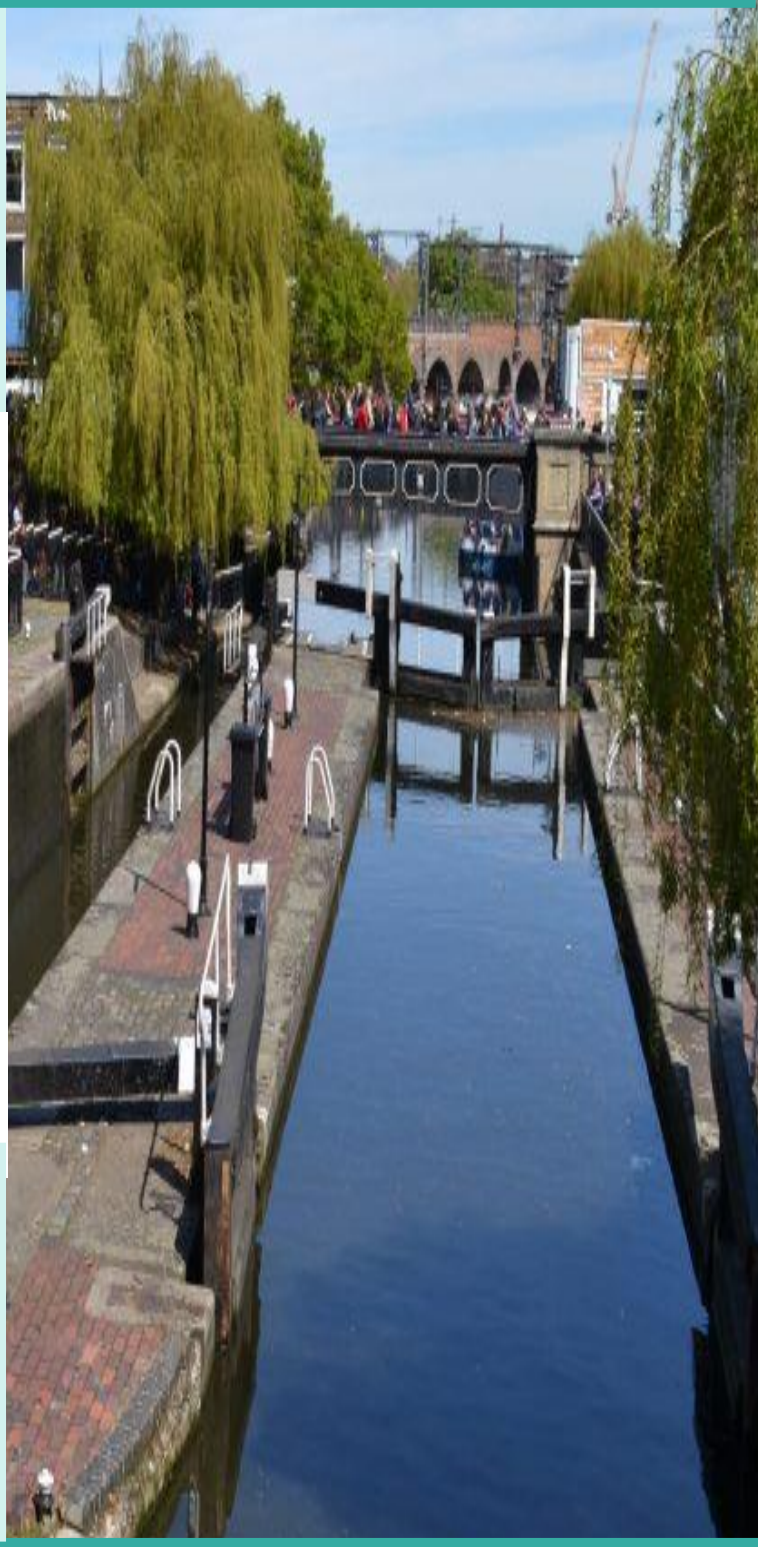
Mental Health Needs Assessment for Adults

Camden 2025



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Executive summary

Introduction

This Mental Health Needs Assessment (MHNA) is the culmination of research conducted over a period of ten months during 2024. The process included numerous informative discussions with people invested in and passionate about the mental health and wellbeing of Camden residents and communities. It is the intention of this report to represent the insights so generously shared in the process.

Aim

The aim of this Mental Health Needs Assessment report is to broaden the understanding of the mental health needs of adults living in Camden. It uses clinical data about mental health conditions to illustrate the extent to which they affect Camden communities. It discusses many of the wider determinants of mental health and reports what residents say influences their feelings, behaviours, and their ability to best manage their mental health. It identifies support across the borough that aims to meet emergent need, finally reflecting on the extent to which this is possible and proposing changes that, if accepted and implemented, could better support mental health and wellbeing in the borough.

Objectives

The objectives of this needs assessment are to:

- Highlight risk factors of poor mental health, including key vulnerable population groups in Camden and be able to compare it to London and the national picture, where data is available.
- Use data to understand the prevalence of diagnosed mental health conditions and the demographics of people with mental health conditions.
- Identify local mental health data trends and compare Camden to London and England where possible.
- Explore the protective mental health support available in Camden.
- Identify gaps in the support offer.
- Identify inequalities and barriers to accessing wider support and mental health services.
- Co-create actionable recommendations to improve mental health in Camden by incorporating insights from people with lived experience and mental health professionals, ensuring that proposed solutions are relevant, practical, and aligned with the community's needs.

Methodology

To comprehensively understand the mental health needs of adults in Camden, a mixed-methods approach was employed, integrating epidemiological data, stakeholder consultations, and co-production with people with lived experiences of mental health conditions. This innovative methodology emphasised inclusivity, contextual relevance, and collaboration to uncover nuanced insights into Camden's mental health landscape.

Main findings

The findings of this report are split into three sections:
Section 1: **Need** (risk factors, key population groups at risk, prevalence of mental health conditions)
Section 2: **Available Support** (current local services and interventions)
Section 3: **Gaps** in current service provision

Section 1: Need

Protected characteristics as risk factors for mental health

Age: Mental health issues are prevalent across all age groups.

- Young adults (18-34) experience high levels of anxiety and depression that could be attributed to societal pressures, academic stress, and the impact of social media. The transition from Child and Adolescent Mental Health Services (CAMHS) to adult services is a challenge for many people.
- Older adults (60+) are also at risk of depression and anxiety, particularly due to social isolation, poor housing conditions and limited access to therapies.

Gender reassignment: Transgender people face significant mental health challenges, including increased rates of anxiety, depression and suicidal ideation, often due to stigma and discrimination.

Marriage & civil partnership: Stable and supportive intimate relationships promote better mental health outcomes. Conversely, abusive or troubled relationships have higher risks of mental health issues.

Pregnancy & maternity: Perinatal depression and anxiety are common, influenced by hormonal changes, social support and life stressors such as financial strain or relationship problems.

Race & ethnicity: Minoritised people, particularly Black and South Asian people, face higher rates of mental health issues due to structural inequalities, racism, and socio-economic factors. Specific groups of people, such as members of Black African communities and young Bangladeshi men, experience unique challenges.

Religion & belief: Religious beliefs can provide protective benefits for mental health, but experiences of discrimination (e.g., Islamophobia or antisemitism) contribute to higher risks of mental health problems.

Sex: Women report higher levels of anxiety and depression than men, experiencing additional risk factors from domestic and sexual violence. Men are less likely to seek mental health support, potentially contributing to higher suicide rates amongst men.

Sexual orientation: LGBTQ+ people face increased risks of mental health challenges, driven by stigma, discrimination and minority stress, especially in environments where their identity is not accepted.

Disability: People with physical or learning disabilities are more likely to experience mental health issues due to social isolation, discrimination and barriers to accessing care.

Social determinants of mental health

Socio-economic factors: Financial hardship, income inequality, and deprivation have a major impact on mental health. The prevalence of income-deprivation and child poverty elevate vulnerability to poor mental health. Camden has 21% of residents in income-deprived households and more than 30% child poverty in some wards, leading to elevated mental health risks.

Education & employment: Higher levels of education correlate with better mental health outcomes, while low education levels are linked to higher mental health risks. Camden, with high educational attainment levels, still has areas where low qualification rates contribute to mental health challenges. Employment offers protection, but insecure work or poor working conditions can lead to higher stress levels. Camden's higher economic inactivity rate (25.4%) compared to the national average, reflects a challenge for mental well-being.

Social networks & isolation: Strong social support networks improve mental health outcomes, while loneliness and isolation contribute to poor mental health. Camden has a higher-than-average rate of single-person households (39%), with older adults being particularly vulnerable to isolation. The COVID-19 pandemic further exacerbated this problem, especially for those with pre-existing mental health conditions.

Housing, neighbourhood, and environment: Poor living conditions and unsafe environments can contribute significantly to mental health issues. Camden residents face unique housing challenges, with over two-thirds living in rented accommodation and a notable proportion in overcrowded housing. Housing insecurity, including issues like mold and poor repairs, is a significant stressor, especially for older adults and those in deprived areas. While Camden has more green spaces compared to other inner London boroughs, access to these spaces is inequitable, with deprived areas having fewer green spaces, exacerbating mental health inequalities.

Crime and violence: Camden has a higher crime rate than London, with violent crime significantly above the national average. Research suggests that living in areas with high crime can harm mental health, both directly through violence and indirectly through stress.

Domestic violence and abuse (DVA): Domestic violence is a significant factor in mental health issues, particularly for women. Camden's rates of domestic violence are higher than the national average, and victims often face complex mental health challenges. Stigma around male victims and fear of child removal prevent many from seeking help.

Health and healthcare: Disparities in access to healthcare can worsen mental health conditions. Camden faces issues with care coordination, post-discharge support, and crisis response, especially for those with mental health conditions like personality disorders, mild traumatic brain injuries, or psychosis. These gaps in care increase the risk of mental health deterioration.

Residents at higher risk of poor mental health

Inclusion health groups, including people who are homeless, use drugs, or face marginalisation, often have substantial mental health needs. However, access to mental health support is inconsistent. Specific groups at higher risk in Camden include:

- Drug and alcohol users: Many people with substance use issues also have mental health needs but face barriers to receiving treatment.
- Homeless people: Camden has a high homelessness rate, with a large proportion facing severe mental health challenges. People recently released from prison are particularly vulnerable.
- Refugees and asylum seekers: This group faces significant mental health challenges due to trauma and uncertainty about their legal status.
- People with autism and neurodivergence: People with autism are at higher risk of mental health issues, particularly due to a lack of preventive support.
- Unpaid carers: Many carers, who provide support for people with mental and physical health needs, experience their own mental health challenges, including stress and strain.

Impact of COVID-19 pandemic

The COVID-19 pandemic led to increased mental health issues, particularly anxiety, depression, and loneliness, affecting vulnerable groups such as young people, those living alone, and ethnic minorities. However, since 2023, residents have reported improvements in mental well-being. The pandemic's long-term effects continue to affect mental health, with many people seeking help for new forms of anxiety.

Mental health conditions and service use

1. **Depression:**
   - Incidence: 5,040 adults (1.8%) registered with a Camden GP were diagnosed with depression for the first time in 2023/24, higher than the London (1.3%) and England (1.5%) averages.
   - Prevalence: 29,416 adults (10.7%) in Camden were recorded as having depression, higher than the London average (9%) but lower than the England average (12.6%).

2. **Serious mental illness (SMI):**
   - Incidence: Data on new SMI cases was not available.
   - Prevalence: 4,496 adults (1.4%) in Camden were recorded with conditions like schizophrenia, bipolar disorder, or other psychoses, which is higher than both London (1.1%) and England (0.9%) averages.

3. **Mental health service use:**

- Age trends: Younger people are more likely to access iCope talking therapy and secondary mental health services, with a decline in service use among older adults. This could be due to greater awareness and willingness to seek help among younger people.
- Gender differences: Women form the majority of both referrals and service users for both iCope and secondary mental health services, suggesting possible barriers to mental health access for men or a greater help-seeking behaviour among women.
- Deprivation: A higher proportion of people using secondary mental health services (65%) were from deprived backgrounds compared to those using iCope (47%), highlighting the connection between socioeconomic status and the severity of mental health needs.
- Ethnic disparities: Disparities in service access were observed, with underrepresentation of White and Asian groups, potentially due to stigma or cultural factors, while Black, Mixed, Other, and Unknown ethnicities had better representation.

4. North Central London (NCL) borough comparisons:

- Referrals to iCope: Camden had lower referrals to iCope compared to other NCL boroughs, despite having the highest incidence of depression in London.
- Service Uptake: Attendance at iCope therapy services was low and declining, despite high depression incidence and prevalence in Camden.
- Referrals to Secondary Mental Health Services: Camden, with the highest prevalence of severe mental illness in NCL, also had the highest number of referrals to secondary mental health services, a trend that has been increasing.
- Attendance at Secondary Mental Health Services: Attendance at secondary services has been increasing since 2021/22 but remains lower than that of Haringey, even though Camden has the highest SMI prevalence in NCL.

5. Suicidal thoughts:

- 542 adults in Camden presented to their GP with suicidal thoughts, with the highest prevalence in the 45-54 age group (22% of cases).
- Women accounted for 62% of these cases.
- Deprivation was a key factor, with 60% of those experiencing suicidal thoughts coming from deprived areas.

- Ethnic disparities showed overrepresentation in White, Mixed, Other, and Unknown ethnic groups, suggesting either better access to services or higher prevalence.

6. **Domestic violence, homelessness, substance use, and unpaid carers:**
   - Domestic violence and abuse (DVA): 40% of adults flagged for domestic violence had a mental health condition, mostly depression. Women were more likely to be on the depression register, while men were more likely to be on the SMI register.
   - Homelessness: 35% of homeless adults were on the depression register, and 16% were on the SMI register.
   - Substance use: 52% of adults with substance use were recorded on a mental health register. Those with illicit drug use were more likely to be on mental health registers than those with alcohol dependency.
   - Unpaid carers: 77% of unpaid carers were not recorded on mental health registers, though younger carers were more likely to be on the depression register. Women were more likely to be recorded as carers and to be on mental health registers.

Section 2: Mental health support in Camden

Camden's mental health services are provided by a wide network of partners, including the North London Foundation Trust (NLFT), Primary Care, Camden Council, and community organisations. These services span the spectrum from preventative initiatives to specialist mental health care for those diagnosed with mental ill-health.

Strengths of the mental health support sector in Camden:

- Partnership working: Strong collaboration across sectors ensures holistic care, exemplified by initiatives like the Reach Out Camden Alliance and Camden Core Teams.
- Voluntary and community sector: Plays a vital role in meeting diverse mental health needs, with long-term support, walk-in appointments, flexible group activities often proving more effective than short-term statutory services.
- Culturally sensitive services: Efforts to provide mental health support that considers Camden's diverse communities and efforts to recognise/address and prevent racism are seen as a growing strength.
- Trauma-informed practices: Many services are recognised for their trauma-informed approaches, improving outcomes for users.
- Holistic, person-centered care: Programs like care navigation and advocacy services are highly valued for supporting people with complex needs.

Section 3: Gaps

Findings identified through qualitative data

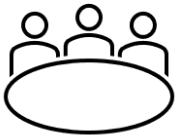
This assessment involved engagement with people who have lived experience of mental health conditions through focus group discussions to gain a deeper understanding of the local mental health challenges and their experience of accessing services in Camden. Additionally, insights were gathered through interviewing and group discussions with professional stakeholders such as mental health service providers and commissioners in Camden. This approach was instrumental in identifying key barriers and challenges in mental health service delivery in Camden.

We heard from -

32 participants
(Aged 18 and above)

25 Mental Health Professionals

15 GPs



4 Group Forums

Focus group discussions

The discussions with 32 participants in Camden revealed critical challenges and opportunities within the local mental health service landscape. Participants highlighted barriers to accessing services, including long waiting times for care, with some waiting lists extending up to two years, causing distress and isolation. The quality of care was inconsistent, with positive experiences from some community-based services, but negative experiences with some healthcare professionals due to misdiagnoses or inappropriate treatments. Stigma, both societal and internalised, emerged as a key issue impacting people' willingness to seek help.

Available community support systems/services were valued for their accessibility, but a clear need for more local hubs and low-cost therapy options was highlighted. Concerns were raised about resource allocation, with participants questioning the disconnect between funding increases and service accessibility, calling for greater transparency and systemic reforms. Additionally, participants emphasised the need for improved education and training for GPs, teachers, and parents to better address mental health issues, alongside culturally sensitive care to ensure inclusivity.

Stakeholder and service provider interviews

The interviews with professional stakeholders and group discussions revealed critical service gaps and challenges, particularly for marginalised populations and those with complex mental health needs. Below are the key findings:

Gaps in services

1. Housing and healthcare disconnect: Limited collaboration between housing services and healthcare prevents holistic support for vulnerable people. Social prescribers and GPs often lack awareness of community-based resources, leading to underuse of available services.
2. Employment support gaps: Strict referral pathways and workforce shortages limit access to employment support, particularly for those not under the care of clinical teams. Stigma and discrimination further hinder workplace inclusion.
3. Lack of supportive care: Lack of resources to provide supportive care services such as befriending and advocacy support (which existed earlier).
4. Limited integration of community-based services: Core teams remain NHS-led and specialist-oriented, failing to achieve true multi-agency collaboration.
5. Lack of specialist mental health support in the voluntary sector: Care navigators in voluntary sector organisations are often referred complex mental health cases, that they are not equipped to handle. Insufficient outreach services and advocacy support further limit accessibility.
6. Fragmented communication and integration: Poor coordination between primary and secondary care services, lack of interoperability between electronic health records, and confusion over responsibilities contribute to fragmented patient care.
7. Centralisation of services: The shift towards national service models reduces local continuity and personalisation, limiting engagement for people in distress who do not access formal care.
8. Funding availability and allocation: Voluntary and community sector (VCSE) Stakeholders highlighted the lack of funding and structural incentives to work in partnerships with other organisations.
9. Risk aversion in mental health services: People with high-risk profiles or those with co-occurring needs (dual diagnoses) face significant barriers to accessing mental health care due to concerns over service capacity and risk management.

10. Lack of long-term support: Provision of long-term support was identified as a prominent ongoing need which is not being met by the current time-limited services. Crisis support is insufficient, particularly on weekends.
11. Inadequate support for autistic people without learning disabilities: Autistic adults face long waiting times, misdiagnosis, and a lack of tailored mental health and social care services.
12. Gaps in transition support for young people: Poor coordination between Child and Adolescent Mental Health Services (CAMHS) and adult services leads to abrupt discharge rather than continued engagement, leaving many young adults without adequate support.
13. Non-mental health services: Stakeholders noted that the current available mental health services did not reach everyone, speculating more use of support offered by community organisations, libraries and other informal settings.
14. Challenges in mental health service accessibility across boroughs: Place-based services create barriers for people living outside Camden but registered with Camden GPs, leading to delays in care.

Recommendations

Please note - These recommendations have since been further refined and prioritised by Camden's Mental Health Partnership Board and will therefore be taken forward in a revised form that differs from how they are presented in this report but remain true to the findings from data and contributions from stakeholders.

This report outlines strategic recommendations to improve mental health support in Camden by addressing barriers to access, enhancing service integration, and tackling the social determinants of mental health. Key recommendations include:

1. **Addressing socioeconomic determinants** – Integrate mental health services with housing, employment, and financial assistance programs, ensuring holistic support for people in deprived areas.
2. **Expanding outreach and access** – Increase volunteer diversity, establish low-barrier community hubs, develop culturally tailored initiatives, and enhance advocacy and community connector programs.
3. **Promoting trauma-informed and culturally sensitive practices** – Implement trauma-informed care, provide culturally competent training

for staff, and collaborate with faith-based organisations to reduce stigma and improve engagement.

4. **Improving integrated care and service coordination** – Strengthen multi-agency collaboration, improve service pathways between clinical and voluntary sectors, and introduce mental health trainee placements in primary care.
5. **Expanding long-term and preventative support** – Develop community-based mental health hubs, reinstate home visits for vulnerable populations, and increase access to non-pharmacological interventions like therapy and peer support. Expand the Primrose intervention within GP practices to improve early diagnosis and immediate care.
6. **Enhancing crisis response** – Establish dedicated crisis centres that are easily accessible and offer immediate support.
7. **Increasing education and awareness** – Launch public awareness campaigns to reduce stigma, train frontline workers in mental health literacy, and improve early identification of distress.
8. **Fostering co-production and community involvement** – Strengthen partnerships with service users, carers, and community organisations to co-design and evaluate services based on local needs.
9. **Supporting marginalised groups** – Expand targeted outreach for LGBTQ+, ethnic minority, and disabled people to ensure equitable access to mental health support.
10. **Co-occurring needs** – Simplify service access for people with co-occurring needs.
11. **Funding allocation** - Ensure transparent allocation of funding to areas with the greatest unmet needs.

1. Introduction

This Mental Health Needs Assessment (MHNA) is the culmination of research conducted over a period of ten months during 2024. The process involved numerous informative discussions with people invested in and passionate about the mental health and wellbeing of Camden residents and communities. It is the intention of this report to represent the insights so generously shared in the process.

The Centre for Mental Health define a mental health needs assessment as a process by which a local council or other public body seeks to understand the mental health and wellbeing of its population, and how well people's needs are being met by the services that are available[1]. It is often one aspect of a local joint strategic needs assessment (JSNA) which is a statutory requirement / role of local authorities with public health responsibilities. Findings from needs assessments can be used to identify areas requiring change and influence that change.

Mental health, as defined by the World Health Organisation (WHO) is "a state of well-being in which an individual realises their own abilities, can cope with the normal stresses of life, can work productively, and is able to contribute to their community"[2]. Poor mental health can profoundly impact a person's quality of life, limiting their ability to engage in work, education, and social activities. Beyond the personal toll, it imposes significant economic burdens through increased healthcare costs and reduced productivity[3].

Over the past decade, as a society we have become more conversant about mental health[4]. As a topic it has gained increasing prominence, becoming a focus of public discourse and political decision-making. A number of key national and local strategies aimed at enhancing mental health outcomes have been developed (see appendix A) whilst discussions about access to timely and integrated mental health care, and commitments to reduce health inequalities, pervade legislation and local and national policies and plans[5,6,7,8]. While national and local strategies aim to advance mental health initiatives, challenges related to care quality, accessibility and inequality persist, particularly at a local level[9]. Progress is being made, however goals such as enhancing accessibility and reducing disparities across the population experiencing mental health conditions remain unmet[10].

The last Camden MHNA was conducted in 2021. Since then, major societal changes - precipitated by the COVID-19 pandemic and the ongoing cost-of-

living crisis - and their impact on residents' mental health, have increased the demands placed on mental health services. This has generated calls for changes to be made to the way the sector and our wider social landscape adapts and responds, to be able to meet the need that creates demand[11]. These changes necessitate this updated MHNA, providing information on the local picture in Camden, identifying emerging challenges and service gaps. Importantly, although needs assessments are used to inform commissioning decisions that shape the provision of services that meet the needs of people and communities[1], this MHNA is *not* linked to immediate commissioning plans and there is no funding attached to it. Instead, it aims to act as an influencing piece, by providing robust evidence to inform discussions related to decision-making and the strategic planning of mental health support in Camden.

Governance for the report was provided by the Camden Mental Health Partnership Board (MHPB), a group that brings together key stakeholders from primary and secondary health care services, adult social care, housing and health and wellbeing directorates in Camden Council, local community based and voluntary sector organisations and local people with lived experience of using local mental health services (See Appendix B).

2. Aim

The aim of this MHNA is to broaden understanding of the mental health needs of adults living in Camden. It uses clinical data about mental health conditions to illustrate the extent to which they affect Camden communities. It discusses many of the wider determinants of mental health and reports what residents say influences their feelings, behaviors, and their ability to best manage their mental health. It identifies support across the borough that aims to meet emergent need, finally reflecting on the extent to which this is possible and proposing changes that, if made, could better support mental health and wellbeing in the borough.

As a result of working closely with various stakeholders, including people with lived experience, mental health professionals, and voluntary sector organisations, the report aims to deliver informed recommendations for local consideration. They are based on qualitative and quantitative evidence, integrating personal narratives, professional insights, and data trends to shape solutions aimed at improving mental health outcomes and addressing mental health inequalities in Camden.

3. Objectives

The objectives of this needs assessment are to:

- Highlight risk factors of poor mental health, including key vulnerable population groups in Camden and be able to compare it to London and the national picture, where data is available.
- Use data to understand the prevalence of diagnosed mental health conditions and the demographics of people with mental health conditions.
- Identify local mental health data trends and compare Camden to London and England where possible.
- Explore the protective mental health support available in Camden.
- Identify gaps in the support offer.
- Identify inequalities and barriers to accessing wider support and mental health services.
- Co-create actionable recommendations to improve mental health in Camden by incorporating insights from people with lived experience and mental health professionals, ensuring that proposed solutions are relevant, practical, and aligned with the community's needs.

4. Methodology

To comprehensively understand the mental health needs of adults in Camden, a mixed-methods approach was employed, integrating epidemiological data, stakeholder consultations, and co-production with people with lived experiences of mental health conditions. This innovative methodology emphasised inclusivity, contextual relevance, and collaboration to uncover nuanced insights into Camden's mental health landscape[*1]. The components of the methodology are -

4.1 Literature review and data analysis

A review of literature and epidemiological data was conducted to establish an evidence-based foundation. Key objectives included identifying the need through the following data sources:

* It is important to note that, the themes, findings, and recommendations identified through the stakeholder consultations and focus group discussions are based on the perspectives of those who participated and may not reflect the entire spectrum of mental health challenges or service provision in Camden.

Table 1: Data sources

Qualitative data	Quantitative Data
• Literature review on wider determinants of mental he alth and the impact of intersectional ity and protected characteristi cs on mental health. • Focus group discussions with people with lived experience of mental health conditions. • Stakeholder/service provider interviews.	• Epidemiological data and national statistics e.g. Office of National Statistics data sets, Public Health Outcomes Framework (Fingertips). • Previous data analysis from national surveys and needs assessments in Camden and review of existing Camden strategic initiatives (See Appendix A). • Mental Health illness databases obtained from the North Central London Data User Group, Integrated Care System. • Service use data from the voluntary sector (where available).

4.1.2 Co-production with people with lived experience

Three facilitators with lived experiences of mental health conditions were recruited to co-design and implement focus group discussions (FGDs). This innovative approach ensured the research was both inclusive and reflective of real-world experiences. The recruitment of lived experience facilitators was supported by staff from The Advocacy Project, who advised on job description development, advertising and the selection of candidates for interview.

Facilitator recruitment and training:

- **Recruitment:** Job descriptions were tailored to highlight the importance of lived experience. Collaborations with the Advocacy Project in Camden helped identify suitable candidates.
- **Interview panel:** A panel member with lived experience was involved in selecting facilitators to ensure alignment with the co-production ethos alongside two public health professionals.

- **Training program:** A three-day program (3 hours per session) equipped facilitators with the skills to lead discussions effectively and sensitively. This included:
    - Developing and refining a co-produced topic guide to ensure questions were relevant and accessible.
    - Facilitation skills emphasising inclusivity and diversity.
    - Managing difficult conversations and establishing ground rules.
    - Role-playing scenarios to build confidence.
    - Awareness of discrimination and participant signposting to support resources.

4.1.3 Focus group discussions (FGDs)

Five FGDs were conducted with 32 residents who either self-identified as having a mental health condition or felt that the term "mental health condition" resonated with them. Participants ranged from those with clinical diagnoses to those experiencing mental health challenges without formal diagnoses.

Process:

- Facilitators co-developed the discussion topic guide, ensuring questions were relevant and accessible.
- Each FGD was facilitated by two trained facilitators, with a third on standby for feedback and support.
- Feedback meetings involving facilitators and strategists were held after every FGD to provide time for reflection, to support continuous improvement in facilitation techniques and to ensure all facilitators felt supported and safe.

Key themes explored:

- Accessibility and quality of mental health services.
- Community support and stigma.
- Challenges in navigating care pathways.

The discussions provided valuable insights into accessibility, quality of care, stigma, and community support in Camden as experienced by the participants. Facilitators led the discussions, creating a supportive and empathetic environment that allowed participants to share their experiences and challenges openly.

Rationale for co-production

Co-production was central to the methodology as it recognises the unique and invaluable perspectives of those with lived experiences of mental health challenges. Traditional research approaches often fail to capture the complex realities faced by people, particularly those in underserved or marginalised

communities. By involving people with lived experiences as partners in the research process, the needs assessment aimed to ensure findings were authentic[12]. The approach was innovative – it included people with lived experiences as facilitators, breaking down traditional researcher-participant hierarchies. By integrating their perspectives into every stage—from topic guide development to data collection—the methodology produced findings that were practically relevant. The involvement of people with lived experiences as facilitators not only enriched the research process but also fostered a sense of ownership and mutual learning. The whole process aligned with the core principle of co-production, promoting equality, mutual respect, trust and enriching the data collection process with diverse perspectives.

4.1.4 Stakeholder engagement

Engaging with local service providers and key stakeholders was integral to understanding service provision and identifying unmet needs. It took two forms:

- **One-to-one interviews:** Conducted with 25 stakeholders to gather insights on service delivery challenges, strengths, and gaps.
- **Group discussions:** Held with the Mental Health Partnership Board, GP Forum, Social Prescribing Forum, and the Reach Out Camden Alliance (Mind, Likewise, Hillside Clubhouse, Voiceability, Advocacy Project).

These discussions highlighted the complexity of mental health needs in Camden, with specific demographic groups and risk factors emerging prominently and provided insights into the nature and strengths of support in Camden.

4.1.5 Integration of findings

The data from FGDs, stakeholder interviews, and the literature review and data analysis were synthesised to provide a holistic understanding of mental health in Camden. This approach ensured that the assessment was:

- Grounded in evidence and lived experiences.
- Reflective of the social and wider determinants of health.
- Informed by diverse voices, including those of people traditionally underrepresented in mental health research.

5. A Note about language

In researching and writing this report we have carefully considered the language we use. We recognise that the way ideas are framed can have unintended consequences or reinforce negative stereotypes about mental health. To address this, the report:

- uses first person language to avoid defining people by their illness whilst always respecting the terms preferred by residents, facilitators, and colleagues during our conversations.
- avoids the use of words that stigmatise mental health conditions.
- uses neutral language rather than words often associated with victimhood and affliction.

Table 2: The table below defines the key terms used throughout the report, reflecting above principles.

Terms	Definition
Well-being **or** positive mental health	Well-being or positive mental health refers to a state where an individual is generally coping well with life's challenges, experiencing satisfaction, and feeling mentally resilient. Importantly, this does not imply the absence of a mental health diagnosis. Many people who have had mental health conditions can still experience positive well-being when they are managing their conditions effectively and are supported by protective factors.
Protective factors	Protective factors in mental health are conditions or influences that enhance well-being and reduce the risk of mental health issues. They help people cope with stress and adversity, promoting resilience. Examples include having strong social support, emotional regulation skills, stable housing, financial security, and access to mental health services. Strengthening these factors can improve overall mental well-being and reduce vulnerability to mental health challenges.
Mental health conditions	Mental health conditions refer to diagnosed mental health disorders, which can be either common mental health conditions (such as anxiety or depression) or serious mental illnesses (such as schizophrenia or bipolar disorder). These diagnoses are usually made by a healthcare professional and imply that the individual has met specific criteria for

	the condition, impacting their thoughts, feelings, or behaviours.
Mental ill health or poor mental health	Mental ill health is often used interchangeably with poor mental health, though it can encompass a range of experiences, from mild to severe. It can refer to moments or periods where a person's mental health is compromised, but it does not always indicate a diagnosed condition.

These distinctions are essential as they highlight that mental health exists on a spectrum, and positive well-being can coexist with a mental health diagnosis.

6. Findings

The findings of this MHNA are reported using three main sections. The 'Need' section examines risk factors, and population groups most affected in Camden by mental health conditions. It uses data to report the comparative prevalence of mental health conditions (national and local). The 'Support' section maps elements of the local service offer and identifies interventions available to address needs within the borough. Finally, the 'Gaps' section reports the gaps in current mental health service provision as reported by lived experience and service provider stakeholders.

6.1 Section 1: Need

This section is split into three parts. Firstly, an overview of the risk factors for poor mental health and wellbeing. Risk factors for poor mental health are conditions, experiences, or characteristics that increase the likelihood of developing mental health conditions. These factors can be biological, psychological, social, or environmental, and they may interact with each other to influence a person's mental wellbeing and therefore represent the drivers for mental health need and an indication where primary prevention activities can take place. The first part of this section reviews the impact of protected characteristics and social determinants on mental health and resident groups at highest risk. It includes observations from Camden stakeholders. The second part of the section looks at the impact of the pandemic on mental health and wellbeing. Finally, this section looks at the incidence and prevalence of mental ill health, including expressed need where Camden residents' mental health conditions have been investigated and diagnosed with a subsequent referral to, and accessing of, services.

6.1.1 Risk factors for mental health

6.1.1.1 Protected characteristics

Nine personal characteristics are protected from discrimination under the Equality Act 2010. These characteristics can influence mental health, sometimes serving as protective factors, and at other times contributing to increased risk and higher need. Figure 1 below depicts the nine protected characteristics. It is followed by a summary of how each characteristic potentially impacts and increases mental health risk.

Figure 1: Protected Characteristics Equality Act 2010

6.1.1.1.1 Age

Mental health challenges manifest differently across age groups, with unique stressors and challenges at each life stage.

- People aged 18-34 report high levels of anxiety and depression, often influenced by social pressures, academic stress, the impact of social media and the pervasive use of technology. While technology can offer support and resources, it has also been known to contribute to increased anxiety, depression, and feelings of isolation[13].
- Local Service providers stated that those moving from Child and Adolescent Mental Health Services (CAMHS) to adult services encounter significant challenges in accessing adult services and were therefore at higher risk of poor mental health outcomes. Adult

services are less comprehensive compared to CAMHS' wrap-around approach, increasing the risk of young people disengaging with services during this critical transition phase.

- Local service providers also stated that adults over 60 face elevated risks of depression, social isolation, and the adverse impacts of poor housing conditions. Additionally, they are known to not access mental health services and support they need. There are also concerns about over-reliance on medication, with limited referrals to talking therapies, resulting in less effective, holistic care.
- People over 65, are more prone to cognitive decline, and can experience isolation, both of which can exacerbate mental health challenges. Age-related stigma can also prevent older people from seeking help, resulting in an increase of untreated mental health conditions[13].

6.1.1.1.2 Gender Reassignment

People undergoing gender reassignment face unique mental health challenges, including high levels of anxiety, depression, and suicidal ideation. These issues are often compounded by experiences of stigma, discrimination, and lack of access to appropriate healthcare[14].

The Government Equalities Office tentatively estimates that around 0.3-0.8% of the UK population are transgender. The 2021 Census identified 245 trans women (0.14%) and 217 trans men (0.12%) in Camden, based on responses from 177,909 (94%) residents aged 16 and over who volunteered to answer the gender identity question[15].

6.1.1.1.3 Marriage and Civil Partnership

Stable and supportive intimate relationships are associated with better mental health outcomes[16]. Conversely, people in strained or abusive relationships may experience increased levels of mental health conditions[17]. Section 6.2.7 highlights the local picture of domestic violence and abuse (DVA) in Camden.

6.1.1.1.4 Pregnancy and Maternity

Pregnancy and maternity bring both psychological and physiological changes that can impact mental health. Perinatal depression and anxiety

are common among pregnant and postpartum women, influenced by hormonal changes, social support, and life stressors[18,19]. A Perinatal Mental Health Needs Assessment, currently in progress, will provide insight into the mental health experiences of women resident in Camden during pregnancy and after birth.

6.1.1.1.5 Race and Ethnicity

Race and ethnicity can shape and impact mental health outcomes. Black and minoritised ethnic communities often face higher levels of mental health conditions due to systemic inequities and racial discrimination. The Black Mental Health Manifesto[20] cites structural inequalities such as poverty, housing insecurity and unemployment – all disproportionately experienced by Black communities – as being significant contributors to poor mental health outcomes. These and other social determinants are deeply linked to historical and ongoing injustices, leading to cycles of disadvantage that exacerbate mental ill health.

The 2023 Camden Annual Public Health Report focused on the mental health of adolescents, especially adolescents from minoritised ethnic communities. The report identified mental health challenges as disproportionately higher for young Black and minoritised people than for young people who were white. Structural inequalities and experience of racism were cited as key contributors to these disparities[21].

Table 2 presents the 2021 Census data on the ethnic composition of Camden, London, and England[22]. The data shows Camden's population to be more diverse than the overall population of England and Wales but not as diverse as London.

Table 3: Ethnic Composition of Camden, London, and England (2021 Census)

Ethnicity Group	Camden (%)	London (%)	England (%)
White	59	42	81
Asian	18	23	10
Black/African/Caribbean	9	15	4
Other Minority Groups*	14	20	5

** Includes Eastern European, Hispanic, Middle Eastern, Mixed, and Unknown categories.*

Locally, service providers contributing to this MHNA reported that:

- Black African communities experience greater mental health challenges than other communities due to social isolation, financial instability and limited support, all of which have been worsened by the cost-of-living crisis and job insecurity.
- Young Asian British Bangladeshi men (20-30 years) face increasing mental health needs, impacted by cultural stigma, economic pressures, and lack of targeted support.
- Low-income and non-White groups encounter barriers to accessing mental health services such as systemic racism and language issues.
- Low-income and non-White groups live in poorer quality housing, experience greater social isolation and financial instability than White populations: conditions that cause people chronic stress and further deterioration of well-being.

6.1.1.1.6 Religion and Belief

Religious and spiritual beliefs can both positively and negatively impact mental health. For some, religious practices provide a source of support and coping mechanisms, contributing to better mental health[23]. However, religious intolerance or conflict with personal beliefs can lead to stress and mental health conditions[24]. Experiencing discrimination because of religious belief - such as Islamophobia or antisemitism - can make people feel 'othered', can exacerbate social exclusion and then contribute to poorer mental health outcomes, particularly among minority faith groups[25].

2021 census data reported that 47% of Camden residents described themselves as having no religion compared to 37.2% nationally. 30% of Camden's population identified as Christian, fewer than the national average of 46.2%. 16% of people in Camden identified as Muslim compared with 6.5% of people nationally and 4.8% of people in Camden identified as Jewish which is ten times greater than the national rate of 0.5%.

6.1.1.1.7 Sex

Mental health differences between men and women are well-documented. Sex-related factors, gender inequity, gender roles, and gendered risk factors as social determinants of mental health, intersect with other structural inequalities in their overall effect on mental health. Women generally report higher rates of depression and anxiety compared to men[26,

and women with severe mental illness have a higher risk of experiencing domestic and sexual violence than women without severe mental illness[27]. Men are more likely to use substances in ways that lead to long-term mental health problems and to engage in antisocial behaviour, partly due to social norms surrounding masculinity.[28] Men commit 86% of all violent crimes but are also twice as likely to be victims of violence than women.[29] Men report lower life satisfaction than women. (See section 6.2.7for specific local data on domestic violence and substance use).

Gender roles and expectations seem to influence differences in health-seeking behaviour and create further disparities in mental health outcomes. Women are more likely than men to seek help for mental health issues, including accessing talking therapies and primary care services. Men are less likely to seek timely help, often attributed to stigma and societal expectations around masculinity, which can lead to delays in diagnosis and treatment[30].

Men's perceived reluctance to help-seek has been identified as contributing to higher male suicide rates[31] Whilst potentially true, this simplistic assertion negates the likelihood that it is multiple and interacting barriers that reinforce and strengthen obstacles to men accessing professional support[32]. In the UK, men account for approximately three-quarters of all deaths by suicide. Suicide rates are particularly high among men aged 45-49 and those older than 90 years, often linked to economic stress, relationship breakdowns, and isolation. Women are more likely to attempt suicide but with lower lethality[33].

6.1.1.1.8 Sexual Orientation

LGBTQ+ people face challenges such as stigma, discrimination, and minority stress, which can adversely affect their mental well-being. LGBTQ+ is an acronym for "lesbian, gay, bisexual, transgender and queer" with a "+" sign to recognise the limitless sexual orientations and gender identities used by people[34]. Studies confirm that LGBTQ+ populations are at higher risk for mental health conditions, such as depression, anxiety, and suicidal ideation[35].

Table 3 shows the 2021 Census data on sexual orientation of Camden, London and England. Camden has a slightly higher proportion of residents

identifying as LGBTQ+ (6.2%) compared to both London (4.3%) and England (3.2%).

Table 4: Sexual Orientation Data from the 2021 Census[36]

Location	Response Rate (%)	Gay or Lesbian (%)	Bisexual (%)	Other (%)	LGBTQ+ Total (%)
Camden	94%	3.7%	2.5%	N/A	6.2%
London	90%	2.2%	1.5%	0.5%	4.3%
England	92.5%	3.2%*	N/A	N/A	3.2%*

*(*England's data includes all LGBTQ+ identities combined)*

6.1.1.1.9 Disability

People with physical or intellectual disabilities are at higher risk of experiencing poor mental health due to factors such as social isolation, discrimination, and barriers to accessing appropriate care[37]. They may encounter stigma both within the healthcare system and in broader society, which can prevent them from seeking/accessing timely support[38]. Additionally, the intersection of disability with other protected characteristics, such as age or ethnicity, can further compound the challenges people with disabilities face[39].

The 2021 Census data indicate that Camden has seen a decline in the proportion of residents identified as disabled and "limited a lot" (identified as having a disability that severely limits day-to-day activities), falling from 9.9% in 2011 to 8.3% in 2021. This reduction (1.6%) was smaller than the decrease observed across London (2.3%, from 9.4% to 7.1%) and in line with the national trend in England (1.6%, from 9.1% to 7.5%)[40].

6.1.1.2 Social determinants of mental health

The previous section reflected upon how our mental health can be impacted, positively or negatively, by protected characteristics. Alongside these, other elements of social identity, for example, social class, education, attractiveness[41] can similarly protect or negate our mental health. Wider social determinants of health then serve to further impact mental health.

These identities do not operate independently but intersect to produce unique experiences of discrimination, disparity and privilege: this is referred to as **intersectionality**[42]. In relation to mental health, intersectionality can shape people' experiences and affect their access to health services.

Health outcomes are influenced not only by individual factors but also by social structures and systems of power and these can act as important risk factors for shaping individual mental health outcomes[43].

The World Health Organisation describes social determinants of mental health as non-medical factors that influence health outcomes to which people are exposed across the life course[44]. They affect individual mental health outcomes, and, if unchallenged, perpetuate mental health disparities within and between populations. Examples of social determinants are factors such as income, employment, socioeconomic status, education, food security, housing, social support, discrimination and childhood adversity amongst others. Significantly, exposure to protective or harmful social determinants is not random[45], rather it is linked to wider forces and systems that shape the conditions of daily life. Social determinants can be more important than health care or lifestyle choices in influencing health[46] and can produce and reproduce intergenerational inequalities. Mental health is profoundly influenced by social determinants because they are experienced at individual and societal levels and shape the environment that then either supports or harms mental well-being[47].

6.1.1.2.1 Socio-economic factors

The impact of socioeconomic factors on mental health plays out throughout someone's life. They include education, employment and income. Research indicates that people facing financial hardship are more likely to experience mental health conditions[48]. Emerging evidence about the mental health impact of the Covid-19 pandemic suggests that experiences of job and financial losses, related housing insecurity, reduced access to mental health services and increased social isolation contributed to higher levels of anxiety, depression and other mental health conditions[49].

Financial inequity not only marginalises vulnerable populations but also creates barriers to accessing healthcare. People living in poverty often face greater difficulty securing timely and appropriate mental health support, experience higher rates of illness, and have a shorter life expectancy than those in more affluent circumstances[50]. This suggests socio-economic disadvantage is both a risk factor for and a consequence of poor mental health[51].

Camden is a socially and economically diverse borough and income disparities are stark. 21% of Camden's population live in income-deprived

households with child poverty rates exceeding 30% in some wards despite the borough's overall affluence. The Index of Multiple Deprivation (IMD) 2019 ranked Camden 132 of 317 local authorities in England, indicating substantial disparities in income, health, education, and housing[52]. The 2021 Census reported how dimensions of deprivation further affect the population: 52.5% of Camden households experience one or more dimension of deprivation. 0.7% of Camden households were impacted by all four dimensions of deprivation, ranking Camden the second-highest borough in London for this measure[53].

Education
A positive experience of education is a protective factor: whilst higher levels of education are associated with better mental health outcomes, leaving school early and low educational attainment can contribute to poor mental health[54]. Although overall levels of educational attainment within the borough of Camden are high - the 2021 Census reported that 57% of residents aged 16yrs+were educated to degree level or equivalent - 6.2% of the population had no qualifications.[55] This is higher than the London average of 5.5% and lower than the England average of 6.6%.

Experiences of employment differ and can be protective or harmful to mental health. Employment can protect mental health through the social interaction, stimulation and potential financial stability it offers. However, poor-quality work marked by contract insecurity, poor conditions, workplace discrimination, can be detrimental, and cause or increase stress and anxiety. Income loss, especially when tied to job insecurity and concerns about debt, significantly worsens mental health outcomes[56].

In December 2023, 25.4% of adults aged 16-64 years in Camden were "economically inactive" (full-time students, people with caring responsibilities, retirees, and those unable to work due to long-term illness or disability). More people are economically inactive in Camden than across London (21.4%) and Great Britain (21.2%)[57].

6.1.1.2.2 Social networks

Strong social support networks, high levels of community engagement and strong relationships are factors that help protect and maintain good mental health. Conversely, feeling socially isolated, experiencing discrimination, and

living within disconnected areas with low social cohesion can negatively impact mental well-being.

Many Camden residents, including older adults, report feeling socially isolated and lonely[58]. Camden ranks 16th out of the 33 London boroughs for the predicted risk of loneliness in people aged 65 and over. 12% (28,000) of Camden residents are currently 65 years or older: a population that is predicted to increase by 25% over the next decade[58].

Experiences of social isolation and loneliness which were exacerbated by the COVID-19 pandemic are known to be contributors to mental health issues such as depression, anxiety, and suicidal ideation[47]. For people with severe mental health conditions, experiences of loneliness are commonplace due to multiple barriers such as social stigma, cognitive challenges, and economic hardship, that can affect and limit their social participation[59].

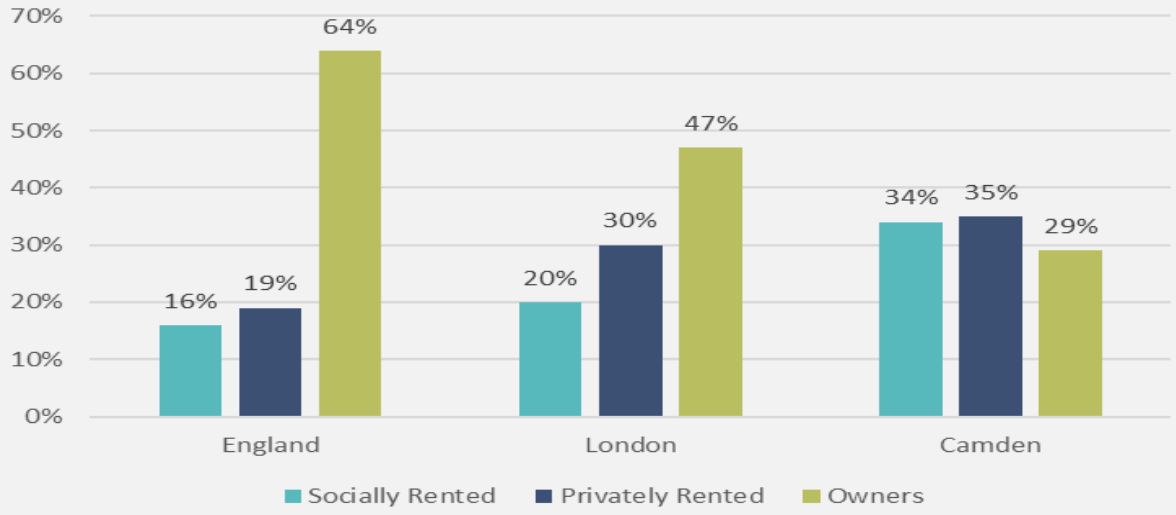
39% of households in Camden are single occupancy households, with over a quarter of these residents being older adults. 70% of Camden residents are single, separated, divorced, or widowed. The percentage of single residents is higher than for both London (60%) and national averages (53%)[60].

6.1.1.2.3 Housing, neighbourhood and environment

The conditions people live in, determined by, for example, housing quality, neighborhood safety, access to green spaces, can significantly affect their mental health. Poor living conditions and unsafe environments are risk factors for, and linked to, higher levels of stress and mental health disorders[61].

Figure 2 below presents the unique housing landscape in Camden: in 2023 over two thirds of residents lived in private (35%) or social (34%) rented housing, values higher than both London and England. 29% of Camden residents were homeowners, fewer than half the value nationally. 10% of Camden households were classified as overcrowded, this is similar to the London average (11%)[62].

Figure 2: Social renting, Private Renting and Homeowners in Camden compared with London and England



Source: Home Ownership in the UK: Key statistics 2023

Local service provider interviews identified insecure housing as a major risk factor for poor mental health, with people facing trauma through living in poor conditions, with the added stresses of having to engage with housing services (council and private landlords) and secure support to rectify issues. Poor housing conditions, including problems like mould and inadequate repairs, were identified as major risk factors impacting mental health. These issues are particularly pronounced among older adults and people living in deprived areas.

Being in nature is protective of mental health. The experience can help reduce people's levels of stress, improve their mood and promote overall psychological well-being[63]. 25% of land in the borough of Camden is designated park and open spaces making it a much greener place than other inner London boroughs. However, access to these spaces is not equitable with more deprived areas having fewer green spaces than affluent areas. The effect of limited access to green spaces for people living in deprived areas may exacerbate mental health inequalities recognising that environmental stressors are increasingly recognised as factors that can negatively affect mental health[64].

6.1.1.2.4 Crime and violence

Camden had the second highest crime rate compared to other London boroughs in 2023/24. The overall crime rate in Camden in 2023/24 was 35.5

per 1,000 people which compares poorly to London's and England's overall crime rate of 28.5 and 32.7 crimes per 1,000 population respectively[65]. Research indicates that living in a high crime area may affect mental health through direct or indirect pathways.[66]

6.1.1.2.5 Domestic violence and abuse (DVA)

Domestic violence and abuse is a key driver of women's mental ill health, self-harm and suicide[67]. It can have a severe and long-lasting impact on mental health with one in two women seeking mental health support due to domestic abuse[68]. Whilst there is a strong association between having mental health problems and being a victim of domestic abuse, mental ill health is also a risk factor for abuse perpetration. Victims and survivors with mental ill health are likely to have other complex needs and survivors often find it difficult to access the support they need[69].

Nationally, 2.3 million people over 16 years are estimated to have experienced domestic abuse in the year 2023/24. This equates to 1.6 million women and 712,000 men[70]. Both Camden and London reported rates of 34.5 per 1000 population – higher than the England rate of 30.6 per 1000. This represents 7700 recorded domestic violence incidents in Camden in 2023.

Locally, service providers described both men and women who have experienced domestic violence as often facing complex mental health challenges. The stigma surrounding male victims of domestic violence was considered to add additional difficulty to accessing support. Women, especially from minoritised communities, were reluctant to acknowledge the additional need their mental health conditions created or seek to support, due to a fear of their children would be removed from their care. See section 6.2.7 for more data on DVA.

6.1.1.2.6 Health and healthcare

Access to quality healthcare services is important for those experiencing poor mental health, yet disparities in access—often linked to socioeconomic status or geographic location—can worsen mental health conditions by delaying or preventing timely access to care[71].

Local service providers, particularly general practitioners, highlighted issues related to health care and perceptions of health care of those experiencing mental health conditions:

- **Care coordination**: A lack of communication between clinicians, especially during hospital admissions and discharges, often leads to compromised care continuity. This is particularly problematic for people with personality disorders, who frequently fall through service gaps due to inconsistent follow-up.
- **Post-discharge**: Service providers emphasised the lack of intermediate support for people discharged from hospitals. Without transitional care, these people are left without the necessary support to stabilise, increasing their risk of relapse or deterioration.
- **Crisis response**: Patients experiencing mental health crises, especially those who disengage from services, are often left unsupported, which can lead to worsening conditions due to inadequate crisis intervention.
- **Undetected needs of people with traumatic brain injury (TBI)**: People with mild TBIs, especially those with subtle behavioural changes post-injury, often go unrecognised within the healthcare system. This leads to unaddressed mental health needs, which can strain family dynamics and contribute to social isolation.
- **Psychosis and fear of hospitalisation**: Fear of being admitted to psychiatric wards often deters people experiencing psychosis from seeking timely help, delaying essential crisis support and exacerbating their conditions.

6.1.1.3 Residents at higher risk of poor mental health

6.1.1.3.1 Inclusion health groups

'Inclusion health groups' is a term used to collectively refer to a wide range of people who have experiences of marginalisation. It includes people who are homeless, use drugs and/or alcohol, vulnerable migrants, Gypsy, Roma and Traveler communities, sex workers, people in contact with the justice system and victims of modern slavery[72].

A 2023 Inclusion Health Needs Assessment[72] reported Camden populations defined in this way as having substantial and complex mental health needs, including schizophrenia and emotional instability. This particularly applied

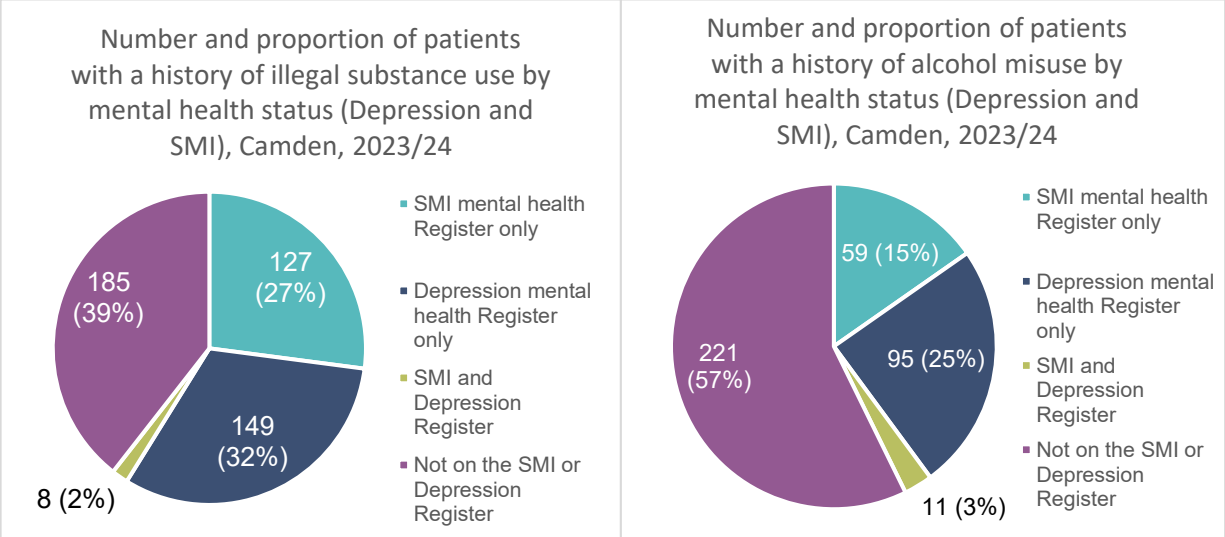
to people who were homeless or had recently left prison and who had co-occurring drug and alcohol dependency needs. It also found that despite high levels of need, access to support was inconsistent, with many people receiving medication without adequate counselling or therapy, leaving underlying issues unaddressed. Common mental health conditions were also reported to be prevalent but often untreated, leading to a pervasive sense of poor mental health being an accepted norm for people in 'inclusion groups' and further highlighting unmet mental health need.

The following section provides an overview of several of the 'inclusion health' population groups as highlighted by stakeholders.

6.1.1.3.2 Drug and alcohol use

1,199 (66%) people in substance use treatment in Camden have an identified mental health support need. This is lower than London (73%) and England (72%).
Figure 3 below shows the number and proportion of people registered with a Camden GP with a history of alcohol and substance use broken down by their mental health status in Camden in 2024.

Figure 3: Number and proportion of patients with a history of alcohol and substance use, 2023/24



811 Camden residents were coded as presenting alcohol or substance use need by primary care services in 2023/24 (for more details please refer section 6.2.7).

Local service providers, particularly general practitioners, reported that people with minor drug or alcohol use are frequently excluded from receiving mental health support. Local data shows that 22% of those in drug and alcohol treatment with identified mental health needs are not currently receiving any mental health support> This is the same as London, but higher than the national rate of 18%.

Detailed information about drug and alcohol use in Camden is reported in a recent needs assessment[73].

6.1.1.3.3 Homeless people including people who sleep rough

Homelessness creates a unique set of challenges that impact on the health and wellbeing of people who are homeless. Homelessness is defined as lacking a stable, safe, and adequate place to live. It includes sleeping rough, living in temporary accommodation or hostels, and sofa-surfing. 150,000 people in London are estimated to be homeless.[74]. Camden has the second highest population of homeless people in London[75] with increasing numbers of people sleeping rough.

The life expectancy of people experiencing homelessness is significantly lower than the general population, estimates suggesting 47 years for men and 43 years for women[76]. This disparity is driven by multiple intersecting disadvantages, including chronic physical and mental health conditions, substance use, social exclusion, economic hardship and more. Accessing support is often hindered by fragmented systems and inadequate outreach.

917 people were recorded as homeless in 2023/24 on Camden primary care data systems. This is an increase of 26% since 2022/23. 465 people (49%) had a diagnosed mental health condition, highlighting the mental health burden experienced by this group (refer to section 6.3 for more information).

Stakeholders interviewed for this report identified homelessness as inextricably linked to poor mental health. Providers stated that homeless people, particularly those with severe mental illnesses, faced multiple barriers trying to access health and social services, exacerbating their vulnerability. People recently released from prison and living in probation hostels were a known, high-risk population. Clinical providers observed that this group, particularly Black men, faced significant barriers to accessing

mental health services and were more likely to be detained or sectioned under the Mental Health Act.

6.1.1.3.4 Refugee and asylum seekers

Studies have shown that refugees and asylum seekers are particularly vulnerable to mental health issues due to the trauma of displacement, experiences of war or persecution, and the stressors of adapting to a new environment[77].

Stakeholders identified asylum seekers and refugees as a high need and risk priority group locally, with concerns about their mental health not being addressed as they waited for their legal status to be resolved. In many cases their lack of stable housing, the complexity of immigration law and the uncertainty surrounding their immigration status contributed to asylum seekers and refugees experiencing significant mental health challenges.

In September 2024, 1,565 people in Camden were classified as being refugees or asylum seekers, comprising 0.71% of Camden's total resident population (220,903). This is higher than the London (0.56%) and England (0.40%) rates[78].

6.1.1.3.5 People with autism and who are neurodivergent

The Camden Autism Plan estimates that there will be 2,500 autistic adult residents by 2040[79].

The link between autism and mental health illness is profound. Studies indicate that around 70% of people with autism meet the diagnostic criteria for one mental health or behavioural disorder, such as anxiety, attention deficit hyperactive disorder (ADHD), or oppositional defiant disorder, and 40% meet criteria for two or more disorders[80].

The National Autistic Society (NAS) attribute high rates of mental illness among people with autism to a lack of preventive support stating that 67% of autistic adults experienced anxiety as a result and that 33% experienced serious mental health problems due to this issue[81]. 16% of adults with autism are in full time paid employment despite 77% of unemployed people with autism wanting to work. 66% (91) of adult residents in Camden with both autism and learning disabilities were not in employment. Negative attitudes

and misconceptions about autism and learning disabilities in the workplace likely limit opportunities for employment, further compounded by a lack of tailored support to engage in employment[82].

Concerns about the mental health challenges faced by neurodivergent - particularly autistic - people were raised by service providers interviewed for this report. They reported that neurodivergent and autistic people often require specialist support and are at heightened risk of mental health conditions when their needs go unmet. People requiring more intensive, long-term support, were recognised as often not fitting typical service criteria, causing gaps in their care and inadequate access to necessary resources.

Local GPs interviewed for this report had noticed an increase in Attention Deficit Hyperactive Disorder (ADHD) diagnosis especially in residents in the 20–40 age group. This was attributed to ADHD diagnoses following assessments by non-NHS providers and was described as creating additional need. This has resulted in people experiencing long waiting times to access specialist care (where GPs lack the expertise to manage ADHD treatment).

6.1.1.3.6 Unpaid carers

The Camden Carers Survey reported that 7% (14,605) Camden residents identified themselves as carers providing unpaid support for people with mental and physical health needs. Many unpaid carers had challenges themselves, including emotional stress, financial strain, and health issues caused by the demands of caregiving. 5% of unpaid carers themselves have long-term illnesses or are disabled (for more information on carers in Camden refer to section 6.3).

6.1.1.4 The impact of the COVID-19 pandemic

National, international and local studies document the impact the COVID-19 pandemic on the health and wellbeing of societies and people. The Understanding Society and COVID-19 Mental Health & Wellbeing Study reported increased levels of anxiety, depression, and loneliness, among younger adults, women, and those with pre-existing conditions[83,84]. The 2021 Children and Young People's Mental Health Survey highlighted a concerning rise in emotional disorders among children, with the prevalence of probable mental disorders nearly doubling since 2017 with implications into adulthood[85].

Vulnerable population groups in Camden, including young people, people living alone, residents on low-incomes and ethnic minority communities, reported heightened levels of loneliness during the pandemic[86].

Similarly, Office of National Statistics (ONS) data[87] from 2020 and 2021 reported that during the pandemic 2020 and 2021, Camden residents experienced an overall decline in their mental wellbeing: increased anxiety, decreased life satisfaction and a reduced sense of 'life being worthwhile' were all reported. Positively, since 2023, residents have reported improved life satisfaction and reduced anxiety levels - a positive trend towards regaining wellbeing.

The Centre for Mental Health estimated that up to 10 million people in England - nearly 20% of the population - will require new or additional mental health support as a direct result of the pandemic[88]. Local service providers highlighted an increase in the number of people seeking mental health support for the first time, with many attributing their anxiety to the prolonged impacts of the COVID-19 pandemic. They described this cohort of people as "grappling with new forms of anxiety that disrupt their work-life balance and overall mental health". Stakeholders emphasised that social isolation and disconnectedness, particularly as experienced by minoritised communities and older adults, had worsened due to the ongoing cost-of-living crisis, housing instability, and the lingering effects of the pandemic.

6.2 Mental health conditions

The previous sections highlighted a range of risk factors known to impact mental health and sought to identify what this means for people living in the borough of Camden whilst recognising that exposure to risk factors does not always lead to a diagnosed mental health condition. This section uses national and local data to better understand the extent of diagnosed mental illness in Camden. It reports the incidence and prevalence of mental health conditions, reports service referral, engagement and access data, and reflects on the data referring to demography and equity of access to appropriate NHS services.

The term 'incidence' reflects the number of new cases of a given medical condition in a population within a specified period of time. The term 'prevalence' is the proportion of a particular population found to be affected by a medical condition at a specific time[89].

According to the Adult Psychiatric Morbidity Survey (2014)[90], approximately 1 in 6 adults in England reported experiencing a common mental health disorder (CMD), with women (20.7%) more affected than men (13.2%), especially among younger adults and people living in deprived areas. The Health Survey for England (2019) similarly reported that nearly 19% of adults experienced high psychological distress, with higher rates among women (21%) compared to men (16%), and people in socioeconomically disadvantaged regions[91].

In 2023, 6.3% of people in England used secondary mental health services, an increase from 5% in 2020-21[92]. In numerical terms, this indicates that 1.34 million people were using adult mental health services in 2023/24[93]. While national data indicates a rising prevalence of mental health conditions and an increasing number of people accessing services, this does not necessarily reflect the full extent of need or demonstrate that people receive appropriate support. The Mental Health Foundation estimated that approximately 8 million people with mental health needs were not receiving appropriate support from mental health services[94]. Many people experiencing mental health difficulties do not seek help due to stigma, lack of awareness, or barriers to accessing services, including long waiting times, complex referral pathways, or limited availability of culturally appropriate care. The discrepancy this represents between those who need and require support and those who actually receive it, suggests that gaps remain in mental health service provision, and that this will particularly be the case for underserved and marginalised groups[95].

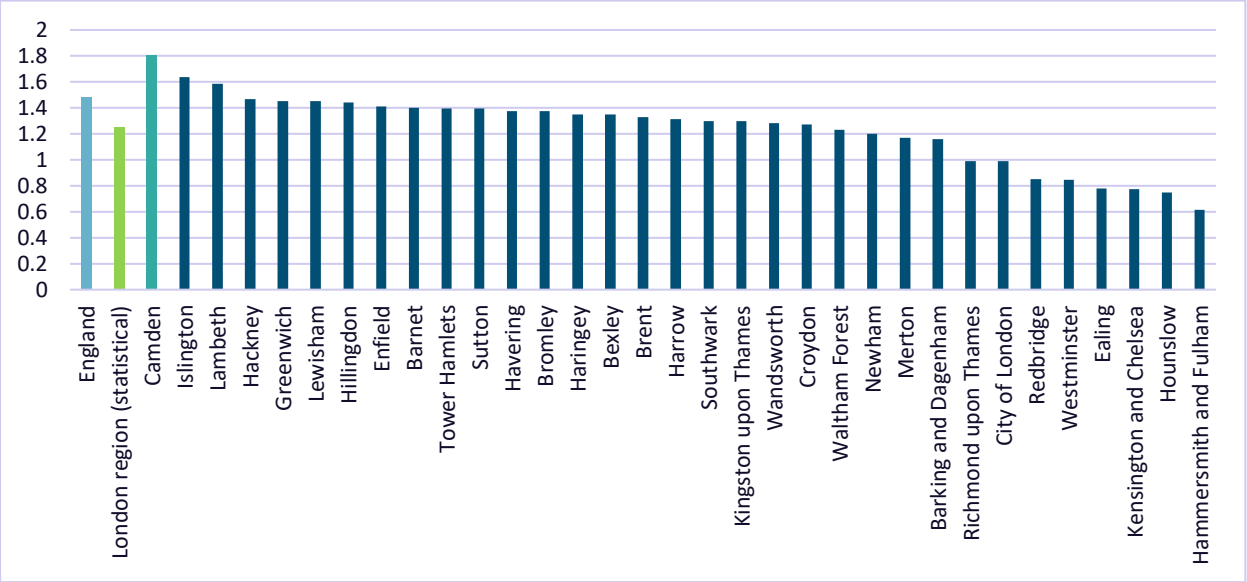
Recorded incidence and prevalence of mental health conditions in Camden
In primary care, GP data on diagnosed mental health conditions are recorded on two “disease registers”, which are used to monitor and manage patient care. The depression register is used to record people diagnosed with mild to moderate forms of depression. The Serious Mental Illness (SMI) register records more severe conditions, including diagnoses of schizophrenia, bipolar disorder, other psychoses and people on lithium therapy.

The following section uses data from the registers to report the incidence and prevalence of depression and SMI amongst people aged 18 years and over, in Camden making comparisons to London and England[96].

6.2.1 Depression incidence:

In 2023/24, 1.8% (5040) adults registered with a Camden GP were recorded with depression for the first time. Figure 4 below shows that the incidence of depression in Camden was the highest of all London boroughs. It was also higher than the overall London (1.3%) and England (1.5%) rates.

Figure 4: Incidence of depression (18+), national, regional and borough comparison, 2023/24

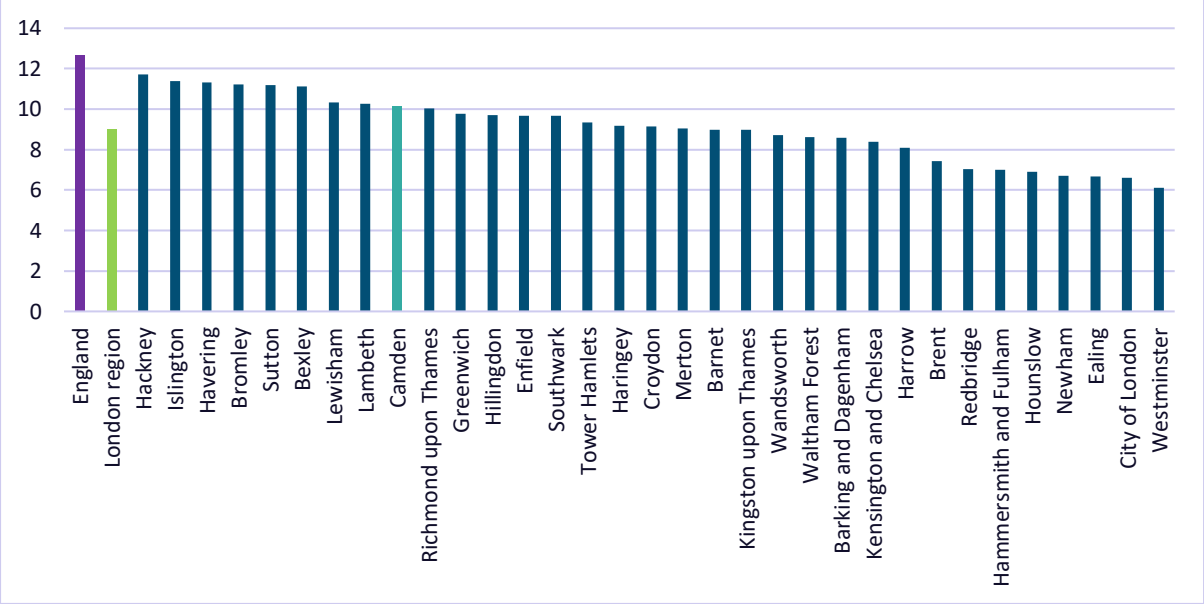


Source: Quality and Outcomes Framework (QOF), NHS England

6.2.2 Depression prevalence

In 2023/24, 10.7% (29,416) of adults registered with a Camden GP were recorded with depression. Figure 5 below shows that although the prevalence in Camden was higher than London (9%), it was not the highest across all London boroughs, and it was lower than England (12.6%).

Figure 5: Prevalence of depression (18+), national, regional and borough comparison, 2023/24



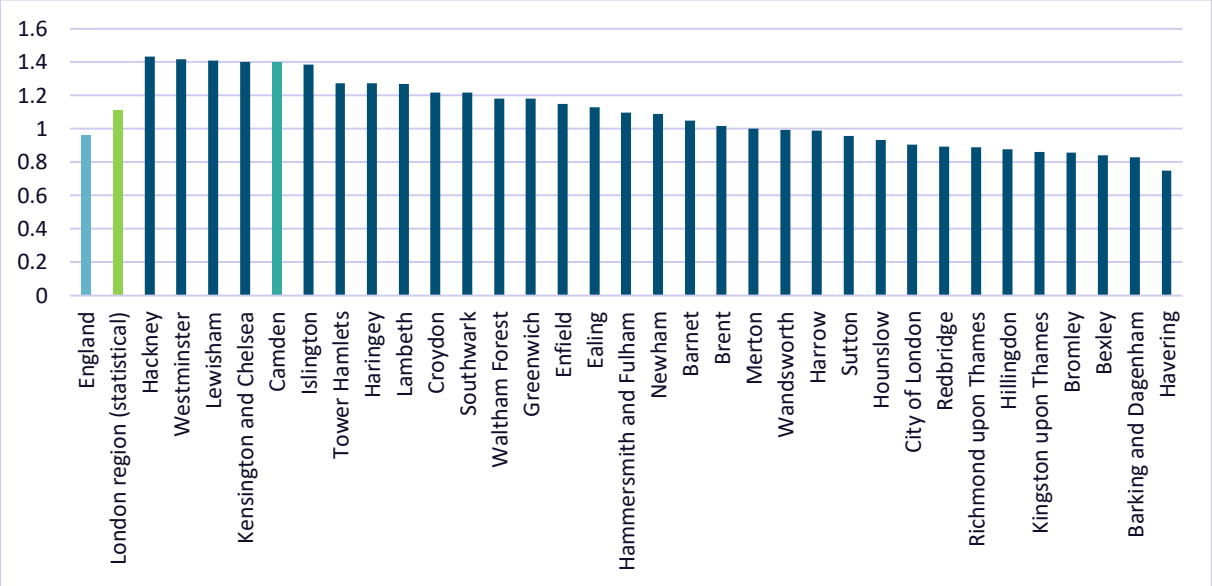
Source: Quality and Outcomes Framework (QOF), NHS England

6.2.3 Serious Mental Illness (SMI)- Schizophrenia, bipolar disorder, and other psychoses

SMI incidence – This data was not available.

SMI prevalence
In 2023/24, 1.4% (4,496) of adults registered with a Camden GP were recorded on the SMI register. Figure 6 shows that the Camden prevalence was higher than both the London (1.1%) and England (0.9%) rates. Camden recorded the fifth highest SMI prevalence across all London boroughs.

Figure 6: Prevalence of schizophrenia, bipolar disorder, and other psychoses (18+), national, regional and borough comparison, 2023/24



Source: Quality and Outcomes Framework (QOF), NHS England

6.3 People with domestic violence, homelessness, substance use and unpaid carers flag in the past 12 months 2023/24

Of the risk factors of mental illness recorded in primary care, data on domestic violence, homelessness, substance use and unpaid carers was requested through the North Central London Integrated Care Board (NCL ICB). Table 5 provides insights into the incidence and trends of mental health conditions among individuals registered with the above-mentioned risk factors in Camden, highlighting variations across age groups, gender, levels of deprivation, and ethnicities.

Table 5: People with domestic violence, homelessness, substance use and unpaid carers flag (2023/24)

Factor	Data from 2023/24	Age	Sex	Deprivation	Ethnicity
Domestic Violence and Abuse (DVA)	680 adults registered with a Camden GP were noted (or 'flagged') as reporting domestic violence in 2023/24. 40% (269) of these were on the depression register, 7% (48) on SMI register and 2% (10) on both.	People aged 55 years and older reported the highest number of DVA incidents, however, 77% (170 people) were not on a mental health register. 62% of people (82) under 34 years were recorded on the depression register. The SMI register includes a small minority of people with domestic violence flags across all ages, with the highest share (9.1% [12]) in the youngest age group.	Flagged cases of domestic violence are more than 10 times higher for women than men. More women are on the depression register (41%) compared to men (26%). A higher proportion of men are on the SMI register (12%) compared to women (6.7%). 10% more males are on neither register.	71% (486 out of the total 680 with a DVA flag) of the DVA cases are from the most deprived quintiles (IMD 1 to 5).	Disclosure to and recording of DVA by GPs is highest for White people followed by Asian and Black people. Among White people, 54% (163 put of 329) were on the SMI or depression or both registers. Black 41% (38 out for 92) and Asian people 42% (62 out of 146) were on the SMI or depression or both registers. People of Mixed and Other ethnicities, (17 and 23 respectively) were evenly split between being on the depression register and not being on any register (and less than 5 on the SMI registers). People of Unknown ethnicity had the fewest cases (19 patients), with 12 (63%) on the depression register only.
Homelessness	906 adults registered with a Camden GP were flagged as experiencing	Rates of homelessness were highest amongst people aged 45-54	Twice as many men (621) were affected by homelessness	75% (687 out of the total 906) of the people flagged as	White people are most frequently recorded as being homeless (49%, 445), followed by Black

	homelessness. 35% (323) were on the depression register and 16% (148) on the SMI register. 2% were on both the depression and SMI registers. The remaining 47% (435) were on neither the depression nor SMI registers.	years. Younger people (under 34 years) were more likely to be on the depression register and 35–44-year-olds were most likely to be on the SMI register. The proportion of people not recorded on any mental health register increased with age, reaching 82% of those people aged 65 years and over.	as women (285). However, a higher proportion of women were on the depression register 116 [41%] than men 207 [33%]. The proportion of women and men on the SMI register was similar. 5% more men were on neither register.	homeless were from the areas of highest deprivation (IMD 1 to 5).	(17%, 158) and Asian (16%, 148) people. 33% (148) of White people were on the depression register and 18% (83) on the SMI register. 18% (29) of Black and 11% (17) of Asian people were on the SMI register, 31% (50) and 37% (56) were on the depression register respectively. Homeless people from Mixed and Other ethnic groups had the highest recorded depression register rates at 44% (24) and 51% (34) respectively.
Substance use	809 adults registered with a Camden GP were flagged for substance use. 421 (52%) of these were recorded on a mental health register. Where people *were* recorded, users of illicit substances were more likely to be registered on both mental health registers than people presenting with alcohol	Substance use was highest amongst people aged 35-64 years. Both depression and SMI was largely recorded among the 25-65 age group and declining for above 65.	Like homelessness, almost twice as many men (582) were flagged for substance use than women (228). A higher proportion of women (57%, 132) were on the SMI, depression or both registers	Substance use was most prevalent in areas of highest deprivation - 72% (592) in IMD 1 to 5.	Substance use was most recorded for White people (577), followed by Black (74) and Asian (58) people. Half of White people were not on any register, however 29% (167) were on the depression-only register. People of Mixed and Other ethnicities had the highest depression register-only rates 38% (15) and 48% (12) respectively. Black 30%

	dependency exclusively.		than those on neither compared to men (49%, 289).		(22) and Asian groups 33% (19) were disproportionately over-represented on the SMI register-only.
Unpaid Carers	2,108 adults registered with a Camden GP were flagged as being an unpaid career. 77% (1,618) were on neither the SMI nor depression registers. 18% (389) were on the depression register only, 4.5% (96) were on the SMI register only, and fewer than 1% (7) were on both the SMI and depression registers.	Younger carers are more likely to be on the depression register than older carers. The likelihood of being on neither register increases across older cohorts.	Twice as many women (1421) were recorded as carers than men (687). 23% (341) of women and 21% (149) of men registered as carers were also on the depression, SMI or both registers.	Carers were more or less, evenly distributed across the 10 IMD levels.	White people were the largest group of unpaid carers (1,348), followed by Asian (339) and Black (194) people. Despite this, carers from Mixed and Other ethnicities were most frequently recorded on the depression register of all ethnic groups. Unpaid carers from Black and Unknown groups had the highest SMI-only rates.

Of all the people flagged with a DVA, homelessness, substance use or unpaid carer code, older people (55+) are the least likely population group to be on depression or SMI registers, while younger people (under 34) are the most likely to be on the depression register. Based on national data, the Mental Health Foundation estimates that most people with DVA, homelessness and substance use codes are likely to have a mental health problem[97]. However, data for Camden reveals that only half of people registered with these codes have a diagnosed mental health condition. This suggests that the prevalence of mental health issues in Camden may be understated, with the possibility of undiagnosed and undocumented cases.

Additionally, 77% of unpaid carers were not on any register indicating they did not have a documented serious mental illness or depression. However, national data from the Mental Health Foundation[98] suggests that nearly 71% of carers experience poor physical or mental health. This discrepancy suggests that the prevalence of mental health problems among unpaid carers in Camden may be significantly underestimated, and the actual burden of mental health issues could be much higher.

Women are disproportionately affected by DVA, evidenced by their higher rates on the depression register compared to men. Conversely, men have higher rates on the SMI register. Homelessness and substance use are more prevalent among men, yet women affected by these issues are more likely to be on mental health registers. In the case of unpaid carers, women are twice as likely to be recorded as carers compared to men, with similar proportions of both sexes on mental health registers.

A significant proportion of people affected by DVA, homelessness, and substance use live in areas of highest deprivation, with 71% of DVA cases, 75% of homeless people, and 72% of people with substance use falling into this category. In contrast, unpaid carers are evenly distributed across deprivation indices, indicating that caregiving responsibilities span socioeconomic status.

White people have the highest disclosure rates for DVA, homelessness, substance use and unpaid caring, followed by Asian and Black people. They also have higher rates on mental health registers. Black and Asian people are on both depression and SMI registers while people of Mixed and Other ethnicities are the population group most frequently logged on the depression register.

6.4 People with suicidal thoughts

542 adults registered with a Camden GP in 2023/24 presented to their GP with suicidal thoughts. 15% (83) were aged 25-34 years, 8% (44) were 35-44 years, 22% (120) were aged 45-54 years, 16% (86) were 55-64 years and 15% (81) were aged 75 years or. This distribution suggests that suicidal thoughts affect people across a wide range of ages in Camden, with the highest prevalence observed in the 45-54year age group. 62% (337) of people who presented to their GP were women. Suicidal thoughts were more prevalent (60%, 301) amongst people living in areas of deprivation (IMD 1-5).

64% (345) of people were White, 14% (75) were Asian, 7.9% (43) were Black and 12.4% (67) of people were from Mixed, Other, or Unknown ethnicity. This shows an overrepresentation of the White, Mixed, Other and Unknown ethnic groups (compared to their total population proportions) and potentially indicates better access by these groups or more prevalence of suicidal thoughts.

This data highlights that people across demographic groups in Camden have suicidal thoughts and share their thoughts with their GP. This is particularly the case for women rather than men, for people living in areas of deprivation, and for older adults.

6.5 Service referral and access data 2023-2024

While some conditions are managed by GPs within primary care, others lead to referrals for further support from other services. The following section includes referral and access data for iCope talking therapy service and secondary mental health services.

6.5.1 iCope talking therapy service data

In primary care settings, GP data on mental health conditions are recorded on “disease registers” used to monitor and manage patient care and record a wide range and severity of mental health conditions. The depression register is used to record people diagnosed with mild to moderate forms of depression. Table 6 reports referral and access data for iCope talking therapy services in Camden by age, sex, deprivation, and ethnicity.

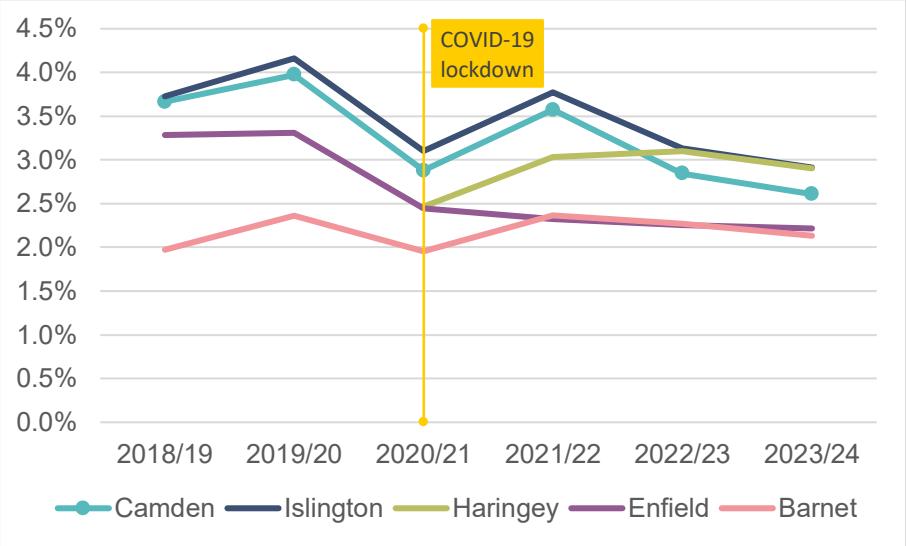
Table 6: iCope service referral and access (2023/24)

Service	Data from 2023/24	Age	Sex	Deprivation	Ethnicity
Referrals to iCope	8,784 adults registered with a Camden GP were referred to iCope talking therapy services in 2023/24.	74% of all referrals to iCope talking therapy services were for 18–44-year-olds (6,498 adults). 33% of referrals were for people aged 25–34-years. Referrals declined steadily for subsequent age cohorts with only 6.6% of people aged 65 – over 75 years being referred to talking therapies by their GP.	Women (68%, 5,979) accounted for more than two-thirds of the referrals to iCope talking therapy services	Deprivation data related to referrals to iCope was incomplete, providing no information about area of residence for 26% of referrals. However, the data available indicate that 47% (4,067) of people referred to iCope were resident in IMD 2-5 (areas of higher deprivation), compared to 29% of people resident in IMD 6-10 (areas of lower deprivation).	2021 census ethnicity data reported that 59% of Camden residents were White, 18% were Asian, 8% were Black and 15% were of Mixed or 'Other' ethnicity. Referral to iCope data indicates that White and Asian people are proportionately underrepresented (49%, 4,314 and 16% 1,393 respectively), that Black people were proportionately represented (8%, 707) and that people of Mixed or 'Other' ethnicity were disproportionately overrepresented (27%, 2,371).
iCope attendance	5,627 (64%) adults registered with a Camden GP and referred to iCope talking therapy service, attended the service.	74% (4,165) of people attending iCope were aged 18-44 years. Attendance was highest for 25–34-year-olds (34%) declining over subsequent age cohorts.	70% (3,964) of people attending talking therapies were women, 30% (1,633) were men.	44.7% (2704) of people attending iCope were resident in IMD 1-5 (areas of higher deprivation).	Data reporting uptake of iCope talking therapy service by people who had been referred indicates that White 51% (2,845) and Asian people 16% (893) were proportionately underrepresented, Black people 7.5% (422) were proportionately represented and people of Mixed, Other or Unknown ethnicity were overrepresented 26% (1467).

6.5.1.1 North Central London (NCL) comparison of iCope Talking Therapy services (referrals and attendance)

Figure 7 compares the referrals of adults to iCope across NCL boroughs. Referral rates have declined along with three other NCL boroughs since 2018. Whilst Camden had the second highest prevalence of depression across NCL (see figure 5), it ranked third for referrals in 2023/24.

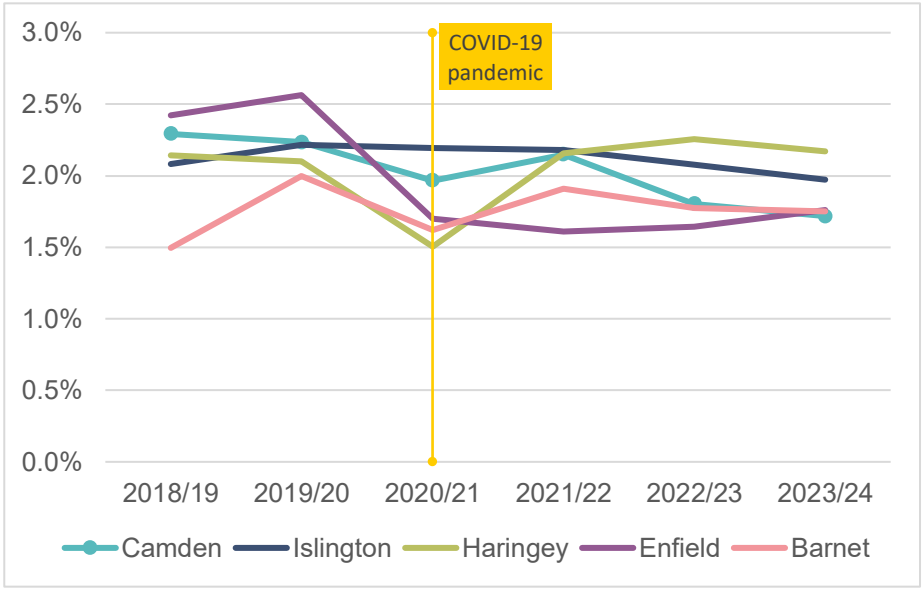
Figure 7: Patients (18+) referred to Talking Therapies, 2018-2024



Source: iCope services and HealtheIntent

Figure 8 shows the uptake of talking therapies (attendance at appointments). The uptake has declined since 2018 and is the second lowest compared to other NCL boroughs.

Figure 8: Patients (18+) attending Talking Therapies, 2018-2024



Source: iCope services and HealtheIntent

6.5.2 Secondary mental health service access and referral

Table 7 reports the service referral and access data for secondary mental health services in Camden.

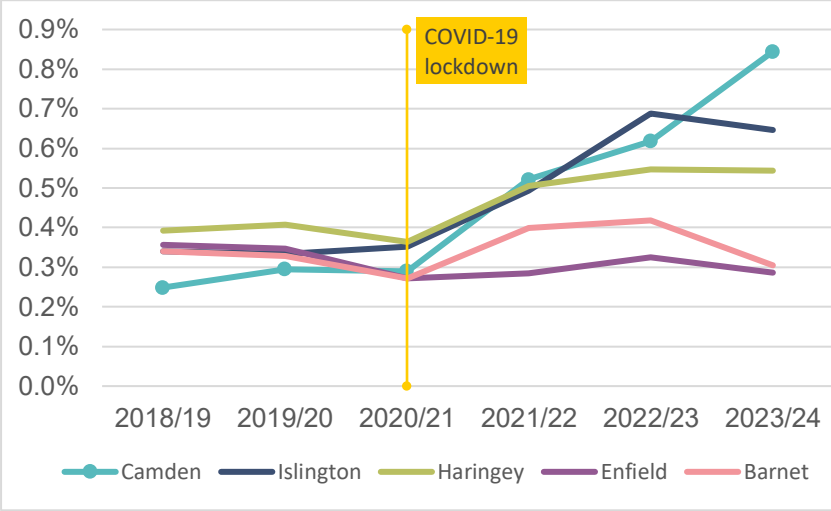
Table 7: Secondary mental health service referral and access (2023/24)

Service	Data from 2023/24	Age	Sex	Deprivation	Ethnicity
Referrals to Secondary mental health service	2,843 people (adults) registered with a Camden GP were referred to secondary mental health services.	69% (1, 952) of people referred to secondary mental health services. were aged 18-44 years. Referrals were highest for 25–34-year-olds (31%, 874). Referral numbers steadily decline for older cohorts – 6.5% of 65-75+ year olds were referred.	60% (1,714) of people referred to secondary mental health services were women.	68% (1811) of people referred to secondary mental health services were resident in IMD 1-5 (areas of higher deprivation).	Referral to secondary mental health services data indicates that White and Asian people were proportionately underrepresented (55% and 16% respectively), Black and Mixed, Other or Unknown ethnicity people were overrepresented (10%, 274 and 19%, 540 respectively).
Secondary mental health service attendance	Data reports that 7,916 people attended secondary mental health services in 2023/24. This is higher than the number of people referred to secondary mental health services in the same period (2023/24).	64% (5,001) of people attending secondary mental health services were aged 18-44 years. Attendance was highest for 25–34-year-olds, declining over subsequent age cohorts until the age of 74 years. The access rate increased slightly for people aged 75 years and over.	61% (4,846) of people accessing secondary mental health services were women.	63% (4718) of people attending secondary mental health services were resident in IMD 1-5 (areas of higher deprivation).	Data reporting uptake of secondary mental health services by people who had been attending indicates proportionate attendance by White people (59%, 4,706). Asian people 15% (1,202) were proportionately underrepresented and access by Black people 9% (722) was proportionate. People of Mixed, Other, or Unknown ethnicity were overrepresented 16% (1,286).

6.5.2.1 North Central London (NCL) comparison of secondary mental health services data (referrals and attendance)

Figure 9 compares the referrals of adults to secondary mental health services across North Central London (NCL) boroughs. Referral rates to secondary mental health services have increased since 2018. In 2023/24 Camden had the highest referral rate in NCL. This aligns with the high prevalence of SMI in Camden.

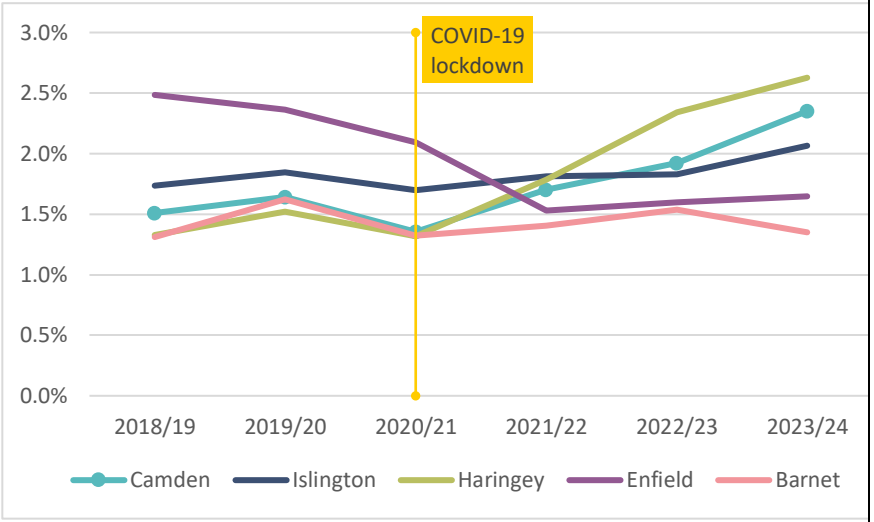
Figure 9: Referrals to secondary mental health service, 2018-24



Source: HealtheIntent and NCL ICS HealtheIntent data platform

Figure 10 compares the attendance of adults to secondary mental health services across NCL. Attendance rates have increased since 2018. In 2024/24, the attendance rates were second highest in NCL.

Figure 10: Patients attending secondary mental health service, 2018-24



Source: HealtheIntent and NCL ICS HealtheIntent data platform

Overall, the referral and access data for iCope talking therapies and secondary mental health services, highlights that inequalities persist - despite the high prevalence of depression and SMI in Camden these conditions are not always proportionately reflected in referral and access rates. These inequalities are more prominent for some population groups particularly older people, socially disadvantaged people and minoritised people.

A number of trends emerge from the data that might speak to people's 'ability to reach' services and their 'ability to seek' services being linked to accessing mental health services. Young peoples' ability in these domains seems well developed, people's ability as they age, less so. Young people are the primary beneficiaries of referrals to iCope and secondary mental health services. They are also the primary users of both types of services. Referral to and use of both services declines across older age cohorts. This could be attributed to perceptions of mental health - younger people having greater mental health awareness and literacy and feeling less stigmatised about using services. Conversely older adults' referral to and use of services might be negatively impacted by difficulties recognising mental health symptoms and a perceived normalcy of having mental health issues in later life and prioritisation of physical health concerns.

In relation to sex, women are the primary beneficiaries of referrals to iCope and secondary mental health services and the primary users of these services. Lower referral rates and use of services by men could be in-keeping with men being less likely to seek help for their mental health than women, indicating less ability to both seek and reach services. This assumption does, however, fail to explore the complexities of access.

Ethnic disparities were also very evident. This was particularly the case for people of Black or Mixed, Other or Unknown ethnicity, who were overrepresented in data indicating referral to and use of secondary mental health services. Over-representation might indicate less access to lower intensity iCope services that in turn results in later presentation to compulsory mental health treatment if mental health conditions have deteriorated. It might be related to mental health awareness, literacy and feeling stigmatised about using services. Previous or anticipated experiences

of racism when accessing mental health services is another potential barrier to seeking mental healthcare for these groups specifically.

Finally, disparities in relation to referral to and access of both types of mental health services were particularly pronounced by deprivation indicator measures (IMD). The majority of people referred to and using secondary mental health services lived in areas of higher deprivation. While this highlights the link between socioeconomic status and the severity of mental health needs, it might also raise questions about the perceived appropriateness of services to meet the needs of different population groups.

6.6 Section 2: Mental health support in Camden

The North London Foundation Trust (NLFT), Primary Care, Camden Council and wider community partners provide mental health support and service offers for residents that aim to span the spectrum of mental health need. This offer ranges from services within the community that are preventative and protective, in that they work to raise awareness of mental health and to support people to maintain their mental health and wellbeing, through to the provision of specialist health services that aim to meet the care and treatment needs of people experiencing mental ill health.

This section of the report provides an overview of some - but far from all - of the support available locally. It is informed by interviews with stakeholders, including residents with lived experience. It was not possible to speak to every organisation in the borough working to support mental health. As a starting point, Mental Health Partnership Board (MHPB) members were asked to help identify potential organisations to be interviewed. From a wide range of suggestions, those who were available were interviewed. Every contributor to the report suggested additional organisations that could be included.

Mental health support in Camden is described for the reader in line with the Mental Health Foundation's categories of prevention - primary, secondary and tertiary.

Primary prevention involves promoting good mental health for all (targeting everyone in the community) and aims to stop people from developing

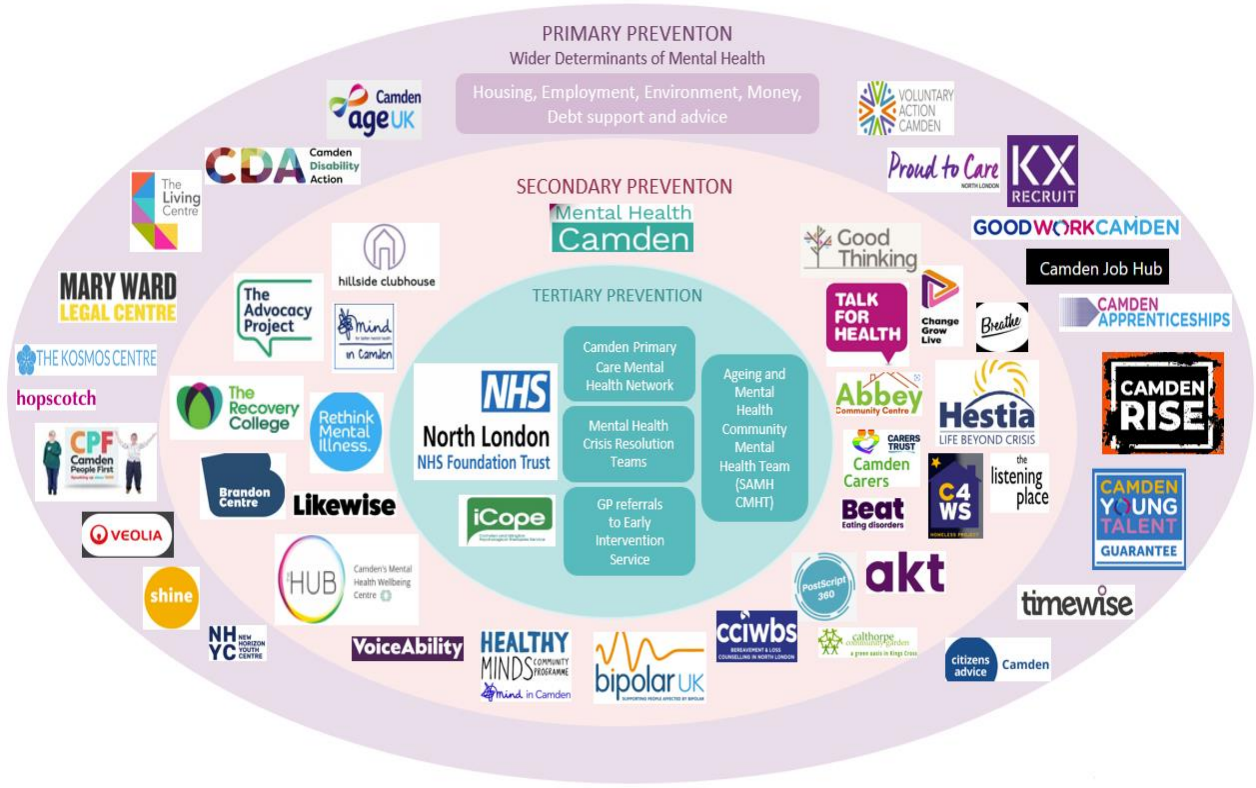
mental health problems. This includes anti-stigma campaigns and awareness raising such as Mental Health Awareness week.

Secondary prevention supports people who are more likely to develop mental health problems, either because of traits they were born with or because of experiences they have had. This could include people who identify as LGBTQIA+, people who have experienced trauma, and victims of hate crimes.

Tertiary prevention focuses on people with diagnosed mental ill-health with the aim being to reduce their symptoms, empower them to manage their well-being and reduce the risk of relapse.

The figure below highlights a number of services that comprise the current mental health service offer in Camden. Many, but not all have contributed to this report. These services are categorised into relevant tiers of prevention (primary, secondary, or tertiary) based on their areas of work. However, it is important to note that some organisations operate across multiple prevention tiers and are not limited to just one type of prevention.

Figure 11: Overview of services supporting Mental Health in Camden



6.6.1 Primary prevention in Camden

Voluntary Action Camden (VAC) has developed a team of health advocates who engage with residents to explore community-based solutions to improving health. This includes "*Community Links*" which provides access to care navigation and social prescribing services designed to ensure residents receive appropriate support tailored to their needs.

Age UK Camden provide a range of services that aim to support residents, many with complex mental health needs. Service provision ranges from access to care navigators for those with long-term health conditions and complex cases, to link workers located within GP practices who aim to connect primary care and community resources in a way that will positively support a service users mental health.

Both VAC and Age UK Camden work closely with other community organisations to provide integrated care and build a holistic support network for residents.

Holborn Community Association uses a person-centered approach, exemplified by use of clear, non-judgmental and non-clinical language, to engage people in activities and conversations that positively support their mental wellbeing. Staff tackle issues such as loneliness and support people to build new meaningful relationships through participation in creative activities and community cooking and eating.

Hopscotch provides wraparound services mainly to women and children. They offer welfare benefit advice, mental wellbeing advocacy, women's groups to promote mental and physical health, and also provide homecare service. A unique and much valued element of the organisation is that it offers long term support of up to 12 months. This comes through one-on-one and group sessions, and workshops focused on mindfulness, resilience, and self-care practices that are culturally sensitive. The approach is holistic and includes a focus on issues such as functional mobility, sleep hygiene, and nutrition, in recognition that these factors play a crucial role in overall well-being.

Castlehaven Community Organisation provides holistic support to residents. They have established strong partnerships with local organisations,

GP surgeries and colleges to ensure residents can access both practical and emotional support. Their projects include a membership program for people aged 60 plus, free afterschool & weekend activities for young people, health & well-being sessions, environmental and horticulture sessions, and an emergency food bank.

Mental Health Camden is a comprehensive online resource residents and services can use to access information about a wide range of local services working to support mental health needs, using the search tool to navigate the often-complex mental health care landscape. Somewhat uniquely it addresses how racism, whether institutional or interpersonal, can exacerbate mental health conditions and hinder recovery and provides resources on mental health services for those affected by racism.

6.6.2 Secondary prevention in Camden

The Reach Out Camden Alliance

The Reach Out Camden Alliance is a multi-sector partnership of mental health-focused organisations that aim to inform people about the range of services in Camden. It comprises Mind in Camden, Likewise, Voiceability and The Advocacy Project.

They represent a comprehensive range of services designed to help people manage their mental health, access timely support, and engage fully in community life. Its' ethos focuses on building people's strengths, aiming to ensure that those with mental health needs can actively participate in their communities. This partnership, which includes service users, also collaborates to enhance support for residents.

Mind in Camden supports people with serious mental health needs each year. It is affiliated to National Mind, and offers a range of services, including social prescribing services. Core elements of the service offer include

- The Healthy Minds Community Program that works with adults struggling with their mental health, isolation or social exclusion, and supports them in reconnecting with their community.
- The Phoenix Wellbeing & Mental Health Recovery Service that provides co-produced support spaces, peer support and workshops, counselling and therapies.

- The “Voices Unlocked” project that targets support at people who reside in prisons, secure units and Immigration Removal Centres and who hear voices.
- The Cultural Advocacy Project to promote mental health across diverse communities.

Likewise works with people to create opportunities to build and support mental wellbeing through learning, doing and belonging. The service offer includes client-led, 1 to 1 support via its “6-8 Session service” and floating support services, and through access to creative therapies and community support and development activities. Likewise provides targeted support to challenge inequalities experienced by marginalised communities. This includes Queer Space and Trans Space for identity-specific groups, and joint work with Mind in Camden to reach and meet the mental health needs of Black British groups and communities.

Hillside Club House runs a varied program of activities and support to rebuild confidence, help people to re-engage with their community and develop a sense of purpose. It offers specialist employment and benefits support, through Individual Placement and Support (IPS) services, working closely with employment experts to enhance referrals and outcomes.

The Listening Place offers sustained, face-to-face support for people experiencing suicidal thoughts who feel life is no longer worth living. The service is delivered by trained volunteers and provides free, face-to-face, confidential, and ongoing support. The service helps people feel less isolated and more connected and works closely with other mental health services to create comprehensive care pathways for those most in need.

Nafsiyat is an intercultural therapy centre committed to providing effective and accessible psychotherapy and counselling services to people from diverse religious, cultural and ethnic communities. The service takes referrals from health professionals and accepts self-referrals. It provides short-term culturally sensitive therapy to people, groups and couples, in different languages where required.

6.6.3 Tertiary prevention in Camden

General practitioners (GPs) serve as a key point of contact for people experiencing mental health difficulties, offering guidance and referrals to specialist services[99]. As the first point of access for many people, primary care is uniquely positioned to provide holistic, person-centred mental health support throughout a patient's life, including during major life events such as pregnancy and bereavement[100]. When asked, many people express a preference to receive mental health care in primary care settings due to their accessibility and anonymity which reduces mental health related stigma.

iCope talking therapy service or psychological therapies, are effective and confidential treatments delivered by fully trained and accredited NHS practitioners. They help with feelings of depression, excessive worry, social anxiety or post-traumatic stress disorder (PTSD). People can be referred by their GP or self-refer to these services without having a diagnosed mental health condition. Talking therapies are also used to support mental health problems arising from having physical health conditions such as diabetes, cancer and long-term pain.

Specialist mental health services for Camden residents are provided by the North London Mental Health Foundation Trust. Most services are community based although there is in-patient provision. Service provision for Camden residents is listed here.

Camden Community Core Teams are a partnership between North London NHS Foundation Trust, Mind in Camden, Likewise and Hillside Clubhouse. The Teams are geographically spread with locations in North-West Camden, Kentish Town and South Camden.

The Core Teams collaborate with GPs, specialist mental health services, housing, and social care to provide holistic, person-centered support. Their focus is on building relationships and fostering shared responsibility across the mental health system and working with people, their support networks, and surrounding systems. The Core Team service offer aims to meet a range of needs, from social care, peer coaching, and holistic wellbeing services (often in partnership with voluntary sector providers) to mental health assessments brief therapies and prescribing.

Focus Homeless Community Mental Health Team provide specialist mental health services for street homeless people in Camden. The service uses assertive outreach to engage with people on the street or living in the hostel pathway and experiencing mental ill-health. The service offer includes mental health assessments, treatment, and crisis planning. The team works closely with the Routes off the Street Team, homeless hostel staff and homeless people to develop personalised treatment plans.

6.6.4 Mental health support sector strengths

Semi-structured interviews and focus group discussions were held with a wide range of stakeholders and residents (many with lived mental health experiences). Analysis of the resulting narrative data is reported here to provide insights, from the perspectives of participants, into the perceived strengths of the current mental health support landscape in Camden. Some key strengths were identified across the prevention tiers:

- There is a broad commitment to partnership work between services in the borough. This was a strong, cross-sector observation, within and between prevention tiers, that recognised the interdependencies of organisations and the importance of working together given that no one service can meet all the needs any one person has. To respond to mental health need holistically, organisations and services must work together and work hand-in -hand with the person in need. Locally, good examples of this way of working include the Reach Out Camden Alliance and The Camden Core Teams. This commitment to preventative, community focused work that is multi-disciplinary in nature and offers an integrated treatment response, supportive of and service-user led is a strength.
- The Voluntary and Community Sector - This sector was mentioned extensively by professional stakeholders and residents alike. The perception was that it is an active, thriving sector in Camden that supports and meets a wide range of mental health need. Statutory health partners were explicit about how important working closely with voluntary sector colleagues was. GPs in particular, recognised that voluntary and community-based support meets holistic need more effectively by offering long-term support that extends beyond the 6–8-week standard offer made by statutory partners, yielding better outcomes in the process. Statutory stakeholders expressed a desire to

work with a broader range of voluntary and community sector (VCSE) organisations more frequently for these reasons, also acknowledging this as a gap.

- Stakeholders with lived experience identified being able to access immediate, appointment-free drop-in services and support (e.g. coffee mornings and art sessions) from community-based services like Mind in Camden and The Hive as a strength.
- The provision of talking therapies for young adults within the familiar, comfortable setting of organisations such as The Hive which works hard to reduce stigma that can be a barrier to access was recognised as a strength. Being able to access these services at The Hive was highly valued by young adults and recognised this as a system strength to be rolled out more widely as a default offer rather than being prescribed medication.
- The opportunity to spend sufficient time with people to develop trust and establish a human connection is being practised by some services and was identified as good practice by many.
- The provision of Care Navigators within voluntary sector organisations, and use of volunteers to support people to be able to access care (for example, supporting people to travel to appointments and effectively acting as befrienders and buddies) was valued by residents.
- Access to Link Workers and Community Navigators prepared to work in advocacy capacities for people with complex needs was described as a strength and asset by all stakeholders.
- The provision of services striving to meet the needs of Camden's diverse communities in culturally sensitive ways was recognised as increasing and therefore an emergent system strength.
- The impact of racism and discrimination on mental health is recognised by voluntary sector organisations who have explicitly developed specific, targeted peer-led provision to go some way to acknowledging and challenging racial disparities in mental health outcomes[101].
- The widespread commitment to services being trauma-informed was welcomed as a strength by both users and providers of services.
- The range and diversity of local services was felt to be broad, from informal 'side-by-side' community support (support that develops incrementally and is led by inputs from the service user) through care navigation and social prescribing to formalised treatment.

- Specialist employment support is commissioned and available to support people receiving care from clinical mental health providers, back into employment.

Other local activities that strengthen and underpin the importance of mental health support in Camden:

- Camden Council's Homelessness and Rough Sleeping strategy includes addressing the wider needs of homeless people, including their mental health.
- The North London Mental Health Foundation Trust implemented several initiatives to support homeless people with mental health needs including dedicated Discharge Coordinators, employed to support homeless people ready for hospital discharge find appropriate accommodation as well as coordinating with outreach services such Focus.
- Camden Council's Adult Social Care Strategy and Commissioning Board actively co-produces strategies with groups such as autistic adults to ensure services are tailored to their mental health needs.
- The Tavistock and Portman Trust is committed to engagement work with faith groups in Camden to improve access for communities that may be cautious of statutory services. As a Trust they use educational events to raise awareness of psychological needs, particularly among older adults and migrant women.
- There is a focus from the Clinical Lead from Live Well, UCLH led by the NCL ICB, on integrating physical health checks for patients with Severe Mental Illness (SMI) and improving access to mental health information through resources like the Mental Health Camden website.
- For young adults, the Clinical Lead for Young People and Transitions has helped link them to more opportunities, with the recent creation of a Young Adults Team (focusing on the 18-25 age group) providing flexible, targeted support.

6.7 Section 3: Gaps in mental health support

The processes used to elicit mental health system strengths, reported above, were also used to identify system gaps: focus group discussions and semi-structured interviews were held with a wide range of stakeholders which included residents (with lived mental health experiences) and professionals. Analysis of the resulting narrative data is reported here to provide insights,

from the perspectives of stakeholders, into the perceived gaps of the current mental health service landscape. Some of the gaps are deemed common to multiple services and across prevention tiers. Stakeholders were more forthcoming about perceived gaps than strengths. From the perspective of this report, they are not reported to infer blame, rather to transparently represent stakeholder's contributions as they were assured would be the case.

6.7.1 Gaps revealed through focus group discussions

Focus group discussions held with residents with lived experience identified gaps in the current mental health landscape from their perspectives. Many people revealed deeply personal insights into their experiences of managing mental health conditions as residents of Camden. Many spoke about the internal challenges they faced, such as the difficulty in acknowledging their need for help and overcoming the stigma surrounding mental health. Others discussed external barriers, highlighting the nature of service delivery and the difficulties they encountered when trying to access appropriate support. The reported gaps are grouped thematically below-

Education and awareness in communities

The need for enhanced education and awareness was identified as important. Participants observed that while GPs are often the first point of contact for mental health concerns, they may not always have the specialist training required for more complex cases. As a result, some participants experienced challenges in receiving accurate diagnoses and appropriate care. This highlights the importance of providing GPs with additional support and resources to better address the complexities of mental health. The need for better education and awareness emerged as a critical factor. Multiple participants described being misdiagnosed and receiving inappropriate treatment and care. Increasing education for healthcare professionals and the public - especially secondary school teachers and parents - was seen as essential to enable early identification, reduce stigma and improve the overall quality of care.

Stigma

Stigma also played a critical role in shaping participants' experiences. The discussions revealed that societal stigma and internalised feelings of shame affected people's willingness to seek help and impacted their interactions with healthcare services. Participants' experience of their own internalised stigma about mental health conditions further exemplified this issue.

Advocacy and support: One participant mentioned that because they were articulate and able to advocate for themselves, they received better care pointing out on the challenges other people may face with language barriers or for those who may not have the confidence or ability to articulate their needs.

> ***Peckwater was one of the best places, and I've been to mental health places all over the country, it was a fantastic facility.***
> ***There were lots of tiers of staff. There were psychiatrists, but there was also social workers and support workers.***
> ***But I also think I get good care, because I know what to ask for. I think I'm quite articulate, and expressing myself as to what's going on, I can get help, but I do know there are an awful lot of people that can't.***
> ***Advocating for yourself seems to be making a big difference in terms of how provision is.***

Community Support and Resources

The discussions emphasised the value of community-based support systems. Participants highlighted the positive impact of services like The Hive and Camden Mind, for providing accessible support and fostering a sense of community. There was a strong call for expanding these resources. Participants suggested the need for more local hubs where people could access immediate support. This reflects a broader need for additional community-based resources and low-cost therapy options to bridge gaps while waiting for more formal care.

> *I would like to see more services, not big, they don't have to be big, but just somewhere where you can get up, Monday morning, I'm feeling shit, but I can take a walk for 10 minutes, have a coffee, not in a big building, it doesn't have to be big.*

> *I was attending an adult facility, people with mental health issues who were artists. I used to find it difficult leaving the house but when I attended these sessions, you could just go in and paint or do whatever you wanted to, it helped me get out.*
> *And once I was out of the house, it helped me also take up voluntary work eventually. And I was doing really well.*
> *I was just getting along. And then suddenly the studio moved to another part of London. And I was devastated!*
> *I couldn't do the three modes of transport journey that it took to get there. And yes, I just went downhill.*

Barriers to access

Participants shared concerns about the challenges in accessing mental health services, particularly highlighting long waiting times for therapy and psychiatric care. Some participants mentioned waiting lists that extended up to two years, and one person described the distress of waiting for several hours in A&E for immediate help. These experiences contributed to feelings of frustration and isolation for some, suggesting that the system may benefit from improved efficiency and more timely support, especially in crisis situations.

> *I wanted to be on the waiting list for the personality disorder service, and that's two years. And my psychiatry has been waiting two or three years.*
> *When you're in crisis, you know it's coming, and you need help just then. You don't need your doctor to say, I will write to someone and get you a psychiatrist.*
> *You know, they haven't had the training, or they haven't got the time, and they say go to A&E if you feel any worse.*
> *I think, things need to be accessible much quicker.*

Access to information on available services: Several participants pointed out that they only found out about available services "by default" or through word-of-mouth. One participant shared how they had no idea about Camden's crisis services or user involvement groups until they stumbled across them.

> *I think there should be more awareness of what services are available within the bereavement kind of circle and not just go directly to big organisations, wherever they're available in Camden. I wasn't aware of what's available to approach my GP. Obviously, once you're in the circle, then you find out more, but I just didn't know.*

Quality of care

The views on the quality of care varied significantly. Some participants had positive experiences with community-based services such as Camden Mind and Hestia, which offer immediate, appointment-free support. However, others faced issues with the quality of care received from healthcare professionals.

Consistency in care providers: Many participants highlighted the distress caused by a lack of continuity with GPs and psychiatrists.

> *I've been having sessions online, because it takes 35 minutes to walk. But there was a period where my psychiatrist left and went on to bigger things at the trust.*
> *So, there's been a period of about 8 or 9 months where I didn't have anyone. They couldn't fill that position; they advertised it for like 8 or 9 months.*

> *Consistency. That's the other issue. You get different GPs because it's a practice, I had the same issue with turnover GPs. You've confided in someone and put it all out there at some point... You tell them the same story, give it out, which can be quite stressful and traumatic.*

Over-reliance on medication: Multiple participants expressed their reluctance to accept prescribed medication as a first-line treatment, rather than being offered alternatives like therapy or counselling. For example, one participant mentioned feeling rushed into medication, especially at a younger age, while another described the need for places like The Hive to offer talking therapies and advice before medication is considered.

> *I will say Brandon Centre's really good because it's focused around, I think, 16 to 24. I will say I did go to my GP first, I was very disappointed. They just didn't offer me fairly enough in (enough time). There's always sometimes a bit of a rush to medication, I think, which is annoying. I think people should hopefully be able to have places like Hive and get access to some talk, to some advice, as we had before considered medication, especially at a younger age.*

Lack of time: Participants acknowledged the immense pressures on the healthcare system, particularly the strain on individual GPs, which they identified as a gap in service provision. This highlighted the need for increasing resources, staff, and support for GPs.

> *I think GPs are also just really overwhelmed as well with how many people need the service, and sometimes they're just like, I just can't. And they have five minutes. And they've got to type up the notes in the next five minutes that's actually the next appointment*

> *when you go to the doctor, you get five minutes. You don't even get five minutes because he's writing his notes. And I always find it very stressful when I go to the doctor. And I find that, the doctors probably don't have the time to tell you about all the services. I do think it's a time issue*

Cultural sensitivity of mental health services

Cultural factors were also highlighted as impacting mental health care. Participants shared experiences where cultural perceptions influenced their interactions with the healthcare system. For instance, one participant mentioned feeling like an "alien" due to cultural disconnects in mental health services. Another person noted that their background influenced their perception of racism and discrimination within healthcare settings. The discussion suggested that cultural competence among healthcare providers is essential to ensure that all patients feel understood and respected, regardless of their background.

6.7.2 Gaps revealed through professional stakeholder interviews

Lack of coordination between housing and health services

Housing insecurity and poor living conditions were repeatedly identified as issues that are deeply linked to both mental and physical health. Some stakeholders felt that despite this, these factors were not consistently addressed by health and social care services. Service providers commented that a lack of coordination between housing services and healthcare, created barriers to holistic support for vulnerable people.

Voluntary and community sector organisations highlighted that social prescribers and GPs do not always have sufficient awareness of local resources and services. They felt this lack of awareness led to under-use of valuable community-based support. As a result, patients with mental health conditions missed out on opportunities for holistic care that could complement medical interventions.

Barriers to employment support for people with mental health conditions

The prioritisation of referrals from clinical teams and the contractual limitations that prevent primary employment support teams (i.e working with mild to moderate mental health conditions such as anxiety and depression) from working with self-referrals was felt to cause significant service gaps. Logistical delays in onboarding staff due to NHS processes further hindered timely provision of services. A national challenge in recruiting skilled personnel into Individual Placement and Support (IPS) and Employment Advisor (EA) roles, was felt to exacerbate service delivery issues. Additionally, a lack of specialist support for complex employment retention cases, which had previously existed in Camden was reported to have been discontinued.

Stigma and discrimination in the workplace remain barriers, as many people with mental health conditions are hesitant to disclose their diagnosis, limiting their access to necessary support.

Lack of supportive care services

Many people, particularly those with anxiety or low confidence, were known to face significant challenges in physically accessing mental health services. Whether due to mobility issues or mental health conditions, some people were unable to get to services on their own. This highlighted the importance of befrienders or buddies to support people in accessing care. However, there was a lack of sufficient resources to fund adequate support, and the available support (volunteers) were not diverse enough to meet varied needs.

Some people, particularly those with complex needs, required advocacy services to help navigate essential systems, such as attending court hearings or dealing with financial issues. The absence of designated advocates in these

cases placed additional strain on link workers and community navigators, who often stepped in to support out of necessity but were not equipped or resourced for this role.

Home visits for isolated or housebound people were reported to have become rare due to capacity issues, and despite the pressing need. Organisations such as North London Cares, which once provided such services, no longer operate, and existing initiatives such as Ageing Better were regarded as limited in scope. The human connection provided through outreach work and home visits had diminished, leaving a major gap in support for housebound people.

The cessation of community connectors in Camden, previously managed by Age UK Camden and linked with social prescribing services, had left a void in accessible community-based support. This had been difficult to replicate with volunteers, and emphasised the importance of skilled, paid outreach workers.

Gaps in integration of VCSE are NHS services

The concept of Core Teams, being preventive and community-focused, was not considered to have fully materialised in practice. Instead, stakeholders felt these teams remained specialist-oriented, functioned as NHS-led entities and featured limited genuine multi-agency collaboration. This disjointed approach was felt to have resulted in services that were not well integrated with community-based organisations, leading to fragmented care and unmet needs.

Funding challenges and centralisation of services

Stakeholders highlighted the lack of structural incentives for partnership and collaboration amongst organisations, which further exacerbated by the availability of limited funding.

Some VCS staff highlighted that national centralisation of some services for example the Samaritans' shift to a single national number, was felt to disrupt local relationships and personalised care resulting in reduced continuity in ongoing services and support.

Furthermore, this created a competitive and bureaucratic environment and increased risk aversion in service provision, particularly in cases involving complex issues (e.g. alcohol and substance use).

Lack of specialist mental health support in voluntary sector

VCS staff highlighted that GPs tended to refer patients with mental health needs to care navigators (within voluntary sector organisations), who were not equipped to handle the cases: this created a bottleneck in effective service delivery. The complexity of mental health referrals often leads to misallocation of resources.

Care navigators, while effective, lack the specialist knowledge needed to address complex mental health conditions. The increase in mental health needs had not been matched by adequate resources or expertise within these services.

Challenges in communication across health services

Clinical service providers identified gaps in communication and integration between primary and secondary care services, noting the result of this to be fragmented patient care. Poor information-sharing mechanisms were thought to result in confusion over responsibilities for essential health checks, creating a "ping-pong" effect where neither service takes ownership. The lack of interoperability between electronic health systems further exacerbates this issue, hindering seamless transitions and continuity of care.

Frequent staff turnover in mental health services disrupts continuity of care, as new team members often lack prior knowledge of shared service goals and strategies. Senior leaders highlighted that repeated changes in personnel mean they must constantly revisit and explain service objectives, leading to inefficiencies and hindering long-term care planning.

Service leads reported a disconnect and disagreements between primary care (GPs) and secondary care (mental health trusts) regarding responsibilities for physical health checks of patients with mental health conditions. This lack of alignment leads to essential health needs being overlooked.

Barriers due to risk profiles (co-occurring needs) in mental health services

Service providers reported that a reluctance to engage with people with co-occurring needs led to their exclusion from care, contributed to worsening conditions and would potentially create more acute crises down the line. This reflected a broader issue of risk aversion within mental health services, where the most vulnerable people may be left without adequate support.

Care leavers, people with a forensic history, and those with a history of childhood sexual abuse (CSA) often find themselves without service provision. While they are frequently signposted to various services, there are limited options that adequately meet their needs, as much existing provision has strict exclusion criteria.

Lack of long-term support/crisis support

The lack of long-term support for people with mental health needs was felt to be a significant gap by many stakeholders: time-limited services have not aligned well with meeting people's ongoing needs. Social care assessments were felt to be similarly under-resourced, again leaving many people without necessary support. Barriers to accessing personal budgets and care assessments, particularly for people without a social worker were reported. People who require intensive, long-term support, such as those with learning difficulties or dual diagnoses, often do not fit fixed service criteria. Crisis support was reported to be limited, particularly at weekends, and access to Talking therapies insufficient. Finally, a shortage of walk-in spaces and poor signposting of available services further hindered access.

Inadequate support for autistic people without learning disabilities

Many autistic adults experience long waiting times for assessments and face misdiagnosis, particularly autistic women who may be incorrectly diagnosed with personality disorders. A lack of safe spaces and appropriate interventions then contributes to avoidable crises and exacerbates health inequalities.

Autistic people without learning disabilities face barriers in accessing social care and mental health services. These services are often not autism-informed or integrated, leaving people isolated and inadequately supported.

Challenges in support for young people and transitions

The management of non-attendance and engagement in adult services was identified as being less supportive than to CAMHS, with non-attendance resulting in discharge rather than re-engagement efforts. System capacity issues and rigid thresholds exacerbate this situation, making smooth transitions and continuous support for young people difficult to ensure as they move into adult services.

Although the reduction in support when young adults transition from CAMHS to adult mental health services should be managed through a transitions protocol, stakeholders reported that in practice this often fails due to logistical and capacity constraints, leaving many young adults without adequate support.

This inability to secure timely handovers from CAMHS to adult services due to capacity issues leads to prolonged gaps in care. The inconsistency in moving from CAMHS to adult services further complicates this transition, leaving many young people without necessary support during a critical time in their lives.

Funding limitations prevent comprehensive support for all young people, particularly those with less complex needs who might not qualify for specialist interventions. The transition from CAMHS to adult mental health services is problematic, as exemplified by the following quote, with many young people finding they don't meet the thresholds required for adult services, resulting in them not receiving the care they need.

> *this is my second-to-last day at The Hive. And so, there is quite a big drop-off from 24 to 25. And even though I'm going through quite a bad time now, there's still no transition to an equivalent service.*

Source: Comment by a young participant from the Focus Group Discussions

Non mental health service support

Stakeholders reflected that available mental health services did not reach everyone, particularly those in distress but not engaged with formal care systems. It was highlighted that 75% of people who die by suicide had not engaged with mental health services in the year preceding their death, raising questions around where people go to seek help, and speculating that it might be community organisations, libraries, or other informal settings.

Challenges in mental health services accessibility and integration across boroughs

GPs said that strain on the NHS and the complexity of navigating services across different boroughs made it difficult for them to find suitable mental health support for their patients. The increasing responsibility for mental health management within general practice, combined with inadequate integration across boroughs, led to delays in diagnosis and treatment, further exacerbating mental health conditions for patients in their experience.

Mental health services being place-based, pose challenges for patients registered with Camden GP's but living in neighbouring boroughs. This geographic mismatch creates barriers to accessing appropriate services.

7. Recommendations

Please note - These recommendations have since been further refined and prioritised by Camden's Mental Health Partnership Board and will therefore be taken forward in a revised form that differs from how they are presented in this report but remain true to the findings from data and contributions from stakeholders.

Engagement with all stakeholders elicited a great depth of feeling, with many commonalities emerging from lived experience stakeholders and service provider perspectives. Both cohorts of contributors agreed about many of the needs and themes that emerged from the engagement processes: the formulation of recommendations, reported below, reflects this.

1. Address socioeconomic determinants of mental health

- **Integrate mental health services with social support**: Improve alignment of mental health services with housing, employment, and financial assistance to better address the social determinants of health, particularly in Camden's most deprived areas. This should include advocacy for housing security and job support.
- **Expand employment support services**: Train clinicians to refer patients to employment support services and increase the number of specialists embedded in community mental health teams to facilitate recovery through economic stability

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2. Expanding access to mental health support

- **Diverse volunteer recruitment**: Increase efforts to recruit volunteers from varied cultural, ethnic, and socioeconomic backgrounds to enhance the cultural competence of mental health services. In Camden, volunteers play a key role in supporting voluntary sector activities within GP practices, engaging residents in community-based health initiatives, and addressing wider determinants of health. For example, Volunteer Health Advocates by VAC promote voluntary sector activities, while Age UK Camden's care navigators assist older people with complex needs. Expanding diverse volunteer recruitment can improve accessibility and responsiveness of these services to the local population.
- **Expand mental health support**: Develop mobile mental health teams, walk-in community hubs, and low-barrier access points to reach people who are reluctant or unable to engage with traditional services. Prioritise community spaces, grassroots organisations, and faith-based groups to foster trust and increase service uptake.
- **Enhance befriending, advocacy & community connector programs:** Expand advocacy services to help people navigate the mental health system. Reinvest in community connector models to link primary care with voluntary sector support, enhancing the social prescribing pathways. Properly resourced with trained staff, this program can streamline access to both clinical and non-clinical services.

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3. Promote trauma-informed and culturally sensitive practices

- **Trauma-informed care integration**: Implement trauma-informed practices across all service touchpoints, ensuring sensitivity to past

experiences of people, especially those exposed to crime, homelessness, or economic hardship.

- **Culturally competent services**: Address the diverse needs of Camden's multi-ethnic population by training staff in cultural sensitivity and tailoring outreach efforts. Collaborate with local community leaders and organisations to bridge gaps in service access and reduce stigma.
- **Faith-based mental health initiatives**: Partner with faith groups to develop tailored mental health projects, improving service accessibility for communities cautious of statutory systems.

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4. Improve integrated care and service coordination

- **Enhance neighbourhood-level integrated care**: Foster multi-agency collaborations between health, social care, and voluntary sectors to provide holistic support. This should address broader determinants of mental health, such as housing, employment, and financial security.
- **Integrated pathways between services**: Strengthen the coordination between clinical services and the voluntary sector to ensure a seamless care journey, reducing long waiting lists and minimising service fragmentation.
- **Trainee placement in GP surgeries**: Introduce mental health trainee placements in primary care settings to improve capacity, accessibility and early intervention in primary care.

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5. Expand long-term and preventative support

- **Develop community-based mental health hubs**: Establish additional low-barrier mental health hubs to offer informal support and social interaction, preventing crises before they occur. These hubs should provide both immediate support and longer-term therapeutic options.
- **Reinstate home visit programs**: Expand home visits for older adults, people with severe mental health challenges, and those with mobility issues, ensuring equitable access to care for housebound populations.
- **Increase availability of non-pharmacological interventions**: Prioritise therapy, counselling, and peer support services over medication, especially for younger people. This balanced approach should reduce the expressed over-reliance on pharmaceuticals.
- **Expand the Primrose intervention in primary care**: Broaden the scope of successful interventions like the Primrose program, which

integrates mental health support within GP practices, to improve early diagnosis and treatment.

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6. Prioritise crisis response and immediate care

- **Establish dedicated mental health crisis centres**: Create easily accessible crisis centres that provide immediate mental health support, reducing the strain on emergency services and minimising wait times during acute episodes.

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7. Increase education, awareness, and stigma reduction

- **Public awareness campaigns**: Continue to deliver campaigns to reduce stigma, educate the public about mental health conditions, and promote help-seeking behaviours. Target these campaigns to marginalised and high-risk groups, including ethnic minorities and men at risk of homelessness.
- **Training for frontline workers**: Encourage GPs, teachers, and healthcare professionals to recognise early signs of distress, manage difficult situations, and provide appropriate referrals to mental health services. Ensure that frontline staff are aware and are signposted to training course offered/commissioned by the Camden Council.

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8. Foster co-production and community involvement

- **Expand co-production efforts**: Actively involve service users, carers, and community members in the design and evaluation of mental health support. This collaborative approach will ensure that services are tailored to the needs of Camden's diverse population.
- **Align resources with community needs**: Utilise partnerships with the voluntary sector to align resources with community needs, ensuring effective use of available funding and support services.

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9. Support for identity-specific and marginalised groups

- **Proactive outreach to underserved communities**: Increase outreach efforts for identity-specific groups, such as LGBTQ+ people, ethnic minorities, and those with disabilities. Focus on building trust and reducing access inequalities.

- **Develop identity-specific initiatives**: Establish targeted programs that address the unique challenges faced by specific communities, ensuring equitable access to mental health support.

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10. Co-occurring needs

• **Simplify access to services & address co-occurring needs challenges:** Reduce bureaucratic barriers to mental health services, ensuring people with co-existing conditions receive timely and appropriate support.

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11. Funding allocation

• **Increase transparency in funding & resource allocation:** Ensure fair distribution of mental health funding, prioritising areas with the greatest unmet needs and long-standing service gaps.

8. Glossary

APMS - Adult Psychiatric Morbidity Survey	IHGs - Inclusion Health Groups
ADHD - Attention Deficit Hyperactive Disorder	IMD - Index of Multiple Deprivation
Black and minority ethnic (BME)	IPS - Individual Placement and Support
CAMHS - Child and Adolescent Mental Health Services	MH - Mental health
CCG – Clinical Commissioning Group	MHNA - Mental Health Needs Assessment
CYPMHS - Children and Young People's Mental Health Survey	ONS – Office of National Statistics
DVA - Domestic violence and abuse	PCNs - Primary Care Networks
GHQ-12 - General Health Questionnaire-12	QOF - Quality and Outcomes Framework
GPs - General Practitioners	SM - Substance Use
EA - Employment Advisor	SMI - Serious Mental Illness
HSE - Health Survey for England	TBI - Traumatic Brain Injury
NCL – North Central London	VAC - Voluntary Action Camden
ICB - Integrated Care Board	VCSE – Voluntary and Community Sector
NLFT – North London Foundation Trust	WHO – World Health Organisation

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Appendices

Appendix A: Key National and Local Strategies and Commitments

Strategies	Details
Health and Social Care Act 2012[6]	The Health and Social Care Act 2012 marked a pivotal moment in the UK's mental health policy, pledging to ensure parity of esteem between mental and physical health. This commitment aimed to guarantee that people with mental health issues receive the same quality of care as those with physical health issues.
Five Year Forward View for Mental Health (2016)[7]	The Independent Mental Health Taskforce's Five Year Forward View for Mental Health, published in February 2016, acknowledged the persisting gaps in care quality and service accessibility and recommended comprehensive strategies to improve mental health outcomes. Key recommendations included: Providing timely access to care and integrating mental and physical health services, promoting good mental health and preventing poor mental health, improving access to employment, quality relationships, and community integration, and addressing inequalities, as mental health issues disproportionately affect those living in poverty, the unemployed, and those facing discrimination.
NHS Long Term Plan (2019)[8]	The NHS Long Term Plan reinforced the above commitments, emphasising the need for expanded and enhanced mental health

	services across the country. It underscored the importance of early intervention, integrated care, and community-based support.
Community Mental Health Framework for Adults (2019)[102]	The *Community Mental Health Framework for Adults and Older Adults* outlined a new approach to delivering integrated, person-centered mental health care. It aimed to break down barriers between primary, secondary, and community mental health services, ensuring more seamless care. The framework emphasised holistic, place-based models of care, addressing both medical and social needs, and encouraged collaborative work across health, social care, and voluntary sectors to enhance the quality of life and well-being of people with mental health conditions.
Prevention Concordat for Better Mental Health (2019)[103]	The Prevention Concordat for Better Mental Health represents a collective commitment from various organisations to prioritise the prevention of mental health issues and promote wellbeing. This initiative fosters collaboration across sectors to create environments that support mental health and reduce inequalities.
NHS Advancing Mental Health Equalities Strategy (2020)[104]	The Advancing Mental Health Equalities Strategy by NHS England focuses on addressing inequalities in mental health care by ensuring equitable access, experiences, and outcomes for diverse communities. The strategy outlines core actions to tackle

	disparities faced by marginalised groups, including people from Black, Asian, and minority ethnic backgrounds, LGBTQ+ people, and those with disabilities. It emphasises co-production, improving data collection on inequalities, and fostering culturally competent services to enhance fairness in mental health provision across the system. The goal is to reduce barriers and improve mental health outcomes for all.
Mental Health Recovery Action Plan (2021)[105]	In response to the mental health challenges exacerbated by the COVID-19 pandemic, the government announced the Mental Health Recovery Action Plan in March 2021. Supported by £500 million in funding, the plan aimed to address the pandemic's impact on the public's mental health, focusing on expanding access to services and providing targeted support for those most affected.
Local Policy – Better Mental Health Better Lives Better Communities North London Mental Health Partnership Clinical Strategy 2024 - 2029	Camden is part of the North London Partners in Health and Care, which has developed a comprehensive Five-Year Strategy for Mental Health and Wellbeing. This strategy aims to transform mental health services, emphasising collaborative care, prevention, and community-based support. Key goals include reducing health inequalities, enhancing crisis care, and promoting mental wellbeing across all age groups.

Appendix B: Membership of the Mental Health Partnership Board

Role	Organisation
Head of ASC Strategy and Commissioning	London Borough of Camden
Managing Director – Camden Division	North London Mental Health Partnership
Assistant Director Integrated Commissioning Mental Health & Learning Disabilities	North Central London Integrated Care Board/London Borough of Camden
Public Health Consultant	London Borough of Camden
Clinical Lead: Place (Camden)	North Central London Integrated Care Board
Clinical Director - Recovery & Rehabilitation Division	North London Mental Health Partnership
Director	Likewise (Voluntary Sector Organisation)
Associate Clinical Director	The Tavistock and Portman NHS Foundation Trust
Clinical Services Director	The Tavistock and Portman NHS Foundation Trust
Associate Clinical Director	The Tavistock and Portman NHS Foundation Trust
Head of ASC Operations	London Borough of Camden
Director of Integration - Camden Directorate	North Central London Integrated Care Board

Service Director	Central And Northwest London NHS Foundation Trust
Head of Children's Integrated Commissioning	North Central London Integrated Care Board/London Borough of Camden
Assistant Director for Place, Integration, Transformation and Delivery (Camden)	North Central London ICB
Head of Children's Integrated Commissioning	North Central London Integrated Care Board/London Borough of Camden
Commissioning Manager – Substance Use Public Health	London Borough of Camden
Chief Executive	Hopscotch Women's Centre
Service Manager – Prevention and Wellbeing	London Borough of Camden
Head of Mental Health	Riverside
Drug and Alcohol	Change, Grow, Live (CGL)
Chief Executive	Mind in Camden
Regional Head (Mat Cover for Kathleen Dolby)	St Mungo’s
Referral Partnerships Coordinator	The Listening Place
Head of Visitor Support	The Listening Place

Health Transformation and Partnership Development Manager	Voluntary Action Camden
Coproduction partner	Via The Advocacy Project
Coproduction partner	Via The Advocacy Project
Coproduction partner	Side-By-Side Network
Personal Assistant	London Borough of Camden