2. Adults: Common mental health disorders

2.1. Introduction

Common mental health disorders include mood disorders such as depression, and anxiety disorders such as generalised anxiety disorder and post-traumatic stress disorder (PTSD) (see Box 4).

GPs systematically record data about who has been diagnosed with depression. This means we have much more local data about people with depression than we do about people with other common mental health disorders.

This section addresses the needs of adults age 19-64. For more information about common mental health disorders in older adults (age 65+) see the Older Adults section of this chapter.

Box 4: Disorders[i,ii,iii,iv,v]

There is no single definition of common mental health disorders, so for the purposes of this report, we follow the convention used in NICE guidance and include:

Depression – A mood disorder with a range of physical and mental symptoms, which can include loss of appetite, changes in sleeping patterns, low mood, hopelessness and suicidal ideation.

Generalised anxiety disorder – A disorder in which anxiety is experienced about a wide range of issues to the extent that it interferes with daily life.

Panic disorder – Regular, recurring panic attacks. A panic attack is a period of intense and overwhelming fear, during which physical symptoms such as shortness of breath and chest pains may be experienced.

Obsessive-compulsive disorder (OCD) – A disorder in which someone experiences repeated unwanted and unpleasant thoughts (obsessions) and feels that they need to carry out certain acts (compulsions) in order to relieve the negative feelings these thoughts trigger.

Post-traumatic stress disorder (PTSD) – An anxiety disorder developed following a traumatic experience. Symptoms can include insomnia, difficulty concentrating, irritability and flashbacks.

Social anxiety disorder – Persistent and overwhelming fear of certain social situations or acts.

For more information on any of these disorders, see the Royal College of Psychiatrists' collection of fact sheets.

Box 5: Levels of severity[vi]

These disorders can occur with different levels of severity.

The following definitions are reproduced directly from the NICE guidance *Common mental health disorders: Identification and pathways to care*.

Mild – Relatively few core symptoms (although sufficient to achieve a diagnosis), a limited duration and little impact on day to day functioning.

Moderate – All core symptoms of the disorder plus several other related symptoms, duration beyond that required by minimum diagnostic criteria, and a clear impact on functioning.

Severe – Most or all symptoms of the disorder, often of long duration and with very marked impact on functioning (for example, an inability to participate in work-related activities and withdrawal from interpersonal activities).

Persistent sub-threshold – Symptoms and associated functional impairment that do not meet full diagnostic criteria but have a substantial impact on a person's life, and which are present for a significant period of time (usually no less than six months and up to several years).

2.2. Causes and risk factors

The stress-vulnerability model

Stakeholders working with people with mild to moderate mental health problems in Hackney and the City of London have found that the needs of their clients predominantly relate to stress at work.

The 'stress-vulnerability' model for common mental health disorders describes how certain risk factors make a person more vulnerable to common mental health disorders, and states that such disorders are triggered by one or more stressors.[vii] A stressor might be a traumatic event, a crisis, an interpersonal or occupational challenge (such as a divorce or workplace stress) or a change in circumstances (such as having children or becoming ill).[viii]

A recent National Institute for Clinical Excellence (NICE) literature review found that genetic factors predisposed people to a range of common mental health disorders, while environmental factors played more of a role in determining which particular disorder was experienced by an individual.[ix]

Risk factors

Individual history of common mental health disorders: Personal history of a particular disorder is typically a strong risk factor for a recurrence of that disorder, but a history of any common mental health disorders may also be a risk factor for other disorders. Depression illustrates the high risk of recurrence, with 50% of those who experience a first major depressive episode going on to have a second, 70% of those who experience a second going to have a third, and 90% of those who experience a third going on to have more. [x] Post-traumatic stress disorder (PTSD) illustrates the more general risk, with a history of common mental health disorders identified as a risk factor for this disorder. [xi]

Genetic and biological risk factors: Family history is a known risk for all common mental health disorders. [xii] Biological risk factors include endocrine disorders[1] (which are a known risk factor for depression) and hormonal changes during or after pregnancy.[xiii]

Environmental factors: This includes early life adversity (such as neglect, abuse and poor parent-child relationships), socioeconomic factors (such as poverty and unemployment) and social factors (such as a lack of supportive and confiding relationships). [xiv]

Demographic factors: Younger age, being female and lower educational achievement are all risk factors for depression, PTSD and anxiety.[vii] These factors may have both a biological and an environmental component.

Personality traits: A tendency towards 'neuroticism' – a collection of personality traits including anxiety, fear, frustration and loneliness – is a risk factor for common mental

[1] These are hormone disorders such as hypothyroidism.

health disorders.[xv] Some traits may be more pronounced than others; this can link to which disorder develops. For example, the use of worrying as a coping strategy is linked to the development of anxiety disorders[ix] and perfectionist beliefs are linked to obsessive-compulsive disorder (OCD).[xvi]

2.3. Local data and unmet need

Mental health services for working age adults in Hackney and the City are described in Section 2.7.

2.3.1. Numbers affected – known to services

Table 1 provides current service use figures for preventative, primary and secondary care for common mental health disorders in Hackney and the City.

The majority of residents receiving services for common mental health disorders are receiving them through primary care – either from their GP or through short courses of cognitive behavioural therapy (CBT) offered by Improving Access to Psychological Therapies (IAPT) services.

Just over 8,000 Hackney and the City residents between the ages of 19 and 64 have depression recorded by their GP; this is 4% of those in this age group registered with a GP. Just under 8,000 adult residents of Hackney and the City in this age group began an IAPT referral in 2014. We do not know the overlap between those receiving IAPT services and those with depression recorded by their GP.

Separate data are not available for Hackney and the City of London.

Table 1: Hackney and the City of London residents (age 19-64) using services for common mental health disorders

Type of service	Service	Service users	Dates	Number	Caveats
Prevention	City and Hackney Wellbeing Network	All accepted to Wellbeing and Prevention Pathway	Apr 2015 – Jun 2015	148	
Primary care	General practice (1)	All those with depression recorded by their GP	Snapshot: Apr 2014	8,050	May not be all those receiving treatment (2)
	Improving Access to Psychological Therapies (IAPT)	Numbers of new referrals that began in the year	Jan 2014 – Dec 2014	7,935	Ages 18-64.
	City and Hackney Wellbeing Network	All accepted into low or high intensity talking therapies	Feb 2015 – May 2015	139	All ages; not limited to common mental health disorders
Secondary care	East London NHS Foundation Trust (ELFT)	All service users with a recorded primary diagnosis of depression	Apr 2013 – Mar 2014	164	41% of service users have a recorded primary diagnosis (3)
	ELFT	All those in Payment by Results (PbR) clusters 1-8 (4)	Snapshot: Mar 2014	1,341	68% of service users have a recorded PbR cluster

City and Hackney Mental Health Network data provided by City and Hackney Mind, August 2015; GP data extracted from the GP register by Clinical Effectiveness Group (CEG), Blizard Institute, April 2014; IAPT data from publically available quarterly reports;[xvii] ELFT data provided by ELFT, September 2014.

Notes:

(1) Data cover Hackney and the City residents registered with a GP in Hackney, the City of London, Tower Hamlets and Newham.

(2) Some people who receive treatment for depression from their GP do not have it recorded by their GP in a manner that is possible to extract from the GP register. In 2013, an audit by City and Hackney CCG found 5,233 people on depression or anxiety medications who are not recorded as having depression, anxiety or serious mental illness.[xviii]

(3) It is not always clinically appropriate to provide a service user with a diagnosis. Some service users have more than one diagnosis; only the primary diagnosis data has been provided.

(4) Payment by Results clusters are a needs-based rather than diagnosis-based designation. However, clusters 1-8 are broadly for common mental health disorders.

2.3.2. Numbers affected – estimated

We can use national estimated prevalence figures for certain common mental health disorders to derive approximate predictions of the number of people in City and Hackney living with these conditions, not just those who are diagnosed or known to services. These estimates are from a range of different sources, and so are not necessarily directly comparable with each other.

We estimate that approximately 53,000 adults aged 19-64 in Hackney and 1,300 adults aged 19-64 in the City of London currently meet the diagnostic criteria for at least one common mental disorder (Table 2). It is important to note that the length of time spent with the disorder may be a few weeks or several years, and that some of these adults will have more than one common mental disorder.

For all the conditions listed in Table 2, the estimated prevalence is higher in women than in men. Overall, 20% of women are estimated to have one or more common mental health disorders at any given time, compared to 13% of men. The most common disorder is mixed anxiety and depression.

Table 2: Estimated number of Hackney and the City residents (age 19-64) with common mental health disorders

Condition	National estimated point prevalence			Hackney: Estimated number			City of London: Estimated number			Total
	Men	Women	All	Men	Women	All	Men	Women	All	
Any common mental illness[xix]	12.5%	19.7%	16.2%	20,104	32,557	52,661	584	710	1,294	53,955
Mixed anxiety and depression[xix]	6.9%	11.0%	9.0%	11,098	18,179	29,276	322	396	719	29,995
General anxiety disorder[xix]	3.4%	5.3%	4.4%	5,468	8,759	14,227	159	191	350	14,577
Phobia[xix]	0.8%	2.0%	1.4%	1,287	3,305	4,592	37	72	109	4,701
Obsessive-compulsive disorder[xix]	0.9%	1.3%	1.1%	1,448	2,148	3,596	42	47	89	3,685
Panic disorder[xix]	1.0%	1.2%	1.1%	1,608	1,983	3,591	47	43	90	3,681
Severe depression[xx]			2.7%			8,805			223	9,028
Depressive episode[xix]	1.9%	2.8%	2.3%	3,056	4,627	7,683	89	101	190	7,873
Distribution of severity within all unipolar depressive episodes[xxi]										
Mild			68.5%			5,263			130	5,393
Moderate			23.7%			1,821			45	1,866
Severe			7.7%			592			15	607

National prevalence estimates adjusted by local index of need (MINI2K)[xxii] applied to population figures.[xxiii]
Please note that MINI2K is based on predicted hospital admissions. The adjustments are likely to reflect the demographic and wider determinants of health influencing levels of demand for all services, but as they are not designed for this purpose the resulting figures are indicative only.

2.3.3. Unmet need

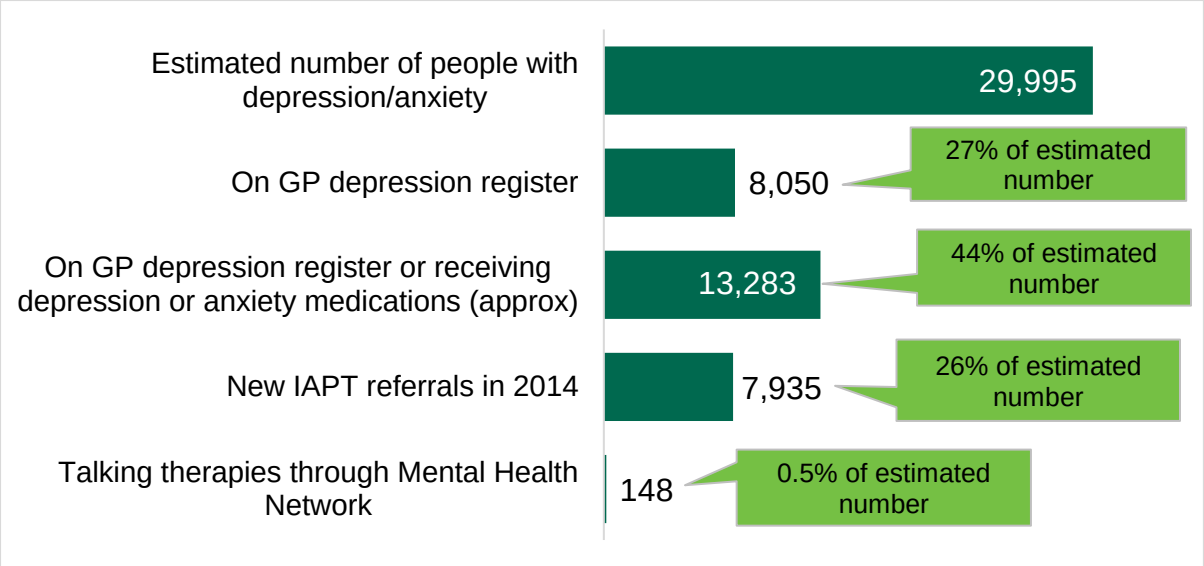
Depression (all levels of severity)

Figure 1 shows how current service use in Hackney and the City compares to the 30,000 residents estimated to have mixed depression and anxiety (Table 2).

The GP register is one indicator of the number of people known to GPs to have depression. Using this indicator alone, it appears that just over a quarter of all those with mixed depression and anxiety are known to GPs.

It should be noted that work by City and Hackney CGG suggests that not all those being treated for depression by their GP are recorded as such. In 2013, 5,233 patients (of all ages) were found to be on current depression or anxiety medications but not recorded as having depression, anxiety, depression or serious mental illness.[xxiv] If we assume that (a) this figure is still representative, (b) all those on such medications were being treated for depression and (c) all those in this cohort were aged 19-64, then still less than half of those estimated to have mixed depression and anxiety are apparently known to their GP.

Figure 1: Estimated number of Hackney and City residents (age 19-64) compared to known service use

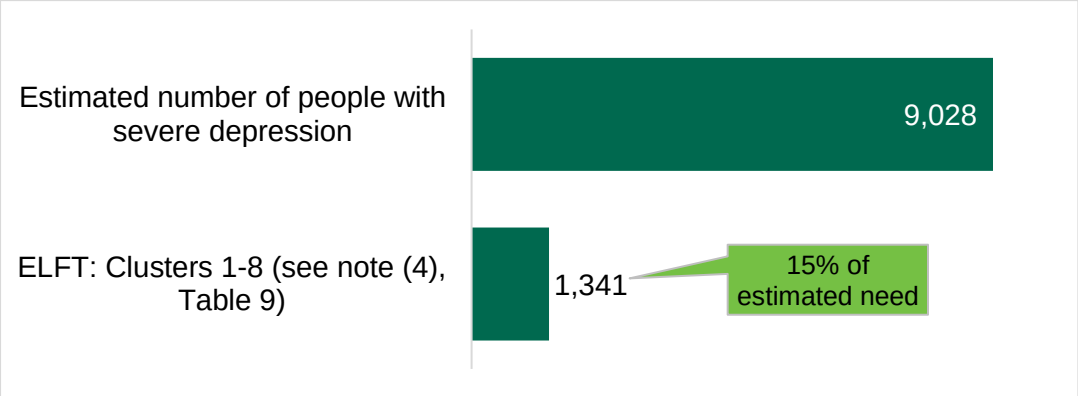


Local data: See Table 1.
Local estimates: See Table 2.

Depression (severe only)

ELFT provides care to approximately 85% of the Hackney and the City residents who receive secondary mental health services.[xxv] It is not clear from the available data how many people are being seen by ELFT for depression. However, Figure 2 suggests that a large majority (around 85%) of those with severe depression in City and Hackney are not receiving secondary care from ELFT. This is not necessarily an unmet need, as not everyone with severe depression will require secondary mental health services.

Figure 2: Estimated number of Hackney and the City residents (age 19-64) with severe depression compared to known service use



Local data: See Table 1.
Local estimates: See Table 2.

Geographic

Figure 3 shows the crude[2] and age-standardised[3] rates of recorded depression in Hackney and the City. The same areas are highlighted as having particularly high and low rates using both methods, suggesting that observed differences are due to factors other than age.

Care must be taken when interpreting these figures. High rates of recorded depression in certain areas may be a result of high levels of need in these areas, but they may also or instead mean that people in these areas are more likely to be receiving help from their GPs for depression, suggesting lower levels of *unmet* need.

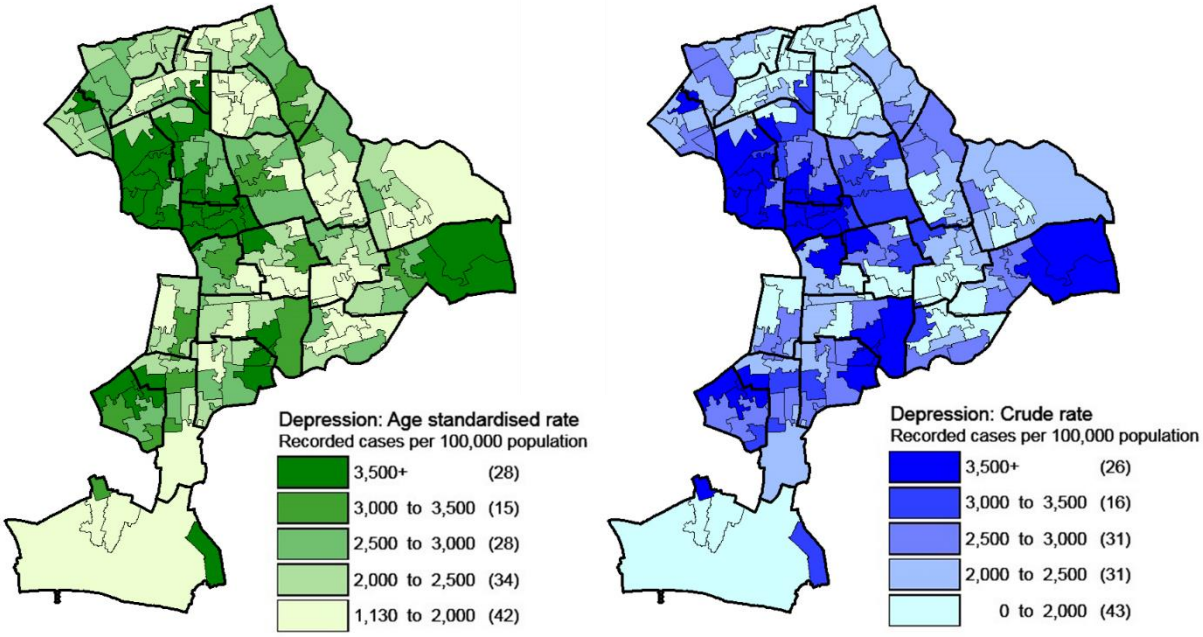
Rates of recorded depression are comparatively high in the Hackney wards of Shacklewell, Clissold and Stoke Newington wards in the west of the borough, Hoxton West ward in the south west, and Hackney Wick ward in the east.

In the City, Portsoken ward in the east and Cripplegate ward in the north both have high rates of recorded depression.

Please note that due to limitations on the data, these figures are for residents of all ages. However, as 94% of Hackney and the City residents with depression recorded by their GP are aged 19-64, these figures can be taken as strongly indicative of patterns for this age group.

[2] This is the rate of depression with no adjustments made to take into account any differences in the underlying population.
[3] This is the rate of depression that you would observe if every population had the same age distribution. It allows you to compare rates in different areas even if the populations have different underlying age distributions.

Figure 3: Map of recorded cases of depression per 100,000 population in Hackney and the City residents (all ages)



Local service data extracted from the GP register by CEG, Blizard Institute, September 2015.
Data covers Hackney and the City residents registered with a GP in Hackney, the City of London, Tower Hamlets and Newham.

2.4. Health inequalities

For detailed information about how mental health interacts with the nine protected characteristics,[4] please see Annex B of the *Analysis of the Impact on Equality* for the Department of Health's *No Health Without Mental Health* cross-government strategy.[xxvi] This paper gives a clear and detailed outline of the key issues for each characteristic and the evidence base behind them. Some information from this paper is included below, but our focus is on local data where available.

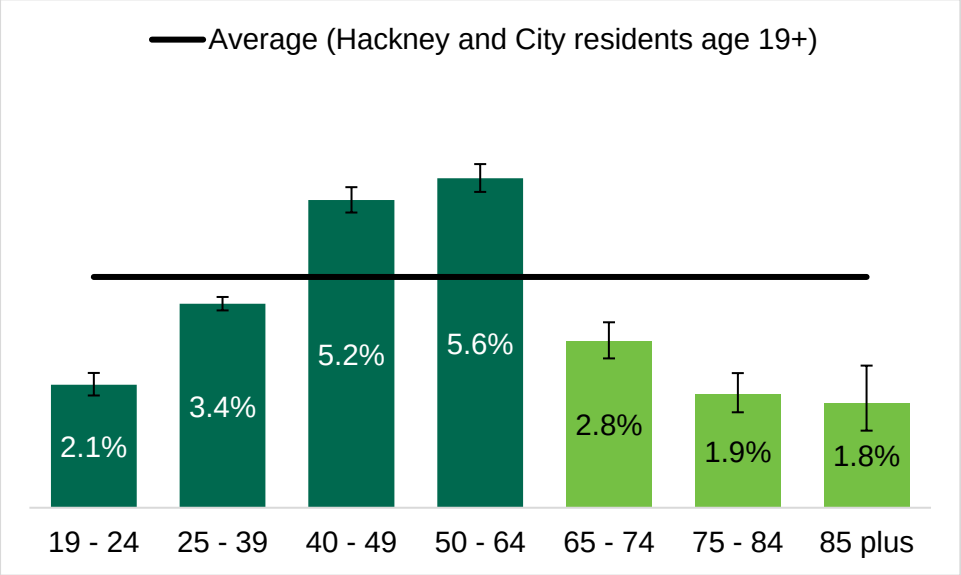
Please note that due to limitations in the data, IAPT figures are for residents of all ages. However, as 96% of Hackney and the City residents accessing IAPT are aged 18-64, these figures can be taken as strongly indicative of patterns for this age group.

2.4.1. Age

Figure 4 shows that in Hackney and the City, the relative chance of having depression (as recorded in GP records) rises with age to a peak at 50-64 before declining steeply. People age 50-64 are almost twice as likely as average to have GP recorded depression, while people age 19-24 are less likely to have a recorded diagnosis.

[4] Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion/belief, sex, sexual orientation.

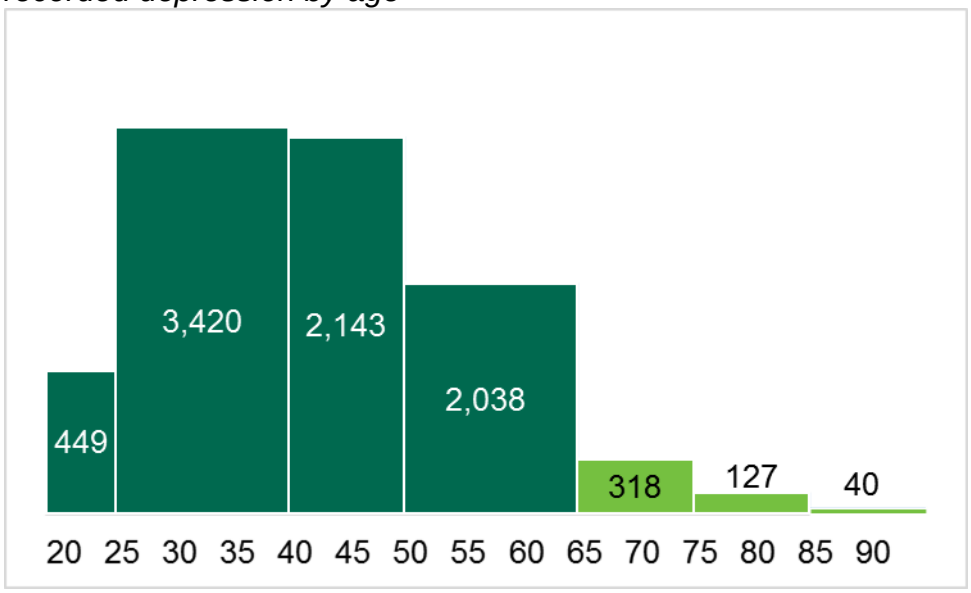
Figure 4: Proportion of Hackney and the City residents with GP recorded depression, by age (as proportion of all those registered with a GP in age band)



Local service data extracted from the GP register by CEG, Blizard Institute, April 2014.
Data covers Hackney and the City residents registered with a GP in Hackney, the City of London, Tower Hamlets and Newham.
Black bars are 95% confidence intervals. This are a statistical indicator of how closely the reported figures are likely to reflect the 'true' or underlying pattern.

Figure 5 shows that despite adults under 40 being much less likely to have depression (as recorded by their GP), nearly half of adults aged 19-64 on GP registers with recorded depression are under 40, simply because Hackney and the City's resident population is so young. (See Chapter 1 of the JSNA, *The People of Hackney and the City*.)

Figure 5: Histogram[5] showing number of Hackney and the City residents with GP recorded depression by age



Local service data extracted from the GP register by CEG, Blizard Institute, April 2014.
Data covers Hackney and the City residents registered with a GP in Hackney, the City of London, Tower Hamlets and Newham.

Further age breakdowns within the 18-64 age group are not available.

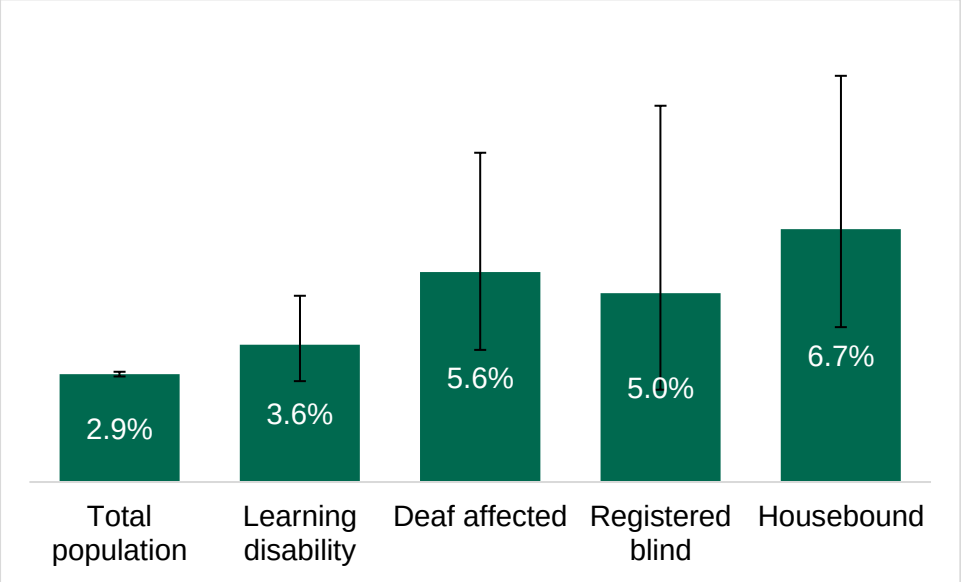
2.4.2. Disability

GP records (April 2014) show that Hackney and the City residents with certain disabilities are at higher risk of depression.

Those who are registered deaf affected or housebound are around twice as likely to have depression recorded by their GP as those who are not. There is no statistically significant difference in depression rates for those who have a learning disability or who are registered blind.

[5] Data from the GP register have only been made available by age groups of different sizes. In order to compare different age groups, we present these figures as a histogram: the area of each rectangle corresponds to the number of people within that age band; the width corresponds to the size of the age band. This means that the height represents how many people *per single year of age* you might expect to see, so if one rectangle is taller than another, it means there are more people *for each year of age*, even if the overall number in the rectangle is smaller.

Figure 6: Proportion of Hackney and the City residents with depression recorded by their GP by disability (as proportion of all those registered with a GP, age <65)

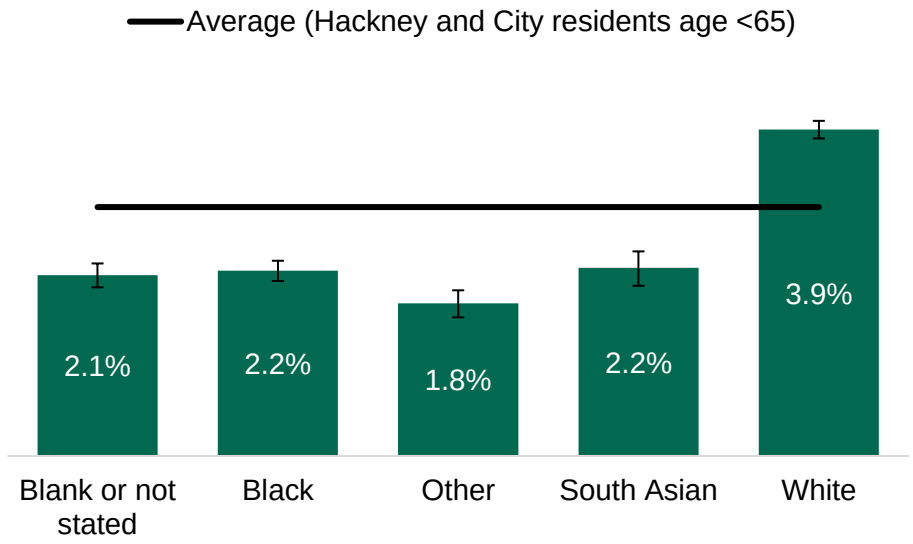


Local data: Extracted from the GP register by CEG, Blizard Institute, April 2015.
Data cover Hackney and the City residents registered with a GP in Hackney, the City of London, Tower Hamlets and Newham.

2.4.3. Ethnicity

In City and Hackney, people who are of White ethnicity are more likely to have depression recorded by their GP than other groups (Figure 7). This is not consistent with national prevalence estimates, where age-standardised rates of common mental health disorders are very similar in White (16%) and Black (17%) adults, and higher in people from a South Asian background (22%). This may reflect local under-diagnosis of common mental health problems in Black and Minority Ethnic (BME) groups, particularly in South Asian residents.

Figure 7: Proportion of Hackney and the City residents under 65 with GP recorded depression, by ethnicity (as proportion of all those registered with a GP)

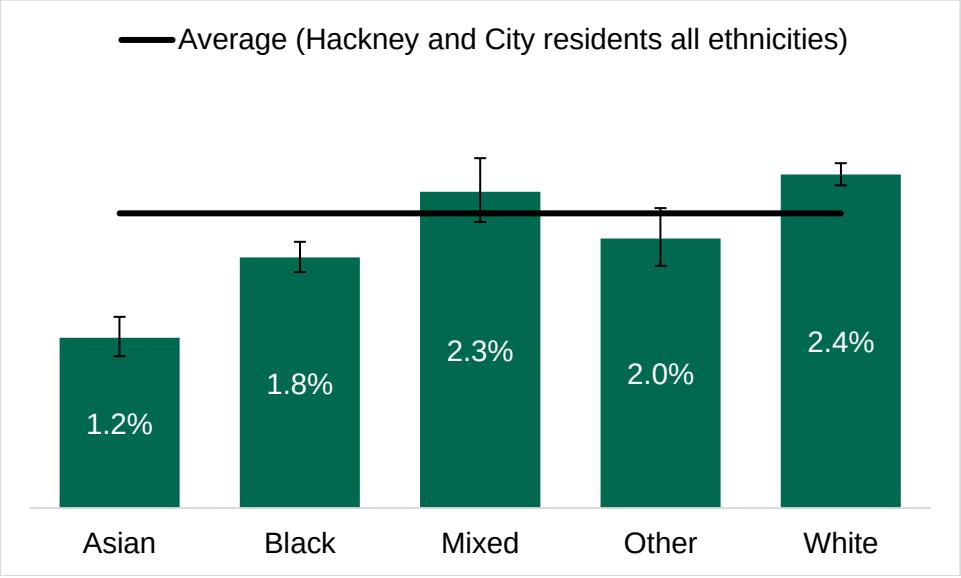


Local data extracted from the GP register by CEG, Blizard Institute, September 2015.
Data cover Hackney and the City residents registered with a GP in Hackney, the City of London, Tower Hamlets and Newham.

Data covers Hackney and the City residents registered with a GP in Hackney, the City of London, Tower Hamlets and Newham.

Asian residents are also the least likely to be accessing IAPT services (Figure 8).

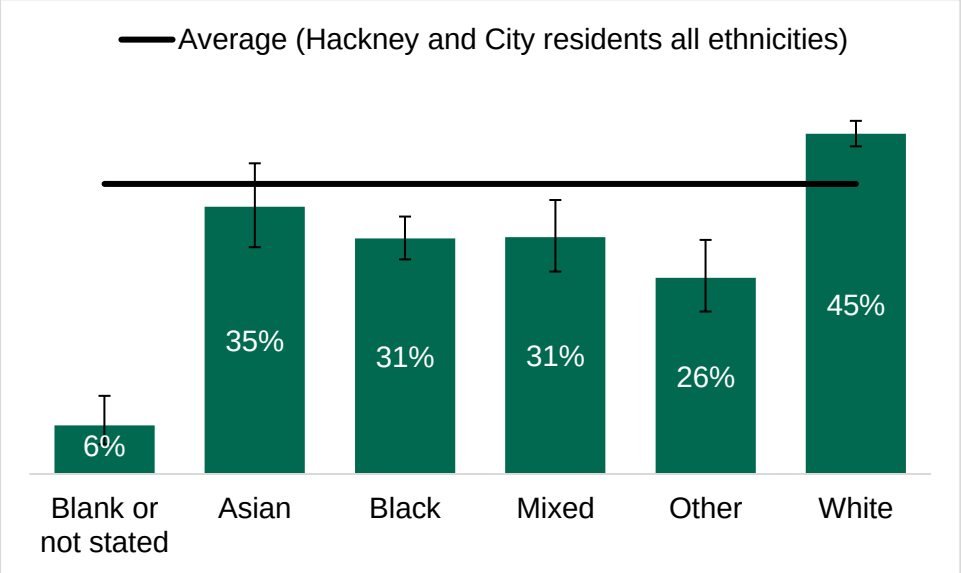
Figure 8: Proportion of Hackney and the City residents accessing IAPT in 2014, by ethnicity (as a proportion of all residents age 19-64)



IAPT Quarterly Reports[xxvii]

Figure 9 shows that the disparities seen in access continue into treatment; a higher proportion of White residents who begin treatment complete it than is the case for residents of all other ethnicities.

Figure 9: Hackney and the City residents completing IAPT treatment in 2014 as a proportion of those starting treatment in 2014, by ethnicity



IAPT Quarterly Reports[xxviii]

The 2014/15 Fund for Health report consolidates the research done by Hackney and the City groups into barriers to healthcare within specific communities.[xxix] A recurring theme for Black, Asian and Minority Ethnic (BAME) groups in this report is the need for information and support to be available in multiple languages and in culturally sensitive formats and settings.

Box 6: Local research: Gambling in the Chinese community

Hackney Chinese Community Services has conducted local insight work into issues faced by Chinese residents with mental ill health.

They found that gambling was a very serious issue in the Chinese community, and recommended raising awareness within the community of the prevalence of the issue and the differences between casual and problem gambling.

Source: Fund for Health 2014/15, Healthwatch Hackney and City and Hackney CCG.

2.4.4. Gender

The national estimated prevalence of all common mental health disorders in adults aged 18-65 is 13% for men and 20% for women (see Table 2). This means that at any given time, women are 58% more likely to be experiencing a common mental health disorder than men.

Both GP and IAPT figures reflect this pattern, with women under 65 in Hackney and the City being 58% more likely to have depression recorded by their GP (in September 2015: 3% of women; 2% of men)[xxx] and 73% more likely to access IAPT services (in 2014: 4% of women as a proportion of those aged 18-64; 2% of men). [xxxi]

Women and men have similar rates of IAPT treatment completion, with 31% of both women and men completing their treatment in 2014.

2.4.5. Maternity

Health visitor activity data indicates that there were 6,731 assessments for post-natal depression in City and Hackney in 2013/14, up slightly from 6,700 assessments in 2012/13. However, the number of mothers recorded as being identified with post-natal depression increased from 92 (1%) in 2012/13 to 341 (5%) in 2013/14.[xxxii] These data are collected within the first six months after birth. It has been suggested this change is due to improved accuracy of data collection methods,[xxxiii] so it is not possible to compare these figures directly.

NICE quotes reviews that have found estimates of 6% post-natal depression at birth to two months and between 6% and 7% at six months.[xxxiv] This suggests the 2013/14 figures from the Homerton Hospital are much closer to the expected national prevalence although local wider determinants of health, such as higher deprivation in Hackney, would predict higher local levels. This may mean that there is potential under diagnosis in Hackney.

2.4.6. Deprivation

Nationally, there is strong evidence that depression is linked to deprivation.

However, we do not see this in the local data. This may be because on average in Hackney deprivation is generally high, with neighbourhoods mixed in terms of affluence, and so we do not have as clear a distinction between people who live in more deprived and less deprived areas as is seen nationally.

2.4.7. Other equality areas

Box 7: Local research: LGBT+ adults' experience of local healthcare

City and Hackney Mind has conducted local insight work into obstacles to a positive experience of health and social care in LGBT+ residents.

Recommendations included:

- specific training on how LGBT+ issues such as discrimination might interact with mental health difficulties;
- sensitive and inclusive language that does not make assumptions about people's sexual orientation or gender;
- clear policies on confidentiality.

Source: Fund for Health 2014/15, Healthwatch Hackney and City and Hackney CCG.

Other legally protected characteristics[xxxv] are gender reassignment, marriage and civil partnership, and religion or belief. Local information was not available at the time

of writing to analyse how common mental health disorders prevalence or service provision are linked to any of these characteristics.

2.5. Comparisons with other areas and over time

Public Health England has produced the *Common Mental Health Disorders Profiles*, a free, online tool that allows users to compare local and national figures on a number of different indicators: http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders

A small selection of indicators are displayed below.

In summary, compared with England as a whole, City and Hackney has lower levels of GP recorded depression, high rates of referral to IAPT services and similarly levels of IAPT completion and improvement.

All figures are combined City and Hackney; separate data are not available.

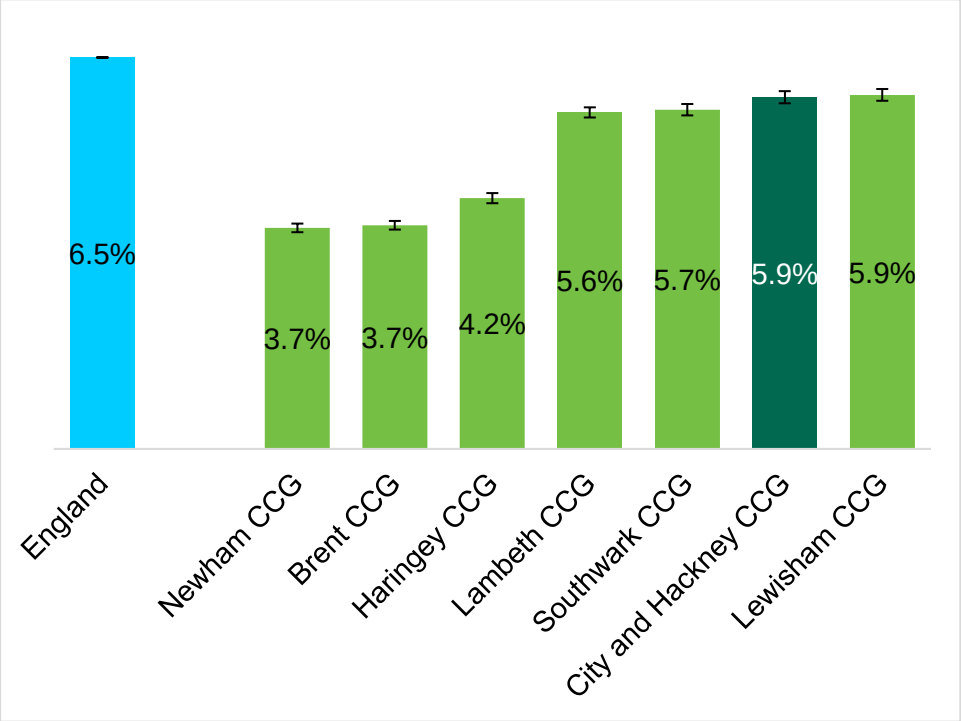
Recorded depression prevalence

Figure 10 shows that City and Hackney has a lower proportion of GP patients with recorded depression than England, though it is at the higher end of its 'statistical peers'.[6] Both Hackney and the City of London are estimated to have greater levels of need than the national average,[xxxvi] so lower levels of recorded depression point to lower levels of detection rather than lower prevalence.

Figure 11 shows that City and Hackney saw a sharp drop in recorded depression between 2011/12 and 2012/13 in a very similar manner to England. This may be due to a change in the way data are recorded or reported, rather than a change in prevalence.

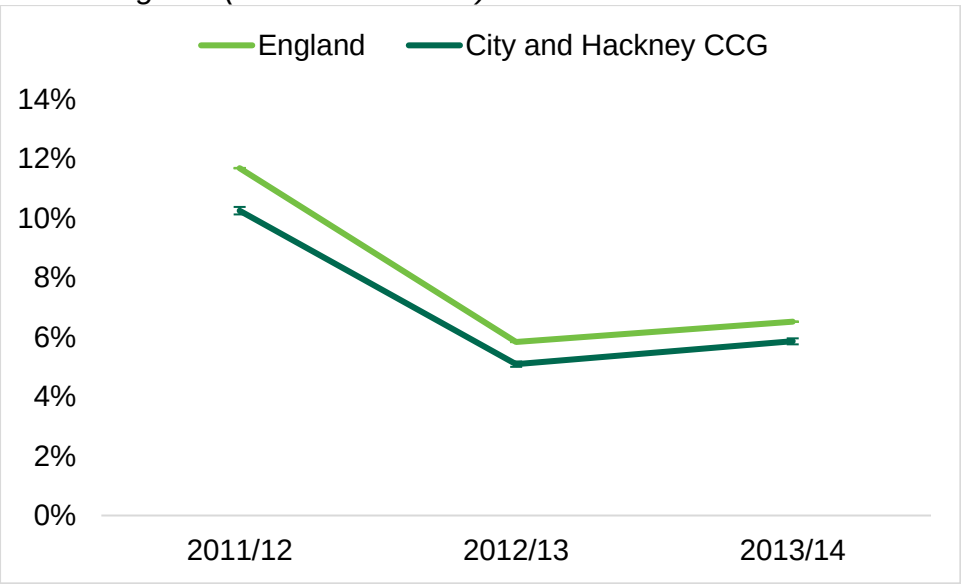
[6] Local authorities with a similar demographic make up to Hackney, used for the purpose of comparisons. This chapter of the JSNA follows the 2014 *Mental Health Needs Assessment*, which used a previous version of Hackney's statistical peers ('London Cosmopolitan'): Brent, Haringey, Lambeth, Lewisham, Newham and Southwark.

Figure 10: Patients with GP recorded depression as a proportion of all patients on the GP register (2013/14)



City and Hackney value statistically significantly lower than England.
Value not available for London.
Data from Quality and Outcomes Framework (QOF), analysis by Public Health England.[xxxvii]

Figure 11: Patients with GP recorded depression as a proportion of all patients on the GP register (2011/12-2013/14)



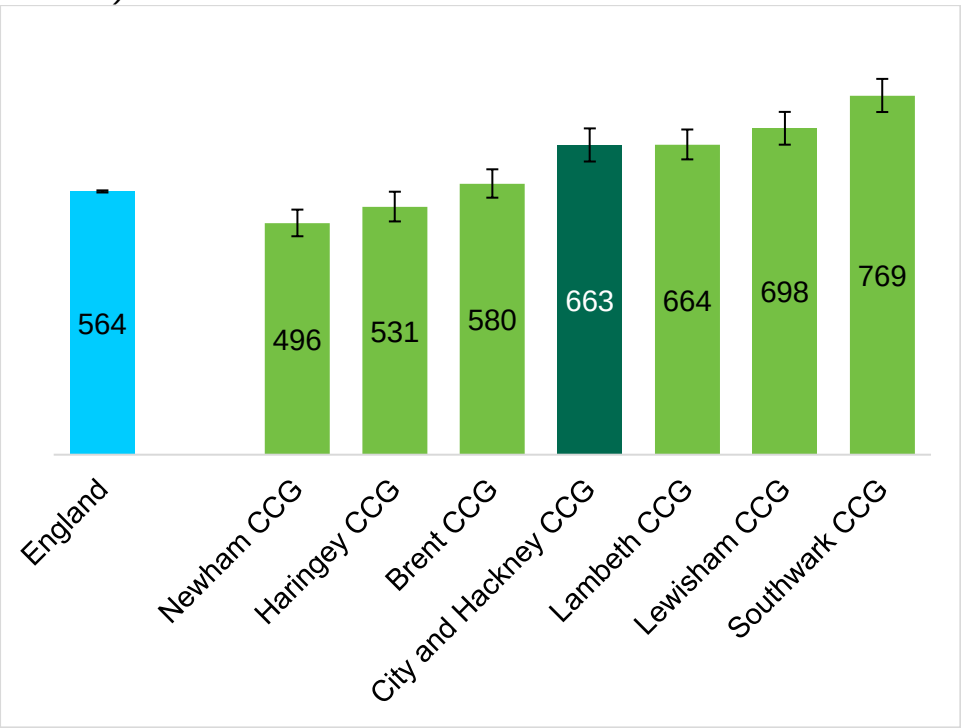
Value not available for London.
Data from QOF, analysis by Public Health England.

Entering IAPT

Figure 12 shows that City and Hackney has more people entering IAPT treatment as a proportion of the population than the national average. There is a wide spread of rates among its statistical peers, with City and Hackney in the middle of this range.

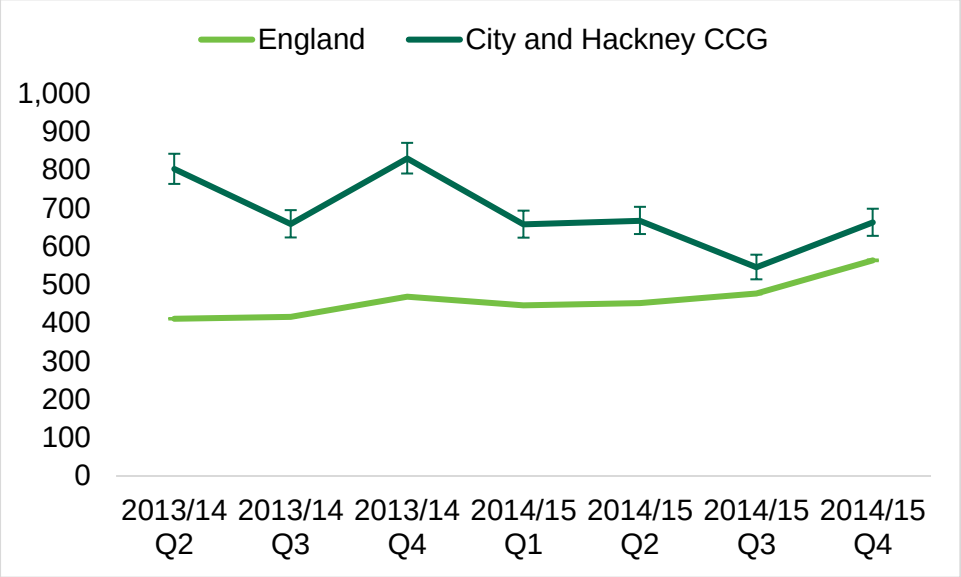
Figure 13 shows that while City and Hackney has had a slight downward trend in the rate of people entering IAPT in the last two years, the national rate has increased steadily over this same period, so that locally the range has fallen from nearly double the national rate in Q2 2013/14 to quite similar levels by Q4 2014/15.

Figure 12: Adults entering IAPT treatment per 100,000 population aged 18+ (Q4 2014/15)



City and Hackney value statistically significantly higher than England.
Value not available for London.
Data from Quarterly IAPT Dataset Reports, analysis by Public Health England.

Figure 13: Adults entering IAPT treatment per 100,000 population aged 18+ (Q2 2013/14 - Q4 2014/15)



Value not available for London.
Data from Quarterly IAPT Dataset Reports, analysis by Public Health England.

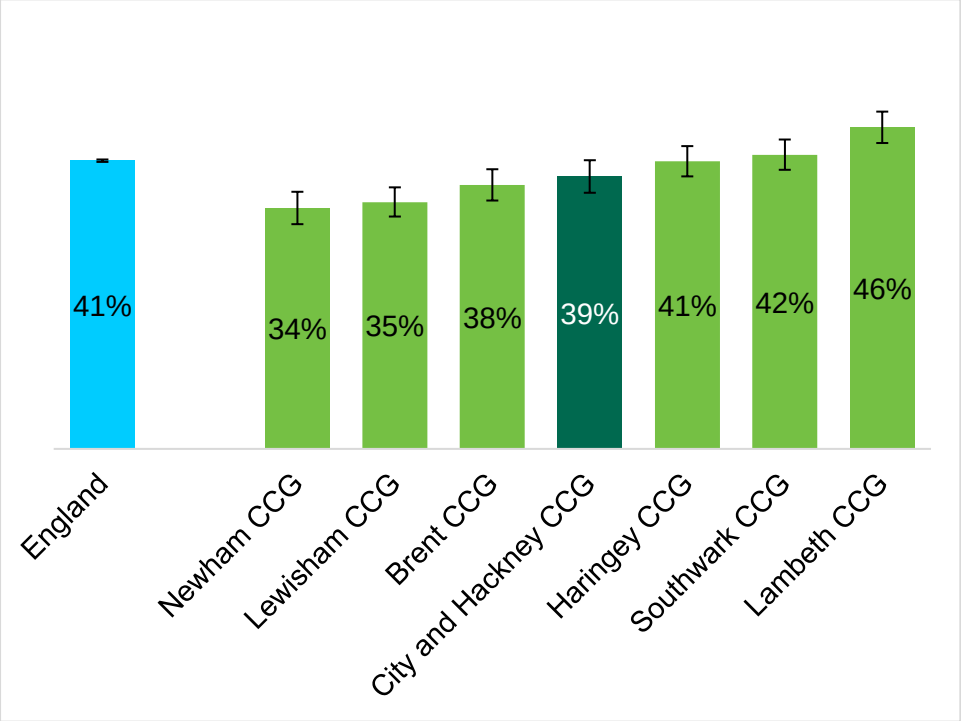
Completing IAPT

Not all referrals to IAPT result in a completed course of treatment (defined as receiving at least two treatment appointments prior to discharge). Nationally, over one in three referrals end without the client having been seen by the service and a further one in five referrals end after a single appointment.[xxxviii]

Figure 14 shows that City and Hackney CCG has similar rates of treatment completion as a proportion of referrals to England and is in the middle of the range of its statistical peers.

No time trend data are available.

Figure 14: Proportion of IAPT referrals who receive and finish a course of treatment (Q4 2014/15)



City and Hackney CCG value not statistically significantly different from England.
Value not available for London.
Data from Monthly IAPT Reports, analysis by Public Health England.

Reliable improvement following IAPT

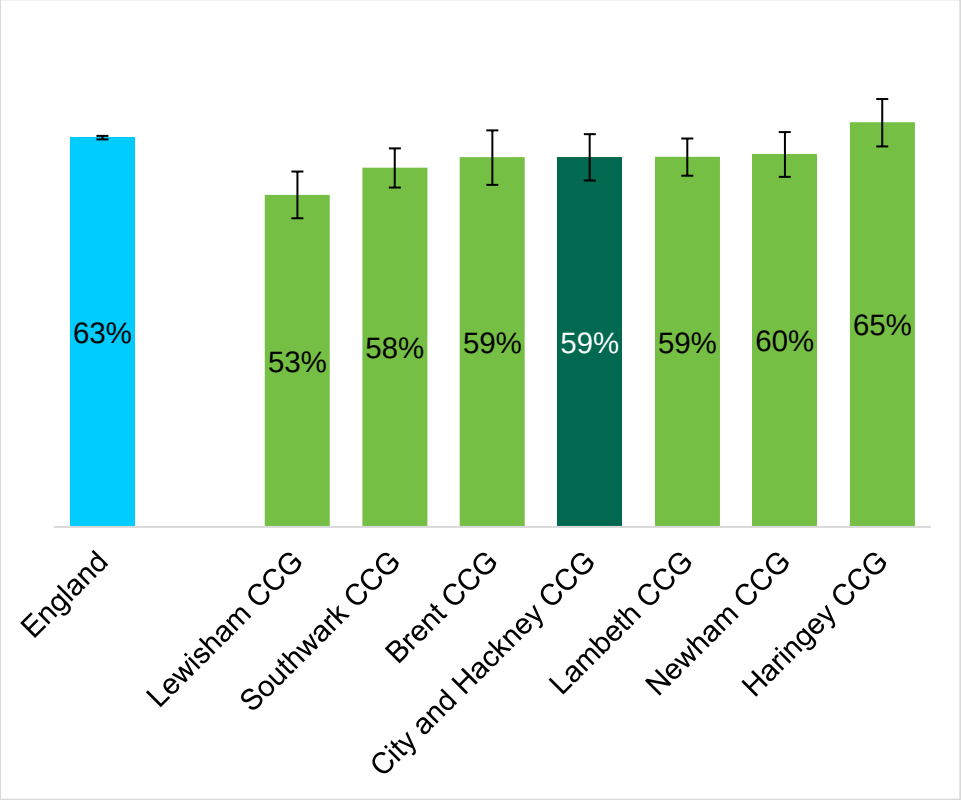
Measures of depression, anxiety or other relevant common mental disorders are taken through validated questions before and after IAPT treatment. 'Reliable improvement' in a service user means that their score on the relevant measure has improved by more than the known measurement error of the scale.

Figure 15 shows that City and Hackney CCG has a similar rate of reliable improvement to England and its statistical peers.

Figure 16 shows that City and Hackney CCG has been steadily improving in rates of reliable improvement over the period Q2 2013/14 to Q3 2014/15, going from around three-quarters of the national rate to statistically indistinguishable from the national rate.

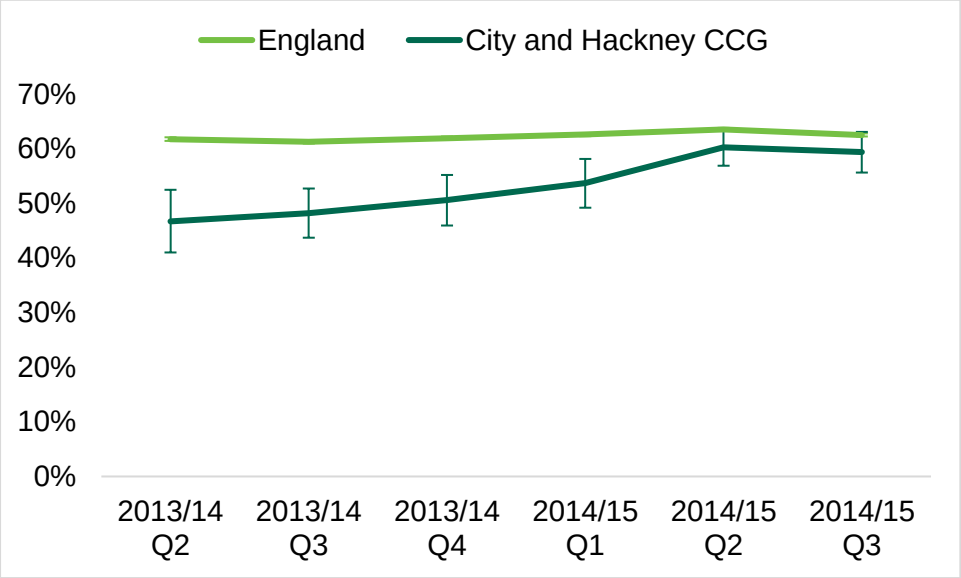
It is also possible to look at 'Moving to recovery' – the proportion of service users whose scores indicated clinical levels of their disorder at the start of treatment and sub-clinical levels at the end of treatment. The pattern seen looking at these data are similar (graphs not displayed; see full tool online to explore).

Figure 15: Proportion of those who have completed IAPT treatment who achieved reliable improvement (Q3 2014/15)



City and Hackney CCG value not statistically significantly different from England.
Value not available for London.
Data from Quarterly IAPT Dataset Reports, analysis by Public Health England.

Figure 16: Proportion of those who have completed IAPT treatment who achieved reliable improvement (Q2 2013/14 – Q3 2014/15)



Value not available for London.
Data from Quarterly IAPT Dataset Reports, analysis by Public Health England.

2.6. Evidence for what works

2.6.1. Prevention

A literature review of prevention in adult mental health was conducted as part of the 2014 City and Hackney Mental Health Needs Assessment.[xxxix] Key findings include:

- CBT is effective in preventing depression and anxiety;
- physical activity is effective in preventing depression;
- promising interventions for reducing post-natal depression include intensive, individualised post-partum home visits, peer-based telephone support, interpersonal psychotherapy;
- targeted and interactive (rather than universal and didactic) interventions are effective at reducing eating disorder risk factors.

NICE guidance on *Common mental health disorders: Identification and pathways to care* highlights key priorities for implementation of treatment and care pathways.

Key points are summarised below:

2.6.2. Identification

GPs and other health and social care providers should consider a diagnosis of common mental health disorders in all service users. There is a very strong relationship between long-term physical illness and depression/anxiety (see Section 6). Standard questions should be asked at physical health consultations to identify missed mental health diagnoses.

2.6.3. Treatment, care and support

Box 8: Local case study: Depression and community support

B was an unemployed Turkish woman with depression. Her mental ill health meant she had very low energy and found it physically challenging to do day-to-day tasks.

She started volunteering with a local community organisation on an occasional basis – as often as her low energy and other commitments would allow. The friendly and supportive environment helped her to make social connections and see that her skills and contributions were valued.

With positive feedback, meaningful work and regular social contact, she gained in confidence and her depression improved, allowing her to start to look for work. Six months after starting to volunteer, she found a job as a teacher.

Adapted with permission from a case study provided by the Hackney Refugee Forum.

Treatment should be provided in a stepped care manner that provides the least intrusive, most effective intervention first. This may include individual or group therapy, and/or medication. There should be clear criteria for each 'step' and movement between steps, which should be based on more than just symptom severity.

Primary and secondary care should work together to provide ongoing support at an appropriate level which minimises the impact of transition between services on service users. This requires well-designed and clear local pathways and good communication between service providers within and outside these pathways, as well as between service providers and service users.

2.7. Services and support available locally

2.7.1. Prevention

The City and Hackney Wellbeing Network, coordinated by City and Hackney Mind and funded by Hackney Council, is a network of voluntary sector organisations providing mental health and wellbeing support to the residents of Hackney and the City. The network contains organisations with links to many of Hackney and the City's diverse communities, providing services that meet cultural needs and expectations.

This network offers a prevention service to those at risk of developing mental ill health which helps to build resilience and alleviate stress, anxiety or low mood.

Information about the network, including current classes and how to make a referral for yourself or someone else, can be found at The City and Hackney Wellbeing Network website.

2.7.2. Identification

Most common mental health disorders are identified and assessed by GPs. For a full list of GP provision in Hackney and the City, see NHS Choices.

New opportunities for health visitors to recognise post-natal depression may arise following the transfer of responsibility of this service to the City and Hackney Public Health team (from October 2015).

GPs also use contact with their patients about other issues for opportunistic assessment in those who seem to be having difficulties with motivation, emotional regulation or other issues.

2.7.3. Treatment, care and support

General practice

Hackney has 43 GP practices and the City has one GP practice. A large proportion of mental health conditions are managed wholly by GPs, with GPs referring patients to primary, secondary or voluntary services as appropriate.

Primary Care Psychology Service and IAPT - Homerton University Hospital NHS Foundation Trust (HUHFT)

Primary Care Psychology offers guided self-help, one day courses and talking therapies using CBT for those aged 18 years and over. Typical difficulties that the service provides support for are: post-traumatic stress disorder, panic attacks, depression and anxiety, anger management, sleep disturbance, relationship problems, low confidence and coping with long-term medical conditions.

Primary Care Psychotherapy Service – Tavistock and Portman NHS Foundation Trust (TAP)

The City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS) is a primary care based mental health service for patients and general practice staff in City and Hackney. Any City and Hackney GP can refer any patient registered with their practice into the service. The service is aimed at people who might otherwise fall through the net of mental health care; targeted patients are those who do not meet criteria for existing primary and secondary care mental health services, or who find it difficult to engage with these services. This includes:

- patients with medically unexplained physical symptoms, including those with high volume notes and multiple previous referrals;
- patients with significant interpersonal difficulties, not suitable for other mental health services or with difficulty engaging in these services;
- people with mental health difficulties who have been discharged from other services or do not meet their referral thresholds;
- frequent attenders for GP consultation.

The PCPCS was designed to complement the primary care IAPT offer and to pick up patients whose needs were more complex or who had a more pronounced risk profile that were outside the scope of the IAPT service. The service operates using an assertive engagement model with proactive attempts to engage with patients, GPs and other health professionals where necessary.

Primary Care Liaison Service - ELFT

The Primary Care Liaison Service works directly with GPs and provides assessment, diagnosis, treatment and signposting to working age adults requiring support beyond that provided in primary care. It typically supports those with common mental health problems who need to step up their care but do not meet the threshold for requiring input from the community mental health teams. Referral to the service is via a single point of entry. Following assessment or treatment, the Primary Care Liaison Service may refer patients on to other teams such as Psychotherapy, Eating Disorder Services or back to Primary Care Psychology.

Enhanced primary care (EPC) is a step down and step up service for patients with severe illness who are stable and managed in primary care.

Secondary care

Where necessary, people with common mental health disorders can be referred by their GP to community or inpatient care and support provided by ELFT.

Voluntary sector

The City and Hackney Wellbeing Network (Section 2.7.1) also offers ongoing support for those with mental health difficulties, as do other voluntary organisations. Over fifty such organisations were identified in the 2014 *City and Hackney Mental Health Needs Assessment*.[xl]

2.8. Gaps in current services

A full review and detailed mapping of current service gaps will be undertaken in 2016. A summary gap analysis will be added to this chapter once the review and mapping is complete.

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