boroughs (range 31.0-233.0) and higher than London region (103.0) or England (57.0) (2009/10 – 2011/12) (HES, 2013)
- Physical care: NAS2 (2014) found that monitoring of physical health risk factors at BEH-MHT was below average and thus well below what should be provided. It was particularly poor for monitoring of glucose control and lipids
- Excess mortality rate for under 75 adults with SMI in Enfield (284.6) was 13th lowest of London boroughs (range 230.9-489.8) and lower than England (347.2) (2012/13) (HSCIC, 2014)

- Economics of psychosis
  - Psychosis annual estimated cost in Enfield: £69.4m (from Kirkbride et al, 2012)
  - Early intervention for first episode psychosis
    - Net savings of £18 for each £ spent (Knapp et al, 2011)
    - Estimated net savings over usual care if all people estimated to develop first episode psychosis in Enfield received care from early intervention psychosis services: £3.0m
    - Intervention cost saving to NHS by end of first year
    - 47.0% of estimated new cases of psychosis were seen by Early Intervention Psychosis services in Enfield
  - Early intervention for the stage which precedes psychosis (Clinical High Risk State)
    - Net savings of £10 for each £ spent (Knapp et al, 2011)
    - Estimated net savings if all people estimated to develop Clinical High Risk State (CHRS) in Enfield received care from early detection services: £5.4m
    - The intervention is cost saving to the NHS by the end of the second year although currently, there are no CHRS services in Enfield
  - Family therapy: Estimated savings to NHS over 3 years if all people in Enfield estimated to have psychotic disorder in previous year received family therapy: £4.8m (from Knapp et al, 2014)
  - CBT: Estimated savings to NHS over 3 years if all people in Enfield estimated to have psychotic disorder in previous year received CBT: £1.1m (from Knapp et al, 2014)
Dementia
- Estimated 3,022 people with dementia in Enfield including 515 in care homes (NHSE, 2015). Number with dementia in Enfield projected to rise to 4,697 by 2030
- Estimated annual cost of dementia in Enfield: £85.5m (based on Knapp & Prince, 2007)
- Primary care
  - Proportion aged over 64 in Enfield on the primary care dementia register (4.61%) (1,901 individuals) was 12th highest of London boroughs (range 3.8-5.2%) and higher than London region (4.4%) or England (4.4%) (September, 2015) (HSCIC, 2015)
  - Dementia diagnosis rate in Enfield: 62.4% (HSCIC, 2015)
    - Dementia whose care was reviewed in last 12 months (79.5%) was 13th highest of London boroughs (63.3-84.6%) and higher than London (77.9%) or England (77.0%)
    - New dementia diagnosis and blood test recorded 6 months before or after entering onto the dementia register (78.1%) was 10th highest of London boroughs (range 63.3-84.4%) and higher than London region (74.8%) or England (74.4%)
- Secondary care
  - 1,846 referrals accepted to memory services (1,475 from primary care and 366 internal referrals from other CMHT’s) (2014/15)
  - During 2014/15 in Enfield for dementia/ cognitive impairment, there were 6,552 contacts with CMHT’s, 9,706 contacts with Day Services, 2,734 contacts with Memory Treatment Clinic, 19 contacts with OT, 715 contacts with Psychology, 2,626 Occupied Bed Days (OBD) for Acute Inpatients and 14,721 OBD’s for continuing care
  - Admission rate for over 65 year olds in NHS Enfield CCG compared to other London boroughs was 12th highest for Alzheimer’s disease, 7th highest for vascular dementia and 14th highest for unspecified dementia (2013/14) (HSCIC, 2014)
  - Emergency admission rate for over 65 year olds in NHS Enfield CCG was 11th lowest London boroughs (2013/14) (HSCIC, 2014)
  - Ratio of inpatient service use for people with dementia to recorded diagnoses in NHS Enfield CCG (74.5) was mid-range for London boroughs (2013/14) (HSCIC, 2014)
- Risk factors for dementia: Compared to other London boroughs, the proportion of people in Enfield was 4th highest for hypertension (13.3%) and stroke (1.2%), 8th highest for coronary heart disease (2.5%), 6th highest for diabetes (7.0%) (HSCIC, 2014) and 8th lowest for smoking (13.6%) (IHS, 2014)

Personality disorder
- Estimated numbers of adults in Enfield with any personality disorder (10,184), antisocial personality disorder (694) and borderline personality disorder (926)
- Estimated annual cost of personality disorder: £47.3m
- Primary care: No information provided
- Secondary care: During 2015/16, there were 3,182 secondary care contacts with people with personality disorder in Enfield (locally provided figures)
**Eating disorder**
- Estimated number of adults in Enfield with an eating disorder: 17,433
- Primary care: No information provided
- Secondary care
  - 77 referrals and 547 attendances for eating disorders in Enfield during 2014/15 (locally provided data)
  - Mean length of stay (excluding leave and unadjusted for outliers) in BEH-MHT for eating disorders (97) was near mean (100) for trusts nationally and mid-range for London trusts (2014/15) (NHS Benchmarking Network, 2015)

**Alcohol use disorder**
- Estimated annual cost of alcohol misuse in Enfield: £138.2m
- Alcohol-specific mortality rate in Enfield (7.5) was 11th lowest of London boroughs (range 4.6-14.8%) and lower than London region (9.0%) or England (11.9%) (2011-13) (LAPE, 2014)
- 12.0% of Enfield Child Protection Plan (CPP) assessments identified alcohol misuse (2014/15) (DfE, 2015)
- Proportion of people above age 15 with different types of alcohol consumption in Enfield (LAPE, 2014):
  - Binge drinkers: 12.2% (30,636 people) 10th lowest of London boroughs (range 7.5-25.3%)
  - Higher risk drinkers: 6.6% (16,574 people) 8th lowest of London boroughs (range 5.3-8.9%)
  - Increasing risk drinkers: 17.5% (43,945 people) 3rd lowest of London boroughs (range 16.8-21.7%)
  - Lower risk drinkers: 75.9% (190,596) people) 3rd highest of London boroughs (range 69.4-76.7%)
  - Abstainers: 22.3% (55,999 people) 14th highest of London boroughs (range 14.3-35.1%)
- Primary care: During 2014/15 in Enfield, no treatment was recorded as occurring in primary care (NDTMS, 2016)
- Secondary care can be provided either in the community or in hospital:
  - Community treatment
    - During 2014/15, 339 people were in treatment for alcohol (333 in the community, 7 inpatients and 12 in residential rehabilitation) (NDTMS, 2016). A further 195 people received treatment for alcohol and non-opiate misuse (232 in the community, 4 inpatients and 11 in residential rehabilitation). The majority were self-referrals.
    - Rate of adults in specialist alcohol misuse services per 1000 population in Enfield (1.6) (equivalent to 354 adults) was 11th lowest of London boroughs (range 0.7-3.4) and lower than London region (2.0) or England (2.3) (2013/14) (NDTMS, 2015)
    - Proportion waiting more than three weeks for treatment in Enfield (4.0%) was low for London boroughs (range 0-10.8%) and lower than London region (1.7%) and England (4.8%) (2014/15) (NDTMS, 2015)
    - Proportion who successfully completed treatment in Enfield (34%) (116 individuals) was mid-range for London borough range (21.9-56.4%) and higher than London region (25.3%) but lower than England (39%) (2014/15)
  - Admissions (2013/14)
- Alcohol-specific admission rate (directly standardised per 100,000 population) in Enfield (231) was 2nd lowest of London boroughs (range 217-607) and lower than London region (346) or England (374). The rate in Enfield has gradually increased from 165 in 2008/9.

- Alcohol-related hospital admission rate (directly standardised per 100,000 population) in Enfield (broad) (1,214) was 13th lowest of London boroughs (range 857-1,635) and lower than London region (1,281) or England (1,253).

- Admission episodes for alcohol-related mental and behavioural disorders (directly standardised per 100,000 population) in Enfield (broad) (238) was 3rd lowest London boroughs (range 194-933) and lower than London region (402) or England (394).

- Estimated net savings if all increasing risk, higher risk and binge drinkers in Enfield received screening and brief interventions in primary care would be £18.7m (crime £9.6m, productivity £5.5m and NHS £3.6m) (Knapp et al, 2011).

### Drug use disorder

- Numbers of adults aged 16-59 in Enfield using different types of drugs in the past year based on national estimates (HO, 2015):
  - Illegal drug use (8.6%): 16,855
  - Cannabis use (6.7%): 13,131
  - Class A drug use (3.2%): 6,272
  - Powder cocaine (2.3%): 4,507

- Estimated prevalence of opiate and/or crack cocaine use per 1000 population in Enfield (7.4) was 14th lowest of London boroughs (range 4.0-18.5) and lower than London region (9.6) or England (8.4) (2011/12). This equates to 1,581 individuals aged 15-64 in Enfield.

- Primary care: During 2014/15, 78 people with opiate use in Enfield received treatment although none were recorded as receiving treatment for non-opiate use (NDTMS, 2016).

- Secondary care (provided either in the community or in hospital):
  - During 2014/15 in Enfield, 487 people received treatment for opiate use from specialist substance misuse services in the community, 9 from residential rehabilitation and 7 people from inpatient care. A further 230 people received treatment for non-opiate use in community care, 11 from residential rehabilitation and 11 people from inpatient care.
  - Rate of adults in specialist drug misuse services per 1000 population in Enfield (4.4) (equivalent to 979 adults) was mid-range of London boroughs (2.4-9.5) and lower than London region (5.1) or England (5.0) (2013/14). In 2014/15, the number of adults in specialist drug misuse services was similar (992).
  - Waiting times: Proportion waiting more than three weeks for treatment in Enfield (1.7%) was low as for most London boroughs (range 0-2.7%) (2013/14).
  - Offenders: Proportion entering prison with substance dependence issues who were previously not know to community treatment in Enfield (63.4%) was 3rd highest of London boroughs (range 36.1-69.8%) and higher than London region (57.1%) or England (46.9%) (2012/2013) (NDTMS, 2014).
Outcomes: Proportion experiencing successful outcomes from treatment in Enfield for:
- Opiate use (10.0%) (50 individuals) was mid-range for London boroughs (range 4.2-14.8%) and slightly higher than London region (9.0%) or England (7.8%) (2013) (NDTMS, 2014). In 2014/15 this was 47 individuals (NDTMS, 2016)
- Non-opiate use (47.2%) (266 individuals) was 4th highest of London boroughs (range 20.4-60.2%) and higher than London region (37.2%) or England (37.7%) (2013) (NDTMS, 2014). In 2014/15 this had reduced to 109 individuals (NDTMS, 2016)

Hospital admission rate for 15-24 year olds due to substance misuse (directly standardised per 100,000 population) in Enfield (43.9) (equivalent to 30 adults) was 3rd lowest of London boroughs (range 39.4-118.7) and lower than London region (65.2) or England (81.3) (2011/12-2013/14) (HES, 2014)

Dual diagnosis
Proportion in Enfield receiving concurrent treatment from mental health services and (2014/15) (NDTMS, 2015):
- Alcohol misuse services (31%/ 104 patients) was mid-range for London boroughs (2014/15)
- Drug misuse services (28.7%/ 278 patients) was 13th highest of London boroughs (range 12.3-46.8%) and similar to London region (28.3%)

Smoking
- Smoking is the single largest cause of long term physical illness and premature death including for people with mental health conditions
- Proportion of adults who smoke in Enfield (13.6%) (32,990 smokers) was 8th lowest of London boroughs (range 11.2-22.2%) and lower than London region (17.0%) or England (18.0%) (IHS, 2014). However, the proportion of primary care population recorded as smokers in Enfield (18.9%) (47,781 smokers) was higher than the IHS figure above, 13th highest of London boroughs (range 13.1-22.0%) and slightly higher than London region (17.8%) or England (18.4%) (2014-2015) (HSCIC, 2015)
- Estimated 23,964 smokers with different mental health conditions in Enfield was (McManus et al, 2010):
  - Common mental disorder: 11,554
  - Psychosis: 458
  - Alcohol dependence (higher risk drinkers): 7,624
  - Drug dependence: 4,328
- Smoking cessation provision (2014/15) (HSCIC, 2015)
  - Proportion of smokers who had record of offer of support and treatment from primary care in previous two years in Enfield (86.5%) was mid-range for London boroughs (range 81.1-93.8%) and similar to London region (86.5%) and England (85.8%)
  - Proportion of all smokers setting a quit date with stop smoking services in Enfield (6.8%) was 11th highest of London boroughs (3.2-35.1%) and higher than London region (6.2%) or England (5.6)
  - Proportion of all smokers achieving a CO validated 4 week quit from stop smoking services in Enfield (1.1%) was 3rd lowest of London boroughs (0.7-16.7%) and lower than London region (2.0%) or England (2.0%) (2014/15) (HSCIC, 2015)
Smoking cessation has at least the same impact on anxiety and depressive symptoms as antidepressants (Taylor et al, 2014) as well as being the most preventable cause of death in people with mental health conditions. No information was provided about smoking cessation for the estimated 23,964 smokers with mental health conditions in Enfield. BEH MHT has started with forensics which is being evaluated before any further roll out although no information was provided about numbers receiving smoking cessation intervention in secondary care.

Self-harm
- Self-harm is an important risk factor affecting around half of people who die by suicide.
- Self-harm rates are higher in people with mental health conditions.
- Estimated proportion of Enfield population who during their lifetime attempt suicide (10.6%/ 25,713 adults) and self-harm (8.6%/ 20,862 adults) (from McManus et al, 2009).
- Admissions rate in Enfield compared to other London boroughs for:
  - Self-harm in 10-24 year olds (125 individuals) was 12th lowest (HES, 2015).
  - Emergency admissions for self-harm was 5th lowest of London boroughs (HES, 2015).
  - Alcohol-related intentional self-poisoning was 2nd lowest (LAPE, 2014).

Suicide
- Mortality rate from suicide and undetermined injury (standardised per 100,000 population) in Enfield (5.5) was 5th lowest of London boroughs (range 4.5-9.9) and lower than London region (7.0) or England (8.8) (2012-14) (ONS, 2015).
- Enfield Lock was identified as a suicide hot spot although 16 people had suicided on rail tracks in Enfield since 2007.
- Majority of suicides by people with mental health conditions.
- No comprehensive Local Suicide Action Plan (LSAP) in the BEH areas.
- Joint partnership between British Transport Police (BTP), BEH-MHT, Papryus (prevention of young suicide) and Maytree.
- Suicide prevention through GP training results in net savings of £44 for every £1 invested (Knapp et al, 2011). If all GP’s in Enfield received such an intervention, estimated savings would be £3.4m after one year, £6.2m after five years and £7.6m after ten years.

Parental mental health conditions
- Parental mental health conditions have a broad range of impacts including on the family and children. Children of parents with a mental health condition are at increased risk of mental health conditions.
- Estimated numbers of parents with different mental health conditions in Enfield:
  - Common mental disorder (15.6%): 11,538 parents.
  - Psychosis (0.46%): 340 parents.
  - Personality disorder (4.4%): 3,254 parents.
  - Eating disorder (7.0%): 5,177 parents.
  - Binge drinkers (12.2%): 9,024 parents.
  - Higher risk drinkers (6.6%): 4,882 parents.
  - Drug dependent (0.74%): 547 parents.
No information was available about the proportion of 20,309 parents in Enfield receiving treatment for common mental disorder, psychosis, personality disorder and eating disorder. BEH-MHT had no mother and baby unit (NHS Benchmarking, 2015). The Enfield Schools and children’s services safeguarding children self-assessment (Enfield, 2014) found that little information was held about the crossover between parental and child mental health.

Low rates of treatment in Enfield for parents in Enfield with drug problems (68 parents in treatment vs estimated 547 parents with drug dependence) and alcohol problems (55 parents vs estimated 13,906 parents who were higher risk or binge drinkers) (2011/12) (NDTMS, 2013)

Parental mental health conditions during the perinatal period

- Estimated number of women who required mental health support during pregnancy or the postnatal period in Enfield (605) was 7th highest of London boroughs (2012)
- Estimated number of new mothers in Enfield with mild to moderate common mental disorder (482-724), PTSD (155), adjustment disorder/distress (724-1446), severe depressive illness (145), psychosis (9.6), chronic SMI (9.6) (JCPMH, 2012)
- Local information provided about local treatment and support for new mothers did not include how many received treatment from different services or associated outcomes

4) Secondary care for adult with mental health conditions

Access to NHS funded adult specialist mental health services

- Access rate to secondary mental health services per 100,000 population in NHS Enfield CCG (1,807) was 15th lowest of London boroughs (range 1,226-3,192) and lower than London region (1,978) or England (2,214) (2014/15 Q4) (HSCIC, 2015). Rate of access per 100,000 population in Enfield reduced from 2,060 in 2013/14 Q1 to 1,807 in 2014/15 Q4
- Access rate with secondary services was associated with deprivation although Enfield had a lower rate than would be expected for its level of deprivation
- Proportion of people in contact with mental health services who were from BME groups in NHS Enfield CCG (21.0%) was 9th lowest of London boroughs (range 6.3-51.9%) compared to London region (29.3%) and England (8.6%) (2012/13) (HSCIC, 2014)
- Attendance rate at A&E for psychiatric disorders per 100,000 population in NHS Enfield CCG (17.3) was lowest of London boroughs (range 17.3-640.3) and lower than London region (215.8) or England (243.5) (2012/13) (HSCIC, 2013). Attendance rate at A&E for psychiatric disorders was not associated with deprivation

Admissions

- Admission rate per 100,000 population in:
  - NHS Enfield CCG (72.0) was 14th lowest of London boroughs (range 27.6-157.2), lower than London region (86.1) but higher than England (69.8) (HSCIC, 2015). Admission rate in Enfield had risen from 59.9 in 2013/14 Q1 to 72.0 in 2014/15 Q2 (HSCIC, 2015)
  - BEH-MHT for adults (313) was 3rd highest of London trusts and just above the upper quartile (299) for trusts nationally (2014/15) (NHS Benchmarking Network, 2015)
  - BEH-MHT for older adult (162) was mid-range for London trusts and just above lower quartile (146) for trusts nationally (2014/15) (NHS Benchmarking Network, 2015)
• Admission rates for people using secondary mental health services in (HSCIC, 2015):
  o NHS Enfield CCG (5.5%) was 2\textsuperscript{nd} highest of London boroughs (range 1.8-5.6%) and higher than London region (3.4%) or England (2.5%) (Q2 2014/15) (HSCIC, 2014). Admission rate for mental health service users had increased over previous 18 months
  o BEH-MHT (3.7%) was 3\textsuperscript{rd} highest of London comparator trusts (range 2.0-4.2%) and higher than London commissioning region (3.3%) or England (2.5) (2014/15 Q4)

• Proportion of admissions which were emergency in (2014/15 Q2) (HSCIC, 2015)
  o NHS Enfield CCG (47.8%) was 3\textsuperscript{rd} lowest of London boroughs (range 30.8-92.9%) and lower than England (73.5%)
  o BEH-MHT (48.6%) was 2\textsuperscript{nd} lowest of London comparator trusts (range 37.3-90.6%) and lower than London commissioning region (66.9%) or England (73.5%)

• Proportion of admissions which were emergency re-admissions in BEH-MHT in 2014/15 Q2 (5.4%) was 3\textsuperscript{rd} lowest of London comparator trusts (range 3.2-15.8%) and lower than London commissioning region (8.0%) or England (9.3%) (HSCIC, 2015)

• Opportunity: Admission rates were lower in Enfield than for BEH-MHT although 2\textsuperscript{nd} highest of London boroughs for people in Enfield already using secondary mental health services. Suggests opportunities to reduce admissions for people already in secondary care

Bed availability
• Acute beds per 100,000 population for BEH-MHT (2014/15) (NHS Benchmarking Network, 2015) for:
  o Adults (25.0) was above the upper quartile (23.8) for trusts nationally but 3\textsuperscript{rd} lowest of London trusts
  o Older adults (19) was below the lower quartile (37) for trusts nationally and 2\textsuperscript{nd} lowest of London trusts

  o Number (22) compared to 75 for the BEH-MHT
  o Occupied bed days (114) compared to 477 for the BEH-MHT
  o Note that the Carnal Farrer had forecast 2,336 bed days required for adult acute external placements in 2013/14

Bed occupancy
• Bed occupancy (excluding leave) for BEH-MHT (2014/15) (NHS Benchmarking Network, 2015) for:
  o Acute adult and older adult (100%) was highest for trusts within London and nationally
  o Long term complex care (97.1%) was 3\textsuperscript{rd} highest for trusts nationally and 2\textsuperscript{nd} highest for London trusts
  o Psychiatric Intensive Care Units (97.8%) higher than upper quartile (91.8%) for trusts nationally and highest for London trusts
  o Medium secure (96.7%) was above upper quartile (95.2%) for trusts nationally and mid-range for London trusts
  o Low secure (93.7%) was below upper quartile (95.4%) for trusts nationally and mid-range for London trusts
  o Eating disorders (74.9%) was below lower quartile (79.2%) for trusts nationally and 2\textsuperscript{nd} lowest of four London trusts
• Occupied bed days (excluding leave) per 100,000 population for BEH-MHT (2014/15) (NHS Benchmarking Network, 2015):
  o Adults (9,156) was above the upper quartile (8,233) for trusts nationally and mid-range for London trusts
  o Older adults (7,005) was below the lower quartile (11,091) for trusts nationally and 2nd lowest for London trusts

• Mean length of stay in days (excluding leave and unadjusted for outliers) for BEH-MHT (2014/15) (NHS Benchmarking Network, 2015):
  o Adults (26.0) was close to lower quartile (26.3) for trusts nationally and lowest of London trusts
  o Older adults (32) was lowest of all trusts with national lower quartile (58)
  o Long term complex care (177) was below lower quartile (321) for trusts nationally and lowest for London trusts
  o Psychiatric Intensive Care Units (49) was near mean for trusts nationally and mid-range for London trusts
  o Medium secure (248) was below lower quartile (337) for trusts nationally and 2nd lowest for London trusts
  o Low secure (256) was below lower quartile (265) for trusts nationally and joint lowest for London trusts
  o Eating disorders (97) was near mean (100) for trusts nationally and mid-range for London trusts

Delayed transfers of care due to NHS and social care

• Proportion of transfers of care which were delayed in BEH-MHT for (2014/15) (NHS Benchmarking Network, 2015):
  o Adults (5.6%) was close to the upper quartile (5.8%) for trusts nationally (2014/15) but mid-range for London trusts
  o Older adults (27.9%) was highest of all trusts and much higher than London trusts

• Days of delayed transfer of care per 1000 beds in BEH-MHT due to (2014/15 Q4) (HSCIC, 2015):
  o NHS (21.1) was 3rd highest of London comparator trusts (range 8.3-25.8), higher than London commissioning region (19.1) but lower than England (24.8) (2014/15 Q4) (HSCIC, 2015). However, annual figures for 2014/15 for BEH-MHT (29.8) was close to lower quartile (29.8) for trusts nationally (NHS Benchmarking Network, 2015)
  o Social care (19.3) was mid-range of London comparator trusts (range 8.1-23.3) and higher than London commissioning region (16.8) but lower than England (21.9)
  o Days of transfer of care for older adults for BEH-MHT (35.7) which was 2nd lowest of London trusts but close to the mean (41.0) for trusts nationally (2014/15 (NHS Benchmarking Network, 2015)

Discharges

• Mental health discharge rate for NHS Enfield CCG (75.1) was 14th lowest of London boroughs (range 35.5 to 153.5) but higher than England (69.8) (HSCIC, 2015). Discharge rate increased from 59.0 in 2013/14 Q1 to 75.1 in 2014/15 Q2
• Days of delayed discharge per 1000 mental health bed days in (2014/15 Q2) (HSCIC, 2015):
• NHS Enfield CCG (19.0) was 13th lowest of London boroughs (range 1.2 to 149.7) and lower than London region (32.2) or England (28.3)
• BEH-MHT (34.2) was 4th lowest of London comparator trusts (range 3.3-76.7) and lower than London commissioning region (34.0) or England (28.3)

- Rate of follow for patients on CPA within 7 days after discharge in NHS Enfield CCG (99.4%) was high for London boroughs (range 91.7-100%) and higher than England (97.0%) (2015/16 Q1) (HSCIC, 2015)

**Detention under the Mental Health Act (MHA)**

- Quarterly rate per 100,000 population at which people were subject to MHA in NHS Enfield CCG (73.0) was 8th highest of London boroughs (range 13.2-103.1) and higher than London region (54.6) or England (39.5) (2014/15 Q4) (HSCIC, 2015). Over the last 18 months, there was an initial reduction in detention rate from 88.5 in 2013/14 Q1 to 60.7 in 2013/14 Q3 which has increased over time to 73.0 in 2014/15 Q4
- Rate of detention under MHA on admission per 100,000 in NHS Enfield CCG (18.8) was 11th lowest of London boroughs (range 10.3-47.7) and similar to England (17.7) (2014/15) Q2 (HSCIC, 2015)
- Proportion of admissions which were MHA detentions in BEH-MHT during:
  - 2014/15 Q2 (33.8%) was 3rd highest of London comparator trusts (range 11.4-38.1%) and higher than London commissioning region (29.3%) or England (25.4) (HSCIC, 2015). Rates varied between 28.4% and 33.8% over the last three quarters
  - 2014/15 (35.6%) was mid-range for London trusts and above the mean nationally (32.9%) (NHS Benchmarking Network, 2015)

**Care Programme Approach (CPA)**

- Rate at which people were on CPA per 100,000 of population in NHS Enfield CCG (566) was 9th highest of London boroughs (range 288-761) and higher than London region (494) or England (460) (Q4 2014/15) (HSCIC, 2015)
- Proportion of people using mental health services on CPA in (2014/15 Q4) (HSCIC, 2015)
  - NHS Enfield CCG (31.3%) was 8th highest of London boroughs (range 17.5-38.9%) and higher than London region (25.0%) or England (20.8%)
  - BEH-MHT (29.0%) was 2nd highest of London comparator trusts (range 17.2-31.8%) and higher than London commissioning region (23.9%) or England (20.8%)
- Proportion of people on CPA for more than 12 months who had a review in (Q4 2014/15) (HSCIC, 2015):
  - NHS Enfield CCG (94.8%) was 15th lowest of London boroughs (range 81.7-98.5%) and similar to London region (94.1%) and higher than England (80.4%)
  - BEH-MHT (93.8%) was 3rd lowest of London MH trusts (range 82.4-97.8%), similar to London Commissioning region (94.2%) and higher than England (80.4%)
- Proportion of people on CPA with HoNOS recorded in (Q4 2014/15) (HSCIC, 2015):
  - NHS Enfield CCG (93.4%) was mid-range for London boroughs (range 83.5-99.1%), similar to London region (93.0%) but higher than England (84.0%)
  - BEH-MHT (91.9%) was 4th lowest of London MH Trusts (range 84.1-98.6%), similar to London Commissioning region (92.7%) but higher than England (84.0%)
Proportion of those on CPA in employment in (2014/15 Q4) (HSCIC, 2015):
- NHS Enfield CCG (3.9%) was 5th lowest of London boroughs (range 2.9-10.6%) and lower than London region (5.7%) or England (6.9%)
- BEH-MHT (4.2%) was lowest of London comparator trusts (range 4.2-9.8%) and lower than London commissioning region (5.7%) or England (6.9%)
- Proportion of people in contact with MH services with employment status recorded in BEH-MHT (37.0%) was 4th lowest of London comparator trusts (range 26.7-81.3%), lower than London commissioning region (47.3%) but similar to England (36.6%)

Proportion of people on CPA in settled accommodation in (Q4 2014/15) (HSCIC, 2015):
- NHS Enfield CCG (66.7%) was 5th lowest of London boroughs (range 56.9-92.0%), lower than London region (77.8%) but higher than England (60.7%)
- BEH-MHT (68.0%) was 2nd lowest of London comparator trusts (range 64.2-91.5%), lower than London commissioning region (78.0%) but higher than England (60.7%)
- Proportion of people in contact with MH services with accommodation status recorded in BEH-MHT (36.9%) was 3rd lowest of London comparator trusts (range 26.3-81.3%) and lower than London region (47.4%) or England (40.6%)

Crisis care

Proportion of people in contact with mental health services with a crisis plan in place in (Q4 2014/15) (HSCIC, 2015):
- NHS Enfield CCG (37.8%) was 7th highest of London boroughs (range 8.0-45.2%) and higher than London region (26.4%) or England (17.6%). However, the proportion with crisis plans in place in Enfield had reduced over the last three quarters
- BEH-MHT (37.8%) was 3rd highest of London Mental Health Trusts (range 11.4- 47.0%) and higher than London Commissioning region (25.2%) or England (17.6%)

Crisis Resolution Home Treatment (CRHT) services:
- Proportion of admissions which were gate kept by Crisis Resolution Home Treatment teams in Enfield (100%) was joint highest of London boroughs (92.0-100%) (England 98.1%) (Q4 2014/15) (NHSE, 2015)
- Crisis Resolution and Home Treatment team face to face contact per 100,000 population in BEH trust (8,748) was highest of London trusts and higher than the upper quartile nationally (4,697) (2014/15) (NHS Benchmarking Network, 2015)

During 2014/15 in Enfield for crisis and emergency, there were (locally provided figures)
- 2,400 contacts with Triage
- 14,160 contacts with Crisis Resolution Home Treatment teams
- 14 contacts with Day Therapy
- 16,344 Occupied Bed Days (OBD)
- 1,778 OBDS for PICU
- 120 OBDS for external placements
- 3,572 OBDS for Recovery Houses

A survey of 89 service user across BEH-MHT regarding their experiences of crisis care highlighted the importance of better community mental health services, being listened to, psychological therapy, good quality inpatient care, and medication reviews (Bhandari & Irvani-pour, 2015). Findings included:
o Large number of service users reported good examples of care in acute wards across BEH-MHT inpatient settings
o 76% had contact with mental health services prior to their most recent mental health crisis with 56% using the CRHTT during their most recent contact
o Review of medication was reported by 25% as possibly something preventing a crisis
o Under use of community services including the voluntary sector, charity organisations, liaison and IAPT services
o Lack of awareness of A&E psychiatric liaison with 53% being unaware of this service
o GPs supported at least 50% of individuals in crises but only referred 12% to mental health services which could improve with mental health training for GP’s

Community secondary care

- Community mental health team caseload per 100,000 population in BEH-MHT for people aged 16-64 (1,865) was 2nd highest of London trusts and above 64 (2,925) was mid-range for London trusts (2014/15) (NHS Benchmarking Network, 2015)
- Community mental health team face to face contact per 100,000 population in BEH-MHT for people aged 16-64 (42,805) was mid-range for London trusts and aged above 64 (53,882) was 3rd highest of London trusts (2014/15) (NHS Benchmarking Network, 2015)
- Assertive outreach: Rate of people accessing Assertive Outreach Services per 100,000 population in NHS Enfield CCG (18.8) was 5th lowest of London boroughs (range 1.9-112.1) and lower than London region (46.2) or England (21.5) (Q2 2014/15) (HSCIC, 2015)
- Contact and day-care attendance rate per 100,000 population in NHS Enfield CCG (15,689) was 10th highest of London boroughs (range 9,256-19,957) and higher than London region (14,025) or England (12,490) (Q2 2014/15) (HSCIC, 2015)
- Recovery houses: No information was provided about the number of bed days in recovery houses and bed and breakfasts

Liaison

Previous research (RAID) highlighted that liaison input for people who were already inpatients resulted in economic savings. However, increases in patients presenting at A&E over the past two years has resulted in activity primarily focused on patients presenting to A&E. Possible reasons include closure of drop in centres. An audit of 576 patients seen by BEH-MHT liaison services between December 2014 and January 2015 found that 10% were referred to the Crisis team and 5.2% were admitted

Balance of between community and inpatient activity in BEH-MHT trust in (2014/15)

- Community care (86.9%) was between the national mean (86.0%) and median (87.0%)
- Hospital care (13.1%) was between the national mean (14.0%) and median (13.0%)
- Proportion of service users under the care of community teams (96.7%) was similar to nationally (mean 98.0%)
- Proportion of service users in hospital (3.3%) was higher than nationally (mean 2.0%)
Diagnostic coding
- Proportion in contact with mental health services with a diagnosis recorded in (2014/15 Q4) (HSCIC, 2015):
  - NHS Enfield CCG (26.8%) was 9th lowest of London boroughs (range 15.7-59.6%) and lower than London region (35.0%) or England (16.4%)
  - BEH-MHT (27.6%) was 3rd lowest of London comparator trusts (range 17.7-48.7%) and lower than London commissioning region (34.0%) but higher than England (16.4%)

Clustering
- Proportion assigned to a mental cluster in
  - NHS Enfield CCG (76.9%) was 14th lowest of London boroughs (range 55.0-92.1%), similar to London (77.1%) but higher than England (69.0%) (2013/14 Q1) (HSCIC, 2014)
  - BEH-MHT (67.6%) was 4th highest of London comparator trusts (range 27.6-79.8%) and higher than London (55.3%) or England (59.0%) (2014/15 Q4) (HSCIC, 2015)
- Proportion of inpatients in BEH-MHT assigned to different clusters varied from 2nd highest to lowest of London trusts (2014/15) (NHS Benchmarking Network, 2015)
- Proportion of community patients in BEH-MHT assigned to different clusters varied from 3rd highest to lowest of London trusts (2014/15) (NHS Benchmarking Network, 2015)
- Proportion of community contacts in BEH-MHT by different clusters varied from highest to lowest of London trusts (2014/15) (NHS Benchmarking Network, 2015)

Secondary mental health care quality indicators
- Patient experience in BEH-MHT of (NHSE, 2013):
  - ‘Access and waiting’, ‘safe and high quality care’, and ‘better information and more choice’ were mid-range for London comparator trusts
  - Building close relationships (7.83) was 2nd lowest of London comparator trusts (range 7.75-8.43) and lower than England (8.11)
- Satisfaction in BEH-MHT
  - Community team patient satisfaction score (62.0%) was lowest of London or other trusts (lower quartile nationally 67.0%)
  - Staff satisfaction score (75.0%) was 2nd lowest of London trust but just below the mean nationally 76.0% (2014/15) (NHS Staff, 2015)
- Safety: Compared to other London trusts, BEH-MHT rates of serious incidents were mid-range, ligature incidents were lowest, incidents of physical violence to patients lowest, and incidents of physical violence to staff 2nd lowest (2014/15)
- Complaint rates in BEH-MHT were mid-range for London trusts and just below the mean nationally (2014/15) (NHS Benchmarking Network, 2015)
- Staff training and experience: Compared to other London trusts, proportion of staff in the last year in BEH-MHT (NHSE, 2014):
  - Receiving job relevant training, learning or development (79.4%) was lowest
  - Receiving health and safety training (55.7%) was lowest
  - Witnessing potentially harmful errors, near misses or incidents was mid-range

- Balance of workforce: Proportion of workforce working in
  - Community services (52.2%) was lower than nationally (mean 54.2%)
  - Hospital services (47.8%) was higher than nationally (mean 45.8%)
- Rate of provision of consultant psychiatrists per 10 beds in different types of unit in BEH-MHT compared to other London trusts varied from highest to 2nd lowest
- Rate of provision of qualified nurses per 10 beds in different types of unit in BEH-MHT compared to other London trusts varied from highest to 2nd lowest
- Rate of provision of PICU therapists per 10 beds in BEH-MHT (0.4) was at lower quartile level nationally and mid-range of London trusts
- Vacancy rates for acute adult workforce as % of WTE in BEH-MHT (32.1%) was highest of any trust nationally or within London with mean level 13.3% nationally

5) Social care and third sector care for adults with mental health conditions

Social care for adults with mental health conditions

- Rate of mental health clients receiving social care per 100,000 population in Enfield (262) was 14th lowest of London boroughs (range 81-1,017) and lower than London region (385) or England (384) (2013/14) (HSCIC, 2014). The rate was not associated with deprivation as would be expected if this was related to need
- New social care assessment rate for adult mental health clients per 100,000 population in Enfield (133) was 16th lowest of London boroughs (range 2-1,917) and lower than London region (332) or England (265) (2013/14) (HSCIC, 2014)
- Social care mental health clients aged 18-64 per 100,000 population in Enfield (2013/14) (HSCIC, 2014):  
  - In residential and nursing care (20.1) was 13th lowest of London boroughs (range 2.8–108.5) and lower than London region (29.7) or England (31.9)
  - Receiving home care (98.1) was 4th highest of London boroughs (range 0-229.6) and lower than London region (46.1) or England (42.2)
  - Receiving day care or day services (15.1) was low compared to other London boroughs (range 0-178.9) and lower than London region (43.2) or England (34)
- Proportion of social care mental health clients in Enfield receiving (2013/14) (HSCIC, 2014):
  - Direct payments (13.4%) was 13th highest of London boroughs (range 0.8-85.7%) and higher than London region (10.7%) or England (10.7%)
  - Direct payments or a personal budgets (59.8%) was 12th highest of London boroughs (range 3.8-100%) and higher than London region (34.5%) or England (28.4%)

Third sector care for adults with mental health conditions

- Ebony People’s Association (EPA) provides culturally sensitive services to black minority ethnic people with mental health issues although the charity has recently expanded to people of all ethnicities. It offers a family-centred service designed to bridge the gap between the community and mental health services. EPA is currently designing a
‘volunteer champion’ project which will see a group of service users become ambassadors for the charity

- Richmond Fellowship is a national charity with an office in Enfield. Its employment advisors accept referrals from secondary mental health services and work with clients on a one-to-one basis with the aim of moving them into employment
- Enfield Saheli is a Voluntary organisation which provides advocacy, advice and support to women who are isolated, vulnerable and going through emotional and mental distress. In the past year, it saw 140 service users who have mild to moderate mental Health needs and 53 service users
- Wellbeing Connect Services: In the past year 80 had accessed advocacy services, 25 received information and advice, 14 monthly support meeting and 30 children and young people
- Enfield Carers Centre: During 2014/15, there were 1,329 new carer referrals, 1,115 carer respite breaks, 860 carers used the emergency card scheme, 522 carers attended training and/or workshop sessions and 117 carers received counselling
- Enfield Children and Young Persons Services is a voluntary organisation which provides advice and support to voluntary and community organisations working with children and young people aged 0-25 years (section 9.8)
- Enfield MIND is a third sector organisation which currently delivers multi-cultural counselling. During 2015 to 2016, 274 referrals were received and 207 attended counselling following assessment with 72% satisfaction rate on different measures. Case workers provide housing advice. The psycho-social Support and Well-being Service offers a range of activities including yoga and relaxation. Personal development courses are also provided as part of the psycho-social support and well-being service delivery

6) Economics of mental health conditions

Local cost of mental health conditions
Estimated costs of child and adolescent conduct disorder in Enfield
- Estimated annual costs of crime by adults who had childhood conduct disorder or sub-threshold conduct disorder in Enfield was £339.3m (based on SCMH, 2009)
- Estimated life time cost of a one year cohort of children and adolescents with conduct disorder in Enfield: £480m (based on Friedli and Parsonage, 2007)

Estimated annual costs of different adult mental health conditions in Enfield (using national costs):
- Depression: £44.8m (based on McCrone et al, 2008)
- Anxiety disorder: £53.3m (based on McCrone et al, 2008)
- Psychosis: £69.4m (based on Kirkbride et al, 2012)
- Dementia: £85.5m (based on Knapp & Prince, 2007)
- Personality disorder: £47.3m (based on McCrone et al, 2008)
- Alcohol misuse: £138.2m (from Knapp et al, 2011)
- Smoking: £68.9m (Nash & Featherstone, 2010)
- Class A drug use: £87.4m (Gordon et al, 2006)
- Medically unexplained symptoms: £104.1m (Birmingham et al, 2010)
Total annual costs of adult mental health conditions in Enfield: £698.9m

Further annual Enfield costs of:
- Mental health conditions to employers in Enfield: £142m (based on NICE, 2009)
- Unemployment costs due to mental health conditions in Enfield: £185.5m (based on McCrone et al, 2008)

Cost for each one year cohort of perinatal depression, anxiety and psychosis in Enfield: £40.7m (from Bauer et al, 2014)

**NHS expenditure on adult mental health conditions in Enfield**

- Proportion of overall CCG expenditure on mental health in NHS Enfield CCG (13.8%) was 13th highest of London boroughs (range 8.6-20.9%) and higher than England (12.7%) (2013/14) (NHSE, 2015) (some concerns about data quality). This measure was correlated with deprivation with Enfield CCG close to expected rate. Enfield CCG was 6th highest for other local authorities at third more deprived decile (range £9.3-£19.2)
- Primary care expenditure rate in NHS Enfield CCG on prescribing:
  - Mental health conditions (£7.48 per person) was 9th lowest of London boroughs (range £3.18-10.20) and lower than England (£12.3 per person) (2013/14) (NHSE, 2015). Expenditure was not associated with deprivation
  - Antidepressant (£35.6) was 6th highest of London boroughs (range £22.3-£54.9) but lower than England rate (54.7) (2014/15 Q4) (HSCIC, 2015). Rate of prescribing was not associated with deprivation as would be expected if prescribing was associated with level of need
  - Hypnotics and anxiolytics (92.4) was 14th lowest of London boroughs (range £50.2-139.9) and lower than England (137.5) (2014/15 Q4) (HSCIC, 2015)
  - Psychoses and related disorders (639) was 13th lowest of London boroughs (range £419-877) and lower than England rate (677) (2014/15 Q4) (HSCIC, 2015). Expenditure on prescribing for anti-psychotic medication was associated with socioeconomic deprivation although lower than expected in Enfield
- Specialist mental health service per person expenditure in NHS Enfield CCG (£136.2) was 15th highest of London boroughs (range £81.3-£272.3) but lower than England (£151.1) (2013/14)
- Cost per bed in BEH-MHT (2014/15) (Benchmarking Network, 2015) for
  - Acute adults (£105,372) was 2nd lowest of London trusts and below the lower quartile nationally (£112,024)
  - Older adults (£98,964) was 2nd lowest of London trusts and below the lower quartile nationally (£113,857)
- Cost per occupied bed day in BEH-MHT (2014/15) (Benchmarking Network, 2015) for:
  - Acute adult (£296) was 2nd lowest of London trusts and below the lower quartile nationally (£330)
  - Older adult (£271) was lowest of London trusts and below lower quartile nationally (£359)
- Cost in BEH-MHT (2014/15) (Benchmarking Network, 2015) for
Acute adult admission (£8,651) was lowest of London trusts and below the lower quartile nationally (£9,337)
Older adult (£271) was lowest of London trusts and below the lower quartile nationally (£359)
Patient on the generic CMHT caseload (£1,656) was lowest of London trusts and below the lower quartile nationally (£1,960)
  - Community care (56.4%) was higher than the mean nationally (51.7%)
  - Hospital care (43.6%) was lower than the mean nationally (48.3%)

Potential economic savings from improved coverage of treatment of mental health conditions
The last mental health strategy included estimated economic savings of different public mental health interventions (Knapp et al, 2011). The following outlines potential economic savings of treatment of mental health conditions in Enfield:

- Conduct disorder: Estimated net savings if parents of all children and adolescents estimated to have conduct disorder in Enfield received parenting interventions would be £29.7m (£24.0m crime savings, £4.1m NHS savings and £1.4m education savings) (section 2.5)
- First episode psychosis: Estimated net savings over standard care if all people estimated to develop first episode psychosis in Enfield each year received care from Early Intervention Psychosis services would be £3.0m (£1.2m NHS savings, £1.4m productivity savings and £0.25m intangible savings). The intervention is cost saving to the NHS after one year (section 3.B.7). Most recent estimates suggest that 47.0% of estimated new cases of psychosis were seen by Early Intervention Psychosis services in Enfield which is lower than 59.4% in England
- Pre-psychosis: Estimated net savings if all people estimated to develop a Clinical High Risk State (CHRS) in Enfield each year received care from early detection services would be £5.4m (£1.8m NHS savings, £3.4m productivity savings). The intervention is cost savings to the NHS by the end of the second year. Currently, there are no CHRS services in Enfield
- Family therapy for schizophrenia: Estimated savings to NHS over 3 years if all people in Enfield estimated to have psychotic disorder in previous year received family therapy would be £4.8m (see section 3.B.2)
- CBT for schizophrenia: Estimated savings to NHS over 3 years if all people in Enfield estimated to have psychotic disorder in previous year received CBT would be £1.1m (from Knapp et al, 2014)
- Increasing risk drinkers: Estimated net savings if all increasing risk, higher risk and binge drinkers in Enfield received screening and brief interventions in primary care would be £18.7m (£9.6m crime savings, £5.5m productivity savings and £3.6m NHS savings) (from Knapp et al, 2011)

7) Risk factors for mental health conditions

Certain factors are associated with increased risk of mental health conditions and poor wellbeing. Addressing such factors reduce associated risk.

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7.1 Deprivation

- Deprivation is associated with increased risk of mental health conditions which then result in a range of further inequalities (Campion et al, 2013)
- Nationally, Enfield is the 64th most deprived of the 326 local authorities in England and 14th most deprived borough in London
- Enfield has 177 LSOA’s which vary in deprivation score from 4.62 to 58.93 (DCLG, 2010)
- Proportion living in 20% most deprived areas in Enfield (27.7%) was 13th highest of London boroughs (range 0-83.8%), the same as London region (27.7%) and higher than England (20.4%) (DCLG, 2013)
- Reduction of inequalities requires action on six policy objectives (Marmot et al, 2010). Information on local programmes to address inequality was not provided.

7.2 Household factors

- Homelessness
  - Associated with increased risk of mental health conditions
  - Statutory homelessness per 1000 households in Enfield (5.0) was 15th highest of London boroughs (range 0.8-12.5) and the same as London region (5.0) but higher than England (2.3) (2013/14) (DCLG, 2015)
  - Rate of households in temporary accommodation per 1000 households in Enfield (17.8) was 8th highest of London boroughs (range 1.3-29.7) and higher than London region (12.8 and England (2.6) (2013/14) (DCLG, 2015)
  - No information was provided about local work.
- Fuel poverty
  - Proportion of households in fuel poverty in Enfield (10.6%) was 10th highest of London boroughs (range 3.9-14.9%) and similar to London region (9.8%) and England (10.4%) (DECC, 2013). This equates to 12,711 households in Enfield (ONS, 2012)
  - Local interventions: Citizens Advice Bureau reported that of the 137 people who came for Energy Best Deal appointments (which are specifically for people in fuel poverty) in 2015, 11 had declared mental health problems. A further 87 Smart Homes grants had been approved for energy efficient measures
- Debt: Debt mediates the impact of socioeconomic deprivation on risk of mental health conditions. Debt advice is cost effective and results in net savings of £4 for each £ spent (Knapp et al, 2011). No information was provided about provision of debt advice including for people with mental health conditions.

7.3 Pregnancy factors

- Smoking in pregnancy is associated with increased risk of childhood mental health conditions
  - Proportion of women who smoke at time of delivery in NHS Enfield CCG (6.7%) was 7th highest of London boroughs (range 1.6-9.8%) and higher than London region (5.2%) or England (5.2%) (2014/15 Q4) (HSCIC, 2015)
  - During 2014/15, 35.6% of the estimated pregnant smoker in Enfield set a quit date which was 2nd highest of London boroughs (HSCIC, 2015). Although self-reported quit rate were 80%, CO validated quit rate was 10% with a further 20% lost to follow up
• Low birth weight is associated with increased risk of mental disorder. Proportion of babies recorded as having a low birth weight (less than 2,500g) in 2014 in Enfield (2.7%) was 8th lowest of London boroughs (range 2.1-5.0%) (ONS, 2015)

7.4 Parental factors
• Parental mental health conditions
  o These have a broad range of impacts including on the family and children. Children of parents with a mental health condition are at increased risk of mental health conditions
  o Treatment of parental mental health conditions is therefore important to prevent a broad range of impacts including mental health conditions in their children
  o Estimated numbers of parents with different mental health conditions in Enfield was estimated in section 3M which highlighted that no information was available about the proportion of 20,309 parents with common mental disorder, psychosis, personality disorder and eating disorder receiving treatment. The Enfield Schools and children’s services safeguarding children self-assessment (Enfield, 2014) found that little information was held about the crossover between parental and child mental health
  o Estimated number of new mothers with different mental health conditions in Enfield included mild to moderate common mental disorder (482-724), PTSD (155), adjustment disorder/distress (724-1446), severe depressive illness (145), psychosis (9.6), chronic SMI (9.6) (JCPMH, 2012)
  o No information about proportion of estimated at least 1,526 new mothers with mental health conditions receiving treatment (section 3M)
• Teenage pregnancy
  o Proportion of deliveries to mothers under the age of 18 in Enfield (0.9%) was 2nd highest of London boroughs (range 0.2-1.0%), higher than London region (0.5%) and similar to England (1.0%) (2013/14) (HES, 2014)
  o Family Nurse Partnership (FNP) supports 72 first time mothers aged 19 and under and reported that 30% of young parents self-report as suffering from depression and anxiety
• Parental unemployment
  o 20% of children without a working parent had a mental disorder compared to 9% of children with one parent working (Green et al, 2005)
  o Proportion of households with dependent children where there was no adults in employment in Enfield (8.5%) was 2nd highest of London boroughs (range 0.9-10.4%) and higher than London region (5.7%) (ONS, 2011). This equates to 10,169 households
  o No information was provided about work targeting the mental health of unemployed or their families

7.5 Child risk factors
• Obesity: Proportion of children in Enfield who were obese in reception year and year 6 was 9th highest of London boroughs and higher than London or England (2013/14) (HSCIC, 2014)
• Child poverty
  o Rates of mental health conditions in children and adolescents from lowest 20% household income are three higher than for those in highest 20% (Green et al, 2005)
  o Proportion of dependent children under 16 living in poverty in Enfield (29.6%) was 6th highest of London boroughs (range 8.8-37.9%) and higher than London region (23.7%) or
Proportion of young people presenting to CAMHS in Enfield who were living in financial difficulty was 19% (Earle et al).

- **Children in need**
  - A child in need has been referred to children’s social care services, and who has been assessed, usually through an initial assessment, to be in need of social care services.
  - Rate of ‘children in need’ per 10,000 people aged under 18 in Enfield (560) (4,533 children) was 11th lowest of London boroughs (range 339-1,159) and lower than London region (685) or England (679) (2013/14) (DfE, 2015).

**Child abuse**

- Child adversity accounts for 30% of adult mental disorder although the more severe the adversity, the greater the risk.
  - Young people aged 11–17 years who experienced severe maltreatment by a parent or guardian were 6.4 times more likely to have current suicide ideation and 4.6 times more likely to have self-harm thoughts than those who were not severely maltreated (Radford/NSPCC, 2011).
  - Repeated sexual abuse/intercourse in England during childhood and adolescence is associated with several fold higher rates of adult mental disorder (Jonas et al, 2011) and attempted suicide (Bebbington et al, 2009).

- Numbers of 11-17 year olds in Enfield estimated to have experienced different types of abuse (from national survey by Radford/NSPCC, 2011):
  - Severe maltreatment: 3,847 individuals
  - Severe physical violence at the hands of an adult: 1,981 individuals
  - Emotional abuse during childhood: 1,952 individuals
  - Severe neglect during childhood: 3,819 individuals

- Estimated numbers who have experienced sexual abuse in Enfield:
  - Non-consensual sexual intercourse before age 16: 1,517 under-18 year olds (Bebbington et al, 2011)
  - Non-consensual sexual intercourse and touching before age 16: 6,724 under-18 year olds (Bebbington et al, 2011)
  - Contact sexual abuse during past year: 546 individuals aged 11-17 (Radford/NSPCC, 2011)
  - A review of the child sexual assault pathway for London (Goddard et al, 2015) recommended the establishment of five Child Houses in London and an enhanced paediatric service at the Havens (sexual assault referral centres).

- Interventions to address and prevent abuse
  - **Child Protection Plans (CPP)**
    - Rate of children who were the subject of a CPP per 10,000 people at the end of the year in Enfield (25.2) was 2nd lowest of London boroughs (range 0-57.8) and lower than London region (37.2) or England (42.0) (2013/14) (DfE, 2015). The number of children who were the subject of a child protection plan during the year in Enfield was 257 with 12 due to sexual abuse (2013/14).
    - Rate of children who were the subject of a new CPP per 10,000 people during the year in Enfield (31.8) (257 individuals) was 6th lowest of London boroughs (range 22.4-75.2) and lower than London region (43.0) or England (52.0) (2013/14).
During 2014/15, the number of children who became the subject of a CPP in Enfield had increased to 342 with 44% due to neglect, 8.2% due to physical abuse, 2.3% due to sexual abuse and 44.7% due to emotional abuse (DfE, 2015).

Proportion of Enfield CPP assessments where factors were identified included domestic violence (46.5%), mental health (29.2%), learning disability (17.3%), physical disability or illness alcohol misuse (12.0%), drug misuse (12.8%), physical disability or illness (12.5%), young carer (4.4%), gangs (2.9%) and child sexual exploitation (2.5%) (2014/15) (DfE, 2015).

Proportion of young people in CAMHS in Enfield who were subject to a CPP was 7% which equates to 111 individuals (Earle et al).

- Local CAMHS: Proportion of young people in Enfield CAMHS who had experienced child abuse was 28% which equates to 444 individuals (Earle et al).

Other interventions including:
- School based programmes to detect and prevent abuse: No information provided.
- Parenting interventions at SPOE: Strengthening Families Strengthening Communities parenting course was completed by 104 parents the between April to July 2014.
- Interventions to address domestic violence (section E.5).
- Expenditure rate on safeguarding children and young people’s services per 10,000 0-17 year olds in Enfield (£1.46m) was 5th lowest of London boroughs (range £1.04-£11.07m) and lower than London region (£2.38m) or England (£1.76m) (2013/2014) (DfE, 2015).

Bullying

- Proportion of 15 year olds who bullied others in the past two months in Enfield (48.1%) was 6th lowest of London boroughs (range 42.6-55.2%).
- Cyber-bullying: Estimated numbers of 10-17 year olds experiencing cyber-bullying in Enfield was 5,276 individuals.

Interventions

- No information was provided about school based bullying prevention programmes.
- School-based interventions to reduce bullying: result in £14 saved for each pound spent (Knapp et al, 2011). If all children aged 5-16 in Enfield received school based bullying prevention programmes, net savings would be £56.7m.

7.6 School factors

School days missed and school exclusions are associated with child mental health conditions and parental factors.

- Proportion of half days missed in Enfield by primary school pupils (4.3%) was 6th highest of London boroughs and for secondary school pupils (5.1%) 3rd highest of London boroughs (2014/15) (DfE, 2015).
- Fixed period exclusion rate in Enfield compared to other London boroughs (2013/14) (DfE, 2014)
  - Primary school (1.2%) and secondary school (8.7%) pupils were 3rd highest.
  - Due to drugs/alcohol use (0.088%) (49 individuals) was 13th highest.
  - Due to persistent disruptive behaviour (0.90%) was 2nd highest.

- Permanent exclusion rate from secondary schools in Enfield (0.22%) was 8th highest of London boroughs (range 0-0.30%) and higher than London region (0.16%) or England (0.12%) (2012/13) (DfE, 2014).
• Information on local provision of school based tier 2 CAMHS interventions is outlined in section 2.2 including Health and Emotional Wellbeing Service (HEWS), educational psychology, Place2Be, Early Years Social Inclusion (EYSI) team, Nurture groups, behaviour support service, pupil referral unit, Change and Challenge (Troubled Families) Programme, and voluntary sector including for young carers (section 7.8.3)

• School-based social and emotional learning programmes to prevent conduct disorder to all 10 year olds in Enfield would result in net savings of £27.1m after five years and £42.7m after ten years (Knapp et al, 2011) (see section 7.11)

7.7 Screen time and sleep deprivation

• Screen time is now the main waking activity of children (Sigman, 2014), associated with poor wellbeing (Sigman, 2012) and displaces many other activities which promote good physical and mental health. Evidence suggests a “dose-response” relationship, where each additional hour of viewing increases the likelihood of experiencing socio-emotional problems’ (PHE, 2014). US Department of Health issued recommended limits for screen time’ as one of its national ‘health improvement priorities’ and a key ‘disease prevention objective’ (US DHHS, 2014). Advice and information could be provided to pupils and parents.

• Sufficient sleep is an important protective factor for wellbeing particularly during childhood. However, more than one in four 14 and 15-year-old girls (28%), and just over a fifth of boys of the same age (22%) do not think they sleep enough to concentrate on their studies (Balding and Regis, 2012). This could be improved through appropriate information to students and parents regarding sleep hygiene which could be liked to information about screen time.

7.8 Child and adolescent higher risk groups

• Looked after children (LAC)
  o LAC have 5-fold increased risk of mental health conditions (Ford et al, 2007)
  o Rates of LAC (per 100,000) in Enfield (43.9) was 13th lowest of London boroughs (range 21.7-104.7) and lower than London region (52.0) or England (60.0) in (2014/15) (DfE, 2015). In March 2015, this had increased 360 children with 226 LAC placed in Enfield by other local authorities
  o Reasons for children starting to be looked after in Enfield included abuse or neglect (48%), absent parenting (19%), socially unacceptable behaviour (11%), family dysfunction (9%), family acute stress (9%) and parents illness or disability (4%) (2014/15) (DfE, 2015)
  o Proportion of LAC who achieved 5+GCSE’s E*-C or equivalent in Enfield (41.7%) was highest of London boroughs and higher than London region (20.8%) or England or (15.3%)
  o 58.4% of LAC estimated to have a mental health conditions were on the CAMHS & EPS caseload in March 2015 which provides a range of targeted services for LAC through HEART
  o A local service audit showed that 56% (72/128) of young adults in the Enfield leaving care service were estimated to have mental health needs
  o “In-Step” Fostering Scheme provides rapid and accessible therapeutic support to foster placements where there is a risk of placement breakdown
• Special education needs (SEN)
  o Children with SEN have higher rates of mental disorder (Parry-Langdon, 2008)
  o Proportion of school age pupils with SEN in Enfield (13.8%) was 9th lowest of London
    boroughs (range 10.3-20.6%) and lower than London region (15.6%) or England (15.4%)
    (DfE, 2015)
  o Proportion of school age pupils in Enfield with statements of SEN where primary need is
    social, emotional and mental health in Enfield (2.7%) was 6th highest of London boroughs
    (range 0.3-3.0%) and higher than London region (2.1%) or England (2.0%) (DfE, 2015)
  o Lack of information about proportion receiving treatment for mental health conditions

• Young carers
  o In Enfield, unpaid care was provided by an estimated 675 individuals under-15 years and
    2,018 individuals aged 16-24 (ONS, 2011). Unpaid care more than 20 hours per week
    was provided by estimated 154 individuals under 15 year and 587 individuals aged 16-24
  o In the previous year, Dazu Young Carers project in Enfield provided counselling to 34
    young carers and Enfield borough provided counselling to 51 young carers

• Not in education, employment or training (NEET): Proportion of 16-18 year olds not in
  education, employment or training in Enfield (3.1%) was 14th lowest of London boroughs
  (range 1.5-5.7%) and lower than London region (3.4%) or England (4.7%) (2014) (DfE, 2015).
  No information was provided about local interventions targeting this group

• Young offenders
  o Young offenders have 3-fold increased risk of mental health conditions and suicide
    (Lader et al, 2000)
  o Large proportion of adolescent offending is associated with mental health conditions
    and could be prevented through provision of NICE recommended treatment particularly
    for conduct disorder. Mental health support for offenders would also reduce subsequent
    re-offending
  o Young offenders in Enfield
    ➢ Rate of 10-18 year olds in the youth justice system per 1000 population in Enfield
      (9.1) (337 individuals) was 7th highest of London boroughs (range 4.5-12.4) and
      higher than London region (7.5) or England (7.0) (2013/14) (MoJ, 2015)
    ➢ Rate of 10-17 year olds receiving their first reprimand, warning or conviction per
      100,000 population in Enfield (472) (155 individuals) was 11th highest of London
      boroughs (range 180-707) and higher than London region (426) or England (409)
      (2014) (MoJ, 2015). Rates decreased both nationally and in Enfield since 2010
    ➢ Expenditure rate per 10,000 0-17 year olds on youth justice in Enfield (£0.34m) was
      8th highest of London boroughs (range 0-£0.76m) (2013/14) (DfE, 2014)
  o Several partnerships include with Youth Development Unit, Community Parenting
    Support, Adolescent Support Unit, Change and Challenge Unit, Engaging with NEET’s,
    and with two resettlement consortia (including Enfield) to address the needs of
    sentenced young people. Statutory caseload has increased was 209 in February 2015
  o Rate of proven re-offending after 12 months in Enfield has increased by 4.9% between
    April 2011 and March 2013 compared to a rise of 2.4% in London
  o No information about proportion receiving treatment for mental health conditions
• Number of asylum seeking children who were looked after in Enfield (35) was 3\textsuperscript{rd} highest of London boroughs (range 0-360), similar to London region (0.14%) and lower than England (0.30%) (DfE, 2015).

7.9 Adult risk factors

• Physical inactivity
  o Physical inactivity rate in Enfield (30.0%) was 10\textsuperscript{th} highest of London boroughs (range 15.7-39.3%) and higher than London region (27.0%) or England (27.7%) (Active People Survey, 2015)
  o Proportion with a mean sedentary time in the last week over 7 hours per day in Enfield (70.9%) was 10\textsuperscript{th} highest of London boroughs (range 61.0-77.8%) and similar to London region (69.8%) and England (70.1%) (2014/15) (WAY Survey, 2015)
  o GP Exercise Referral Service has a number of referral criteria including low level anxiety/depression although no information was provided about numbers seen

• Excess weight and obesity: Proportion of adults in Enfield who were (APS, 2014):
  o Obese (26.0%) was 2\textsuperscript{nd} highest of London boroughs (range 13.0-32.2%) and higher than London region (20.2%) or England (24.0%)
  o Overweight or obese (64.8%) was 4\textsuperscript{th} highest of London boroughs (range 46.0-68.4%), higher than London region (58.4%) but similar to England (64.6%)

• Lack of education is associated with increased risk of developing a mental health condition. Proportion of adults with no qualifications or level one qualification in Enfield (35.8%) (86,894 adults) was 4\textsuperscript{th} highest of London boroughs (range 11.0-43.1%) and higher than London region (28.3%) or England (35.8%) (ONS, 2011). No information was provided about numbers attending adult learning.

• Unemployment, economic inactivity and benefit claimants
  o Unemployment rate (aged 16+) in Enfield (8.3%) (13,200 people) was 6\textsuperscript{th} highest of London boroughs (range 4.5-10.8%) and higher than London region (7.0%) or England (6.2%) (2014) (ONS, 2015)
  o Proportion of long-term unemployed (claiming job seekers allowance for over 12 months) in Enfield (0.85%) (1,760 people) was 6\textsuperscript{th} highest of London boroughs (range 0.27-1.12%) and higher than London region (0.68%) or England (0.61%) (2014) (ONS, 2015)
  o Proportion of the population who were benefits claimants in Enfield (2.4%) (5,071 people) was higher than London (2.1%) or England (2.0%) (2014/15) (ONS, 2016)
  o No local information was provided about targeted mental health interventions for unemployed people or benefit claimants

• Loneliness is associated with poor mental and physical health:
  o Proportion of households in Enfield occupied by a single person (10.8%) (33,359 households) was 9\textsuperscript{th} lowest of London boroughs (range 8.0-34.4%) and lower than London region (12.8%) or England (12.8%) (ONS, 2011)
  o Local information about interventions to reduce social isolation in Enfield is highlighted in section 9.11

• Community instability: Level of population turnover (internal migration) per 1000 resident population in Enfield (111.5) was 5\textsuperscript{th} lowest of London boroughs (range 92.6–207.4) and lower than London region (144.9) but higher than England (90.7) (ONS, 2015)
• Crime and violence
  o Violent crime rates in Enfield was 11th lowest of London boroughs while hospital admission rate for violent crime in Enfield was 7th lowest (PHE, 2015)
  o Sexual offence rate in Enfield was 11th lowest of London boroughs (PHE, 2015)
  o Proportion of Enfield Child Protection Plan assessments where domestic violence was identified (46.5%) (2014/15) (DfE, 2015)
  o Referral rate for abuse of people with learning disability in Enfield was 3rd lowest of London boroughs (HSCIC, 2014)
  o Interventions to address violence included several domestic violence workers, a Domestic Violence Intervention Project (online and phone referral) and Multi Agency Risk Conferences (MARAC) which had 696 referrals involving 773 children during 2015, and several services providing psychosexual interventions

7.10 Adult higher risk groups
Particular groups are at several fold increased risk of developing mental health conditions and therefore need targeted interventions to both treat and prevent such conditions arising:
• Long term physical conditions are associated with increased risk of mental health conditions. Opportunities exist to improve detection and treatment of associated mental health conditions which lead to improved outcomes of physical health. Furthermore, such groups at increased risk benefit from interventions to prevent associated mental health conditions
  o Proportion on primary care registers for different long-term physical conditions in Enfield (HSCIC, 2015):
    ➢ Asthma: 4.9% (15,643 people) was 11th highest of London boroughs
    ➢ Chronic obstructive pulmonary disease: 1.1% (3,400 people) was joint 3rd lowest
    ➢ Coronary heart disease: 2.4% (7,656 people) was 9th highest of London boroughs
  o No information about mental health screening of people with long term physical conditions or targeted interventions to promote their mental health
• Learning disability: Proportion of adults with learning disability in Enfield (HSCIC, 2014):
  o Number of adults with learning disability in Enfield registered with primary care (1,154) was higher than number known to local authority (865 adults)
  o Proportion of adults with learning disability compared to other London boroughs was 11th highest for receiving GP health checks (53.6%), 3rd highest for employment (17.3%), 2nd highest for living in stable and appropriate accommodation (79.8%), 3rd lowest for referral for abuse, 7th highest for using community services (80.3%), 10th lowest for receiving direct payments (25.3%) and 3rd highest for being supported by social services
  o No local information about proportion of 2,073 people with learning disability and mental health conditions in Enfield receiving treatment for such conditions
• Carers
  o Carers are important for the recovery of people with mental and physical health conditions although are at higher risk of developing a mental health condition
  o Proportion of people providing unpaid care in Enfield (1.98%) (6,194 people) was 10th highest of London boroughs (range 0.75–2.4%) (ONS, 2011)
  o Carer-reported quality of life in Enfield was 5th highest of London boroughs (HSCIC, 2013)
  o Assessments rate for carers looking after an adult with a mental health condition per in Enfield (6.3) was 3rd lowest of London boroughs (HSCIC, 2014)
Carers receiving services or advice or information as % of mental health clients receiving community services in Enfield (4.1) was 4th lowest of London boroughs

Proportion of carers who were included or consulted in discussion about the person they care for in Enfield (72.7%) was 3rd highest of London boroughs (HSCIC, 2014)

Proportion of carers who had as much social contact as they would like in Enfield (36.9%) was 11th highest of London boroughs (HSCIC, 2015)

Overall satisfaction of carers with social services in Enfield (41.8%) was 8th highest of London boroughs (HSCIC, 2013)

Locally, Enfield Carers Centre support different types of carers. Key statistics during 2014/15 included 1,329 new carer referrals, 1,115 carers had respite breaks, 860 carers used the emergency card scheme, 522 carers attended training and/or workshop sessions and 117 carers received counselling. The carers GP liaison project funded by Enfield CCG identified nearly 200 new carers this year

- Lesbian, gay, bi-gender transsexual (LGBT): Estimated 6,307 LGBT adults in Enfield (ONS, 2014; ONS, 2015). No information was provided about the number of LGBT people receiving intervention to treat or prevent mental health conditions

- Offenders are at higher risk of mental health conditions and suicide. No local information was provided about the number of offenders receiving intervention to treat or prevent mental health conditions

- Black and Minority Ethnic groups

  - Certain BME groups are at higher risk of mental health conditions

  - Section 3.87 IAPT figures highlighted that the proportion of referrals to IAPT which were from Black and minority ethnic (BME) groups in NHS Enfield CCG (51.5%) was 14th highest of London boroughs, similar to London (50.5) and higher than England (16.4%) (Q4 2014/15) (HSCIC, 2015). No other information was provided about the number of people from BME groups receiving intervention to treat or prevent mental health conditions

- Refugees

  - Refugees are at increased risk of mental health conditions

  - As a proxy measure for refugees, the rate of new migrant GP registrations (per 1,000 resident population) in Enfield (16.7) was 8th lowest of London boroughs (4.8-48.7) and lower than London region (26.4) or England (11.7) in 2014 (Migration Indicators Tool, 2015)

  - No information was provided about treatment or prevention

- Older people groups (HSCIC, 2014)

  - Proportion of people aged over 64 who were supported throughout the year in Enfield (11.5%) was 15th of London boroughs

  - Permanent admissions of people aged over 64 to residential and nursing care per 100,000 population in Enfield (440) was mid-range for London boroughs

  - Proportion of people aged over 64 offered re-ablement services following discharge from hospital in Enfield (3.9%) was 14th lowest of London boroughs (1.2-25.8%) and lower than London region (5.0%)
7.11 Economics of prevention of mental health conditions

Expenditure on interventions to prevent mental health conditions
Public mental health is not one of the prescribed statutory functions of Enfield public health and Enfield does not currently fund any public mental health work. However, Enfield public health contributes strategically through the partnership board and local authority colleagues.

Expenditure on different areas relevant to prevention of mental health conditions highlighted in the previous section include
- Safeguarding: Expenditure rate on safeguarding children and young people’s services per 10,000 0-17 year olds in Enfield (£1.46m) was 5th lowest of London boroughs (range £1.04-£11.07m) and lower than London region (£2.38m) or England (£1.76m) (2013/2014) (DfE, 2015)
- Youth justice: Expenditure rate per 10,000 0-17 year olds on youth justice in Enfield (£0.34m) was 8th highest of London boroughs (range 0-£0.76m) but lower than London region (£0.31m) or England (£0.29m) (2013/14) (DfE, 2014). However, expenditure rate was not correlated with estimated prevalence of conduct disorder or entry rate into youth justice system
- Special schools and pupil referral units: Planned expenditure per 100,000 pupils in Enfield on (2013/14) (DfE, 2014)
  o Special schools (£10.4m) was 13th lowest of London boroughs (range 0-£29.3m) and lower England (£12.4m)
  o Pupil referral units (£2.0m) was 9th lowest of London boroughs (range 0-£13.4m) and lower than England (£2.6m)
- Looked after children
  o Expenditure rate per 10,000 0-17 year olds on looked after children in Enfield (£2.4m) was 7th lowest of London boroughs (range £1.8-£6.7m) and lower than London region (£3.5m) or England (£3.1m) (2013/14) (DfE, 2014)
  o In 2015, the Enfield was awarded £2.1m to set up a Family Adolescent and Support Hub to work with young people identified as being in, on the edge of, or returning from care

Potential savings from prevention of mental health conditions
The last mental health strategy included estimated economic savings of different public mental health interventions (Knapp et al, 2011). The following outlines potential economic savings arising from interventions to prevent mental health conditions in Enfield
- Parenting interventions for conduct disorder: Estimated minimum net savings arising from parenting interventions provided to every parent of a child/adolescent with conduct disorder in Enfield would be £29.7m (criminal justice £24.0m)
- School-based social and emotional learning programmes to prevent conduct disorder result in £84 net savings for each pound spent (Knapp et al, 2011). If such programmes were provided to all 10 year olds in Enfield (ONS, 2015), net savings would be £27.1m after five years and £42.7m after ten years
- School-based interventions to reduce bullying result in £14 saved for each pound spent (Knapp et al, 2011). If all children aged 5-16 years received school based bullying prevention programmes in Enfield, minimum net savings would be £56.7m
Suicide prevention through GP training results in net savings of £44 for every £1 invested (Knapp et al, 2011). If all GP’s in Enfield received such an intervention, estimated savings would be £3.4m after one year, £6.2m after five years and £7.6m after ten years.

Work based mental health promotion: If every adult in employment in Enfield (154,200) (ONS, 2015) received a simple set of interventions to promote their wellbeing, net savings to local employers within one year would be £107.2m Knapp et al, 2011)

8) Levels of mental wellbeing

Mental wellbeing is associated with a wide range of improved outcomes in health, education and employment, as well as reduced crime and antisocial behaviour.

- Proportion in Enfield reporting low life satisfaction score (15.0%) (CI 12.7-17.2) was mid-range for London boroughs (10.7-19.1%) (2014/2015) (ONS, 2015)

- Wellbeing for higher risk groups
  - Quality of life for adults using social care in Enfield (18.4) was similar to other London boroughs (range 17.8-20.1) (2013/14) (HSCIC, 2014)
  - Carer-reported quality of life in Enfield (8.1) was 5th highest of London boroughs (range 6.5-9.0), higher than London region (7.7) but the same as England (8.1) (2012/13) (HSCIC, 2013)
  - Health related quality of life for older people in Enfield (0.71) was mid-range for other London boroughs (range 0.65-0.77) (2012/2013) NHSE, 2013)

9) Protective factors for mental wellbeing

A range of factors promote mental wellbeing (Campion et al, 2012). Information about the local level of such factors as well as relevant interventions to promote them is an important part of a mental health needs assessment.

- Breastfeeding: Proportion of mothers breastfeeding within 48 hours of birth in Enfield (86.7%) was mid-range for London boroughs (range 73.3-92.9%), similar to London region (86.1%) and higher than England (74.3%) (2014/2015) (NHSE, 2015). Locally provided interventions include the health visiting service in Enfield offers support to all new mothers with breastfeeding advice and has breastfeeding peer supporters who work alongside the Health Visitor service within Children's Centres.

- Local wellbeing promotion of parents and young children
  - Family support services to Enfield families with children aged under 5 years are delivered by 23 children’s centres operating across twelve clusters and two family centres
  - Enfield Parenting Support Service provides accessible services for all vulnerable children and their families although no information was provided about numbers from different groups receiving such services (section 2.2)
  - Family Nurse Partnership (FNP) supports 72 first time mothers aged under 20

- Other organisations highlighted as contributing to child and adolescent resilience included Family Nurse Partnership, (section 7.4.2), young carers (section 7.8.3), Place2Be (section 2.3, Solace, Greek Cypriot Women’s Centre, and Enfield Parents and Children

- Early education place provision: Number of 2 year olds benefiting from funded early education in 2015 in Enfield (1,450) was almost double the number in 2014 (DfE, 2015).
- **Level of development in early years foundation stage:** Proportion of children achieving a good level of development at the end of reception in Enfield (2013/14) (DfE, 2014):
  - 57.5% was 7th lowest of London boroughs (range 52.5-75.3%) and lower than London region (62.2%) or England (60.4%)
  - With free school meal status (49.1%) was 13th lowest of London boroughs (range 36.1-68.1%) and between London region (52.3%) and England (44.8%)

- **Schools**
  - Educational attainment
    - Proportion achieving 5+A*-C grade GCSE’s in Enfield (59.7%) was 12th lowest of London boroughs (range 51.3-74.4%) and lower than London region (61.4%) but higher than England (56.8%) (2013/2014) (DfE, 2014)
    - Proportion achieving 5+A*-C grade GCSE’s in 2014/15 in Enfield (53.6%) was lower than London (59.6%) but similar to England (52.8%) (DfE, 2015)
    - Attainment of a Level 2 qualification by the age of 19 in Enfield (87.1%) was similar to London (86.8%) and England (85.4%) (2014) (DfE, 2015)
    - No local information was available on proportion continuing into formal education, apprenticeships or employment with training
  - Dedicated school grant per pupil in 2015/16 in Enfield (£5,187) was lower than London (£5,394) or statistical neighbours (£5,203) and was 7.5% less than previous year (EFA, 2015)
  - Information on local provision of school based mental health promotion is outlined in section 2.2

- **Physical activity**
  - Proportion of adults that engaged in recommended levels of physical activity in Enfield (53.7%) was 9th lowest of London boroughs (46.4-71.2%) (APS, 2015)
  - Proportion that used outdoor space for exercise in Enfield (13.8%) was 14th highest of London boroughs (0.3-24.6%) which was higher than London region (11.8%) (2013/14) (Nature England, 2015)
  - Health trainers saw over 800 clients so far this financial year with an associated 29.4% increase in wellbeing although no information was available on what proportion had mental health conditions (locally provided data)

- **Good health**
  - Proportion of the population reporting general health as excellent in Enfield (31.2%) was 4th highest of London boroughs (range 24.1-33.3%) (WAY, 2015)
  - Healthy life expectancy in Enfield at birth for females (62.7) was 12th lowest of London boroughs (range 55.5-71.2) and for males (62.4) was 11th lowest of London boroughs (range 53.6-69.7) (2011-13) (ONS, 2015)

- **Employment**
  - Proportion of the adult population in employment in Enfield (44.8%) was 10th highest of London boroughs (range 20.8-82.1%) and higher than London region (39.5%) or England (37.7%) (2014 Q4) (ONS, 2015)
  - Enfield draft Healthy Workplace Action Plan (2015) for outlines following actions although no information was available on proportion or number of employees benefiting:
    - CBT Stress Survey for managers and staff
    - Improve staff recognition and normalisation of mental health issues in the workplace
    - Deliver a health fair for Enfield council staff
- Increase internal communication of stop-smoking initiatives

- **Employment for people with mental health conditions**
  - Proportion of people with mental health conditions in employment in Enfield (44.8%) was 10th highest of London boroughs and higher than London (39.5%) or England (37.7%) (2014 Q4) (HSCIC, 2014) (concerns over data quality)
  - Gap in employment rate for those with mental health conditions and overall employment rate in Enfield (28.1%) was 10th lowest of London boroughs (range 0.4-69.0%) and lower than England (36.0%) (2014 Q4) (HSCIC, 2014)
  - Proportion of those on CPA in employment in NHS Enfield CCG (3.9%) was 5th lowest of London boroughs and in BEH-MHT (4.2%) was lowest of London comparator trusts (range 4.2-9.8%) or London (5.7%) (2014/15 Q4) (HSCIC, 2015)

- **Local employment interventions**
  - Enhanced jobs brokerage support (JOBSnet): Advisors trained in mental health to provide a service for people with mental health conditions who can also refer to GPs and IAPT. The JOBSnet service is being marketed in GP surgeries
  - Enfield Children and Young Persons Services found work experience placements for vulnerable young people experiencing mental health issues, learning disabilities or trouble holding down educational or work opportunities
  - Ebony People’s Association (EPA) works with London Metropolitan and Middlesex Universities, taking on social workers as part of their compulsory work placements
  - Richmond Fellowship employment advisors support people from secondary mental health services into employment
  - Peer support training provided by EMU to 14 people in three cohorts with seven moving into work. N18 project (OrganicLea and EMU) offers mental health supported food growing and training scheme
  - BEH-MHT employs 8 apprentices under Admin and Clerical apprenticeship scheme
  - Several other promising initiatives seemed to have not been implemented further

- **Employment for people with learning disability**
  - Employment rate for people with learning disability in Enfield (17.3%) was 3rd highest of London boroughs (range 1.5-22.5%) (HSCIC, 2014)
  - Enfield Council is working with Equals to support young people with learning disabilities to complete work placements within the Council (Rainbow, 2014). This will involve running a pilot with a cohort of five individuals

- **Social contact**
  - Proportion who had as much social contact as they would like in Enfield who were
    - Adult social care users (39.2%) was 14th lowest of London boroughs (HSCIC, 2014)
    - Adult carers (36.9%) was 11th lowest (range 35.4-51.4%) (HSCIC, 2015)
  - Local initiatives to promote social contact include the library, Enfield Saheli, Wellbeing Connect Services, Peer Support, Enfield timebank and EMU over 65’s group
Expenditure on interventions to promote mental health
As outlined in section 7, public mental health is not one of the prescribed statutory functions of Enfield public health and Enfield does not currently fund any public mental health work. However, Enfield public health contributes strategically through the partnership board and local authority colleagues.

- Expenditure rate on local authority children and young people’s services (excluding education) per 10,000 0-17 year olds in Enfield (£6.9m) was 7th lowest of London boroughs (range £5.5m-£41.2m) and lower than London region (£9.2m) or England (£7.8m) (2013/14) (DfE, 2015). However, expenditure rate was not associated with rate of children in need or estimated prevalence of any mental disorder
- Expenditure rate on Sure Start Children Centres and early years per 10,000 0-17 year olds in Enfield (£0.78m) was 13th lowest of London boroughs (range £0.50-£17.18m) and lower than London region (£1.14m) or England (£0.92m) (2013/14) (DfE, 2015)

Potential savings from mental health promotion
Savings from mental health promotion are greatest during childhood and adolescence. Cost effective interventions to promote mental wellbeing during adulthood include:

- School-based social and emotional learning programmes to prevent conduct disorder result in £84 net savings for each pound spent (Knapp et al, 2011). If such programmes were provided to all 10 year olds in Enfield (ONS, 2015), net savings would be £27.1m after five years and £42.7m after ten years
- Work based mental health promotion: If every adult in employment in Enfield received a simple set of interventions to promote their wellbeing, net savings to local employers within one year would be £107.2m (Knapp et al, 2011)
Short summary highlighting opportunities

In the UK, mental health conditions account for at least 30% of burden of disease (WHO, 2014) and result in a wide range of associated impacts and costs. For instance, the estimated annual costs of depression, anxiety, psychosis, dementia, personality disorder, alcohol misuse, smoking, class A drug use and medically unexplained symptoms in Enfield are £698.9m. Annual costs of mental health conditions to employers in Enfield are £142m while annual costs of mental health conditions associated with unemployment in Enfield are £185.5m. The reasons for such large impacts are due to almost a quarter of the population experiencing at least one mental health conditions each year, most lifetime mental health conditions arising before adulthood and a broad range of impacts across different sectors.

A range of effective interventions to treat mental health conditions, prevent mental health conditions and promote mental wellbeing could have a broad range of impacts and associated economic savings with appropriate coverage to those who would benefit. Since the population of Enfield will be 21% larger by 2030, potential opportunities are even greater.

This mental health needs assessments has highlighted some potential opportunities for improving the mental health of Enfield’s population.

1) Treatment of mental health conditions in Enfield
As for the UK, only a minority of people with mental health conditions receive any treatment. Improved coverage and associated outcomes including for higher risk groups would have large impacts and associated economic savings across different sectors even in the short term.

Child and adolescent mental health conditions
Since the majority of lifetime mental health conditions arise before adulthood and increase the risk of adult mental health conditions, it is particularly important to improve coverage of early treatment of mental health conditions during childhood and adolescence.

- The needs assessment highlighted that only a minority of the estimated children and adolescents with different mental health conditions in Enfield received any treatment which reflects the national picture
- Estimated proportion of 5-16 year olds with any mental health condition in Enfield (9.9%) was 7th highest of London boroughs (range 7.1-10.8%) and higher than London region (9.3%) or England (9.3) (Green et al, 2011). This is equivalent to 5,194 individuals
- Conduct disorder: Estimated proportion of 5-16 year olds with conduct disorder in Enfield (6.1%) was 7th highest of London boroughs and equivalent to 3,200 individuals 94 of who were see by generic CAMHS
- Emotional disorder: Estimated proportion of 5-16 year olds with emotional disorder in Enfield (3.9%) was equivalent to 2,046 individuals 282 of who were seen by generic CAMHS
• Hyperkinetic disorder: Estimated proportion of 5-16 year olds with emotional disorder in Enfield (1.7%) was equivalent to 892 individuals 40 of who were seen by generic CAMHS

• Psychosis: During 2013/14, 0.2% presentations to generic Enfield CAMHS were psychotic disorder (one individual) (CORC). However, a review found that 9% of presentations (135 individuals) to Enfield CAMHS were young people experiencing hallucinations and delusions (Earle et al)

• Eating disorder: Estimated 29 individuals aged 10-19 with eating disorder in Enfield (CORC, 2014) although among 16-24 year old women, estimated 70 with anorexia and 188 with bulimia (Smink et al, 2012). However, estimated 4,850 individuals aged 16-24 year olds in Enfield screen for possible eating disorder (using eating disorders screening tool and PHE, 2013) which would suggest a much larger group would benefit from early support. During 2013/14, generic Enfield CAMHS saw 7 individuals with eating disorder (1.7% presentations) (CORC). During 2014/15 in Enfield, the Royal Free CAMHS Eating Disorder Service accepted 29 referrals

• Autistic spectrum disorder was estimated to affect 1,312 under 18 year olds in Enfield. Proportion of presentations to Enfield generic CAMHS which were autistic spectrum disorder (6.6%) was 27 individuals (CORC)

• Alcohol and drug use disorder: Although admission rates for alcohol and drugs were relatively low for London boroughs, no information was provided about provision of other interventions.

• Tobacco smoking: Although the proportion of 15 year olds who were regular smokers in Enfield (2.0%) was 4th lowest of London boroughs, no information was available about interventions to address or prevent smoking

• Self-harm: An estimated 1,704 individuals aged 11-16 had self-harmed. During 2013/14, 4.9% presentations to generic Enfield CAMHS had self-harmed (20 individuals) (CORC). Proportion of Enfield CAMHS presentations with self-harm while a further 12% (181 individuals) had attempted suicide (Earle et al). Enfield CAMHS provides an urgent assessment service for children and young people admitted to North Middlesex and Barnet Hospitals with self-harm and completed 89 DSH assessments between August 2014 and July 2015. Although admission rate for self-harm in Enfield was 9th lowest of London boroughs, admissions for self-harm in Enfield had increased from 57 in 2012/13 to 81 in 2013/14 to 78 in 2015/16. In the previous year, 331 individuals with self-harm and 181 individuals with suicide attempt had been seen by Enfield CAMHS

• However, rates of smoking, alcohol misuse, drug misuse and self-harm are several times higher for those with conduct, hyperkinetic and emotional disorder compared to no disorder (Green et al, 2005; Campion, 2013). Therefore, early intervention for conduct, hyperkinetic and emotional disorder including with parenting programmes will have a significant impacts in almost half of estimated cases of smoking, alcohol misuse, drug misuse and self-harm

Provision of treatment by the four different CAMHS tier was as follows

• Tier 1 universal services
  o Estimated number requiring tier 1 CAMHS In Enfield was 12,060
  o No information about numbers seen provided health visitors, preschool, schools or primary care
• Tier 2:
  o Estimated number requiring tier 2 CAMHS In Enfield was 5,628
  o School based services
    ➢ Health and Emotional Wellbeing Service (HEWS): During the first year in 2014, fourteen schools the service although no information on numbers seen
    ➢ Education psychologists although no information about number seen
    ➢ Place2be worked with 10 schools and during 2013/14 provided self-referral service (3,114 children), one-to-one counselling (153 assessments, 11 short term counselling and 148 long term counselling), therapeutic group work, parent partnership work (610 sessions), multi-agency work with 74 children being referred elsewhere, work with staff to think about the mental health needs of their students (1,492 sessions), training
    ➢ Nuture groups operate in 26 schools supporting children with readiness to learn and building resilience to manage the transition to secondary school. An estimated 280 children are supported per year
    ➢ Early Years Social Inclusion (EYSI) team work with a large number of primary schools but no information on number seen
  o Several other services exist although information was not available on numbers being seen or associated outcomes for most services
    ➢ Web based services including The Big White Wall
    ➢ IAPT Service provides individual and group services for 16 years and over
    ➢ Behaviour Support Service for families and children not attending schools
    ➢ Pupil Referral Units
    ➢ Change and Challenge (Troubled Families)
    ➢ Family and Adolescent Support Hub (FASH) is aimed at children and young people who are on the edge of coming into local authority care
    ➢ CAMHS in the Youth Offending Services (YOS) has a dedicated Tier 2 CAMHS clinician works with young people at risk of or involved in offending
    ➢ CAMHS in Social Care: A dedicated Tier 3 clinician works with social workers, to support children, young people and their families
    ➢ Services provided for children and young people with milder problems - often provided by primary mental health workers (as outreach from Tier 3 CAMHS)
    ➢ Looked after children (LAC): 58.4% of LAC with mental health conditions were seen by Enfield HEART
    ➢ Enfield Parenting Support Service provides services for vulnerable children and their families in Enfield although no information about numbers receiving services
    ➢ No information about parenting interventions for 4,092 individuals aged 5-16 with conduct and hyperkinetic disorder in Enfield
• Tier 3 Multi-disciplinary teams of child and adolescent mental health professionals
  o Estimated number requiring tier 3 CAMHS In Enfield was 1,485
  o During 2014/15, Enfield CAMHS accepted 1,504 referrals and had a caseload of 1,542
  o Number of accepted referrals was higher than the 1,485 under-17 year olds in Enfield estimated to required tier 3 CAMHS
  o 89.2% of cases were seen within 13-weeks
Tier 4: Admission rate for mental disorder per 100,000 aged 0-17 years in Enfield (90.2) was 13th highest of London boroughs, lower than London region (101.9) but similar to England (87.2)

Economics of treatment
- Expenditure: During 2015/16, the CCG and Enfield council is investing £4.67m into CAMHs, including the NHS share of complex care placements. This will increase to £5.46m with new Transformation funds of £0.59m plus CYP funding of £96,500. NHS Enfield CCG is currently investing £0.27m a year in the Royal Free Hospital Eating Disorder service
- Estimated annual costs of crime by adults who had childhood conduct disorder or sub-threshold conduct disorder in Enfield was £339.3m
- Estimated minimum net savings arising from parenting interventions provided to every parent of a child/adolescent with conduct disorder in Enfield would be £29.7m (criminal justice £24.0m, NHS £4.1m, education £1.4m) (from Knapp et al, 2011)

Opportunities for child and adolescent mental health services
- Majority of children and adolescents with mental health conditions in Enfield receive no treatment
- Important since majority of lifetime mental disorder starts before adulthood and early treatment during childhood also reduce adult mental disorder
- Routine data collection required about coverage and outcomes
- Improved coverage of treatment for different mental health conditions particularly at tiers 1 and 2 could have a large impact including subsequent prevention of adult mental health conditions
- Rates of smoking, alcohol misuse, drug misuse and self-harm are several times higher for those with conduct, hyperkinetic and emotional disorder compared to no disorder (Green et al, 2005; Campion, 2013). Therefore, early intervention for conduct, hyperkinetic and emotional disorder including with parenting programmes will have a significant impacts in almost half of estimated cases of smoking, alcohol misuse, drug misuse and self-harm
- Provision of NICE recommended parenting interventions for parents of estimated 4,092 individuals aged 5-16 affected by conduct and hyperkinetic disorders. Engagement with criminal justice to seek shared funding given majority of economic savings occur to criminal justice
- Engagement with schools to facilitate signposting for those affected by mental health conditions since the majority of parents of affected children had consulted teachers about their child’s condition (Green et al, 2005)

Adult mental health conditions
- Common mental disorder
  - Proportion of adults estimated to have a common mental disorder in Enfield CCG (15.6%) was 12th lowest of London boroughs and equates to 36,106 adults
  - Primary care
    - Proportion of people on primary care depression register in NHS Enfield CCG (4.8%) was 12th lowest of London boroughs and lower than London region (5.3%) or England (7.3%) although proportion varied from 0.33% to 11.1% between different Enfield GP practices
  - 30.8% of those estimated to have common mental disorder in Enfield were on the primary care depression register
- Primary care outcomes measures and exceptions rates for treatment of depression were better than most London boroughs although wide variation occurred between different Enfield GP practices
- IAPT in Enfield compared to other London borough: 10th lowest referral rate, 13th lowest rate waiting less than 28 days for first treatment, lowest entry rate into IAPT, 7th lowest completion rate and mid-range for reliable improvement. In the previous year, IAPT had run group interventions for 146 women after birth and 500 school pupils in 39 workshops and internet based psychological therapies were provided to 146 individuals
- Targeted smoking cessation
  - Smoking cessation has at least the same impact on anxiety and depressive symptoms as antidepressants (Taylor et al, 2014)
  - No information was available about coverage and outcomes of smoking cessation for the estimated 11,554 smokers with common mental disorder in Enfield
- Opportunities: Proportion receiving treatment for common mental disorder could be improved with GP training, public health campaigns to improve recognition including at work, provision of internet/computerised psychological treatment and targeted smoking cessation
- **Psychosis**
  - Estimated prevalence of psychotic disorder in Enfield (0.46%) was mid-range for London boroughs (PHE, 2012)
  - Proportion on primary care SMI register in Enfield (1.01%) was mid-range for London boroughs although wide variation between GP practices (0.22-2.63%) (HSCIC, 2015)
  - Primary care prescribing rate of drugs for psychoses and related disorders in Enfield was 9th highest of London boroughs (2014/15 Q4) (HSCIC, 2015)
  - Primary care coverage of physical health of people with SMI in Enfield (HSCIC, 2015)
    - Proportion in Enfield with SMI and comprehensive care plan (82.9%) was 10th highest of London boroughs (range 73.5-85.1%)
    - Compared to other London boroughs, proportion on SMI register in Enfield was 5th highest for blood pressure check, 8th highest for record of blood glucose/HbA1c, 6th highest for alcohol consumption and mid-range for cholesterol check, BMI check and cervical screen (female patients)
    - Exception rate for SMI checks in Enfield CCG 2nd lowest of London boroughs
    - Wide variation between different GP practices for each measure
  - Excess mortality rate for under 75 adults with SMI in Enfield (284.6) was 13th lowest of London boroughs and lower than England (347.2) (2012/13) (HSCIC, 2014)
  - Community secondary services:
    - Early Intervention Psychosis services (EIPS): 47.0% of estimated first episode psychoses were seen by EIPS in Enfield which was lower than 59.4% in England
    - 9.9% of psychosis care spells received psychological therapy in Enfield
    - Absence of clinical high risk services
    - Assertive outreach service provision in Enfield was 5th lowest of London boroughs
  - Opportunities
    - Early intervention psychosis services for all people with first episode psychosis each year in Enfield would result in net savings of £3.0m over usual care (from Knapp et a, 2011).
referral rates could be increased by targeted education interventions for low referring practices

- Early detection services for all people with a Clinical High Risk State each year in Enfield would result in net savings of £5.4m (from Knapp et al, 2011)
- Net NHS savings over 3 years if all people estimated to have psychotic disorder in Enfield received family therapy would be £4.8m and CBT £1.1m (Knapp et al, 2014)

**Dementia**

- Estimated number of people with dementia in Enfield will rise from 3,022 to 4,697 by 2030
- Primary care: Proportion on dementia register, with primary care reviews and appropriate blood tests were relatively high in Enfield (HSCIC, 2015)
- Secondary care:
  - 1,846 referrals accepted to memory services (1,475 from primary care) (2014/15)
  - For over 65 year olds in Enfield compared to other London boroughs, admission rate was 12th highest for Alzheimer’s, 7th highest for vascular dementia and 14th highest for unspecified dementia while emergency admission rate was 11th lowest (2013/14)
- Prevention of dementia by addressing risk factors: Compared to other London boroughs, the proportion of people in Enfield affected by different dementia risk factors was 4th highest for hypertension (13.3%) and stroke (1.2%), 8th highest for coronary heart disease (2.5%) and 6th highest for diabetes (7.0%) (HSCIC, 2014)

**Personality disorder:** Estimated 10,184 adults in Enfield with a personality disorder. No information about primary care provision. Secondary care contacts during 2014/15 were 3,182

**Eating disorder:** Estimated 17,433 adults in Enfield with an eating disorder. No information about primary care provision. Secondary care: 77 referrals and 547 attendances during 2014/15

**Alcohol use disorder**

- Estimated 47,210 binge or higher risk drinkers in Enfield
- Primary care: No treatment recorded during 2014/15
- Secondary care
  - 339 people received treatment during 2014/15 with treatment rates 11th lowest
  - Successful treatment completion mid-range for London boroughs during 2014/15
  - Admission rate relatively low for Enfield compared to London boroughs (2013/14)
- Screening and brief interventions in primary care all increasing risk, higher risk and binge drinkers in Enfield would result in estimated £18.7m net savings (Knapp et al, 2011)

**Drug use disorder**

- Estimated 16,855 adults aged 16-59 used an illegal drug in Enfield in the previous year
- Estimated 1,581 opiate and/or crack users in Enfield
- Primary care: 78 people with opiate use received treatment during 2014/15
- Secondary care: 992 people received treatment for opiate and non-opiate use during 2014/15 with treatment rates mid-range for London boroughs during 2013/14
- Admission rate for 16-24 year for substance misuse 3rd lowest of London boroughs

**Dual diagnosis:** Proportion in Enfield receiving concurrent treatment from mental health services and (2014/15) (NDTMS, 2015):

- Alcohol misuse services (31%/104 patients) was mid-range for London boroughs
- Drug misuse services (28.7%/278 patients) was 13th highest of London boroughs
• **Smoking**
  o Smoking is the single largest cause of long term physical illness and premature death including for people with mental health conditions
  o Estimated 32,950-47,781 adult smokers in Enfield
  o Estimated 23,964 smokers different mental health conditions in Enfield was 11,554 with common mental disorder, 458 with psychosis, 7,624 with alcohol dependence (higher risk drinkers) and 4,328 with drug dependence (McManus et al, 2010)
  o Proportion of all smokers setting a quit date with stop smoking services in Enfield (6.8%) was 11th highest of London boroughs (2014/15)
  o Smoking cessation has at least the same impact on anxiety and depressive symptoms as antidepressants (Taylor et al, 2014) as well as being the most preventable cause of death in people with mental health conditions. No information was provided about smoking cessation for the estimated 23,964 smokers with mental health conditions in Enfield

• **Self-harm**
  o Self-harm is an important risk factor affecting around half of people who die by suicide
  o Self-harm rates are higher in people with mental health conditions
  o Estimated proportion of Enfield population who during their lifetime attempt suicide (10.6%/ 25,713 adults) and self-harm (8.6%/ 20,862 adults) (from McManus et al, 2009)
  o Admission rate in Enfield compared to other London boroughs for:
    ➢ Self-harm in 10-24 year olds (125 individuals) was 12th lowest (HES, 2015)
    ➢ Emergency admissions for self-harm was 5th lowest (HES, 2015)
    ➢ Alcohol-related intentional self-poisoning was 2nd lowest (LAPE, 2014)

• **Suicide**
  o Enfield suicide rate was 5th lowest of London boroughs (2012-14) (ONS, 2015)
  o No comprehensive Local Suicide Action Plan (LSAP) in the BEH areas
  o Majority of people who committed suicide had a mental health condition – improved treatment coverage will reduce suicide
  o GP training: If all GP’s in Enfield received suicide prevention training, estimated savings would be £3.4m after one year, £6.2m after five years and £7.6m after ten years (from Knapp et al, 2011)

• **Parental mental health conditions**
  o Parental mental health conditions have a broad range of impacts including increased risk of mental health conditions in their children
  o No information was available about the proportion of 20,309 parents in Enfield receiving treatment for common mental disorder, psychosis, personality disorder and eating disorder
  o Low rates of treatment in Enfield for parents in Enfield with drug problems (68 parents in treatment vs estimated 547 parents with drug dependence) and alcohol problems (55 parents vs estimated 13,906 parents who were higher risk or binge drinkers) (NDTMS, 2013)
  o Parental mental health conditions during the perinatal period
    ➢ At least 1,526 new mothers in Enfield estimated to have mental health conditions
    ➢ Local information provided about local treatment and support for new mothers did not include how many received treatment/ support from different services
  o Opportunity to target treatment of parent mental health conditions to improve parental, family and child outcomes
Secondary mental health care

• Access to secondary mental health care
  - Access rate to secondary mental health services in NHS Enfield CCG
    - was 15th lowest of London boroughs and lower than London or England (2014/15 Q4)
    - reduced from 2,060 in 2013/14 Q1 to 1,807 in 2014/15 Q4
    - associated with deprivation although Enfield had a lower rate than would be expected for its level of deprivation
  - Access rate to BME groups in NHS Enfield CCG (21.0%) was 9th lowest of London boroughs (2012/13) (HSCIC, 2014)
  - A&E attendance rate for psychiatric disorders in NHS Enfield CCG (17.3) was lowest of London boroughs (range 17.3-640.3) (2012/13) (HSCIC, 2013).

• Admissions for mental health conditions
  - Admission rate in NHS Enfield CCG (2015)
    - 14th lowest of London boroughs and increased over past 18 months
    - Proportion of admissions which were emergency was 3rd lowest of London boroughs
  - Admission rate in BEH-MHT compared to London trusts (2015)
    - For adults was 3rd highest and for older adult mid-range
    - Proportion of admissions which were emergency was 2nd lowest
  - Admission rates were lower in Enfield than for BEH-MHT although 2nd highest of London boroughs for people in Enfield already using secondary mental health services. Suggests opportunities to reduce admissions for people already in secondary care

• Bed availability, occupancy and length of stay (2014/15)
  - Acute beds for BEH-MHT for adults was above upper quartile rate (23.8) for trusts nationally but 3rd lowest of London trusts
  - Acute beds for older adults (19) was below the lower quartile rate (37) for trusts nationally and 2nd lowest of London trusts
  - Bed occupancy for BEH-MHT for
    - Acute adult and older adult (100%) was highest for trusts within London and nationally
    - Psychiatric Intensive Care Units was highest for London trusts
    - Medium and low secure was mid-range for London trusts
  - Occupied bed days per 100,000 population for BEH-MHT for adults was md-range for London trusts but for older people was 2nd lowest of London trusts
  - Mean length of stay in days (excluding leave and unadjusted for outliers) for BEH-MHT was low compared to trusts in London and nationally

• Delayed transfers of care in BEH-MHT
  - Proportion of delayed transfers of care was mid-range for adults (5.6%) in London trusts but highest of all trusts for older adults (27.9%) (2014/15)
  - Rate of delayed transfer of care due to NHS was 3rd highest of London trusts

• Detention under the Mental Health Act (MHA)
  - Detention rate under MHA in Enfield was 8th highest of London boroughs (2014/15 Q4)
  - Detention rate under MHA on admission in Enfield was 11th lowest of London boroughs
  - Proportion of admissions which were MHA detentions in BEH-MHT (35.6%) was mid-range for London trusts but above the mean nationally (32.9%) (2014/15)
• **Care Programme Approach** in Enfield (HSCIC, 2015)
  o Rate at which people were on CPA 9th highest of London boroughs
  o Proportion of people using mental health services on CPA in NHS Enfield CCG was 8th highest of London boroughs and BEH-MHT 2nd highest of London comparator trusts
  o Proportion of people on CPA for more than 12 months who had a review in NHS Enfield CCG was 15th lowest of London boroughs and BEH-MHT 3rd lowest of London trusts
  o Proportion of those on CPA in employment in NHS Enfield CCG (3.9%) was 5th lowest of London boroughs and BEH-MHT (4.2%) was lowest of London comparator trusts
  o Proportion of people on CPA in settled accommodation in NHS Enfield CCG was 5th lowest of London boroughs and BEH-MHT 2nd lowest of London comparator trusts

• **Crisis care**
  o Proportion of people in contact with mental health services with a crisis plan in place in
    – BEH-MHT (37.8%) was 3rd highest of London Mental Health Trusts
    – NHS Enfield CCG (37.8%) was 7th highest of London boroughs although proportion with crisis plans in place in Enfield had reduced over the last three quarters
  o Crisis Resolution and Home Treatment team face to face contact per 100,000 population in BEH trust (8,748) was highest of London trusts (2014/15)
  o A survey of 89 service user across BEH-MHT (Bhandari & Irvanipour, 2015) highlighted that:
    – Review of medication was reported by 25% as possibly something preventing a crisis
    – Under use of voluntary sector, charity organisations, liaison and IAPT services
    – GPs supported at least 50% of individuals in crises but only referred 12% to mental health services which could improve with mental health training for GP’s

• **Community secondary care**
  o Community mental health team (CMHT) caseload per 100,000 population in BEH-MHT for people aged 16-64 was 2nd highest of London trusts and for above 64 mid-range (2014/15)
  o CMHT face to face contact rate in BEH-MHT for people aged 16-64 was mid-range for London trusts and aged above 64 was 3rd highest (2014/15)
  o Assertive outreach: Rate of people accessing Assertive Outreach Services in NHS Enfield CCG was 5th lowest of London boroughs (Q2 2014/15)
  o Contact and day-care attendance rate in NHS Enfield CCG was 10th highest of London boroughs (Q2 2014/15)
  o Proportion of service users in BEH-MHT under the care of community teams (96.7%) was similar to nationally (mean 98.0%) (2014/15)
  o Proportion of BEH-MHT workforce working in community services (52.2%) was slightly lower than nationally (mean 54.2%) (2014/15)

• **Liaison**
  o Increases in patients presenting at A&E over the past two years has resulted in activity primarily focused on patients presenting to A&E
  o Audit of 576 patients seen by BEH-MHT liaison services between December 2014 and January 2015 found that 10% were referred to the Crisis team and 5.2% were admitted
  o Previous research (RAID) highlighted that liaison input for people who were already inpatients resulted in economic savings although current lack of capacity to do this
• **Diagnostic coding:** Proportion in contact with mental health services with a diagnosis recorded in NHS Enfield CCG (26.8%) was 9th lowest of London boroughs (range 15.7-59.6%) and BEH-MHT (27.6%) 3rd lowest of London comparator trusts (range 17.7-48.7%) (HSCIC, 2015)

• **Clustering**
  - Proportion assigned to a mental cluster in NHS Enfield CCG (76.9%) was 14th lowest of London boroughs (range 55.0-92.1%) (HSCIC, 2014) and in BEH-MHT (67.6%) was 4th highest of London comparator trusts (range 27.6-79.8%) (HSCIC, 2015)
  - Proportion of inpatients in BEH-MHT assigned to different clusters varied from 2nd highest to lowest of London trusts (2014/15) (NHS Benchmarking Network, 2015)
  - Proportion of community patients in BEH-MHT assigned to different clusters varied from 3rd highest to lowest of London trusts (2014/15) (NHS Benchmarking Network, 2015)
  - Proportion of community contacts in BEH-MHT by different clusters varied from highest to lowest of London trusts (2014/15) (NHS Benchmarking Network, 2015)

• **Patient experience:** ‘Access and waiting’, ‘safe and high quality care’, and ‘better information and more choice’ were mid-range in BEH-MHT compared to London comparator trusts but for building close relationships was 2nd lowest of London comparator trusts (NHSE, 2013)

• **Satisfaction in BEH-MHT**
  - Community team patient satisfaction score (62.0%) was lowest of London or other trusts
  - Staff satisfaction score (75.0%) was 2nd lowest of London trust (2014/15)

• **Safety:** Compared to other London trusts, BEH-MHT rates of serious incidents were mid-range, ligature incidents were lowest, incidents of physical violence to patients lowest, and incidents of physical violence to staff 2nd lowest (2014/15)

• **Staff training and experience:** Proportion of staff in the last year in BEH-MHT receiving job relevant training, learning or development, and health and safety training was lowest compared to other London trusts (NHSE, 2014)

• **Mental health staffing in BEH-MHT (2014/15)**
  - Balance of workforce: Proportion of workforce working in
    - Community services (52.2%) was lower than nationally (mean 54.2%)
    - Hospital services (47.8%) was higher than nationally (mean 45.8%)
  - Rate of provision of consultant psychiatrists and nurses per 10 beds in different types of unit in BEH-MHT compared to other London trusts varied from highest to 2nd lowest
  - Rate of provision of PICU therapists per 10 beds in BEH-MHT (0.4) was at lower quartile level nationally and mid-range for London trusts
  - Vacancy rates for acute adult workforce as % of WTE in BEH-MHT (32.1%) was highest of any trust nationally or within London with mean level 13.3% nationally

• **Opportunities in secondary mental health care**
  - Improved engagement with BME group (although figures were from 2012/13)
  - Higher admission rate for people using secondary mental health services and high bed occupancy suggest opportunities to reduce through improved coverage of assertive outreach, early intervention psychosis services, prodrome/CHRT services, CBT and family therapy
  - For people on CPA, improving rate of review, employment and settled accommodation
  - Prevention of crisis through medication reviews, improved coordination with primary care and improved provision of early intervention psychosis services
  - Improved staff training and workplace mental health promotion initiatives
Social care for adults with mental health conditions

- Rate of mental health clients receiving social care in Enfield was 14th lowest of London boroughs and lower than London region or England (2013/14)
- Social care mental health clients aged 18-64 per 100,000 population in Enfield compared to other London boroughs (2013/14):
  - In residential and nursing care was 13th lowest
  - Receiving home care was 4th highest
  - Receiving day care or day services (15.1) was low
  - Direct payments (13.4%) was 13th highest

Third sector care for adults with mental health conditions

- Ebony People’s Association (EPA) provides culturally sensitive services to people from different ethnic people with mental health issues
- Richmond Fellowship in Enfield provides employment advisors who accept referrals from secondary mental health services
- Enfield Saheli provides advocacy, advice and support to women who are isolated, vulnerable and going through emotional and mental distress. In the past year, it saw 140 service users who have mild to moderate mental Health needs and 53 service users
- Wellbeing Connect Services: In the past year 80 had accessed advocacy services, 25 received information and advice, 14 monthly support meeting and 30 young people
- Enfield Carers Centre: During 2014/15, there were 1,329 new carer referrals, 1,115 carer respite breaks, 860 carers used the emergency card scheme, 522 carers attended training and/or workshop sessions and 117 carers received counselling
- Enfield Children and Young Persons Services is a voluntary organisation which provides advice and support to voluntary and community organisations working with children and young people aged 0-25 years (section 9.8)
- Enfield MIND offers multi-lingual counselling and during 2014/15 received 274 referrals and delivered counselling to 207 people with high satisfaction rates. Other services include housing support and psychosocial support

Costs of mental health conditions in Enfield

- Total annual costs of adult mental health conditions in Enfield: £698.9m
- Mental health conditions to employers in Enfield: £142m (based on NICE, 2009)
- Unemployment costs due to mental health conditions in Enfield: £185.5m (based on McCrone et al, 2008)
- Cost for each one year cohort in Enfield of perinatal depression, anxiety and psychosis: £40.7m (from Bauer et al, 2014)

NHS expenditure on adult mental health conditions in Enfield

- Proportion of overall CCG expenditure on mental health in NHS Enfield CCG (13.8%) was 13th highest of London boroughs and higher than England (12.7%) (2013/14) (NHSE, 2015)
- Primary care expenditure rate in NHS Enfield CCG on prescribing for:
Mental health conditions (£7.48 per person) was 9th lowest of London boroughs and lower than England (£12.3) (2013/14) (NHSE, 2015)

Antidepressant (£35.6) was 6th highest of London boroughs (range £22.3-£54.9) and lower than England rate (54.7) (2014/15 Q4) (HSCIC, 2015)

Hypnotics and anxiolytics (92.4) was 14th lowest of London boroughs (range £50.2-£139.9) but lower than England (137.5) (2014/15 Q4) (HSCIC, 2015)

Psychoses and related disorders (639) was 13th lowest of London boroughs and lower than England rate (677) (2014/15 Q4) (HSCIC, 2015)

Specialist mental health service per person expenditure in NHS Enfield CCG (£136.2) was 15th highest of London boroughs but lower than England (£151.1) (2013/14) (NHSE, 2015)

Cost per bed in BEH-MHT for acute adults and older adults was 2nd lowest of London trusts and below the lower quartile nationally (2014/15) (Benchmarking Network, 2015)

Cost per occupied bed day in BEH-MHT (2014/15) (Benchmarking Network, 2015) for:

- Acute adult was 2nd lowest of London trusts and below the lower quartile nationally
- Older adult was lowest of London trusts and below the lower quartile nationally

Cost of acute adult and older adult admission and patient on generic CMHT caseload was lowest of London trusts and below lower quartile nationally (2014/15)


- Community care (56.4%) was higher than the mean nationally (51.7%)
- Hospital care (43.6%) was lower than the mean nationally (48.3%)

**Potential economic savings from improved coverage of treatment of mental health conditions**

The last mental health strategy included estimated economic savings of different public mental health interventions (Knapp et al, 2011). The following outlines potential economic savings if all affected by particular mental health conditions in Enfield received certain interventions.

- Parenting interventions for all parents of children and adolescents with conduct disorder in Enfield: £29.7m net savings (£24.0m savings to criminal justice)
- Early Intervention Psychosis services for all people developing first episode psychosis in Enfield each year: £3.0m net savings over standard care (£1.2m NHS savings)
- Pre-psychosis: If all people estimated to develop a Clinical High Risk State (CHRS) in Enfield each year received care from early detection services: £5.4m net savings (£1.8m NHS savings, £3.4m productivity savings)
- Family therapy for schizophrenia: £4.8m savings to NHS over 3 years
- CBT for schizophrenia: £1.1m savings to NHS over 3 years
- Screening and brief intervention in primary care for increasing risk, higher risk and binge drinkers: £18.7m net savings (£9.6m crime savings, £5.5m productivity, £3.6m NHS savings)

**2) Prevention of mental health conditions in Enfield**

Certain factors are associated with increased risk of mental health conditions and poor wellbeing. Addressing such factors reduce risk of mental health conditions and poor wellbeing. Level of coverage of interventions to address such risk factors is low and highlights opportunities for improved coverage across the population targeting higher risk groups:
Inequalities: Proportion living in 20% most deprived areas in Enfield (27.7%) was 13th highest of London boroughs (range 0-83.8%), same as London (27.7%) and higher than England (20.4%) (DCLG, 2013) and suggests that action to address this is area is particularly important

Homelessness: Rate of households in temporary accommodation in Enfield was 8th highest of London boroughs (DCLG, 2015)

Fuel poverty level in Enfield was 10th highest of London boroughs and equated to 12,711 households (DECC, 2013). Interventions included 137 people who came for Energy Best Deal appointments and 87 Smart Homes approved for energy efficient measures

Debt mediates the impact of socioeconomic deprivation on risk of mental health conditions. Debt advice is cost effective and results in net savings of £4 for each £ spent (Knapp et al, 2011). No information was provided about provision of debt advice

Parental factors
- Smoking in pregnancy is associated with increased risk of childhood mental health conditions. Proportion of women who smoke at time of delivery in NHS Enfield CCG (6.7%) was 7th highest of London boroughs (HSCIC, 2015). Proportion of estimated pregnant smokers who set a quit date in Enfield (35.6%) was 2nd highest of London boroughs although CO validated quit rate was 10%
- Parental mental health conditions:
  - Treatment of parental mental health conditions is important to prevent a broad range of impacts including mental health conditions in their children
  - No information about treatment levels or outcomes for estimated 20,309 parents in Enfield with common mental disorder, psychosis, personality disorder and eating disorder or estimated 1526 new mothers with different mental health conditions
  - Low rates of treatment in Enfield for parents in Enfield with drug problems (68 parents in treatment vs estimated 547 parents with drug dependence) and alcohol problems (55 parents vs estimated 13,906 parents who were higher risk or binge drinkers)
- Family Nurse Partnership supports first time mothers aged 19 and under at conception who are at higher risk of mental health conditions. In Enfield, FNP supports 72 young mothers
- Parental unemployment is associated with a doubling of risk of child mental health conditions. Proportion of households with dependent children with no adults in employment in Enfield (8.5%) was 2nd highest of London boroughs. No information provided about work targeting the mental health of the estimated 10,169 households in Enfield

Child obesity: Proportion of children in Enfield who were obese in reception year (12.2%) and year 6 (24.6%) was 9th highest of London boroughs (2013/14) (HSCIC, 2014)

Child adversity
- Child adversity accounts for 30% of adult mental health conditions (Kessler et al, 2011) and is therefore important to address to prevent such conditions from arising.
- Child poverty: Proportion of dependent children under 16 living in poverty in Enfield (29.6%) was 6th highest of London boroughs (HMRC, 2012). Proportion of young people presenting to CAMHS in Enfield who were living in financial difficulty was 19% (Earle et al).
- Child in need rate in Enfield (4,533 children) was 11th lowest of London boroughs (DfE, 2015)

Child abuse is associated with several fold higher rates of mental health conditions
- Estimated numbers who have experienced sexual abuse in Enfield:
  - Non-consensual sexual intercourse before age 16: 1,517 under-18 year olds (Bebbington et al, 2011)
- Non-consensual sexual intercourse and touching before age 16: 6,724 under-18 year olds (Bebbington et al, 2011)
- Contact sexual abuse during past year: 546 individuals aged 11-17 (Radford/ NSPCC, 2011)
- A review of the child sexual assault pathway for London (Goddard et al, 2015) recommended the establishment of five Child Houses in London and an enhanced paediatric service at the Havens (sexual assault referral centres)

- Level of intervention to address abuse
  - Rate of children who were the subject of a CPP per 10,000 people at the end of the year in Enfield (25.2) was 2nd lowest of London boroughs (2013/14) (DfE, 2015)
  - 342 children were subject of CPP in Enfield with 151 due to neglect, 28 due to physical abuse, 8 due to sexual abuse and 153 due to emotional abuse (2014/15) (DfE, 2015)
  - Proportion of young people in Enfield CAMHS who had experienced child abuse was 28% which equates to 444 individuals (Earle et al).
  - School based programmes to detect and prevent abuse: No information provided
  - Parenting interventions: Strengthening Families Strengthening Communities parenting course at SPOE was completed by 104 parents between April to July 2014
  - Expenditure rate on safeguarding children and young people’s services was 5th lowest of London boroughs (DfE, 2015)

- Bullying
  - Proportion of 15 year olds in past two months in Enfield who were bullied by others (48.1%) was 6th lowest of London boroughs and who had bullied others (9.9%) was 10th lowest of London boroughs (2014/15) (WAY Survey, 2015) with estimated 5,276 individuals in Enfield experiencing cyber-bullying
  - No information provided on school bullying programmes
  - If all children aged 5-16 in Enfield received school based bullying prevention programmes, net savings would be £56.7m (from Knapp et al, 2011)

- School factors
  - Compared to other London boroughs, fixed period exclusion rate in Enfield was 3rd highest in primary and secondary schools, 13th highest due to drugs/alcohol use and 2nd highest due to persistent disruptive behaviour (DfE, 2014)
  - Information on local provision of school based tier 2 CAMHS interventions is outlined in section 2.2 including Health and Emotional Wellbeing Service (HEWS), educational psychology, Place2Be, Early Years Social Inclusion (EYSI) team, Nurture groups, behaviour support service, pupil referral unit, Change and Challenge (Troubled Families) Programme, and voluntary sector including for young carers (section 7.8.3)
  - School-based social and emotional learning programmes to prevent conduct disorder to all 10 year olds in Enfield would result in net savings of £27.1m after five years and £42.7m after ten years (Knapp et al, 2011)

- Screen time and sleep deprivation
  - Screen time is now the main waking activity of children, associated with poor wellbeing (Sigman, 2012) and displaces many other activities which promote good physical and mental health. US Department of Health issued recommended limits for screen time’ as one of its national ‘health improvement priorities’ and a key ‘disease prevention objective’ (US DHHS, 2014). Advice and information could be provided to pupils and parents.
Sufficient sleep is an important protective factor for wellbeing particularly during childhood. However, more than one in four 14 and 15-year-old girls (28%), and just over a fifth of boys of the same age (22%) do not think they sleep enough to concentrate on their studies (Balding and Regis, 2012). Information about sleep hygiene could be provided to students and parents.

Child and adolescent higher risk groups

- **Looked after children (LAC)***
  - LAC have 5-fold increased risk of mental health conditions (Ford et al, 2007)
  - Rates of LAC in Enfield was 13th lowest of London boroughs (DfE, 2015) although 226 of 360 LAC placed in Enfield by other local authorities
  - Proportion of LAC with 5+GCSE’s E*-C in Enfield was highest of London boroughs
  - 58.4% of LAC estimated to have mental health conditions were on CAMHS & EPS caseload in March 2015
  - A local service audit showed that 56% (72/128) of young adults in the Enfield leaving care service were estimated to have mental health needs
  - “In-Step” Fostering Scheme provides rapid and accessible therapeutic support to foster placements where there is a risk of placement breakdown

- **Special education needs (SEN) (DfE, 2015)**
  - Proportion of school pupils with SEN in Enfield 13.8% was 9th lowest of London boroughs
  - Proportion of school age pupils in Enfield with statements of SEN where primary need is social, emotional and mental health in Enfield (2.7%) was 6th highest of London boroughs
  - Lack of information about proportion receiving treatment for mental health conditions

- **Young carers***
  - In Enfield, unpaid care was provided by an estimated 675 individuals under-15 years and 2,018 individuals aged 16-24.
  - In the previous year, Dazu Young Carers project in Enfield provided counselling to 34 young carers and Enfield borough provided counselling to 51 young carers

- **Not in education, employment or training (NEET):** Proportion of NEET 16-18 year olds in Enfield was 14th lowest of London boroughs (DfE, 2015). No information about local work

- **Young offenders***
  - Rate of 10-18 year olds in youth justice system in Enfield was 7th highest of London boroughs (MoJ, 2015)
  - Rate of 10-17 year olds receiving their first reprimand, warning or conviction per in Enfield was 11th highest of London boroughs (2014) (MoJ, 2015)
  - Expenditure rate on youth justice in Enfield 8th highest of London boroughs (DfE, 2014)
  - Several partnerships include with Youth Development Unit, Community Parenting Support, Adolescent Support Unit, Change and Challenge Unit, Engaging with NEET’s, and with two resettlement consortia (including Enfield) to address the needs of sentenced young people. Statutory caseload increased to 209 in February 2015
  - Rate of proven re-offending after 12 months in Enfield has increased by 4.9% between April 2011 and March 2013 compared to a rise of 2.4% in London
  - No information about proportion receiving treatment for mental health conditions

- **Asylum seeking children**: Number who were looked after in Enfield (35) was 3rd highest of London boroughs (DfE, 2015)
Adult risk factors

- **Physical inactivity**
  - Physical inactivity rate in Enfield was 10th highest of London boroughs (APSurvey, 2015)
  - GP Exercise Referral Service has a number of referral criteria including low level anxiety/depression although no information was provided about numbers seen

- **Obesity**: Proportion of adults who were obese in Enfield was 2nd highest of London boroughs

- **Lack of educational qualification**: Proportion of adults with no qualifications or level one qualifications in Enfield (35.8%) was 4th highest of London boroughs and equates to 86,894 adults. No information was provided about numbers attending adult learning.

- **Unemployment** rate and long term unemployment rate in Enfield was 6th highest of London boroughs (2014) (ONS, 2015) which equates to 13,200 unemployed adults and 1,760 long term unemployed adults with a further 5,071 benefit claimants. No local information was provided about targeted mental health interventions for unemployed people or benefit claimants

- **Crime and violence**
  - Violent crime rates in Enfield was 11th lowest of London boroughs while hospital admission rate for violent crime in Enfield was 7th lowest (PHE, 2015)
  - Sexual offence rate in Enfield was 11th lowest of London boroughs (PHE, 2015)
  - Proportion of Enfield Child Protection Plan assessments in Enfield where domestic violence was identified (46.5%) (2014/15) (DfE, 2015)
  - Referral rate for abuse of people with learning disability in Enfield was 3rd lowest of London boroughs (HSCIC, 2014)
  - Interventions to address violence included several domestic violence workers, a Domestic Violence Intervention Project (online and phone referral) and Multi Agency Risk Conferences (MARAC) which had 696 referrals involving 773 children during 2015, and several services providing psychosexual interventions

Adult higher risk groups: Particular groups are at several fold increased risk of developing mental health conditions and therefore require targeted intervention to prevent such conditions arising.

- **Long term physical conditions**: Number of adults in Enfield on primary care registers for asthma (15,643), chronic obstructive pulmonary disease (3,400) was coronary heart disease: (7,656 people). No information about mental health screening of people with long term physical conditions or targeted interventions to promote their mental health

  - Number of adults with learning disability in Enfield registered with primary care (1,154) was higher than number known to local authority (865 adults)
  - Proportion of adults with learning disability compared to other London boroughs was 11th highest for receiving GP health checks (53.6%), 3rd highest for employment (17.3%), 2nd highest for living in stable and appropriate accommodation (79.8%), 3rd lowest for referral for abuse, 7th highest for using community services (80.3%), 10th lowest for receiving direct payments (25.3%) and 3rd highest for being supported by social services
  - No local information about proportion of 2,073 people with learning disability and mental health conditions in Enfield receiving treatment for such conditions

- **Carers**
  - Carers are important for the recovery of people with mental and physical health conditions although are at higher risk of developing a mental health condition
Proportion of people providing unpaid care in Enfield (1.98%) (6,194 people) was 10th highest of London boroughs (range 0.75–2.4%) (ONS, 2011)

Carer-reported quality of life in Enfield was 5th highest of London boroughs (HSCIC, 2013)

Assessments rate for carers looking after an adult with a mental health condition per in Enfield (6.3) was 3rd lowest of London boroughs (HSCIC, 2014)

Carers receiving services or advice or information as % of mental health clients receiving community services in Enfield (4.1) was 4th lowest of London boroughs

Proportion of carers who were included or consulted in discussion about the person they care for in Enfield (72.7%) was 3rd highest of London boroughs (HSCIC, 2014)

Proportion of carers who had as much social contact as they would like in Enfield (36.9%) was 11th highest of London boroughs (HSCIC, 2015)

Overall satisfaction of carers with social services in Enfield (41.8%) was 8th highest of London boroughs (HSCIC, 2013)

Locally, Enfield Carers Centre support different types of carers. Key statistics during 2014/15 included 1,329 new carer referrals, 1,115 carers had respite breaks, 860 carers used the emergency card scheme, 522 carers attended training and/or workshop sessions and 117 carers received counselling. The carers GP liaison project funded by Enfield CCG identified nearly 200 new carers in previous year

- Lesbian, gay, bi-gender transsexual (LGBT): Estimated 6,307 LGBT adults in Enfield (ONS, 2014; ONS, 2015). No information was provided about the number of LGBT people receiving intervention to treat or prevent mental health conditions
- Offenders: No local information was provided about the number of offenders receiving intervention to treat or prevent mental health conditions
- Black and Minority Ethnic groups: Although certain BME groups are at higher risk of mental health conditions, only IAPT provided information about referral rates for BME groups. No other information was provided about the number of people from BME groups receiving intervention to treat or prevent mental health conditions
- Refugees: New migrant GP registrations rate in Enfield (16.7) was 8th lowest of London boroughs in 2014. No information was provided about treatment or prevention
- Older people groups
  - Permanent admission rate for people aged over 64 to residential and nursing care in Enfield was mid-range for London boroughs (HSCIC, 2014)
  - Proportion of people aged over 64 offered re-ablement services following discharge from hospital in Enfield was 14th lowest of London boroughs

Expenditure on interventions to prevent mental health conditions

- Public mental health is not one of the prescribed statutory functions of Enfield public health and Enfield does not currently fund any public mental health work
- Expenditure on different areas relevant to prevention of mental health conditions highlighted in the previous section include
  - Safeguarding: Expenditure rate on safeguarding children and young people’s services was 5th lowest of London boroughs (DfE, 2015)
  - Youth justice: Expenditure rate per 10,000 0-17 year olds on youth justice in Enfield was 8th highest of London boroughs but lower than London region (DfE, 2014)
Planned expenditure in Enfield on special schools was 13th lowest of London boroughs and on pupil referral units 9th lowest (2013/14) (DfE, 2014).

Looked after children expenditure rate was 7th lowest of London boroughs (DfE, 2014).

**Potential savings from interventions to prevent mental health conditions (from Knapp et al, 2011)**

- Parenting interventions for all parents of children with conduct disorder in Enfield would result in minimum savings of £29.7m (criminal justice £24.0m).
- School-based social and emotional learning programmes to prevent conduct disorder to all 10 year olds in Enfield would result in minimum net savings of £27.1m after 5 years.
- School-based interventions to reduce bullying for all children aged 5-16 years in Enfield would result in minimum net savings of £56.7m.
- Suicide prevention through GP training for all GPs in Enfield would result in minimum net savings of £3.4m after one year, £6.2m after five years and £7.6m after ten years.
- Work based mental health promotion to every adult in employment in Enfield would result in minimum net savings to local employers within one year of £107.2m.

**3) Promotion of mental wellbeing**

Certain factors are associated with mental wellbeing and promoting such factors is associated with a range of improved outcomes including mental wellbeing. Level of coverage of interventions to promote such factors is low but opportunities exist to improve this coverage and assessment of outcomes particularly for higher risk groups and at organisational levels.

- **Wellbeing levels:** Compared to other London boroughs, Enfield had:
  - Mid-range adult life satisfaction (ONS, 2015)
  - Similar mental wellbeing (WAY, 2015)
  - Similar quality of life for adults using social care (HSCIC, 2014)
  - 5th highest carer quality of life (HSCIC, 2013)
  - Mid-range quality of life for older people (NHSE, 2013)
- **Local wellbeing promotion of parents and young children**
  - Family support services to Enfield families with children aged under 5 years are delivered by 23 children’s centres. ‘Time to talk’ weekly drop in sessions in Children Centres were highly rated by 37 parents who attended during first quarter of 2015/16.
  - Enfield Parenting Support Service provides services for vulnerable children and their families in Enfield although no information about numbers receiving services.
  - Family Nurse Partnership (FNP) supports 72 first time mothers aged under 20.
- **Local organisations highlighted as contributing to child and adolescent resilience included young carers, Place2Be, Solace, Greek Cypriot Women’s Centre, and Enfield Parents and Children**
- **Early education place provision:** Number of 2 year olds benefiting from funded early education in 2015 in Enfield (1,450) almost double the number in 2014 (DfE, 2015).
- **Proportion of children achieving a good level of development at the end of reception in Enfield (57.5%)** was 7th lowest of London boroughs (2013/14) (DfE, 2014).
- **Schools**
  - Educational attainment: Proportion achieving 5+A*-C grade GCSE’s in Enfield (59.7%) was 12th lowest of London boroughs (2013/2014) although fell to 53.6% in 2014/15 (DfE, 2015).
o Information on provision of school based mental health promotion included voluntary sector including for young carers, Place2Be, Early Years Social Inclusion (EYSI) team, Nurture groups and LASS groups, and Health and Emotional Wellbeing Service (section 2.2)

- Physical activity
  o Proportion of adults that engaged in recommended levels of physical activity in Enfield (53.7%) was 9th lowest of London boroughs (46.4-71.2%) (APS, 2015)
  o Health trainers saw over 800 clients so far this financial year with an associated 29.4% increase in wellbeing although no information was available on what proportion had mental health conditions (locally provided data)

- Good health
  o Proportion reporting general health as excellent in Enfield (31.2%) was 4th highest of London boroughs (range 24.1-33.3%) (WAY, 2015)
  o Healthy life expectancy in Enfield at birth for females was 12th lowest of London boroughs and for males was 11th lowest of London boroughs (ONS, 2015)

- Employment
  o Proportion of the adult population in employment in Enfield (44.8%) was 10th highest of London boroughs (ONS, 2015)
  o Enfield draft Healthy Workplace Action Plan (2015) outlines several actions although no information was available on proportion or number of employees benefiting
  o Employment for people with mental health conditions
    - Proportion of people with mental health conditions in employment in Enfield (44.8%) was 10th highest of London boroughs (HSCIC, 2014) (concerns over data quality)
    - Gap in employment rate for those with mental health conditions and overall employment rate in Enfield (28.1%) was 10th lowest of London boroughs (HSCIC, 2014)
    - Proportion on CPA in employment in NHS Enfield CCG (3.9%) was 5th lowest of London boroughs and in BEH-MHT (4.2%) lowest of London comparator trusts (HSCIC, 2015)
  o Local employment interventions
    - Enhanced jobs brokerage support (JOBSnet): Advisors trained in mental health to provide a service for people with mental health conditions who can also refer to GPs and IAPT. The JOBSnet service is being marketed in GP surgeries
    - Enfield Children and Young Persons Services found work experience placements for vulnerable young people experiencing mental health issues, learning disabilities or trouble holding down educational or work opportunities
    - Ebony People’s Association (EPA) works with London Metropolitan and Middlesex Universities, taking on social workers as part of their compulsory work placements
    - Richmond Fellowship employment advisors support people from secondary mental health services into employment
    - Peer support training provided by EMU to 14 people in three cohorts with seven moving into work. N18 project (OrganicLea and EMU) offers mental health supported food growing and training scheme
    - BEH-MHT employs 8 apprentices under Admin and Clerical apprenticeship scheme
    - Several other promising initiatives seemed to have not been implemented further
  o Gaps in local provision in Enfield included lack of training in mental health for staff involved with the Work Programme and voluntary organisations, long waiting times for IAPT, lack of employer support within the borough, more emphasis on learning
disabilities than mental health in the Council and clients worried about losing their benefits if they gain paid employment or voluntary work (Rainbow, 2014)

• Employment for people with learning disability
  o Employment rate for people with learning disability in Enfield (17.3%) was 3rd highest of London boroughs (range 1.5-22.5%) (HSCIC, 2014)
  o Enfield Council is working with Equals to support young people with learning disabilities to complete work placements within the Council (pilot with five individuals) (Rainbow, 2014)

• Social contact
  o Proportion who had as much social contact as they would like in Enfield who were
    ➢ Adult social care users (39.2%) was 14th lowest of London boroughs (HSCIC, 2014)
    ➢ Adult carers (36.9%) was 11th lowest (range 35.4-51.4%) (HSCIC, 2015)
  o Local initiatives to promote social contact include the library, Enfield Saheli, Wellbeing Connect Services, Peer Support, Enfield timebank and EMU over 65’s group

Expenditure on interventions to promote mental health
• Public mental health is not one of the prescribed statutory functions of Enfield public health and Enfield does not currently fund any public mental health work
• Expenditure rate on local authority children and young people’s services (excluding education) in Enfield was 7th lowest of London boroughs and lower than London region or England (DfE, 2015)
• Expenditure rate on Sure Start Children Centres and early years in Enfield was 13th lowest of London boroughs (DfE, 2015)

Potential savings from mental health promotion
Savings from mental health promotion are greatest during childhood and adolescence. Cost effective interventions to promote mental wellbeing include:
• School-based social and emotional learning programmes to prevent conduct disorder to all 10 year olds in Enfield would result in net savings of £27.1m after five years and £42.7m after ten years (from Knapp et al, 2011)
• Work based mental health promotion to every adult in employment in Enfield would result in net savings to local employers within one year of £107.2m (Knapp et al, 2011)
References

Abel KM, Wicks S, Susser ES et al (2010) Birth weight, schizophrenia, and adult mental disorder: is risk confined to the smallest babies? Arch Gen Psychiatry 67(9):923-30


http://pb.rcpsych.org/content/37/7/238.full.pdf+html


Centre for Mental Health (2010), The Economic and Social Costs of Mental Health Problems in

200
2009/10


DH (2014), Closing the Gap: Priorities for essential change in mental health


Enfield (2015) Enfield young people missing from home or care briefing. April 2015 to June 2015


Fitch C, Mamo M, and Campion J. Primary Care Guidance on Debt and Mental Health – 2014 update; Royal College of General Practitioners & Royal College of Psychiatrists; 2014.


201


HMG (2011) No health without mental health


Kinoshita Y, Furukawa TA, Kinoshita K et al (2013), Supported employment for adults with severe mental illness, Cochrane Database of Systematic Reviews Issue 9


Lane (2014), A Qualitative Evaluation of the Growing Together Project


a household survey. Health and Social Information Centre, Social Care Statistics.


Mental Health Strategies (2013), Essex Joint Strategic Needs Assessment for Children’s Emotional Well-Being and Mental Health


NICE (2011) Autism in under 19’s: recognition, referral and diagnosis


203


RCGP/ CMH (2015) Falling through the gaps: perinatal mental health and general practice


