3. Adults: Severe and enduring mental ill health

3.1. Introduction

Severe and enduring mental illnesses include bipolar disorder, schizophrenia, other psychosis, personality disorders, and any other mental health disorder (such as depression or anxiety) of a severe and enduring nature. This section covers bipolar disorder, schizophrenia, other psychosis and personality disorders (see Box 9).

The term 'Severe Mental Illness' (SMI) does not cover all severe and enduring mental illnesses. It is a specific term used in the Quality and Outcomes Framework (QOF) to mean bipolar disorder, schizophrenia and other psychosis. GPs have guidelines for recording data on people with SMI, and so we have much more local data about people with SMI than we do about people with other severe and enduring mental illnesses.

Box 9: Severe and enduring mental health conditions[i]

Bipolar disorder – Characterised by periods of mania (elation so extreme it affects thinking, judgement and behaviours) and depression (unhappiness so extreme it affects thinking, judgement and behaviours).

Schizophrenia – A mental disorder that includes 'positive' symptoms of unusual experiences such as hallucinations and delusions (psychosis), and 'negative' symptoms such as loss of motivation and inability to concentrate.

Psychosis – A range of mental disorders where people experience one or more of delusions, thought disorder, and hallucinations.

Personality disorders – Definitions vary, but these can be thought of as collections of personality traits that make it difficult or impossible to live with yourself and/or other people. Personality disorders include anti-social behaviour disorder and borderline personality disorder.

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

3.2. Causes and risk factors

None of the conditions considered here have a fully understood set of causes. However, current evidence suggests that a combination of genetic predisposition and psychosocial triggers (especially in childhood) are responsible.

Wider determinants of health such as deprivation and level of social support (from family, friends, or public and voluntary sector services) can influence the course, severity and impact of these conditions, as well as the likelihood of certain psychosocial triggers.

Bipolar disorder: A recent National Institute for Clinical Excellence (NICE) review of the evidence on the causes of bipolar disorder[ii] found no clear cause or causes. Genetic factors may influence the risk of developing the condition and psychosocial factors such as childhood neglect, abuse and trauma can influence its course, leading to earlier onset, worse symptoms and a higher chance of comorbidity with other mental health conditions and substance misuse.

Schizophrenia: The cause or causes of schizophrenia are currently unknown, but evidence suggests that genetic factors contribute to the risk of developing the condition, with psychosocial and environmental factors such as abuse and poor parenting, especially in early childhood, also playing a part.[iii]

Psychosis: Psychosis encompasses a large range of different conditions with different causes. As well as being a symptom of other mental health conditions such as schizophrenia, it may also be caused by some physical conditions (including sexually transmitted infections (STIs) and cancer) and substance misuse.[iv]

Personality disorders: There is evidence that personality disorders are caused by a combination of genetic and psychosocial factors. Psychosocial factors linked with antisocial behaviour disorder include harsh and inconsistent parenting;[v] those linked with borderline personality disorder include childhood abuse and poor attachment between parent and child.[vi]

Conduct disorder in children is strongly linked to the development of antisocial personality disorder in adults, with a 40-70% conversion rate.[vii]

3.3. Local data and unmet need

Mental health services for adults with severe and enduring disorders in Hackney and the City are described in Section 3.7.

3.3.1. Numbers affected – known to services

Table 1 provides current service user figures for primary, secondary and voluntary care for severe and enduring mental health disorders in Hackney and the City.

Just over 3,000 Hackney and the City residents between the ages of 19 and 64 are recorded by their GP as having SMI; this is 2% of those in this age group registered with a GP. No GP data are readily available on other severe and enduring conditions such as personality disorders, nor is information available on the severity of depression recorded by GPs. Separate data for the City of London are not available.

In general, mental health conditions in adults need to be of a severe and enduring nature in order to require secondary mental health care, but these are not limited to SMI and personality disorders.[viii] The East London NHS Foundation Trust (ELFT) provides secondary mental health care to at least 85% of Hackney and the City of London residents who receive any such care. Just over 5,000 Hackney and the City residents aged 19 to 64 received any form of secondary care from ELFT in 2013/14.

However, of the 5,000+ service users receiving secondary care from ELFT, only around 1,000 have a primary diagnosis of bipolar disorder, schizophrenia or other psychosis recorded. This does not necessarily mean that only a thousand service users with these conditions are receiving services, as it is not always clinically appropriate to provide a service user with a diagnosis. Some service users have more than one diagnosis; only primary diagnosis data have been provided and are reported here.

Just over 300 Hackney and the City residents were receiving services targeted at those with personality disorders from ELFT at the end of March 2014.

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

Type of service	Service	Service users	Dates	Number	Caveats
Primary care	GPs	All those with SMI recorded by GP	Snapshot: Apr 2014	3,143	See glossary for definition of SMI
Secondary care	East London NHS Foundation Trust (ELFT)	All service users (1)	Apr 2014 – Mar 2014	5,206	
	ELFT	All service users with recorded primary diagnosis of schizophrenia, psychosis or bipolar disorder (1)	Apr 2013 – Mar 2014	1,017	41% of service users have a recorded primary diagnosis (2)
	ELFT	Receiving 'Adult Mental Health Services' in Payment by Results (PbR) clusters 10-15 and 17 (3)	Snapshot: Mar 2014	1,500	Age not specified (4) 68% of service users have a recorded PbR cluster (3)
	ELFT	Receiving treatment from Therapeutic Community and Outreach Service (5)	Snapshot: Mar 2014	311	
Voluntary sector	City and Hackney Wellbeing Network	All accepted to Recovery and Social Inclusion Pathway	Apr 2015 – Jun 2015	274	

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, Blizard Institute, April 2014; ELFT data provided by ELFT, September 2014.

Notes:

(1) Excludes forensic patients, as this group receive separate services.
(2) 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 have been provided.
(3) Payment by Results (PbR) clusters are a needs-based rather than diagnosis-based designation. However, clusters 10-15 and 17 are broadly for psychotic disorders. (No information is available on the overlap between those with a recorded primary diagnosis of schizophrenia, psychosis or bipolar disorder and those in PbR clusters 10-15 and 17).
(4) Adult Mental Health Services are broadly for those aged 18-64.
(5) Personality disorders service.

3.3.2. Numbers affected - estimated

We can use national prevalence figures for certain severe and enduring mental health conditions to derive rough estimates of the number of people in Hackney and the City living with each.

The estimates in Table 2 suggest that the most common severe and enduring mental illnesses in Hackney and the City are severe depression and personality disorders. However, please note that these estimates are from a range of different sources, and so are not necessarily directly comparable with each other. Some people will have more than one of the named conditions.

Table 2: Estimated number of Hackney and the City residents (aged 19-64) with certain severe and enduring mental health disorders

Condition	National prevalence			Hackney estimate			City of London estimate			City & Hackney total estimate
	Men	Women	All	Men	Women	All	Men	Women	All	
Psychosis [xvii]	0.3%	0.5%	0.4%	483	826	1,309	14	18	32	1,341
Schizophrenia [ix]	0.5%	0.5%	0.5%	804	826	1,630	23	18	41	1,671
Bipolar disorder [x]			1.0%			3,261			83	3,344
Severe depression [xi]			2.7%			8,805			223	9,028
Personality disorders (all) [ix]	5.4%	3.4%		8,685	5,619	14,304	252	122	375	14,679
Antisocial personality disorder [xvii]	0.6%	0.1%	0.3%	965	165	1,130	28	4	32	1,162
Borderline personality disorder [xvii]	0.3%	0.6%	0.4%	483	992	1,474	14	22	36	1,510

National prevalence estimates adjusted by local index of need (MINI2K)[xii] applied to population figures.[xiii]
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.

3.3.3. Unmet need

Box 10: Local evidence: Personalised care for those with severe mental health issues

Core Arts has conducted local insight work into the healthcare experiences of Hackney residents with severe mental health issues.

They found that many participants did not understand what was meant by 'managing your own care' or what changes were being made to the delivery and management of care under the Care Act. In particular, participants were not aware of their rights concerning personal health budgets.

They found that GPs were in a strong position to address this issue due to their key role in patient care. They recommended that GPs should make sure they are fully aware of what is available to clients across all sectors, including voluntary services, and that GPs should provide clear information about personal health budgets and personalised care.

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

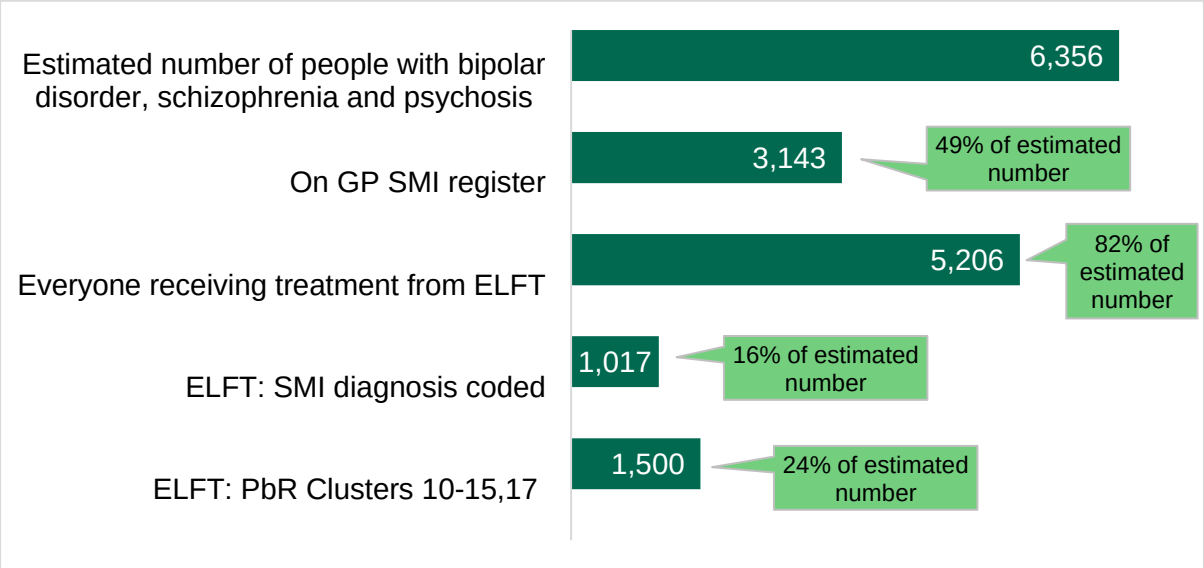
Serious mental illness

Half the number of Hackney and the City residents aged 19-64 estimated to have bipolar disorder, schizophrenia or other psychosis are on the GP SMI register. This suggests that roughly 3,000 people with these conditions may not be known to their GP (Figure 1).

Not everyone receiving services from ELFT has a diagnosis recorded (see Table 1) and not everyone receiving treatment for SMI will have that recorded as their primary diagnosis. For this reason, we have reported three figures for ELFT service use in Figure 1 – the total number of residents aged 18-64 receiving treatment from ELFT, those with an SMI diagnosis coded, and those in the PbR clusters indicating psychosis (see Table 1 for more details).

About half the number of those on the GP register for SMI (3,143 in total) are receiving treatment from ELFT for needs in the PbR relevant cluster (1,500), implying that the other half on the register may be receiving primary care only.

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



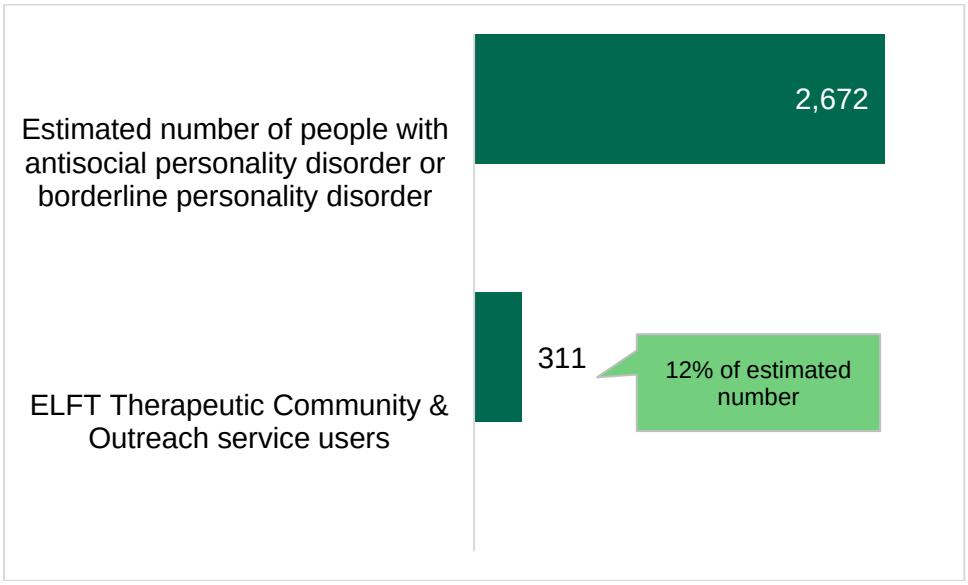
Local data: Table 1
Local estimates: Table 2

Personality disorders

Eleven per cent of those aged 19-64 estimated to have antisocial personality disorder or borderline personality disorder in Hackney and the City were using the Therapeutic Community and Outreach Service at ELFT at the end of March 2014 (Table 1, Table 2).

It should be noted that people with some personality disorders, in particular antisocial personality disorder, tend to be 'treatment resistant' and do not seek or engage with services unless there is an additional reason to do so, such as a legal requirement.[xiv]

Figure 2: Estimated number of Hackney and the City residents (aged 19-64) with antisocial personality disorder or borderline personality disorder compared to known service use



Local data: See Table 1
Local estimates: Table 2

3.4. Health inequalities

For detailed information about how mental health interacts with the nine protected characteristics,[1] 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.[xv] 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.

3.4.1. Age

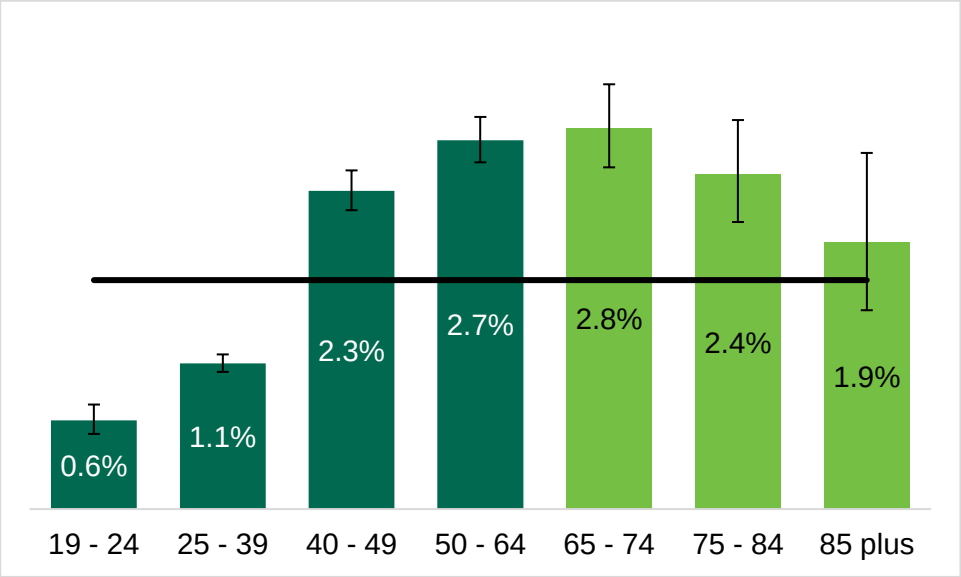
Schizophrenia tends to develop between the ages of 16 and 30,[iii] and early intervention after a first episode of psychosis is recommended by NICE to improve clinical outcomes such as admission rates, symptoms and relapse.[xvi]

Figure 3 shows that in Hackney and the City, the chance of being on the GP SMI register rises with age to a peak at 50-74 before declining. People aged 50-64 are 1.6 times as likely as average to be on the GP SMI register, while people aged 19-24 are less likely than average.

The increasing chance of being on the GP SMI register with age could be an indicator of missed opportunities for early intervention, with people being diagnosed several years after their first episode of psychosis.

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

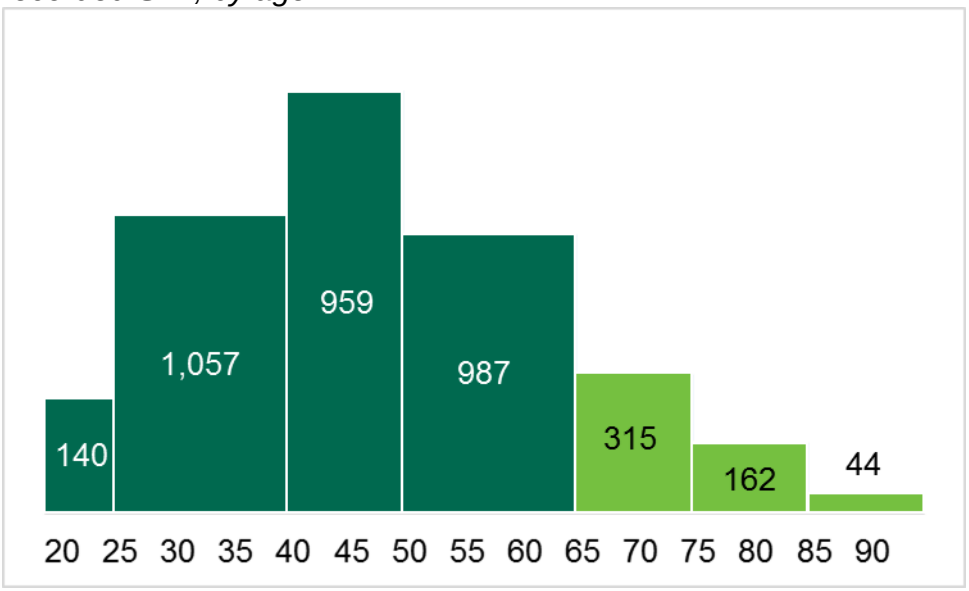
Figure 3: Proportion of Hackney and the City residents on GP SMI register, by age (as a proportion of all those registered with a GP in age range)



Local service data extracted from the GP register by Clinical Effectiveness Group (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 4 shows that despite each individual adult aged 25-39 being much less likely to be on the GP SMI register than an adult aged 50-64, there are similar numbers of adults on the register in each age group (roughly 1,000 in each). This is simply because of the young age profile of Hackney and the City's resident population (see Chapter 1 of the JSNA, *The People of Hackney and the City*).

Figure 4: Histogram[2] showing number of Hackney and the City residents with GP recorded SMI, by age



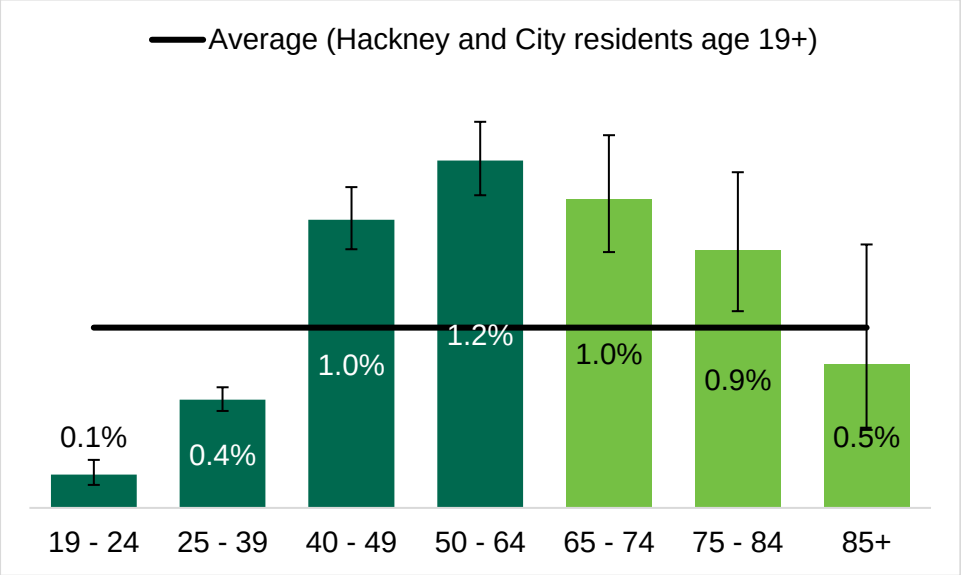
Local service data extracted from the GP register by CEG, Blizard Institute, April 2014.
Data covers Hackney and the City residents registered with a GP in Hackney, the City of London, Tower Hamlets and Newham.

Figure 5 shows that in Hackney and the City, the chance of receiving secondary care from ELFT with a primary diagnosis of SMI recorded follows a similar pattern with age to the GP SMI register, although it appears to have a steeper increase from 19-24 to 50-64.

Figure 6 shows that between the ages of 25 and 74, a similar proportion (around 30-35%) of Hackney and the City residents on the GP SMI register are receiving secondary care from ELFT (with a primary diagnosis of SMI recorded), but at ages 19-24 only 20% on the SMI register are receiving this secondary care.

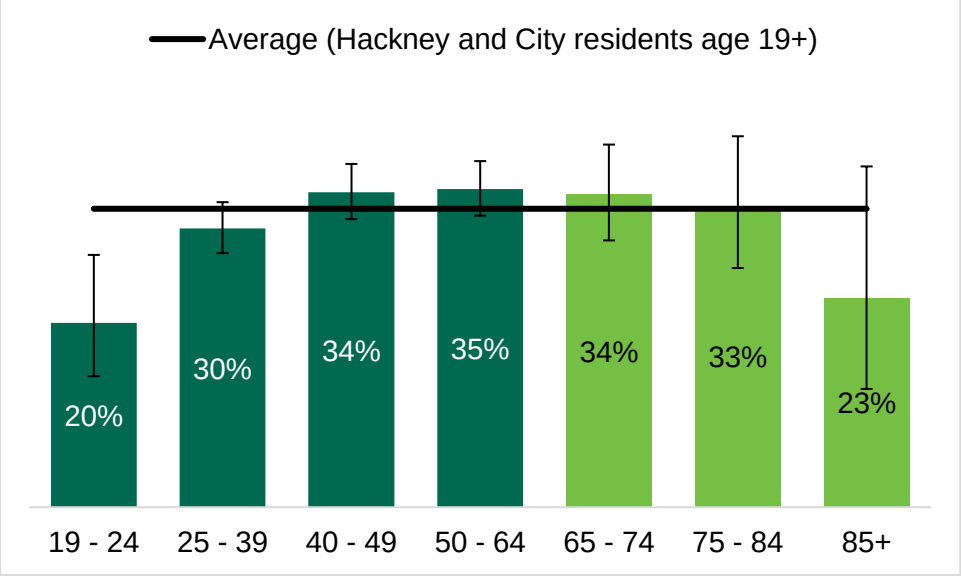
[2] Data from the GP register have only been made available by age groups of different sizes. In order to compare different age groups, we present these figures as a histogram: the area of each rectangle corresponds to the number of people within that age band; the width corresponds to the size of the 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 5: Proportion of Hackney and the City residents receiving secondary care from ELFT in 2013/14 with a primary diagnosis of SMI, by age (as proportion of population)



Local service data provided by ELFT, September 2014.

Figure 6: Proportion of Hackney and the City residents on GP SMI register receiving secondary care from ELFT in 2013/14 with a primary diagnosis of SMI, by age



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

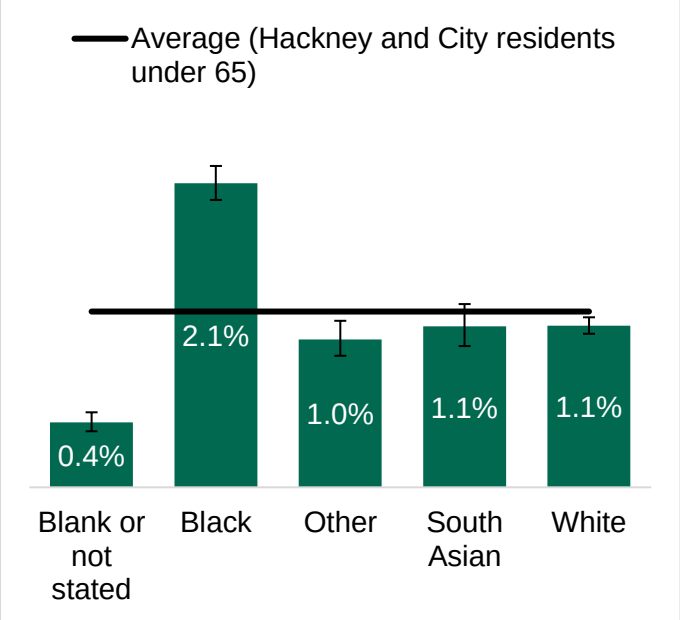
3.4.2. Ethnicity

Black men have a higher estimated rate of psychosis than White men; the age-adjusted estimate for Black men is 3%, compared to less than 1% for White men. The national estimates for both genders combined are less than 1% for the White population, 1% for the Black population and 0.2% for the Asian population.[xvii]

Stakeholders working with the Hackney migrant community have found that recent migrants may not understand how the NHS works or what treatment options they may have. Undocumented migrants also fear being reported to the Home Office by healthcare providers.

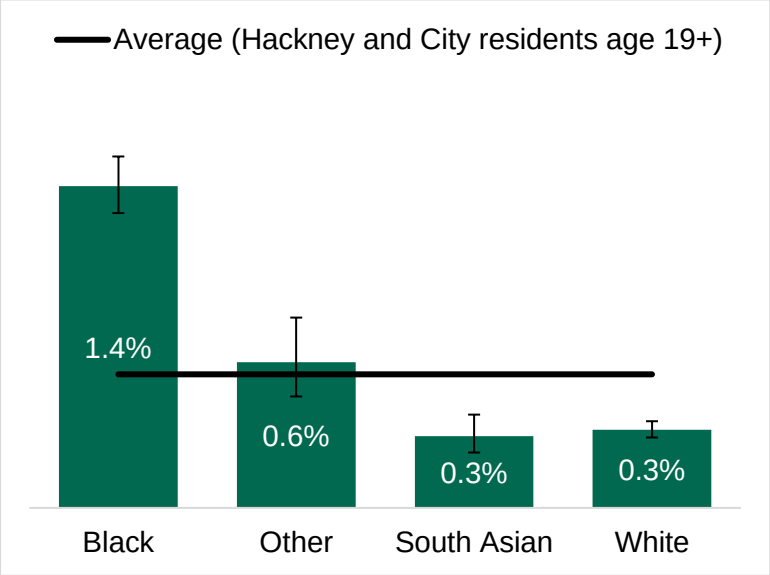
We know that, nationally, people of Black ethnicity, especially Black men, are underrepresented in early interventions for psychosis and over-represented in secondary, especially secure secondary, mental health settings.[xv] The same may hold true in City and Hackney – Black patients are almost twice as likely as White patients to be on the GP SMI register (Figure 7), but over four times as likely to be receiving care from ELFT with an SMI diagnosis (Figure 8). When looking solely at those on the SMI register, Black patients are almost twice as likely as White patients to be receiving ELFT care (Figure 9).

Figure 7: Proportion of Hackney and the City residents with GP recorded SMI, by ethnicity (as a proportion of all those registered with a GP, aged <65, in ethnic group)



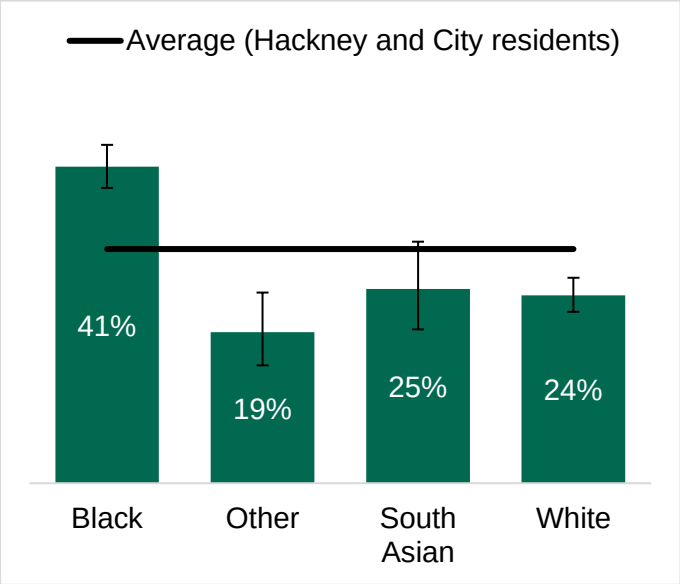
Local service data extracted from the GP register by CEG, Blizard Institute, September 2015.
Data covers Hackney and the City residents registered with a GP in Hackney, the City of London, Tower Hamlets and Newham.

Figure 8: Proportion of Hackney and the City residents aged 19-64 receiving secondary care from ELFT in 2013/14 with a primary diagnosis of SMI, by ethnicity (as proportion of 19-64 population in ethnic group)



Local service data provided by ELFT, September 2014.

Figure 9: Proportion of Hackney and the City residents on GP SMI register (aged <65) receiving secondary care from ELFT in 2013/14 with a primary diagnosis of SMI (aged 19-64), by ethnicity



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

3.4.3. Gender

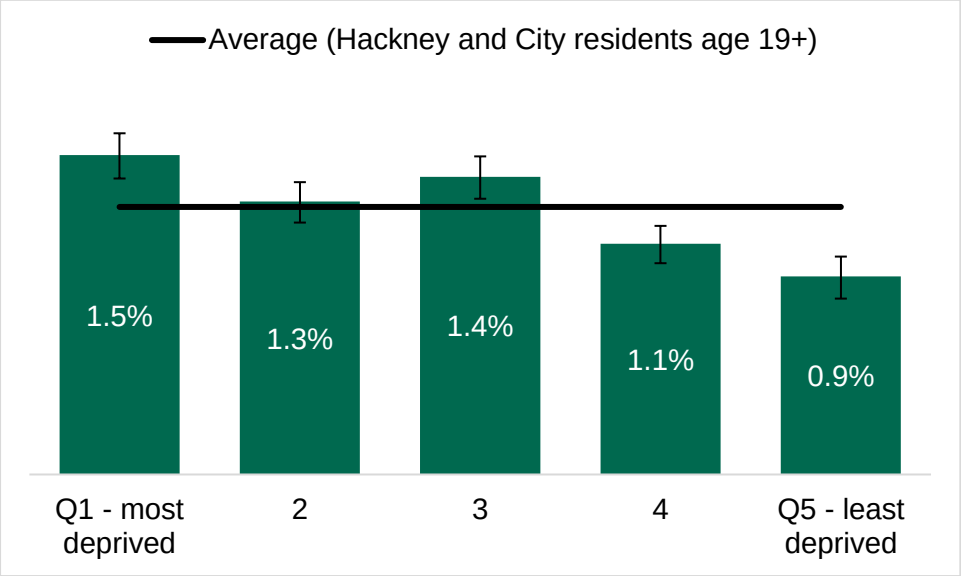
Nationally, men have a similar estimated rate of psychosis to women (Table 2), but are *under-represented* in primary mental health care and *over-represented* in inpatient, especially secure, mental health settings.[xv]

Locally, a man is *more* likely than a woman to have SMI recorded by their GP; 1.0% of women under 65 years old have GP recorded SMI compared to 1.4% of men. This suggests a different pattern to that seen nationally. However, men with GP recorded SMI are more likely to be receiving secondary care from ELFT, which is consistent with national trends. Twenty-seven percent of women and 33% of men with GP recorded SMI are receiving secondary services from ELFT (with a diagnosis of SMI recorded).

3.4.4. Deprivation

In City and Hackney, someone in the most deprived local deprivation quintile is 21% more likely to be on the GP SMI register as someone in the least deprived quintile (Figure 10). No data are available by area deprivation for ELFT care.

Figure 10: Proportion of Hackney and the City residents on GP SMI register by local deprivation quintile as proportion of all those registered with a GP (age <65)



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

3.4.5. Other equality areas

No local data are available on other equality areas. For information on links between severe and enduring mental illness and disability, see the Links between physical and mental health section of this chapter.

3.5. Comparisons with other areas and over time

Public Health England has produced the *Severe Mental Illness 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/severe-mental-illness

A small selection of indicators from the Public Health England tool are displayed in this section.

In summary, Hackney has a high estimated rate of new cases of psychosis, while estimates for the City of London are inconclusive due to the small number of residents. Hackney and the City have a high admission rate for mental ill health, but a similar rate of emergency and Mental Health Act admissions ('sectioning') to the national average, while its rates of delayed discharge are extremely low.

Stakeholders working with people with mental health problems in Hackney and the City of London have found that the needs of their clients with severe and enduring mental health conditions increasingly relate to housing and benefits.

Estimated incidence of psychosis

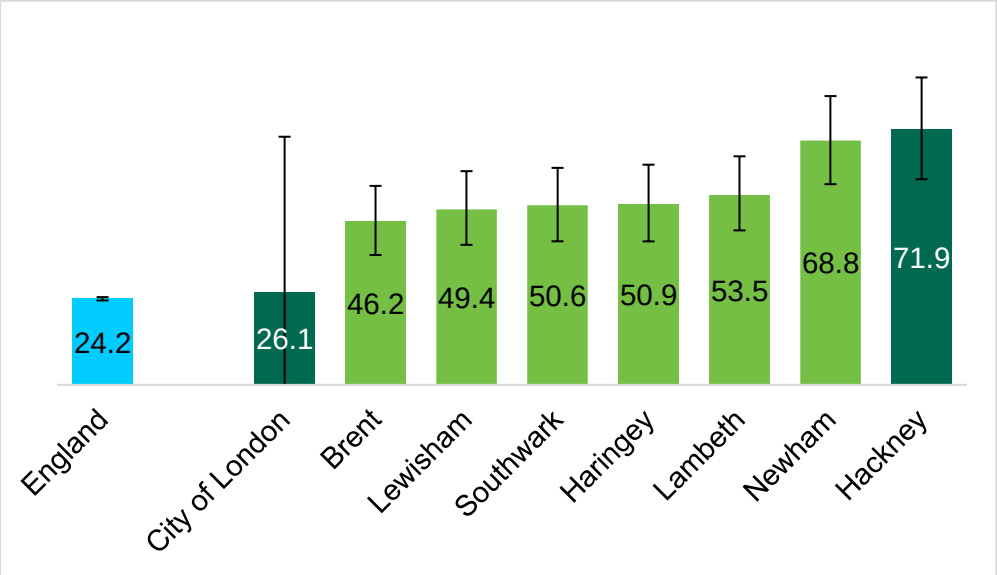
Figure 11 shows that Hackney has high rates of estimated psychosis compared to the national average and most of its 'statistical peers'. [3]

There is significant uncertainty about the estimated rates of psychosis in the City of London, which is due to its small population.

No trend data are available for this estimate.

[3] 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 11: Estimated incidence of new cases of psychosis per 100,000 age 16-64 (2011)



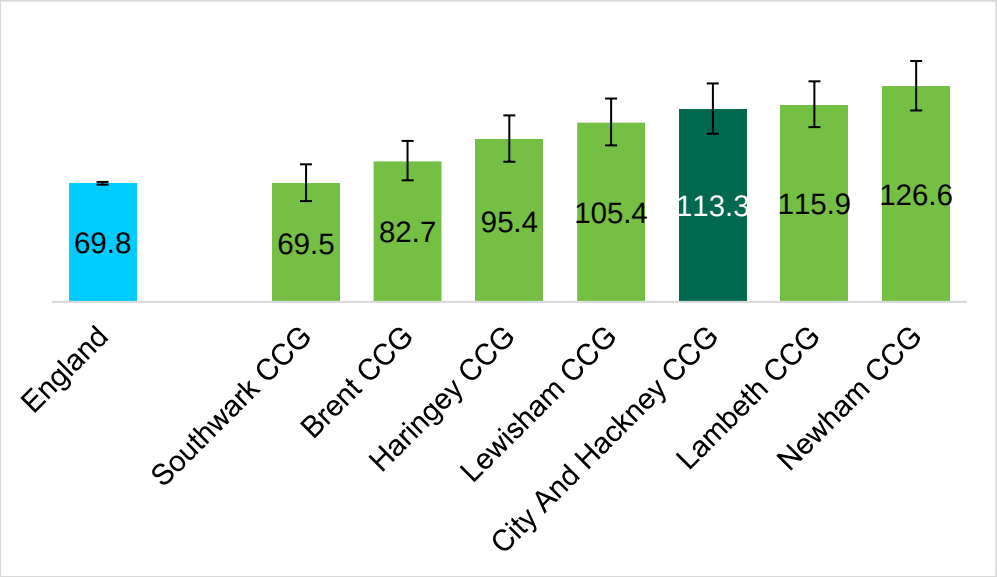
Hackney value statistically significantly higher than England.
City of London value not statistically significantly different from England.
Value not available for London.
Data from PsyMaptic, analysis by Public Health England.[xviii]

Mental health admissions

Figure 12 shows that Hackney and the City has higher rates of hospital admissions for mental ill health than the national average, although it is statistically similar to most of its peers.

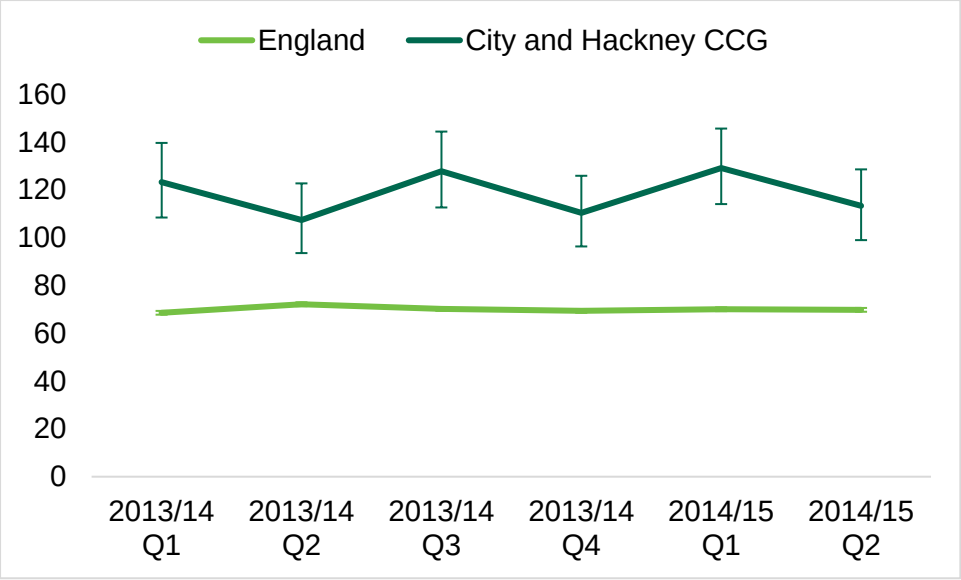
Figure 13 shows that this higher rate of hospital admissions for mental ill health has been consistent over 2013/14 and the first half of 2014/15.

Figure 12: Mental health admissions to hospital per 100,000 population age 18+ (Q2 2014/15)



City and Hackney Clinical Commissioning Group (CCG) value statistically significantly higher than England.
Value not available for London.
Data from Mental Health Minimum Data Set Reports, analysis by Public Health England.

Figure 13: Mental health admissions to hospital per 100,000 population age 18+ (Q1 2013/14 - Q2 2014/15)



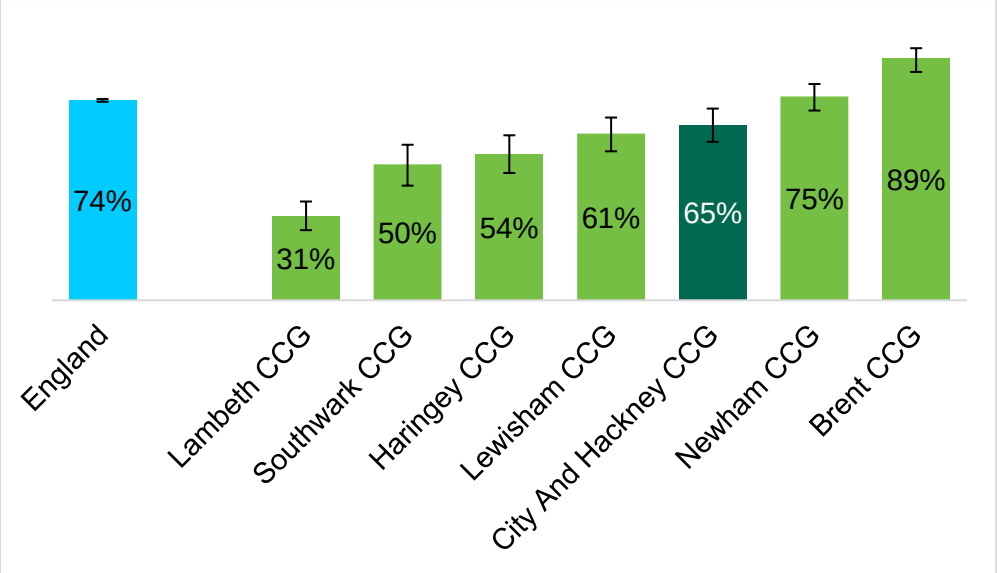
Value not available for London.
Data from Mental Health Minimum Data Set Reports, analysis by Public Health England.

Emergency admissions

Figure 14 shows that City and Hackney has a lower proportion of mental health admissions that are emergency admissions than the national average. Its peers have a wide range, with City and Hackney figures lying in the middle. While the local figure is lower than the national average, it still represents a higher rate of emergency admissions per 100,000 population than the national average (approximately 73

compared to a national average of approximately 51)[4] because rates of admission overall are higher.

Figure 14: Proportion of mental health admissions which were emergency admissions all ages (Q2 2014/15)



City and Hackney CCG value statistically significantly lower than England.
Value not available for London.
Data from Mental Health Minimum Data Set Reports, analysis by Public Health England.

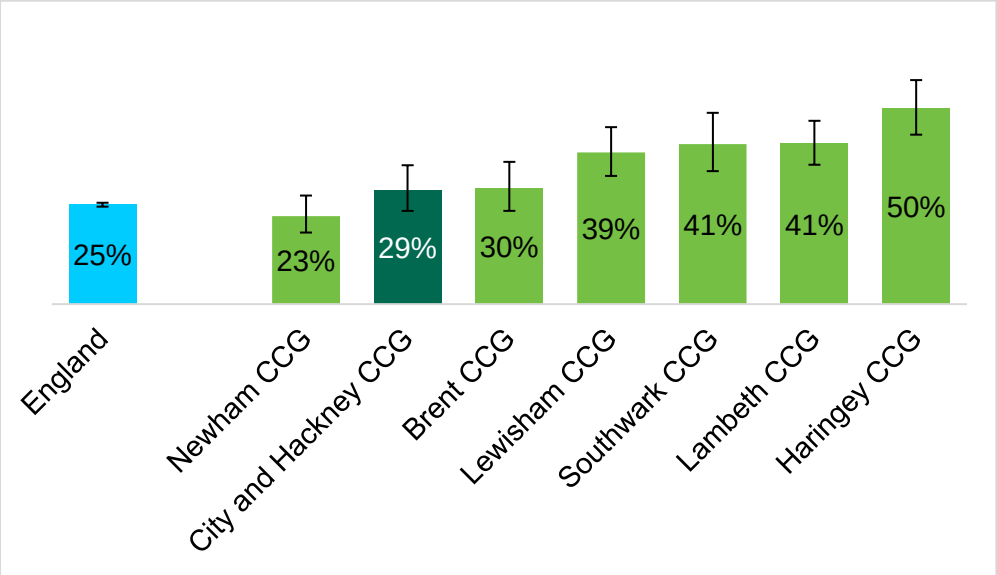
Detentions under the Mental Health Act

Figure 15 shows that City and Hackney has a similar proportion as nationally of admissions that are detentions under the Mental Health Act, and is amongst the lowest of its statistical peers.

Figure 16 shows that this pattern is constant over the year and a half for which figures are available.

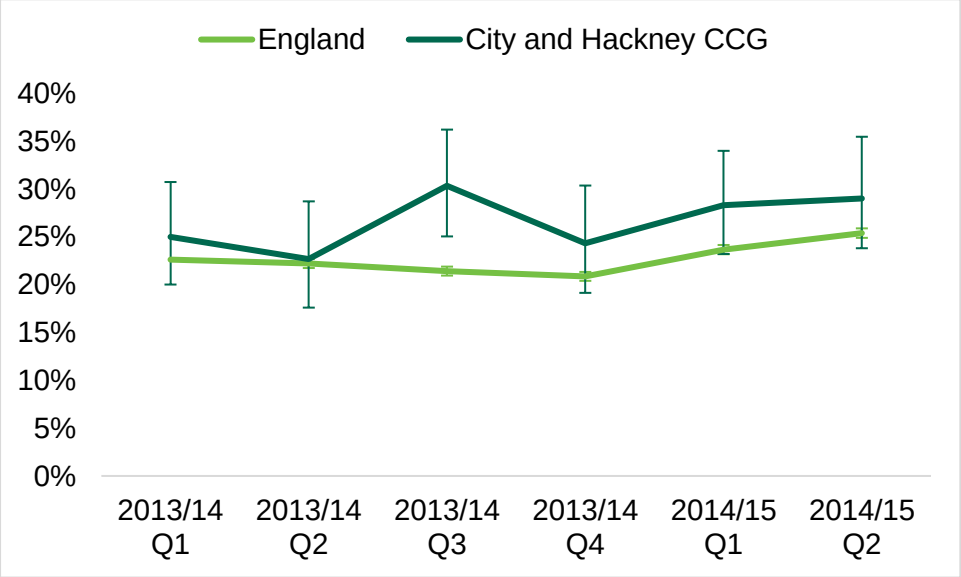
[4] Computed by combining the data in Figure 12 and Figure 14.

Figure 15: Proportion of admissions which were detentions under the Mental Health Act all ages (Q2 2014/15)



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

Figure 16: Proportion of admissions which were detentions under the Mental Health Act all ages (Q1 2013/14 - Q2 2014/15)



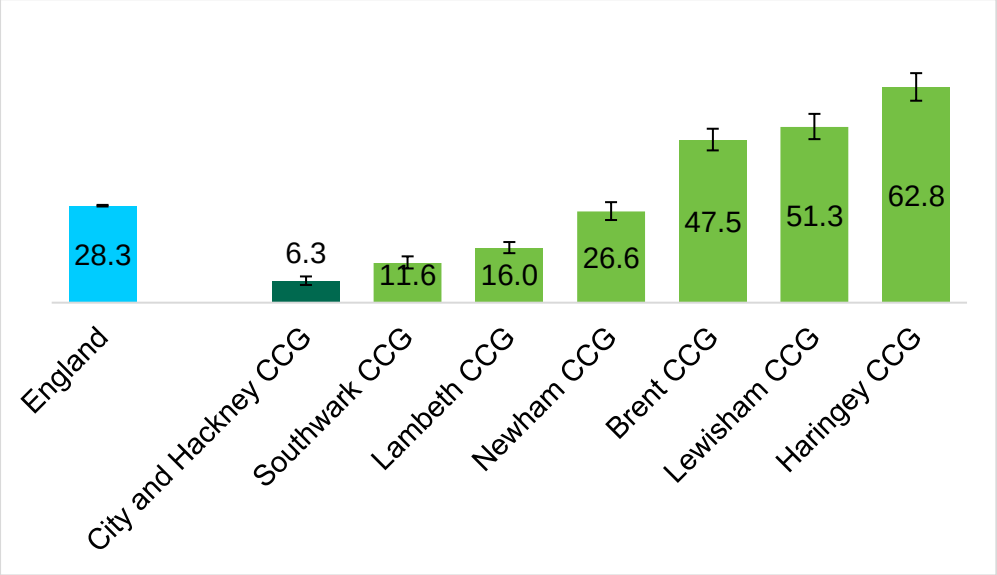
Value not available for London.
Data from Mental Health Minimum Data Set Reports, analysis by Public Health England.

Delayed discharge

Figure 17 shows that City and Hackney has very low rates of delayed discharge in comparison to England and its statistical peers.

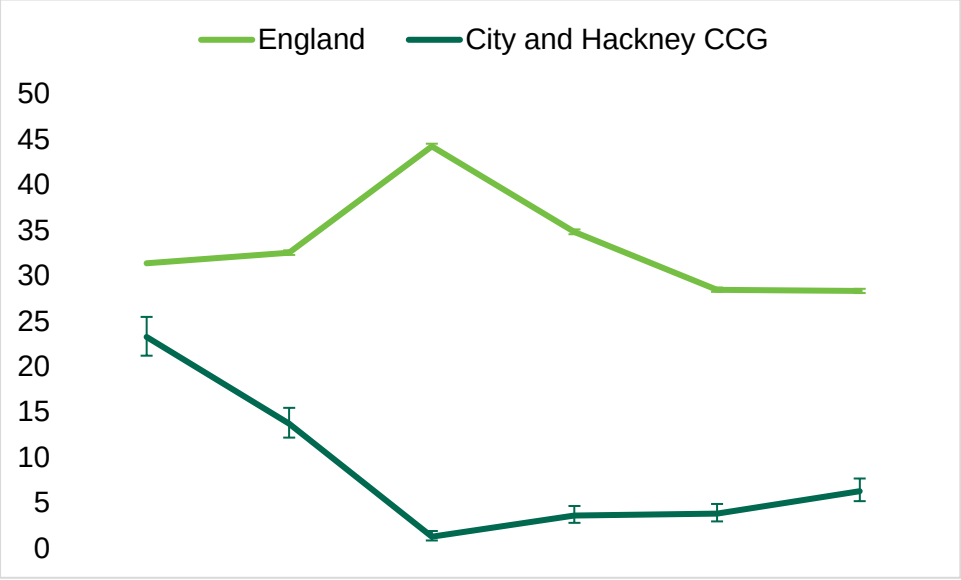
Figure 18 shows that while rates of delayed discharge have been low for the entire period for which data are available, they hit a particular low in Q3 2013/14 and have remained at this level, pointing to good progress in this area.

Figure 17: Days of delayed discharge per 1,000 bed days all ages (Q2 2014/15)



City and Hackney CCG value statistically significantly lower than England.
Value not available for London.
Data from Mental Health Minimum Data Set Reports, analysis by Public Health England.

Figure 18: Days of delayed discharge per 1,000 bed days over time all ages (Q1 2013/14 - Q2 2014/15)



Value not available for London.
Data from Mental Health Minimum Data Set Reports, analysis by Public Health England.

3.6. Evidence for what works

Box 11: The recovery model

The 'recovery model' for mental health forms a central part of NICE guidance and NHS policy for those living with severe and enduring mental ill health.

The model states that people with mental ill health should be supported in a hopeful, person-centred manner to achieve their goals and ambitions and live a meaningful, satisfying life as they define it. It emphasises hope, agency and opportunity for people with mental ill health, as well as social inclusion and 'interdependency' (the ability both to be supported by and to support peers). Each individual is recognised as the expert on their own experience.

It moves away from a medical focus on symptomatic relief as the only aim for those with mental ill health, and allows the individual to decide how important that aspect is to their quality of life. While the name may be suggestive of a defined end point (when someone has 'recovered'), in fact the name is based on the concept from alcohol misuse treatment of being 'in recovery' as a potentially life-long process.

http://www.centreformentalhealth.org.uk/making-recovery-a-reality

Box 12: Service user experience

The fifteen NICE Quality Standards for adult service user experience in mental health emphasise:

- *Patient-centred care* – Those using mental health services should feel optimistic and respected, should share in decision-making (including crisis planning), and should be supported in self-management.
- *Access and information* – People should have access to services as needed, and should understand the process and their options at every stage.
- *Support and continuity* – People's emotional and cultural needs should be recognised and supported, and continuous, supportive relationships should develop between service users and service providers.
- *Reduction in stigma* – This is important both in the community and in those providing services.

For those receiving inpatient care, control, restraint and compulsory treatment must be used at the minimum possible levels.

https://www.nice.org.uk/guidance/CG136/chapter/Quality-statements

The principles summarised in Boxes 11 and 12 apply to all severe and enduring mental health conditions. Table 3 presents some key points from NICE guidance for the specific conditions of bipolar disorder, psychosis and schizophrenia, and personality disorders.

Table 3: Key points from the NICE pathways for bipolar disorder, psychosis and schizophrenia, and personality disorders

	Prevention	Identification	Treatment	Ongoing support
Bipolar disorder **(NICE pathway)**	Not covered in pathway. A literature review conducted for the 2014 *City and Hackney Mental Health Needs Assessment* found no evidence supporting interventions to prevent or delay the onset of bipolar disorder.	In primary care, when a patient presents with depression this may also be an opportunity for identifying bipolar disorder – however, full assessment and diagnosis should take place in a specialist mental health service.	Treatments may include psychological interventions and medication. Psychological interventions should be delivered by therapists with specific training in working with people with bipolar disorder.	Bipolar disorder may be managed in primary care, secondary care, or under a shared care arrangement between primary and secondary care. Patients may move between primary and secondary care depending on their needs and stability. It is important to monitor the physical health of those with bipolar disorder on at least an annual basis.
Psychosis and schizophrenia **(NICE pathway)**	For those identified as having a high risk of developing psychosis (see 'Identification'), therapy is recommended but antipsychotic medication is not. Monitoring and follow up for those who continue to appear at risk but are not diagnosed with psychosis	Assessment and diagnosis should take place in a specialist mental health service. In a primary setting, if someone with high risk factors such as a first-degree relative with psychosis or schizophrenia begins to show signs of developing psychosis, they should	People with a first episode of psychosis should be offered medication and therapy. This should take place in secondary care or in consultation with specialist mental health services. Acute episodes of psychosis require specialist care which may	Outside acute episodes, people with psychosis may receive care in a primary or secondary setting, depending on the stability of their recovery. Interventions for promoting recovery may include therapy and medication. Supported employment programmes are recommended for

	Prevention	Identification	Treatment	Ongoing support
	should continue for up to three years.	receive an immediate referral.	take place in a community or inpatient setting.	those who wish to return to work; education or training may be appropriate for those unable to work. It is important to monitor the physical health of those with psychosis on a regular basis.
Personality disorders **(NICE pathway)**	Not covered in pathway. A review conducted by the Centre for Mental Health found strong evidence that evidence-based early interventions for conduct disorder reduce symptoms and behaviour linked to antisocial personality disorder.[xix] For more details on the long-term outcomes of early intervention, see the Links between physical and mental health section of this chapter	Identification of personality disorders may be possible in those accessing mental health services for comorbid conditions, or in those in contact with the criminal justice system or social care system due to behaviours associated with these conditions.	NICE guidance stresses the importance of autonomy and choice in the treatment of personality disorders, with service users playing an active role in considering treatment options and other choices open to them.	Multi-agency care is often appropriate for people with personality disorders. This may involve the criminal justice system as well as health and social care providers. People with personality disorders should not be excluded from health or social care services because of their diagnosis or behaviours associated with that diagnosis, such as a history of offending behaviour or self-harm.

3.7. Services and support available locally

3.7.1. Prevention

Many severe and enduring mental health problems begin in childhood. For childhood mental health interventions that may have preventative or mitigating benefits into adulthood, please see Children and Young People section of this chapter.

3.7.2. Identification

Identification of severe and enduring mental ill health can occur in primary care, secondary care (for mental or physical health services) or outside the health service – for instance, in the criminal justice system or social care.

Primary care: Identification is supported in primary care by the Tavistock and Portman NHS Foundation Trust's City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS) and ELFT's Enhanced Primary Care Service. Both services aim to support those who have mental health needs that cannot be met by mainstream GP services but who are not immediately suitable for Improving Access to Psychological Therapies (see Section 2 of this chapter) or referral to secondary services. The PCPCS is particularly targeted at those with difficulty engaging with services, which may include those with personality disorders.

Acute secondary care: Identification in healthcare settings such as A&E and inpatient services at the Homerton University Hospital NHS Foundation Trust (HUHFT) is supported by the trust's Rapid Assessment, Interface and Discharge (RAID) Service, which provides specialist assessments and referrals.

Criminal justice: Identification in criminal justice settings is supported by ELFT's Liaison and Diversion Service, which has been running as part of the London Wave 1 Liaison and Diversion Trial Scheme since April 2014. This is one of 25 trial schemes currently running in England. The schemes aim to identify, assess and refer those with mental ill health in contact with the criminal justice service as early as possible.

3.7.3. Treatment, care and support

Early intervention: For those aged 18-35 who have recently experienced psychotic symptoms or who are at a high risk of developing psychosis, ELFT offers an Early Intervention Service.

Crisis services: Crisis services are available through ELFT. This includes the Crisis and Emergency, Liaison and Home Treatment Team for those who require urgent assessment, and inpatient care for those who need a period of hospital admission. There is a 24hr crisis line in operation.

Ongoing support: Long-term support for those with severe and enduring mental ill health is available through ELFT, GP practices and local voluntary sector organisations.

ELFT offers a range of services, including Community Mental Health Teams, Community Rehabilitation and Recovery Teams, Psychotherapy, Occupational/Arts Therapy, Assertive Outreach, and Therapeutic Communities.

Forensic Services (for those convicted of a crime who need specialist treatment and care) are also provided by ELFT, but are commissioned nationally rather than locally.

GPs' roles vary depending on the level of support received from secondary care. For service users whose conditions are managed wholly in primary care, GPs provide regular monitoring of service users' mental and physical health, including any adjustments to medication or referrals to other services.

The City and Hackney Wellbeing Network is a network of voluntary sector mental health services commissioned by the London Borough of Hackney and the Corporation of the City of London. One of its functions is to support those with severe and enduring mental ill health 'to substantially improve their quality of life and avoid unnecessary hospital admissions'.

3.8. 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.

[i] [Web page] Royal College of Psychiatrists. (2015) Problems and disorders. *Retrieved 14th August 2015 from* http://www.rcpsych.ac.uk/healthadvice/problemsdisorders.aspx
[ii] National Collaborating Centre for Mental Health. (2014).Bipolar disorder: The NICE guideline on the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care. NICE CG 185. http://www.nice.org.uk/guidance/cg185/evidence/cg185-bipolar-disorder-update-full-guideline3
[iii] Mueser, K.T. & McGurk, S.R. (2004). Schizophrenia. Lancet 363(9426): 2063-72. http://www.ncbi.nlm.nih.gov/pubmed/15207959
[iv] [Web page] NHS Choices. Psychosis – Causes. *Retrieved 14th August 2015 from* http://www.nhs.uk/Conditions/Psychosis/Pages/Causes.aspx
[v] National Collaborating Centre for Mental Health. (2013). Antisocial Personality Disorder: The NICE guideline on treatment, management and prevention. NICE CG 77. https://www.nice.org.uk/guidance/cg77/evidence/cg77-antisocial-personality-disorder-full-guideline3
[vi] National Collaborating Centre for Mental Health. (2009). Borderline Personality Disorder: The NICE guideline on treatment and management. NICE CG 78. http://www.nice.org.uk/guidance/cg78/evidence/cg78-borderline-personality-disorder-bpd-full-guideline3
[vii] Parsonage, M., Khan, L. & Saunders, A. (2014). Building a better future: The lifetime costs of childhood behavioural problems and the benefits of early intervention. Centre for Mental Health. http://www.centreformentalhealth.org.uk/building-a-better-future
[viii] Health & Social Care Information Centre (2014). Organisational reference tables, Annual Report from MHMDS Returns – England 2013/14. http://www.hscic.gov.uk/catalogue/PUB15990
[ix] Singleton, N., Bumpstead, R., O'Brien, M., Lee, A. & Meltzer, H. (2001). Psychiatric morbidity among adults living in private households, 2000. Office for National Statistics. http://www.ons.gov.uk/ons/rel/psychiatric-morbidity/psychiatric-morbidity-among-adults-living-in-private-households/2000/psychiatric-morbidity-among-adults-living-in-private-households.pdf
[x] Goodwin, F.K & Jamison, K.R. (1990). Manic-Depressive Illness: Bipolar Disorders and Recurrent Depression. Oxford University Press.
[xi] Mathers, C.D., Stein, C., Fat, D.M., Rao, C., Inoue, M., Tomijime, N., Bernard, C., Lopez, A.D. & Murray, C.J.L. (2002). Global Burden of Disease 2000: Version 2 methods and results. World Health Organisation. http://www.who.int/healthinfo/paper50.pdf
[xii] Known as the "Mental Illness Needs Index 2000" or "MINI2K": Glover, G. R., Arts, G., & Wooff D. (2004) A needs index for mental health care in England based on updatable data. *Social Psychiatry and Psychiatric Epidemiology*, 39, 730– 738. MINI2K available from http://www.apho.org.uk/resource/item.aspx?RID=48886
[xiii] Greater London Authority. (2015) GLA 2014 Round SHLAA Capped Household Size Model Short Term Migration Scenario Population Projections. http://data.london.gov.uk/dataset/gla-population-projections-custom-age-tables
[xiv] Kendall, T., Pilling, S., Tyrer, P., Duggan, C., Burbeck, R., Meader, N., Taylor, C. (2009) Borderline and antisocial personality disorders: summary of NICE guidance. BMJ 338:b93. http://www.bmj.com/content/338/bmj.b93
[xv] Department of Health. (2011). No Health Without Mental Health: A cross-Government mental health outcomes strategy for people of all ages: Analysis of the Impact on Equality: Annex B – Evidence Base. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213764/dh_124514.pdf
[xvi] [Web page] NICE Quality Standards. (2015). Psychosis and schizophrenia in adults: Quality statement 1: Referral to early intervention in psychosis services. *Retrieved 4th September 2015 from* http://www.nice.org.uk/guidance/qs80/chapter/quality-statement-1-referral-to-early-intervention-in-psychosis-services
[xvii] McManus, S., Meltzer, H., Brugha, T., Bebbington, P. & Jenkins, R. (2009). Adult psychiatric morbidity in England, 2007: Results of a household survey. NHS Information Centre for Health and Social Care. http://www.esds.ac.uk/doc/6379/mrdoc/pdf/6379research_report.pdf
[xviii] [Web page] Public Health England. Severe Mental Illness Profiles. *Retrieved 1st December 2015 from* http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/data
[xix] Khan, L., Parsonage, M. & Stubbs, J. (2015). Investing in children's mental health: A review of evidence on the costs and benefits of increased service provision. Centre for Mental Health. http://www.centreformentalhealth.org.uk/investing-in-children-report