Kent Joint Strategic Needs Assessment (Kent JSNA)

Kent 'Adult Mental Health' JSNA Chapter Summary Update '2014/15'

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Kent Adult Mental Health JSNA Chapter Update 2015

Summary and Refresh 2015 [1]

Mental Health in Context

> Mental health is everyone's business – individuals, families, employers, educators and communities all need to play their part. Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential.
>
> No health without mental health (DH 2011)[i]

The Chief Medical Officer (CMO), in her 2013 Public Health report, states that mental Illness is the largest single cause of disability and represents 23% of the national disease burden in the UK. It is the leading cause of sickness absence, accounting for 70 million sick days in 2013. It costs the UK economy £70–£100 billion per year; 4.5% of Gross Domestic Product. [ii]

Adults with mental health problems are one of the most socially excluded groups in society often stigmatised and failing to receive the support they need to maintain their physical health. People with severe mental illness die on average 15–20 years earlier than those without, often from avoidable causes. This is an unacceptably large "premature mortality gap". [iii]

The Government's national mental health strategy *No health without mental health* (2011) estimates that one in four adults will experience a mental health problem at some point in their lives and one in six adults has a mental health problem at any one time. The CMO has flagged the impact and importance of the *Time To Change* campaign - the national campaign to end mental health stigma: www.timetochange.org.uk

Aims

This mental health needs assessment has three aims:

- to gather information to plan, negotiate and change services for the better and to improve health in other ways
- to build a picture of current services, ie a baseline
- to encourage discussion on why services might need changing for the better.

Objectives

The objectives of the mental health needs assessment are:

[1] Updated May 2015. This Summary chapter does not cover children's mental health, adult drug use, alcohol use, adults with learning disabilities, dementia and domestic abuse. These issues are covered in other chapters of the JSNA.

Intelligence: it provides a baseline of the current picture of mental health in Kent which can then be used to measure the impact of interventions or service development.

Planning: to help decide what services are required ie for how many people, the effectiveness of these services, the benefits that will be expected, and at what cost.

Efficiency: having assessed needs, measuring whether or not resources have been appropriately directed ie do those who need a service get it? This is related to audit.

Equity: reduce health inequalities through early identification and improving the spatial allocation of resources between and within different groups.

Involvement of stakeholders: conducting a mental health needs assessment can stimulate the involvement and ownership of the various stakeholders in the process and ensure that the Kent Live it Well Strategy has active engagement from all those effected by mental illness. This will be a priority for 2015. Since no single source of information will provide a true picture, this mental needs assessment has identified four areas which, we believe, taken together provide a good body of evidence.

These are:

- analysis of risk factors
- expected prevalence of mental health conditions
- service utilisation vs expected need
- mortality indicators

This JSNA Chapter provides an updated Kent-wide summary of the comprehensive mental health needs assessment where data is available. The CCG area needs assessments, which are tailored to each of the Kent CCGs, are available at http://www.kpho.org.uk. These cover the adult 'working age' population and do not assess needs of children and young people. This is tackled in an update of the Children and Young People's Mental Health Needs Assessment available separately. Some elements that impact on young people, however, will also be tackled here, such as self-harm. This report will not assess the needs of dementia sufferers. It will touch briefly on the mental health of older people, but this is an area that demands a needs assessment of its own.

The challenge of data quality

Where possible we have compared local data to national or regional data. Occasionally it is not possible to break data down to CCG level for Health and Wellbeing Boards and countywide data is also provided.

Data quality for many aspects of this needs assessment is poor. It has been almost impossible to make an overall assessment of service use and need. Nationally this is also a problem therefore this does not single Kent out – however improvements to data input and output are vital for commissioning.

It should also be noted that due to the different modelling approaches used within this needs assessment to demonstrate the various needs of the mentally ill

population of Kent and the CCGs, overall numbers must be viewed with caution and discrepancies may exist.

The data and datasets set out and explored here are not the full picture of mental health in Kent and its eight NHS CCGs. This Needs Assessment will only make a contribution to a wider assessment of population-based need which is beyond the scope of this report. This will require discussion with commissioners, service providers, patients, carers and others to:

- evaluate existing services
- understand capacity and pathways, in relation to evidence of best practice
- understand patient perspectives
- take account of views of patients and their carers on different aspects of care and support.

Mental Health some Definitions

2.1 What is mental health?

Mental health is defined as a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2003)[iv]

There are two main categories of mental illness:

a **Common mental illness** It is estimated that one in four people will experience 'common mental illness' (depression or anxiety) at some point in their life. (National Adult Psychiatric Morbidity Survey, Meltzer 2001). Common mental illness is often described as neurotic disorder in psychiatric surveys.

b **Severe mental illness** It is estimated that three in every 1,000 people will experience 'severe and enduring mental illness' (schizophrenia, psychosis and bipolar disorder). (Oxford Textbook of Psychiatry)

New to the landscape of mental illness are the terms, 'mental wellbeing' and 'recovery' which acknowledge that everyone has a mental health and those people with mental illness can recover and live productive lives. Mental illness affects people in all ages and stages of life, across society, impacting upon family life, friends and relationships, education, finding work, working, caring for others, leisure pursuits and retirement, as well as the impacts purely characteristic of the disorder.

2.2 Links between mental health and physical health

Mental health and physical health are interconnected. [v] People with mental illness suffer from higher rates of illness and premature life expectancy. People with long-term physical health conditions are at increased risk of suffering from a mental illness (Kings Fund, 2012). [vi] One reason why people with mental health problems suffer and die earlier from physical health problems is because their physical health is often neglected. For example:

a People with schizophrenia die 10 years younger than the general population.
b Higher rates of heart disease, stroke, high blood pressure, breast and bowel cancer and diabetes are experienced by people with a serious mental illness.
c People with a serious mental illness are more likely to develop significant health problems at a younger age than the general population, and die sooner from them.
d Depression at age 65 is linked with a 70% risk of dying early.
e A depressed/anxious person who has suffered a heart attack is up to three times more likely to die within two years of having an attack.
f An anxious person has a five times higher risk of dying from coronary heart disease.
g People with mental health problems are more prone to factors that lead to worse health outcomes, such as poor diet, smoking, drug and alcohol misuse and low rates of physical activity. [vii]

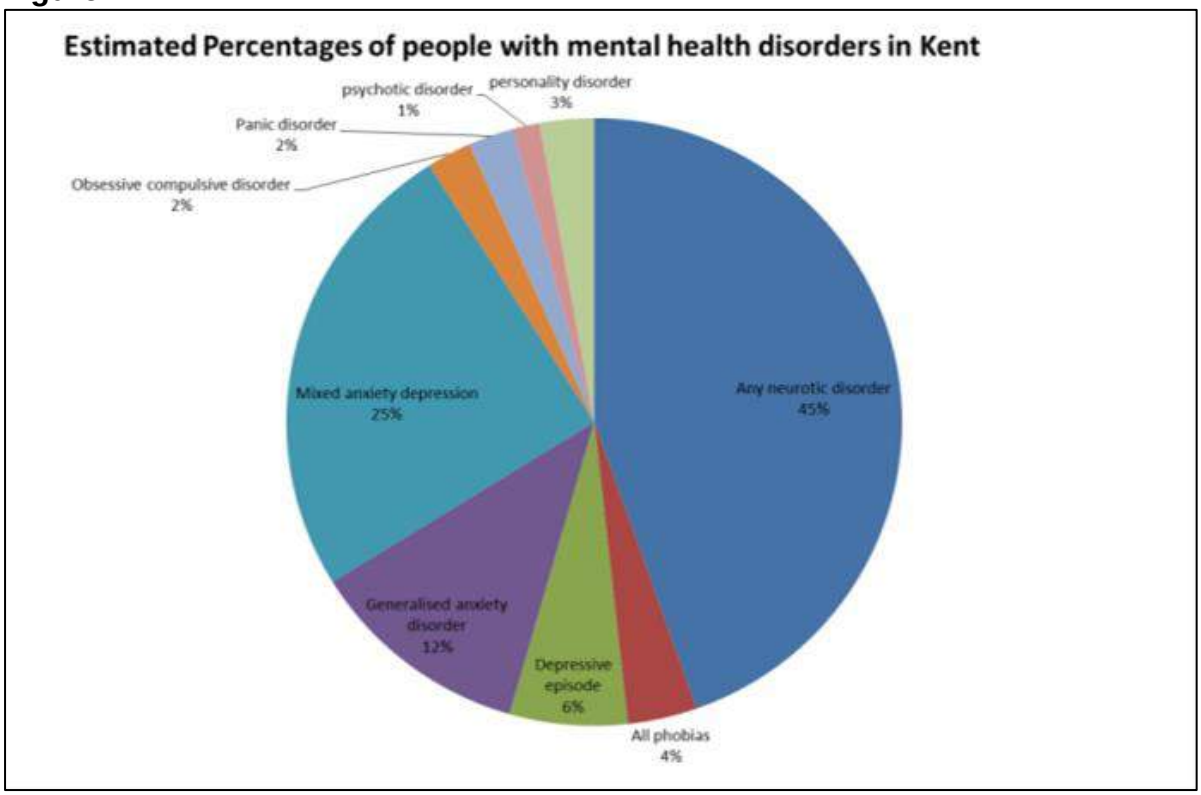
The UK Government strategy: No Health without Mental Health sets out a life course approach that aims to improve outcomes for people with mental health problems and build individual and community resilience and wellbeing in order to prevent mental ill health. The National Strategy is structured around six shared objectives:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

Prevalence of Mental Health Disorders

Some mental health problems are extremely common. Up to one in four people will experience mental health problems at some point in their lives (lifetime prevalence), with approximately one in six suffering from mental health problems at any one time (point prevalence snapshot). The 2007 Adult Psychiatric Morbidity Survey[viii] found that one in seven people aged between 16 and 74 will have two or more disorders. Other conditions are more rare eg psychosis. Figure 1 below sets out the percentage of people with mental health disorders in Kent

Figure 1:



Source: McManus et al 2007 APMS

Many factors affect a person's mental health, from biological to social factors. Some factors are fixed (age) and some factors can be influenced such as:

- family and socio-economic characteristics (marital status, number of children, employment)
- individual circumstances (life events, social supports, immigrant status, debt), household characteristics (accommodation type, housing tenure)
- geography (urban/rural, region)
- societal factors (crime, deprivation).

Groups with higher than expected common mental illness rates are:

- prisoners
- dual diagnosis (drug and alcohol)
- people with a learning disability
- travellers
- offenders and ex-offenders in the community
- students
- economic migrants
- people who experience domestic violence
- people with a disability
- lesbian, gay, bisexual and transgender people.

Applying national survey data, 144,558 people will have a neurotic disorder (Table 1) and this is 12.5% of the total registered population of Kent (aged 18-64). [ix]

Table 1:

Estimated prevalence of common mental illnesses in Kent, by CCG, 2013/14

Area	**Any neurotic disorder**	All phobias	Depressive episode	Generalised anxiety disorder	Mixed anxiety depression	Obsessive compulsive disorder	Panic disorder
NHS Ashford CCG	**11626**	951	1615	3058	6470	612	616
NHS Canterbury and Coastal CCG	**20015**	1637	2780	5265	11138	1054	1060
NHS Dartford, Gravesham and Swanley CCG	**24436**	1998	3394	6428	13599	1287	1294
NHS South Kent Coast CCG	**19905**	1628	2765	5236	11077	1048	1054
NHS Swale CCG	**10640**	870	1478	2799	5921	560	564
NHS Thanet CCG	**12949**	1059	1799	3406	7206	682	686
NHS West Kent CCG	**44987**	3679	6249	11834	25035	2369	2383
Kent	**144558**	11822	20080	38028	80446	7611	7657

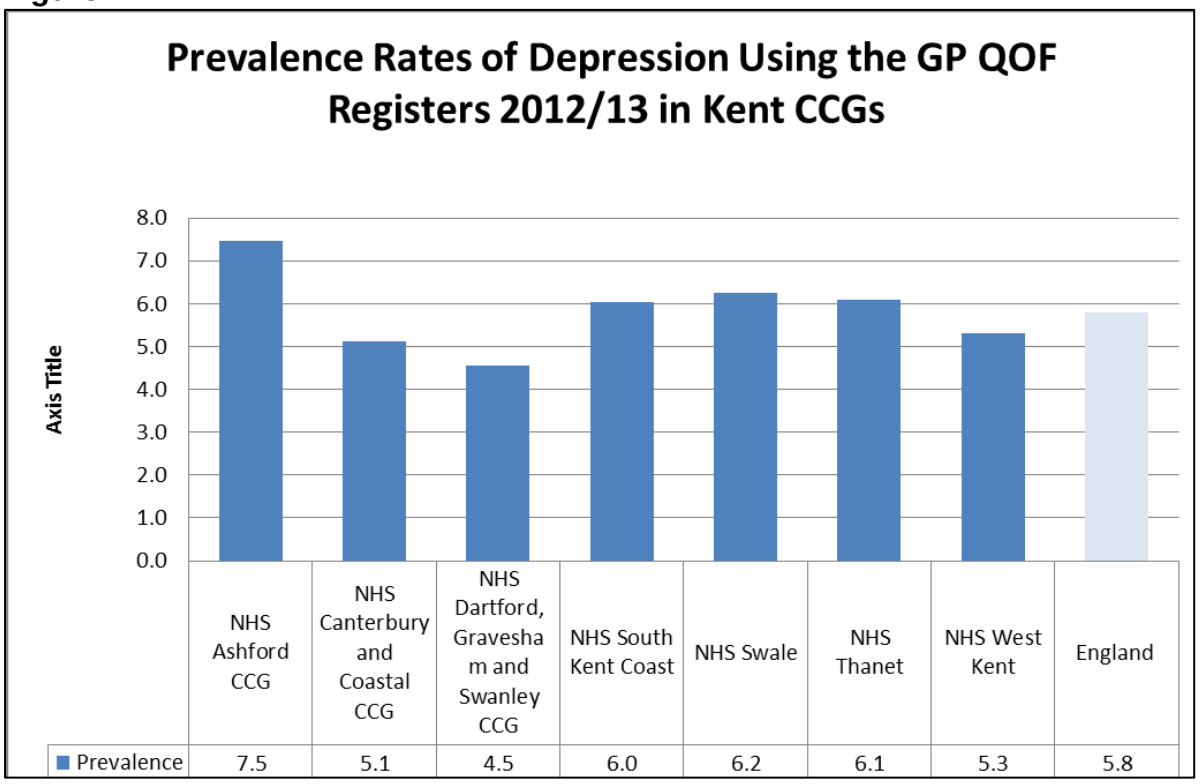
Source: NEPHO, ONS

Half of all adult mental health problems occur before age 15 and 75% before 18 [x]. Tackling problems when they first emerge is both important and cost effective. People who had severe conduct problems in childhood are more likely to have no educational qualifications, be economically inactive and be arrested. [xi] A separate Children's Mental Health Needs Assessment is available. [xii]

3.1 Prevalence of patients recorded with depression on GP systems

As part of the GP contract, which commenced on 1st April 2004, general practices obtain points for achievements against a range of indicators. The system is known as the Quality and Outcomes Framework (QOF) and is used for calculating financial payment. QOF shows the prevalence of patients within the CCG localities who are recorded on a GP register as suffering from depression and on the GP practice mental health register. The mental health register includes patients with schizophrenia, bipolar disorder and other psychoses. Although there is variation between areas, these figures are based on practice registers so differences in recording can affect these prevalence figures. The figures are unadjusted for influencing factors, such as the age of patients in the practice and deprivation.

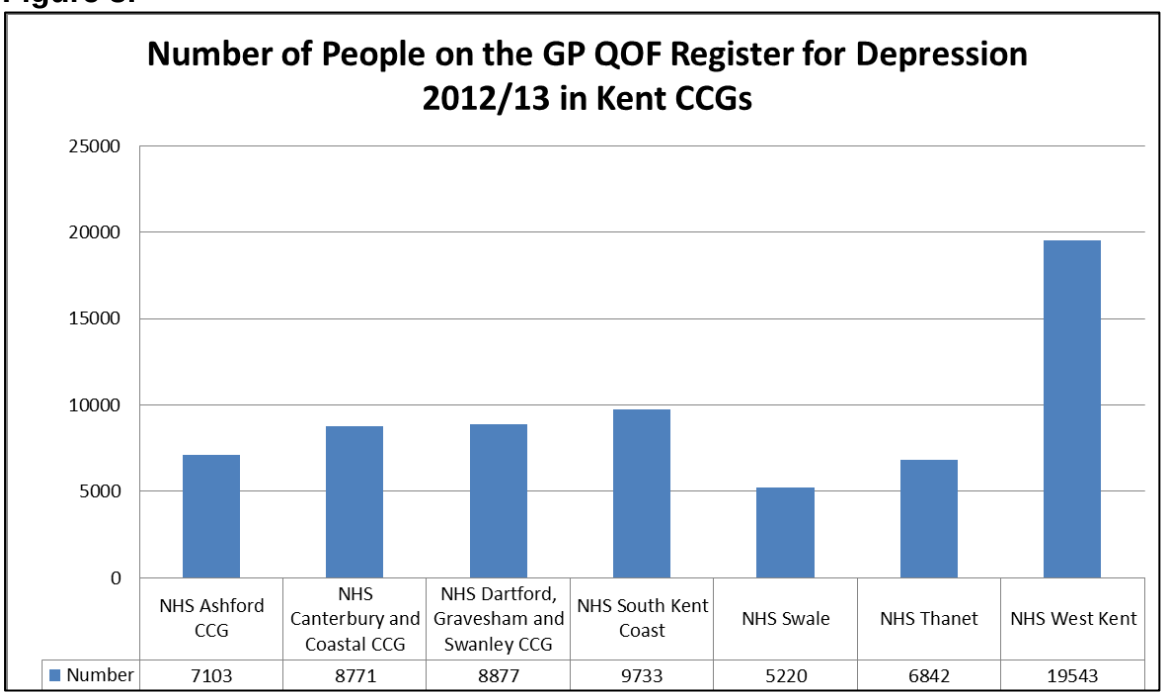
Figure 2:



Source: QOF 2013

For depression QOF rates, Ashford CCG has the highest prevalence rates in Kent compared to the England average. Thanet, Swale and South Kent Coast CCG have slightly higher than the England average for depression (Figure 3). There are just over 66,000 people on the QOF depression register in Kent as a whole.

Figure 3:



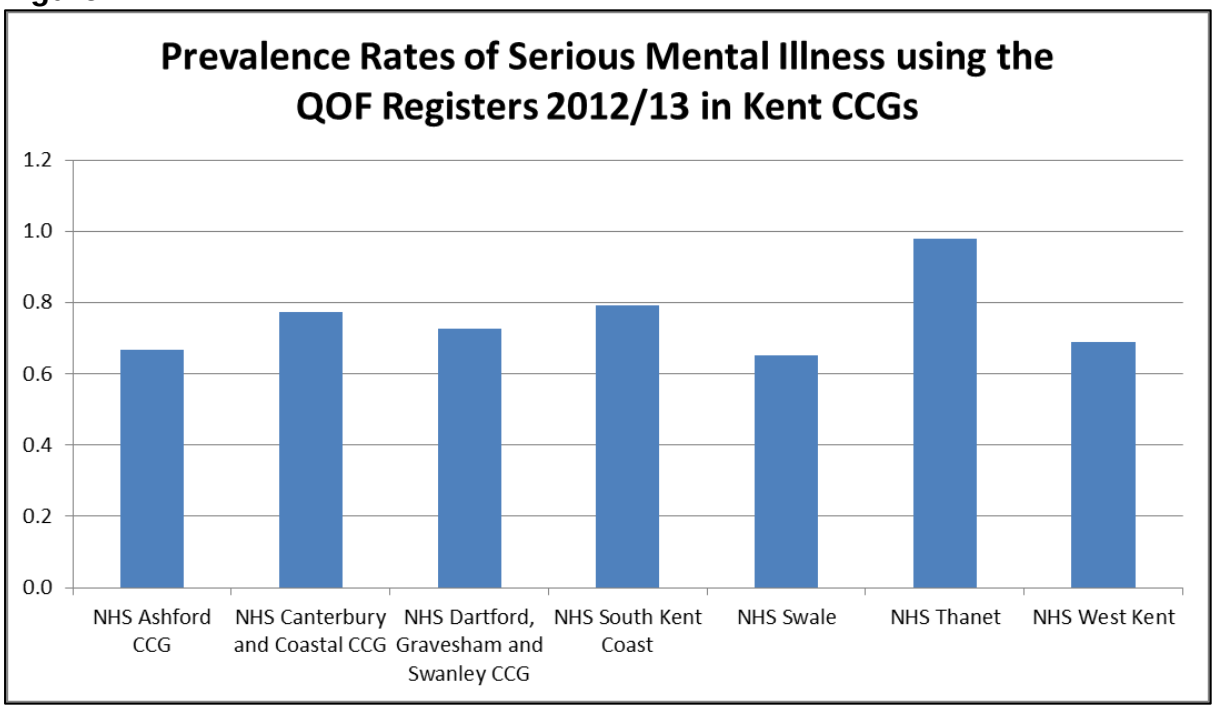
QOF 2013

Kent & Medway Public Health Observatory

Kent County Council kent.gov.uk

The prevalence rate for serious mental illness for England is 0.8 and only one CCG, Thanet, has rates higher than the England average (Figure 4).

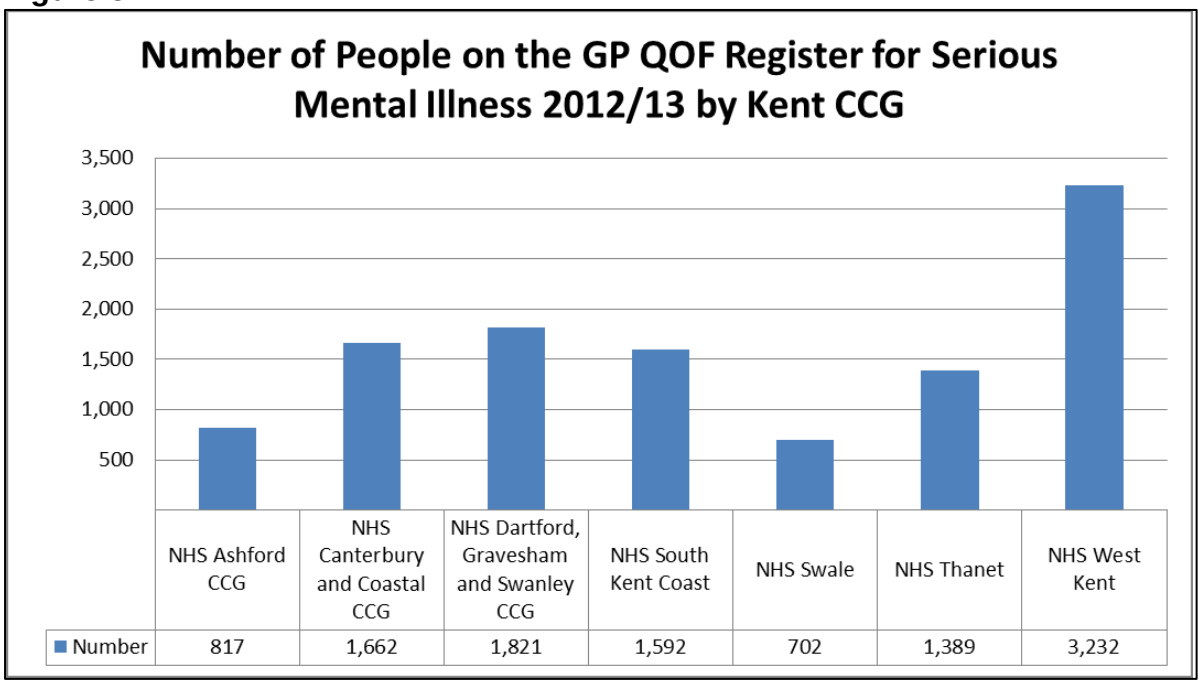
Figure 4:



Source QOF 2013

South Kent Coast CCG has the second highest rates in Kent, followed by Canterbury and Coastal CCG. Across the whole of Kent there are 11,215 people on the QOF register for serious mental illness in 2012-13. West Kent CCG has the highest numbers due to its larger population (Figure 5).

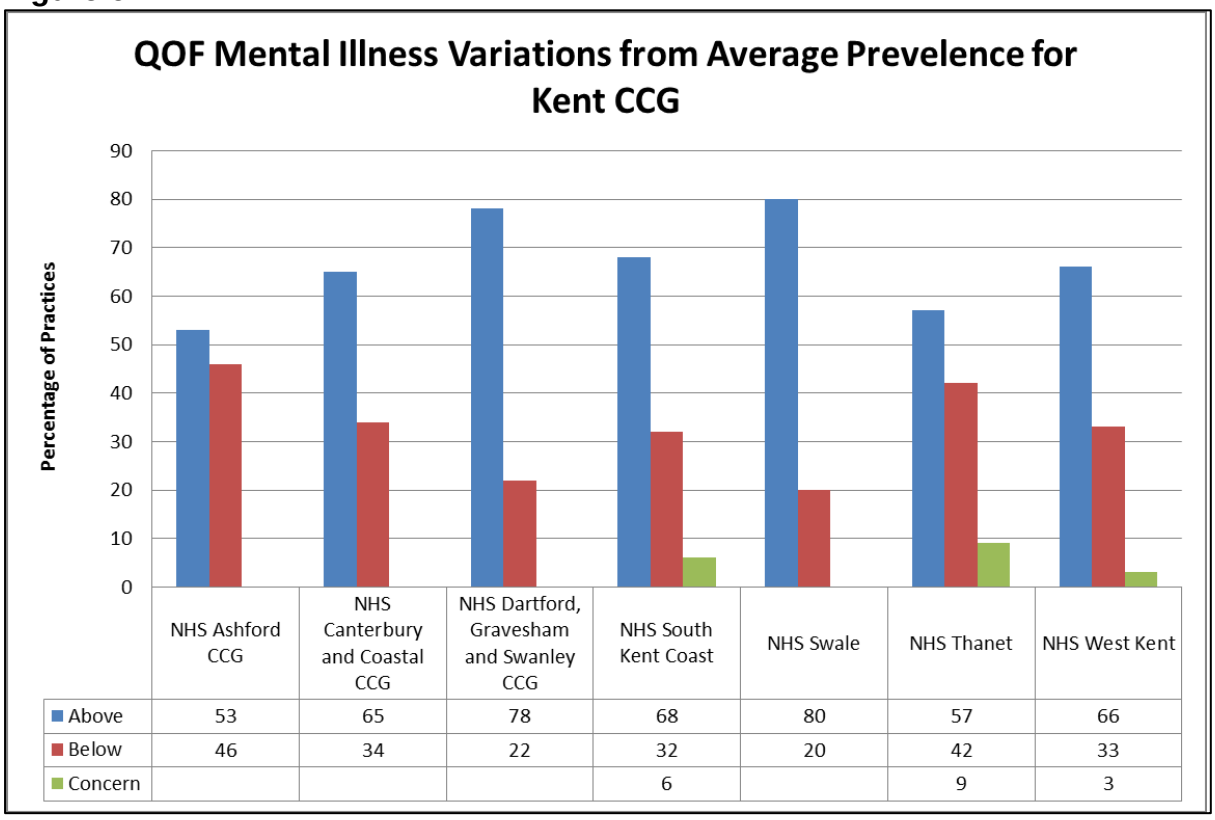
Figure 5:



Source QOF 2013

SKC CCG, Thanet CCG and West Kent CCG QOF data have variations that need further analysis (Figure 6).

Figure 6:



Source KMPHO

In the North of Kent (DGS & Swale CCGs) there are a high percentage of practices meeting the expected needs of patients in primary care for serious mental illness. This is a general indicator that GPs are managing patients appropriately.

Table 2:

Expected Prevelence compared To QOF					
		QOF 2011/12	APMS 2007		
	Depression	Mental Health	1 MH condition (23%)	2+ MH Conditions (7.2)	GAP%
NHS Ashford CCG	12661	793	20598	6448	35
NHS Canterbury and Coastal CCG	15863	1570	36522	11433	52
NHS Dartford, Gravesham and Swanley CCG	14867	1761	41297	12928	60
NHS South Kent Coast	16536	1573	33428	10465	46
NHS Swale	8668	670	17844	5586	48
NHS Thanet	12731	1348	23099	7228	39
NHS West Kent	38182	3135	76935	78171	39

Source KMPHO 2014

Overall the CCG with the highest GAP in unmet need in 2011-12 was DGS CCG (Table 2).

Who is at Risk of Mental Illness and Why?

In this chapter we will cover risks associated with mental illness:

- high risk groups
- deprivation
- long-term conditions
- groups with high prevalence of mental illness.

4.1 High risk groups

There are a number of groups within the population that are at particularly higher risk of developing mental health problems. Targeted intervention for groups at higher risk of mental illness can prevent a widening of inequalities in comparison with the general population. Those at higher risk of mental illness include individuals who have experienced violence or abuse, black and minority ethnic individuals, those with intellectual disability and homeless people. *No health without mental health* noted that the evidence on the incidence of mental health problems in black and minority ethnic groups (BME groups) is complex. This is due to the fact that the term BME covers many different groups with very different cultural backgrounds, socio-economic status and experiences in wider society. Table 3 sets out the percentage risk for key vulnerable groups in Kent

Table 3: Risk of mental health problems in key vulnerable groups.

	Percentage at risk of mental health problems	Estimated number with mental health problems in Kent
Gypsies and travellers	35%	3,500[2]
People who are lesbian, gay or bi-sexual	39.4%	9,450[3]
People with a learning disability	25%	1,125[4]
Those with severe or profound hearing impairment	33.3%	3,000[5]
Marital status: separated	23.3%	7,643
Marital status: divorced	27.1%	30,600
Adult survivors of childhood sexual abuse (*with significant levels of neurotic symptoms*)	12.4%*	13,290[6]
Released prisoners	90%	4,387[7]
Carers	18%	25,000 [8]

[2] Gypsy and Traveller needs assessment KMPHO
[3] University of Kent 2009
[4] PHE Profiles
[5] KCC We Are The People of Kent 2008
[6] Baker & Duncun : Child Sex Abuse, A study in Prevalence in Great Britain. 1985 Child Abuse Neglect sited in Centre for Health and Social Research paper "A safe Place to Talk: Needs Assessment of Adult Survivors of Sexual Abuse" 2001
[7] Approximate number from http://www.kentprobation.org/index.php?page=15

Sufferers of hate crime	60%	742[9]
Adolescents leaving care to live independently	80%	144
Veteran and ex-military*	1-6%	12,000[10]

** Please see Specific Needs Assessment for more details – young military reservists are at higher risk then non-reservists and ex-military aged 18-25 are 50% more likely to commit suicide then general population.*

Prisoners have a twenty-fold higher risk of psychosis, with 63% of male remand prisoners having an antisocial personality disorder, compared with 0.3% of the general population. A separate needs assessment for prisoners is available.

Gypsies and travellers are also at a higher risk of stigma and discrimination and a separate needs assessment for this group is also available.

The remainder of this chapter will describe the risks to three key groups: older people, carers and mothers

4.2.1 Older people with mental illness in Kent

Older age is the single most important predictor for cognitive decline and dementia. Older adults are also particularly at risk of social isolation, as they withdraw from the labour market (which may deprive them of a steady income) and become more susceptible to chronic disease (which may deprive them of their mobility, independence and cognitive skills).

Feelings of isolation can also come about due to the loss of their partner or friends to illness, or due to inattentive or uncaring family members. Social and family isolation, and also bereavement, are significant predictors of depression in older age.

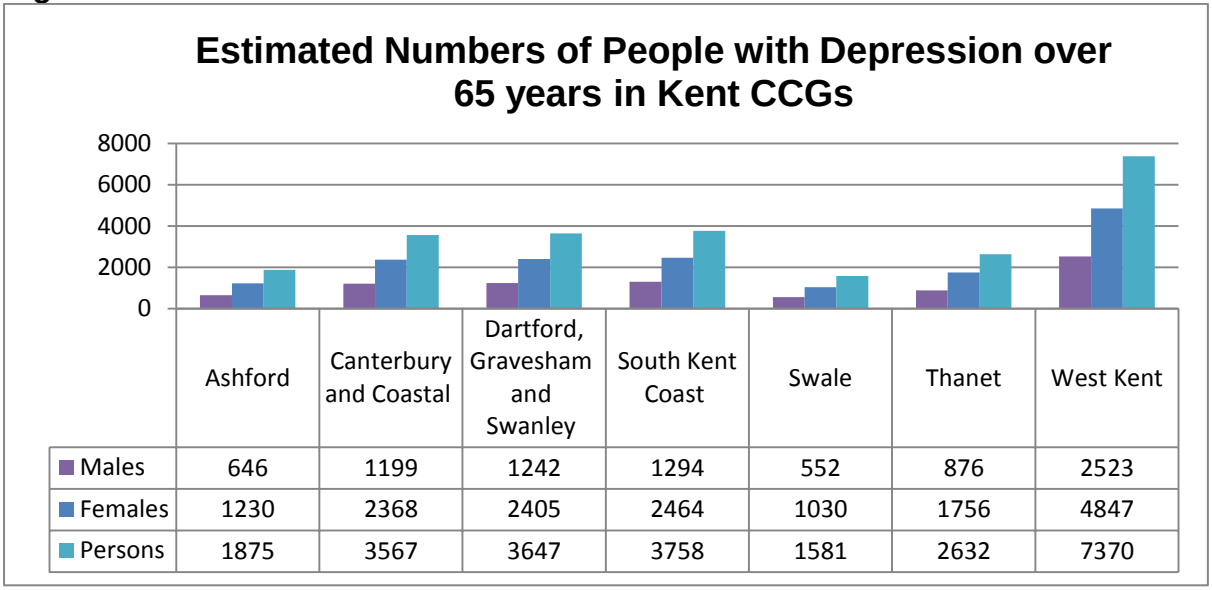
Since chronic physical illness is also a risk factor for depression, the higher prevalence of physical health conditions amongst older people further contributes to elevated rates of depression (Figure 7). Depression in older people is estimated in, and can affect up to, 25% of the population and up to 40% of those living in care homes.[xiii]

[8] Applying national rate from Kent Carers Strategy to Kent Registered adult population

[9] Karlsen, S. & Nazroo, J. Y. (2002) The relationship between racial discrimination, social class and health among ethnic minority groups. American Journal of Public Health

[10] Veteran and Ex-military needs assessment: Dr.Grace Howarth & Jess Mookherjee : K&MPHO 2011

Figure 7:



	Ashford	Canterbury and Coastal	Dartford, Gravesham and Swanley	South Kent Coast	Swale	Thanet	West Kent
Males	646	1199	1242	1294	552	876	2523
Females	1230	2368	2405	2464	1030	1756	4847
Persons	1875	3567	3647	3758	1581	2632	7370

Source: KMPHO 2014

4.2.2 Estimates of the prevalence of schizophrenia and psychosis for older people

One per cent of people over 65 have psychotic illness and half of these have schizophrenia.[xiv] The King's Fund report 'Paying the Price[xv] indicates prevalence rates of 2.6 and 3.6 per 1,000 for schizophrenia in the 64-74 age group (reducing among the older age bands). However, the prevalence of bipolar disorder reduced markedly in the over 65 age group, to approximately 0.2 per 1,000.

4.3 Mental health and wellbeing of carers

The Mental Health of Carers Study (Singleton, 2012) presented the prevalence rates amongst carers of common mental disorders. It found 21% of female carers suffered depression or anxiety and 23% were more likely to have neurotic disorders than women in general. [xvi] Over 91% of carers were not receiving any medication, counselling or therapy for mental, nervous or emotional problems.

The percentage of adult carers who have as much social contact at they would like according to the Personal Social Services Carers survey, is a key Public Health England (PHE) Outcome (PHE Outcome 1.18ii).

The Carers JSNA Chapter Update 2013-14 on the KMPHO website notes that older carers are more likely to be providing unpaid care than younger people, and providing more hours of care. Nearly 14% of people aged 65 or over provide care with more than quarter of these providing 50 hours or more.

Table 4: Personal Social Services Carers Survey 2012/13

	Kent	South East	England
PHOF 1.18ii - Percentage of respondents with as much social contact as they would like.	**33.8**	**40.2**	**41.3**

Source: Personal Social Services Carers Survey 2014

Kent is an outlier for Outcome 1.18ii (Table 4) In 2012-13 only 33.8% of respondents to the Personal Social Services Carers Survey had as much social contact as they would like; compared with 40.2% in the South East and 41.3% in England.[11]

4.4 Maternal mental health

Maternal mental health is an important issue and psychiatric disorders are the leading cause of maternal deaths in the UK.

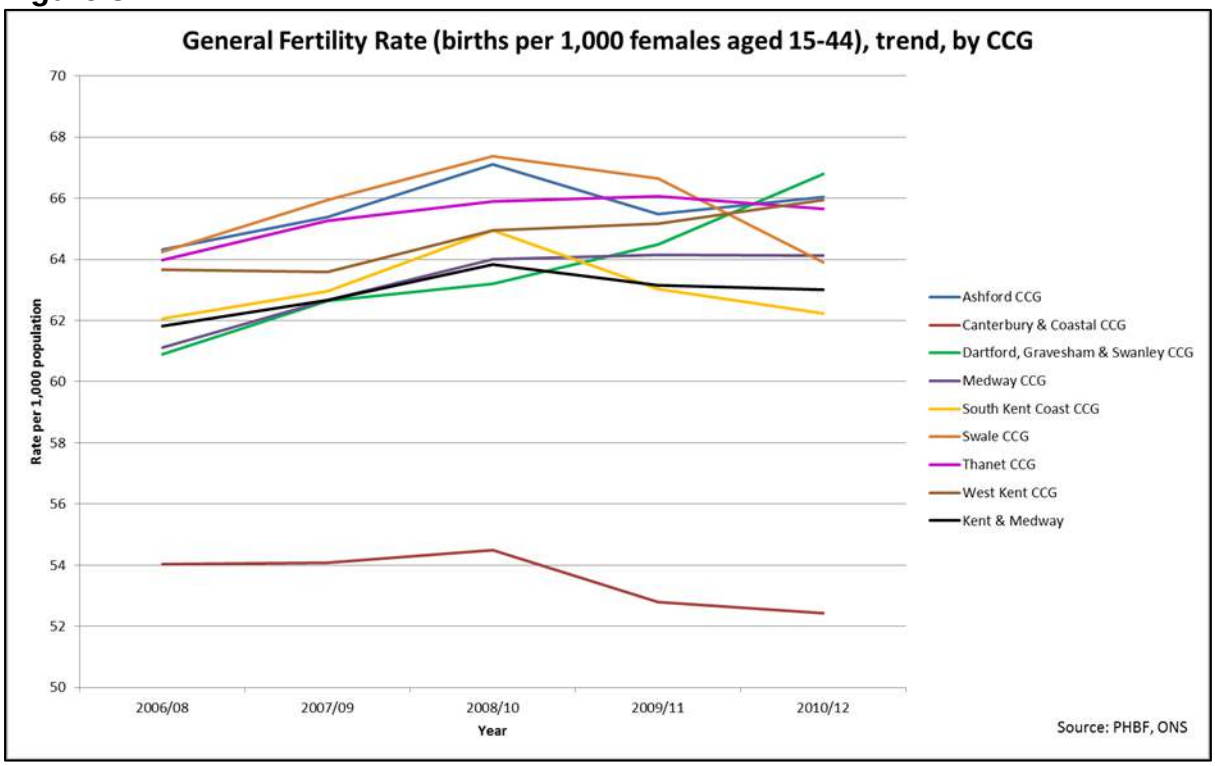
The importance of good maternal mental health is well documented by the World Health Organisation, both for mother and the future development of the child. Women who are chronically depressed are less likely to understand cues from their baby with regard to hunger, distress or happiness and are less likely to breastfeed. [12] With fewer interactions children can become less social and do not perform as well in cognitive and other development tests at the age 18 months to two years.

The number of live births in Kent has fluctuated over the past three years for which data is available with an average of just over 17,600 births per year see Figure 8 for rates per CCG.

[11] PHE Outcomes Framework

[12] http://www.who.int/mental_health/maternal-child/en/ [accessed May 2015]

Figure 8



Source: KMPHO 2013

4.4.1 Postnatal depression

Prevalence of postnatal depression is estimated at between 10-15% (RCPSych). Applying the lower prevalence to Kent live births 2011 for maternal mothers ages 15-44, the estimates for 2011 are derived. In Table 5 the prevalence is projected to 2015 using average growth rate in birth between years 2007-2011.

Table 5: Estimated numbers of women with postnatal depression

CCG	2011	2015
Ashford CCG	148	155
Canterbury and Coastal CCG	202	212
Dartford, Gravesham and Swanley CCG	322	338
South Kent Coast CCG	208	218
Swale CCG	139	145
Thanet CCG	167	175
West Kent CCG	552	579
Kent	**1738**	**1823**

Sources. Public Health Birth file, and CCG and District population distribution

4.4.2 Table 6 below sets out the rates of psychiatric disorders including postpartum psychosis (commonly known as puerperal psychosis). Puerperal psychosis presents in the early postnatal period, up to three months after delivery and is a

severe and relatively rare form of postnatal mental illness affecting between 0.1 and 0.2% of all new mothers.

Table 6: Rates of perinatal psychiatric disorder per thousand maternities

Rates of perinatal psychiatric disorder per thousand maternities	
Postpartum psychosis	2 in 1000
Chronic serious mental illness	2 in 1000
Severe depressive illness	30 in 1000
Mild-moderate depressive illness and anxiety states	100-150 in 1000
Post-traumatic stress disorder	30 in 1000
Adjustment disorders and distress	150-300 in 1000

Source: Guidance for commissioners of perinatal mental health services. Joint Commissioning Panel for Mental Health (JCPMH).

4.4.2.1 Teenage mothers face additional risks

Teenage pregnancy is associated with a range of poor outcomes for both mother and child. Teenage mothers are at increased risk of postnatal depression and poor mental health, are more likely than older mothers to have low educational attainment, be unemployed or living in poverty at age 30. Their children experience higher rates of infant mortality and low birth weight, A&E admissions for accidents and have a much higher risk of being born into poverty.

4.4.3 What is best practice?

A comprehensive perinatal mental health strategy should encompass all levels of service provision no matter if those services are commissioned by the NHS Commissioning Board or Clinical Commissioning Groups. Robust care pathways, education, training and resourcing of non-specialists is essential to ensure that "the right patient reaches the right service where they are seen by the right professional at the right time". [13]

A full Maternal Mental Health Needs Assessment will be completed in the autumn of 2015.

Deprivation and Mental Health Inequality

Major risk factors for mental health problems are poverty, poor education, unemployment, social isolation and major life events. People in deprived areas face more of these challenges than those living in less deprived areas and, as a result, are at higher risk of developing mental health problems. [xvii] A review of large scale studies of mental health problems undertaken by Social Exclusion Unit of the Cabinet Office in 2004 [xviii], reported that mental health problems are more common among people who are unemployed, have fewer educational qualifications, have

[13] Guidance for commissioners of perinatal mental health services. Joint Commissioning Panel for Mental Health (JCPMH).

been looked after or accommodated, are on a low income or have a low standard of living.

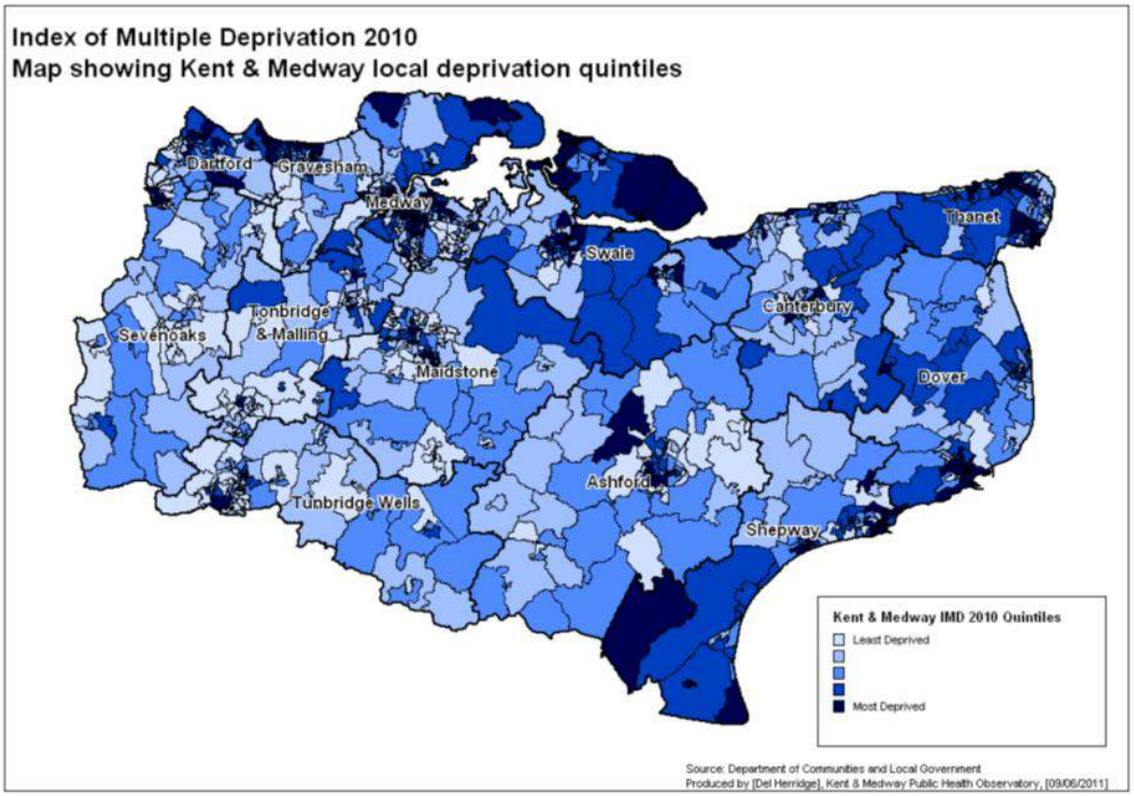
In summary the main reasons for the link between deprivation and mental health risk are:

- increased risk of major traumatic life events and stressors
- poorer coping strategies leading to poorer resilience
- feelings of shame and inferiority and exclusion resulting from social comparison. [xix]:

In 2007-08 19.7% of households in Kent were estimated to be in poverty, after housing costs.[xx] For the KCC area alone the proportion was 19.5%. The average proportion of households in poverty for the KCC area places the county 102nd out of 152 county and unitary authorities. This is within the lowest third of authorities (one being the most poor).

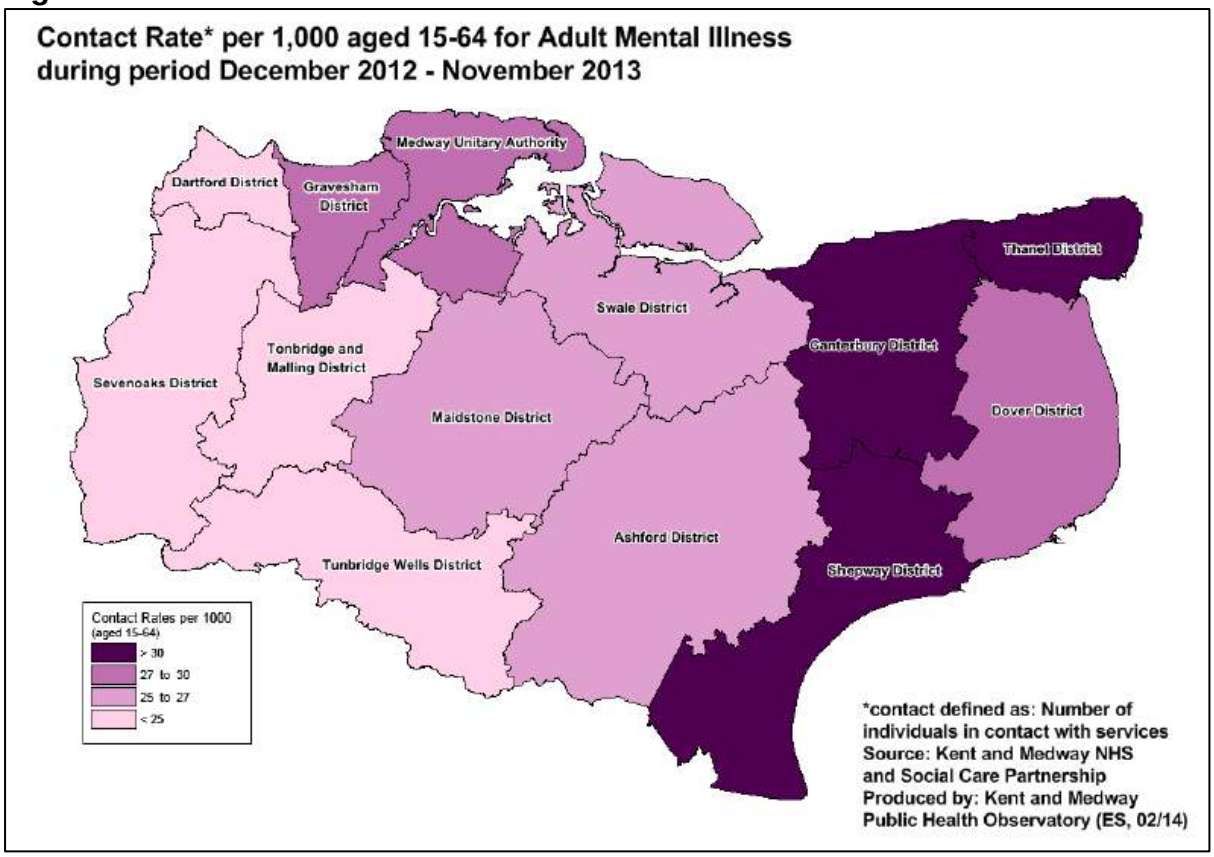
There is also a great degree of variation in poverty within each Kent district. Seven of the 12 Kent districts have middle layer super output areas (MSOAs) which are in both the national highest and lowest 20% of households in poverty, illustrating that areas with relatively high poverty levels are located close to areas with relatively low levels. This is particularly apparent in Shepway, where 23% of the district's MSOAs are within England's highest 20% in poverty, and yet 15% are within England's lowest 20% in poverty. The highest levels of deprivation are seen by communities living within the district of Thanet, Swale, Medway and Dartford and Gravesham (see Figure 9). There are pockets of deprivation in West Kent, mainly to the east of the CCG and in the urban areas.

Figure 9



KMPHO 2013

Figure 10: Contact rates for Mental Health Services in Kent



Kent & Medway Public Health Observatory

Kent County Council kent.gov.uk

The map in Figure 10 above presents the differing contact rates across Kent per 1,000 of the population with Community Mental Health Teams (CMHTs). It correlates significantly with social deprivation (Figure 9).

5.1 Long-term conditions and deprivation

Having a long-term condition increases the risk of a mental health problem. Overall, the evidence suggests that at least 30% of all people with a long-term condition also have a mental health problem. [xxi] People with long-term conditions and comorbid mental health problems disproportionately live in deprived areas and have access to fewer resources of all kinds. The interaction between comorbidities and deprivation makes a significant contribution to generating and maintaining inequalities. [xxii]

The Level of Need in the Population

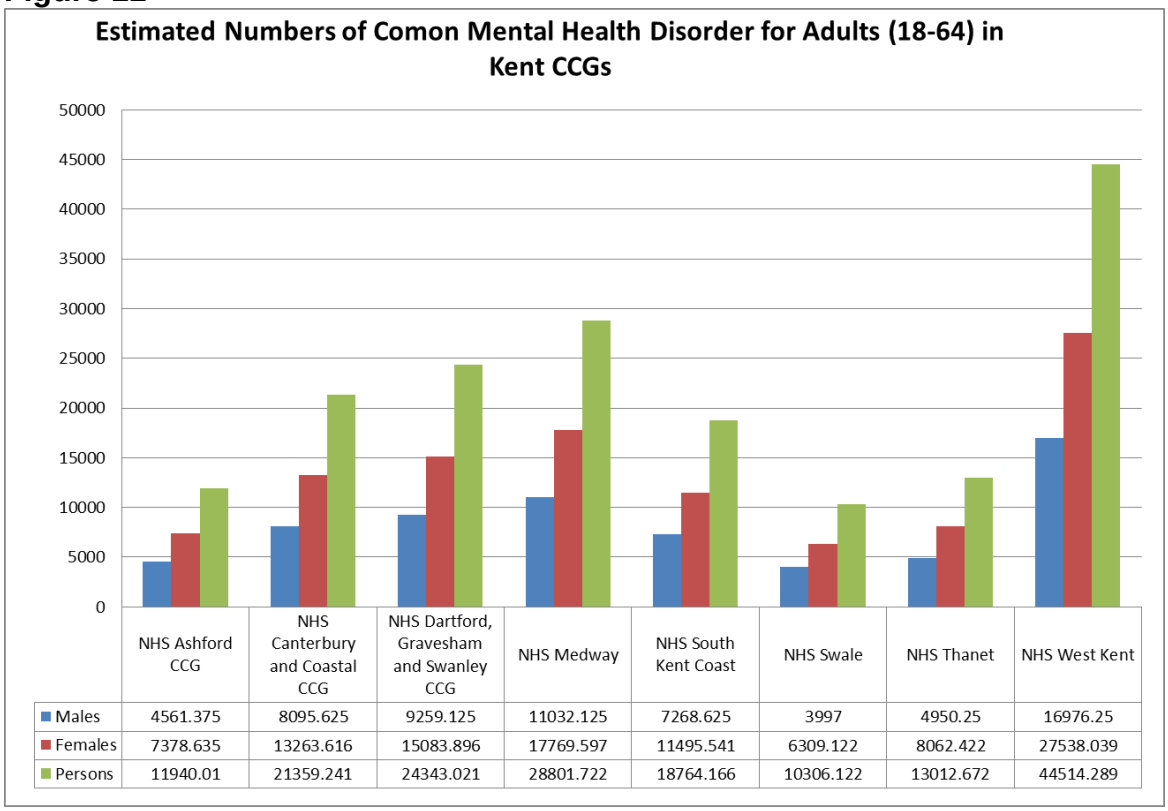
The key mental health issues explored in this chapter are:

- common mental health problems
- serious mental illness
- dual diagnosis
- eating disorders
- suicide and self-harm

6.1 Common mental health problems in working aged people (16-65)

Nearly one third of GP consultations are related to common mental health problems such as anxiety and depression.

Figure 11



	NHS Ashford CCG	NHS Canterbury and Coastal CCG	NHS Dartford, Gravesham and Swanley CCG	NHS Medway	NHS South Kent Coast	NHS Swale	NHS Thanet	NHS West Kent
Males	4561.375	8095.625	9259.125	11032.125	7268.625	3997	4950.25	16976.25
Females	7378.635	13263.616	15083.896	17769.597	11495.541	6309.122	8062.422	27538.039
Persons	11940.01	21359.241	24343.021	28801.722	18764.166	10306.122	13012.672	44514.289

Source: KMPHO 2007 APMS

In Figure 11 it can be seen that overall women show higher rates of CMDs than men, however there are a few age groups among certain conditions that buck this trend:

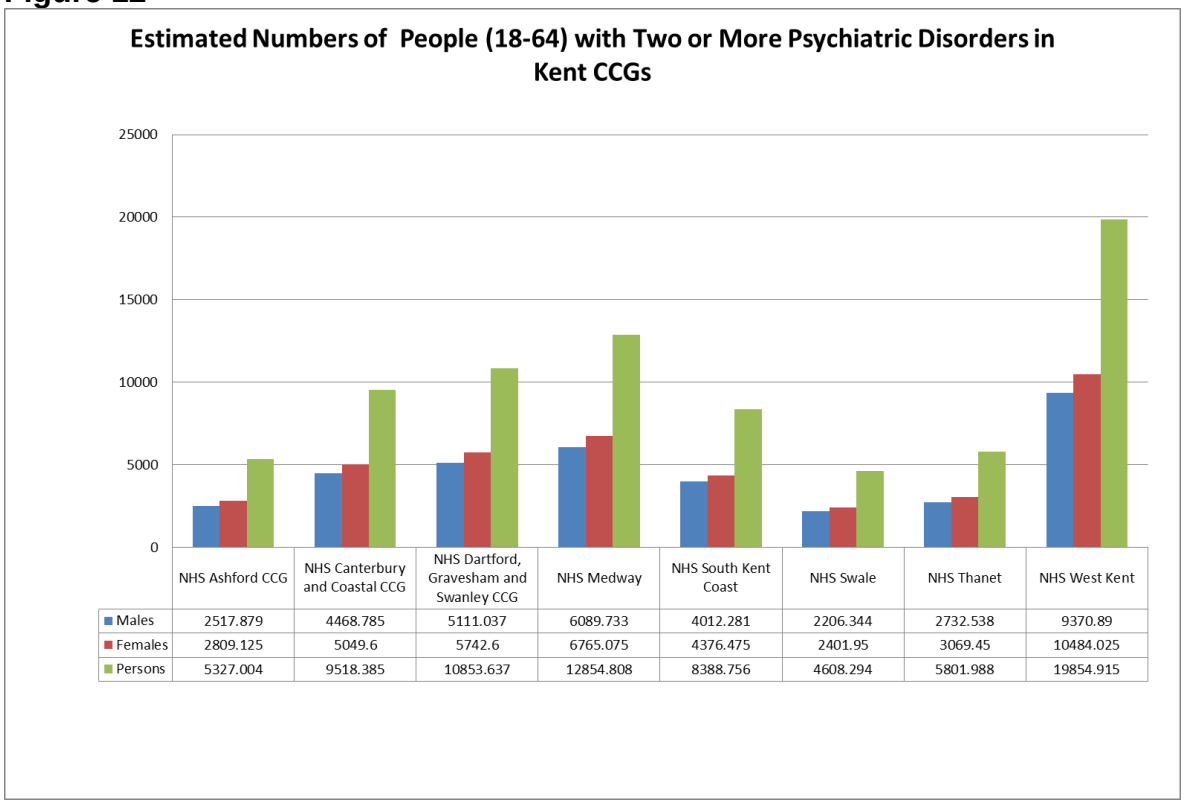
a Men aged 16-24yrs and 65-74yrs have higher predicted rates of panic disorder than women of the same age (men = 1.4% and women = 0.8% in 16-24 age group, men = 1.0% and women = 0.1% in 64-75 age group).
b Depression episodes are more common among men aged 25-34 than women of the same age range (2.7% and 1.7% respectively).
c Obsessive compulsive disorder was found to be slightly more prevalent in men aged 35-44 than women of the same age group (1.2% and 1.0% respectively) and equally prevalent among men and women aged 25-34 (1.5%).

These APMS 2007 estimates are based on national statistical models which take into account local circumstances such as, income, employment, age and rates of physical illness (co-morbidity). It is known that:

- common mental illness is more frequent in deprived areas
- rates of anxiety and depression are higher in older people
- common mental illness is more frequent in unemployed people
- rates of depression are higher in people with long-term physical health conditions

There is a note of caution when attempting to understand estimated numbers of people with mental health problems; many people have more than one problem (co-morbidity) which means that numbers will not necessarily add up to the total Kent population. The APMS 2007 statistical model estimates that 77,203 people in Kent are likely to have a co-morbidity of psychiatric conditions see Figure 12.

Figure 12



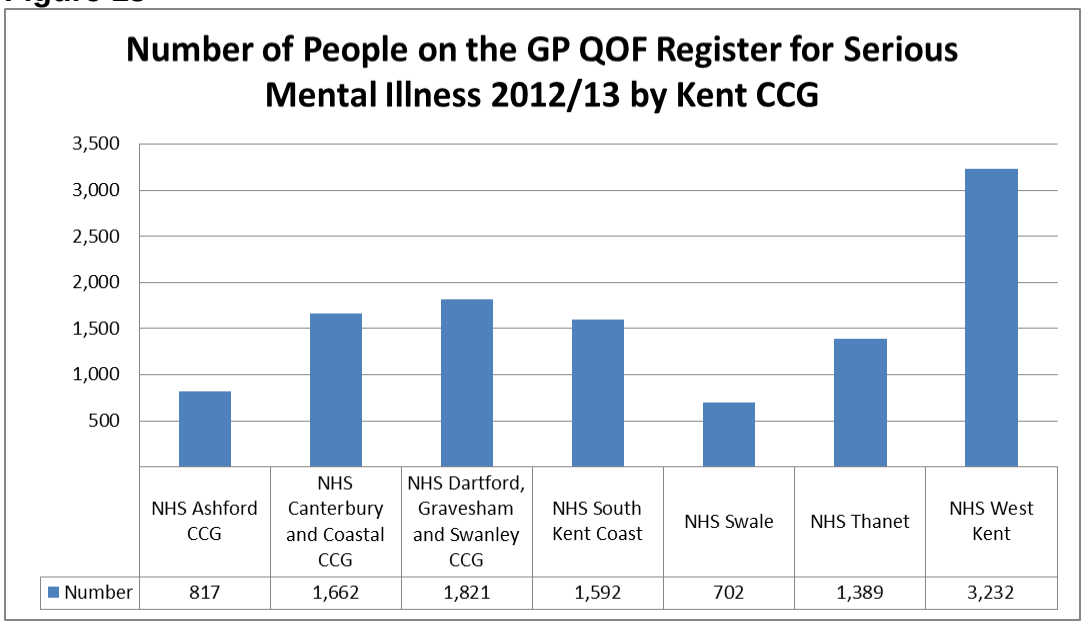
	NHS Ashford CCG	NHS Canterbury and Coastal CCG	NHS Dartford, Gravesham and Swanley CCG	NHS Medway	NHS South Kent Coast	NHS Swale	NHS Thanet	NHS West Kent
Males	2517.879	4468.785	5111.037	6089.733	4012.281	2206.344	2732.538	9370.89
Females	2809.125	5049.6	5742.6	6765.075	4376.475	2401.95	3069.45	10484.025
Persons	5327.004	9518.385	10853.637	12854.808	8388.756	4608.294	5801.988	19854.915

Source KMPHO 2013

6.2 Working aged people (16-65) with serious mental illness

There are 11,215 patients recorded on GP Quality and Outcomes Framework (QOF) registers as having a serious mental illness within Kent CCGs, see Figure 13. A full understanding of the epidemiology of severe mental illness is challenging due to changes to diagnostic criteria; the differences in the study populations; and the variability of the course and duration of illness.

Figure 13



	NHS Ashford CCG	NHS Canterbury and Coastal CCG	NHS Dartford, Gravesham and Swanley CCG	NHS South Kent Coast	NHS Swale	NHS Thanet	NHS West Kent
Number	817	1,662	1,821	1,592	702	1,389	3,232

Source QOF 2013

Kent & Medway Public Health Observatory

Kent County Council kent.gov.uk

There are broadly four categories of serious mental health problems. The conditions are:

- schizophrenia (or psychotic disorder)
- bipolar disorder
- personality disorder
- eating disorder

These conditions are explored further below.

6.2.1 Schizophrenia (or psychotic disorder)

The 2007 Adult Psychiatric Morbidity Survey found that the prevalence of probable psychosis was found to be 0.5% in adults aged 16-74yrs. Based on this analysis Table 7 presents the predicted rates of people with psychosis across Kent.

Table 7: Projected rates and increases of people with psychosis from 2013 to 2020 by Kent CCGs

Kent CCGs	2013	2016	2020
NHS Ashford CCG	310	315	325
NHS Canterbury and Coastal CCG	548	634	578
NHS Dartford, Gravesham and Swanley CCG	630	634	643
NHS South Kent Coast CCG	486	484	483
NHS Swale CCG	267	268	270
NHS Thanet CCG	338	343	351
NHS West Kent CCG	1156	1155	1159
Kent	4481	4509	4566

Source: KMPH0 2013

The mean age of first contact with mental health services for people with psychosis is between 25 and 35 years for both sexes, with women generally falling ill three to four years later than men.

The standardised mortality ratios in psychosis are 2.5 times those of the rest of the UK population.

6.2.2. Bipolar disorder (or affective disorder)

Bipolar disorder is a serious condition with around one person in 100 being diagnosed with the condition. Bipolar disorder can occur at any age, although it often develops in people who are between 18-24 years of age. Both men and women, and people from all backgrounds, can develop bipolar disorder. There is an estimated 15,030 people with bipolar disorder in Kent and Medway (Table 8).

Table 8: Number of people in Kent and Medway with Type 1 or Type 2 Bipolar Disorder for 2011 and 2021

Area	2011			2021	
	Male	Female	All	Female	All
Eastern and Coastal Kent	3,220	3,291	6,511	3,350	6,574
Medway	1,168	1,105	2,272	1,184	2,377
West Kent	3,035	3,212	6,247	3,144	6,166
Total	7,423	7,608	15,030	7,679	15,117

Sources: South East Plan Strategy-based (Nov 08): Population Forecasts by 5 year age group and gender. Population 15-64 used.
Assumed prevalence rate of 1.4%

6.2.3 Personality disorders

Personality disorder is a cluster of disorders that relate to abnormal responses and behaviours but where psychosis is not necessarily present. Personality disorder can exhibit as violent or criminal behaviour and in milder cases can be linked to behavioural problems or impulsivity.

Only antisocial and borderline personality disorders were assessed in the 2007 Adult Psychiatric Morbidity Survey, however there are a number of other personality disorders which tend to be grouped in to three groups (A - suspicious, B – emotional and impulsive, and C - anxious). Antisocial and borderline personality disorders are both part of group B, emotional and impulsive. People with antisocial personality disorder (ASPD) are characterised by the presence of three or more of the following criteria since the age of 15 or earlier and with characteristics persisting into adulthood (therefore diagnosis is only possible for over 18s):

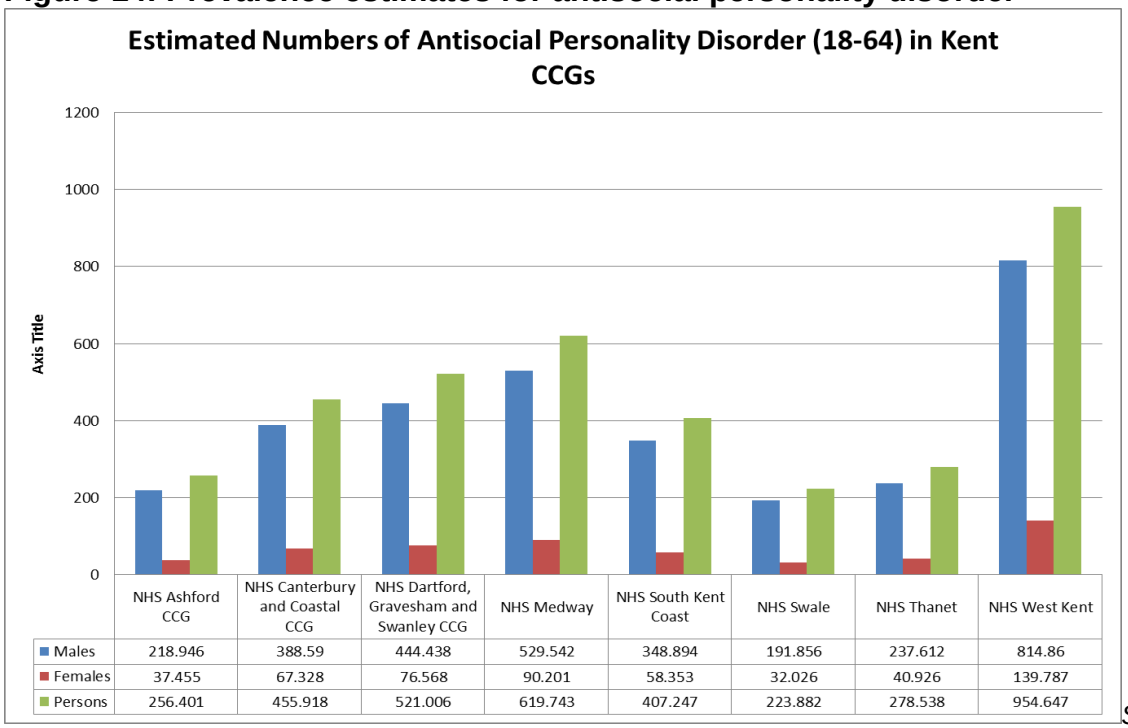
- irresponsibility
- deceitfulness
- indifference to the welfare of others
- recklessness
- a failure to plan ahead
- irritability and aggressiveness.

People with Borderline Personality Disorder (BPD) are characterised by the presence of five or more of the following criteria (with diagnosis possible in childhood):

- frantic efforts to avoid real or imagined abandonment
- pattern of unstable and intense personal relationships
- Unstable self-image
- impulsivity in more than one way that is self-damaging
- suicidal or self-harming behaviour
- affective instability
- chronic feelings of emptiness
- anger
- paranoid thoughts or severe dissociative symptoms (quasi-psychotic).

Nationally only 0.3 of respondents were diagnosed as having antisocial personality disorder and 0.4% as having borderline personality disorder. In Kent there are a predicted 3,713 people with antisocial personality disorder (Figure 14).

Figure 14: Prevalence estimates for antisocial personality disorder

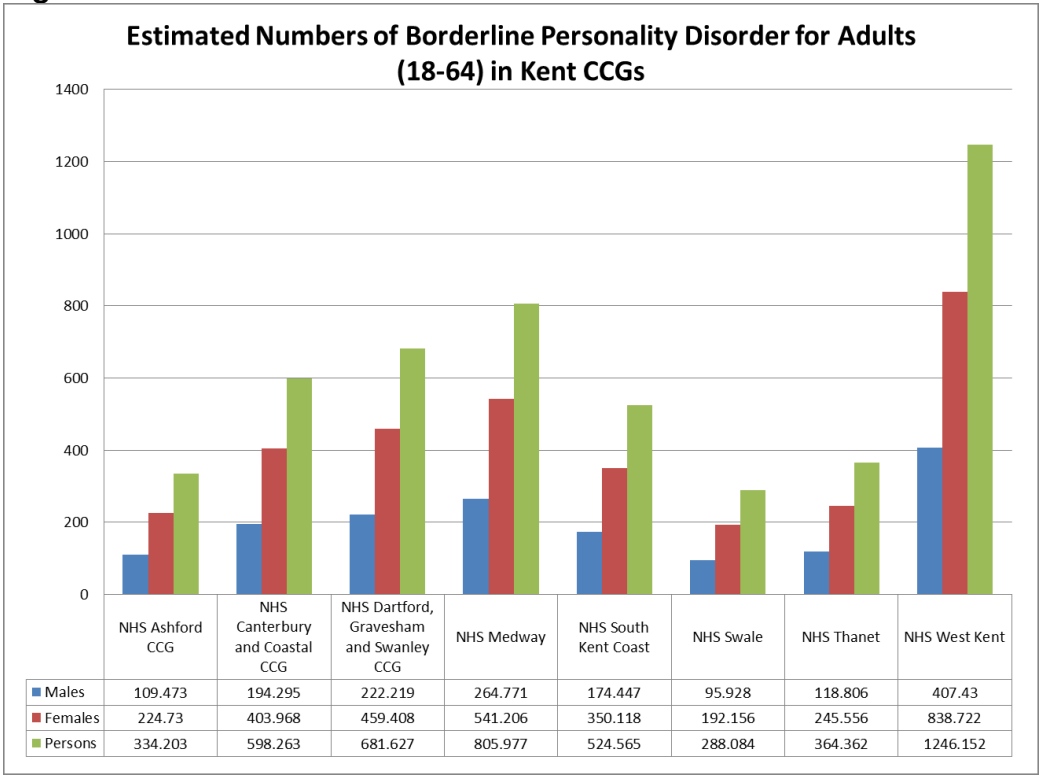


	NHS Ashford CCG	NHS Canterbury and Coastal CCG	NHS Dartford, Gravesham and Swanley CCG	NHS Medway	NHS South Kent Coast	NHS Swale	NHS Thanet	NHS West Kent
Males	218.946	388.59	444.438	529.542	348.894	191.856	237.612	814.86
Females	37.455	67.328	76.568	90.201	58.353	32.026	40.926	139.787
Persons	256.401	455.918	521.006	619.743	407.247	223.882	278.538	954.647

Source KMPHO 2014

In Kent there are a predicted 4,841 people with borderline personality disorder (Figure 15)

Figure 15



	NHS Ashford CCG	NHS Canterbury and Coastal CCG	NHS Dartford, Gravesham and Swanley CCG	NHS Medway	NHS South Kent Coast	NHS Swale	NHS Thanet	NHS West Kent
Males	109.473	194.295	222.219	264.771	174.447	95.928	118.806	407.43
Females	224.73	403.968	459.408	541.206	350.118	192.156	245.556	838.722
Persons	334.203	598.263	681.627	805.977	524.565	288.084	364.362	1246.152

Source KMPHO 2013

6.2.4 Adults with attention deficit disorder

People with attention deficit hyperactivity disorder are restless, disorganised, impulsive, and lack concentration. Most people will experience some of the symptoms of ADHD at some time however, people with ADHD consistently have many of the symptoms, which impairs normal functioning. This can lead to problems at work, being unable to maintain relationships and low self-esteem. ADHD is commonly spoken of as a condition affecting children but it can persist into adulthood.

Identifying the possible presence of ADHD involves a six question screen which assesses the presence of six characteristics of ADHD. Presence of four or more characteristics suggests a clinical assessment may be warranted. Clinical assessments for ADHD were not carried out as part of the APMS and it is noted that the proportion of people with four or more characteristics is likely to be an over estimate of the prevalence of ADHD and a score of six is likely to be an underestimate.

The Adult ADHD Self-Report Scale-v1.1 (ASRS-V1.1) does not take into account differences in behaviour across different situations (work/home life) or the age of onset of characteristics, which are important aspects of a clinical diagnosis of ADHD. Overall 8.2% of adults showed four or more characteristics of ADHD and 0.6% showed all six characteristics. The prevalence of ADHD characteristics (four or more) tends to decrease with age, with the highest rates among those aged 16-24yrs.

Previous studies have suggested that ADHD may be two to four times more likely to be found among men than women. However, no significant differences in the presence of ADHD characteristics by gender were found in the APMS.

Around 7,060 Kent residents in 2012 were estimated to have five - six characteristics of ADHD. This is predicted to rise by almost 2,600 by 2015.

6.3 Dual diagnosis: mental health and substance (drugs alcohol or both) misuse

The term 'dual diagnosis' relates to the broad spectrum of mental health and substance misuse problems that any individual might concurrently experience. The nature of the relationship between these two conditions is complex and varies from individual to individual.

Dual diagnosis affects a third of mental health service users, half of substance misuse service users and 70% of prisoners. Service users with a dual diagnosis typically use NHS services more.[14]

Table 9 shows 'episodes' of care that are provided in Kent 'Structured Substance Misuse Treatment' services. The term 'episodes' of care means the episode of treatment and one person may have a number of 'episodes' of care. (Please note that although this is helpful for payment – this is not the best way to assess the need of patients in treatment.) A dual diagnosis needs assessment was completed in 2011[xxiii]. Alcohol is the primary substance of misuse for 39.7% of dual diagnosis clients. This is comparatively high with only 27.3% of non-dual diagnosis clients with alcohol as their primary substance.

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Table 9: Total number of episodes in which the client has dual diagnosis

	2008/09	2009/10	2010/11	2011/12	2012/13
Total Number of Episodes in which the Client has Dual Diagnosis	340	388	678	783	848
Total Number of Episodes	6165	4755	5822	6205	9088
Proportion of Episodes in which the Client has Dual Diagnosis	6%	8%	12%	13%	9%

Source: KDAAT 2014

The proportion of episodes of care for dual diagnosis has decreased substantially from 2010-12 (Table 9) and the reasons for this are unclear.

The proportion of clients with a dual diagnosis differs greatly between districts with more than 30% of clients from Maidstone, Tonbridge and Malling, Sevenoaks and Tunbridge Wells respectively with a dual diagnosis compared to only 9% in Ashford (Table 10). The cause of this inconsistency is not described. The prevalence of

[14] National Mental Health Development Unit and The NHS Confederation, 2009, p1

coexisting mental health issues amongst substance misuse clients is in contrast to data sourced by K&M Partnership NHS and Social Care Trust (KMPT) that show the lowest adult mental health contact rates[15] in Sevenoaks, Tonbridge and Malling and Tunbridge Wells.

Table 10: Proportion of clients with Dual diagnosis status for those in treatment by District: 2013/14

	Dual diagnosis	%	All in treatment
Sevenoaks	57	40%	143
Tonbridge & Malling	72	39%	183
Tunbridge Wells	102	37%	275
Maidstone	113	30%	381
Canterbury	118	19%	627
Swale	100	18%	554
Dover	68	18%	388
Shepway	74	17%	438
Gravesham	58	17%	348
Dartford	20	14%	138
Thanet	100	14%	701
Ashford	30	9%	324
Total	**912**	**20%**	**4500**

Source: KMPHO 2014

6.4 Eating disorders

The Adult Psychiatric Morbidity Survey in 2007 found that 1.6% of adults met both the threshold for clinical assessment for an eating disorder and a severe mental disorder. Applying this data to the Kent population, it is estimated that 22,408 women and 4,199 men in Kent have an eating disorder. It significantly impacts on women.

Anorexia Nervosa is a syndrome where someone maintains a low weight due to a preoccupation with their body weight, fear of fatness and a pursuit of thinness. In anorexia nervosa, weight is maintained at least 15% below that expected, where an adult's body mass index (BMI)[16] is below 17.5kg/m2. Eating disorders significantly impact on women and the lifetime prevalence of anorexia nervosa is three times as high among women as men (Hudson et al., 2007). [xxiv] There is a separate Eating Disorder Needs Assessment 2014 on the Kent and Medway Public Health Observatory website.[xxv]

[15] Kent and Medway Public Health Observatory, 2014

[16] Calculated as weight in kilograms divided by height in meters squared.

6.5 Suicide and self-harm

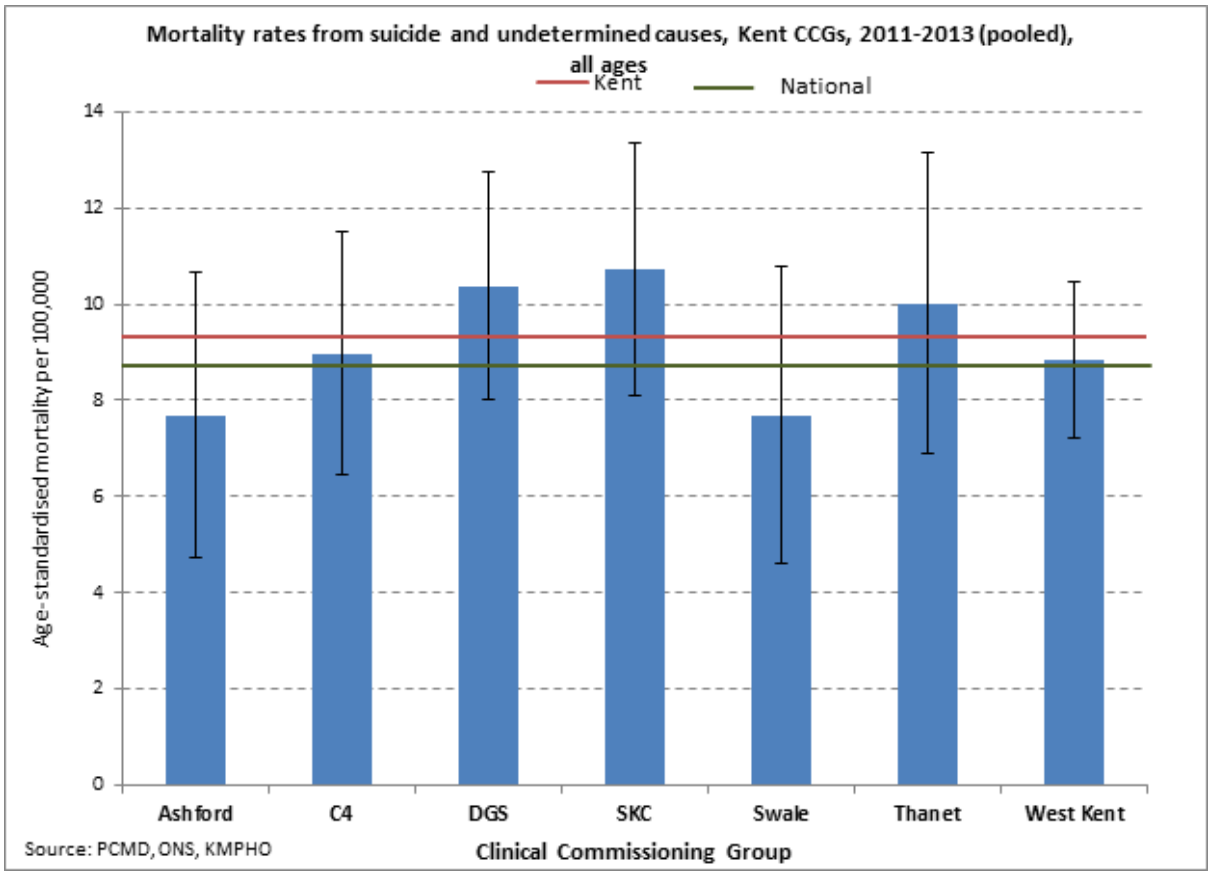
The effect of someone committing suicide is devastating for families and friends of the individual concerned. The impact can be felt across the whole community.

Suicide is the largest cause of death amongst people aged 25-44. Suicide rates in Kent are 9.2 suicides per 100,000 population (2011-13 pooled data) higher than the national rate of 8.8 per 100,000 (2011-13 pooled data).

In 2013 there were 147 suicides or deaths by undetermined causes in Kent (116 men and 31 women). Undetermined cause is a category of coroner verdict that is counted along with suicide by the Office of National Statistics and is regarded as 'probable' suicide. This figure of 147 suicides is an increase from 121 in 2012. Most suicides in Kent are committed by men aged between 30 and 60.

A comparison of the suicide mortality rate within individual CCGs to the Kent average and national average is possible (Figure 16). There is variation across the Kent CCGs (and Health and Wellbeing Board areas) with Thanet, South Kent Coast, and Dartford Gravesham and Swale CCGs having higher suicide rates than the Kent average.

Figure 16: National and Kent mortality rates for suicide and undetermined causes



6.5.1 Self-harm (para suicide)

There are various definitions of self-harm; some include harm with suicidal intent whilst others exclude this behaviour. Much of what is known comes from two key sources: NICE Guidance (2012) and a report from the Royal College of Psychiatry in 2010. Although the evidence, epidemiology and local service data is poor, developing the topic of self-harm is a current local concern of Health and Wellbeing Boards so for this reason the review has been included in the Needs Assessment.

The NICE guidelines use a relatively broad definition:

"Self-poisoning or self-injury, irrespective of the apparent purpose of the act". [xxvi]

Self-poisoning is the intentional use of more than the prescribed or recommended doses of any drug and includes ingestion of non-ingestible substances, overdoses of recreational drugs and severe alcohol intoxication.[xxvii]

The main forms of self-injury are: cutting, burning, hanging, strangulation, scratching, banging or hitting body parts and mutilation.

The most common type of self-injury in the UK is cutting and this is often repetitive. Although it was thought that cutting was more common in females there is some evidence that this may no longer be the case. Incidents of hanging have also increased over the past few decades. [xxviii]

More people attend hospital for self-poisoning than self-injury; however studies of the general population indicate that self-injury is more common. [xxix] An audit of A&E attendances for self-harm in Kent hospitals found that the majority of people (71%) presented following self-poisoning. [xxx]

Self-neglect is also considered an indirect form of self-harm and includes: physical risk-taking, sexual risk-taking, mismanagement of physical conditions and eating disorders. This definition excludes these forms of self-neglect and focuses only on self-injury and self-poisoning.

6.5.2 Epidemiology

It is estimated that the UK has one of the highest rates of self-harm in Europe. It is estimated that there are over 200,000 hospital attendances for self-harm in England annually with an estimated attendance rate of approximately 400 per 100,000 people. It is difficult to collate an accurate analysis of the epidemiology of self-harm in England as it remains a relatively hidden issue with many people never disclosing their behaviour, let alone seeking healthcare support. In a recent survey only 42% of men and 53% of women in the UK reported seeking medical or psychological help after self-harming and fewer young people report seeking healthcare support. [xxxi] The statistics below represent a summary of what is currently known from available data sources.

In 2007 the Adult Psychiatric Morbidity Survey found that 4.9% of adults (aged 16 or over) reported having self-harmed at some point in their lifetime. This was an increase since the last survey in 2000 with incidence rising most rapidly in women aged 16-24 (from 6.5% in 2000 to 11.7% in 2007).

There was no significant difference in the incidence of self-harm between men and women of any age group except in young adults aged 16-24 where rates were considerably higher in young women compared to young men (17.0% compared to 7.9% respectively).

Applying this rate to the 2012 mid-year population estimate for Kent (1,480,200) suggests that we would expect approximately 5,920 hospital attendances for self-harm in Kent hospitals over 12 months.

In a three month audit of A&E attendances for self-harm in adults (age >16) in Kent hospitals a total of 180 people presented for treatment related to self-harm. In comparison to the expected number of attendances modelled above, this appears to be considerably lower than expected. This figure, however, excludes attendances in children and it is difficult to extrapolate an annual figure from a relatively small sample. In contrast to this, admission rates for self-harm in Kent are significantly higher than the England average (Table 11).

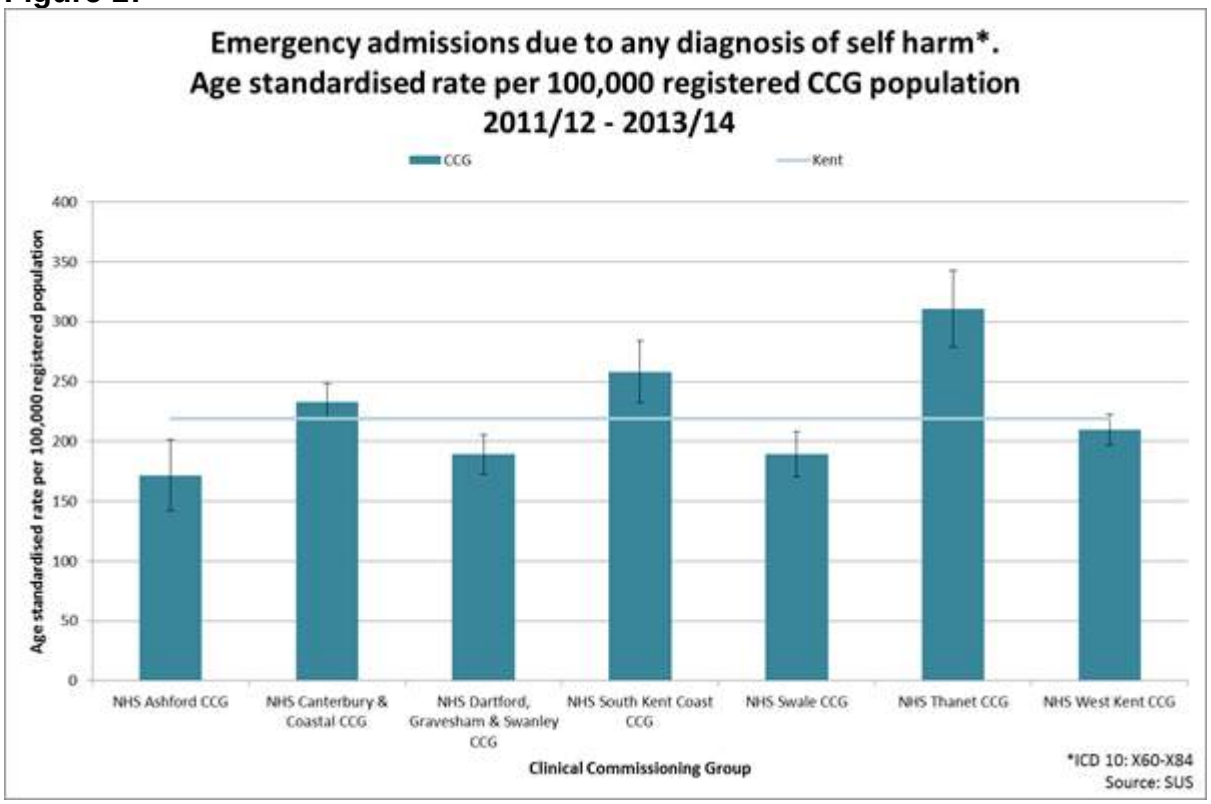
Table 11: The directly age standardised rate (per 100,000 population) of hospital admissions for self-harm in Kent in 2011/12 in comparison to the national average

Admissions for self-harm in Kent	Kent Self-harm admission rate	England average self-harm admission rate	England worst self-harm admission rate	England best self-harm admission rate
3141	**227.7**	**207.9**	**542.4**	**51.2**

Source: Public Health England. Health Profiles

Applying data pooled over two-three years, it appears in Figure 17 that Canterbury CCG, South Kent Coast and Thanet CCGs have higher then Kent average rates of admissions to hospital for self-harm compared to other Kent CCGs.

Figure 17



In general, younger people are more likely to self-harm than older people and women are more likely to self-harm than men. Rates of self-harm peak at the ages of 15-19 years in females and 20-24 years in males.

a Data from the Kent Audit of Self-Harm supports these statistics; 37% of attendances at A&E were for people age 16-25 and of these 72% were female.
b It is estimated that at least one in 15 young people self-harm at some point in their lifetime. A recent survey of 15-16 year old school pupils in Oxford found that 13.2% of 15-16 year olds reported self-harming at least once in their lifetime (n=6020) with rates higher in girls than in boys (20.2% compared to 8.6% respectively).
c Two thirds of people presenting at hospitals for self-harm are <35 years old and 2/3^{rds} of this group are female.

Table 12: The crude rate of hospital admissions for self-harm in children (per 100,000 population aged 0-17 years) in Kent in 2011/12 in comparison to the national average:

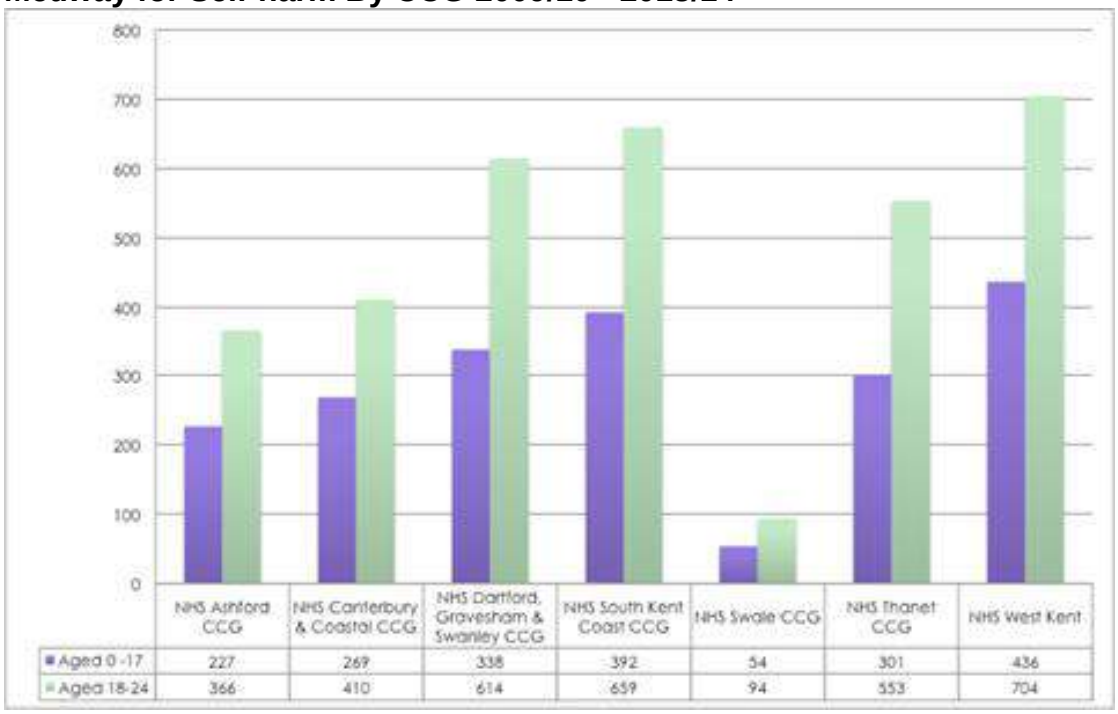
Admissions for self-harm in Kent	Kent self-harm admission rate	England average self-harm admission rate	England worst self-harm admission rate	England best self-harm admission rate
376	**116.5**	**115.5**	**311.9**	**26.0**

Source: Child and Maternal Health Observatory. Child Health Profiles. 2012

The self-harm admission rate for children in Kent is not significantly higher than the England average (Table 12).

a Rates of self-harm are significantly higher in South Asian women in England compared to white men or women or South Asian men. Rates are highest in South Asian women aged <35. South Asian women are also less likely to attend A&E following a repeated episode of self-harm.
b There is currently conflicting evidence regarding rates of self-harm in other ethnic groups in England.
c People who self-harm repeatedly are at greater risk of suicide than the general population with some studies demonstrating a 30-fold increase in risk of suicide, with greatest risk in the six months after the first episode of self-harm. Men who self-harm are more than twice as likely as women to die by suicide with the risk for both genders increasing with age.
d Certain methods of self-harm are also associated with higher risk of subsequent suicide. These include: hanging, strangulation and suffocation.

Figure 18: Attendances by Kent Residents at A&E Departments Kent and Medway for Self-harm By CCG 2009/10 - 2013/14



	NHS Ashford CCG	NHS Canterbury & Coastal CCG	NHS Dartford, Gravesham & Swanley CCG	NHS South Kent Coast CCG	NHS Swale CCG	NHS Thanet CCG	NHS West Kent
Aged 0-17	227	269	338	392	54	301	436
Aged 18-24	366	410	614	659	94	553	704

*Sources: KMPHO: A&E Dataset, Secondary Users' Service (*Extraction criteria = Arrival Date between 1st April 2009 and 31st March 2014, A&E patient group = 30)

The number of 16-24 year olds of Kent Residents at A&E Departments Kent and Medway for self-harm by CCG 2009-10 – 2013-14 needs further analysis (Figure 18). There is evidence that adults in the following groups in the UK are at higher risk of self-harm: (NICE 2012).

- being single and in the lowest household income quintile
- the unemployed and those in debt
- single people, divorced people and the socially isolated
- people experiencing relationship breakdown

- single parents
- people who misuse alcohol and drugs
- those exposed to violence
- victims of child abuse
- people exposed to multiple adverse life events
- those with a family history of self-harm.

It has been found that social isolation and physical or mental illness are particular risk factors for older people who self-harm. [xxxii]

The evidence relating to causal factors in adolescents presents a slightly different picture with the following identified as additional underlying causes of self-harming behaviour:

- difficulties associated with sexuality
- relationship issues (friends, family, boyfriend/girlfriend)
- physical or sexual abuse
- bullying
- academic pressure
- personal characteristics such as perfectionism, self-criticism and poor body image.

The physical and emotional changes associated with puberty are thought to compound these stressful experiences. The average age of onset of self-harm in children is 12-13, similar to the onset of puberty.

The following have also been identified as potential determinants of the relatively high rates of self-harm in South Asian women:

- arranged marriage or the rejection of an arranged marriage
- disputes with husbands or parents-in-law
- cultural conflict
- social isolation.

The influence of wider cultural factors on self-harm is an area requiring further research.

Population groups at specific risk of self-harm include:

- prisoners
- looked after children
- asylum seekers
- lesbian, gay and bisexual people
- carers, families and friends of those who self-harm. [xxxiii]

6.5.3 What can be done to reduce self-harm?

The multiple causes and motives for self-harm require a robust multi-agency and cross-departmental response.

The reports from the Royal College of Psychiatrists and the National Inquiry into self-harm among young people made the following recommendations:

a Self-harm should be explicitly included in any strategy to increase mental health, emotional wellbeing and resilience. Promoting emotional wellbeing and resilience from an early age can help children develop alternative coping mechanisms and avoid resorting to self-harm.
b The increasing role of social media in promoting self-harm or providing experiences likely to increase the risk of self-harm (eg exposure to others who self-harm, bullying, peer pressure or social isolation) need to be explored and reflected in any prevention and management strategy, particularly at a national level with the monitoring of harmful internet websites.
c The link between self-harm and substance misuse should also be considered in all drug and alcohol strategies.
d There is an ongoing need for cross-sector training for all frontline staff on identifying and responding to self-harming behaviour. A number of programmes have been evaluated including STORM (Skills-based Training on Risk Management) and ASIST (Applied Suicide Intervention Skills Training) although the high level of participant satisfaction was the only outcome measure quoted.
e Schools were identified as an appropriate setting to provide self-harm prevention interventions with peer support and counselling services identified as approaches worthy of further research.

There is also need for more accessible information for those who self-harm and their family, carers and friends.

In addition, recent international evidence review into self-harm and suicide in adolescents recommended the following universal and targeted approaches to prevent self-harm and suicide in this specific age-group:

Population Measures

- school-based psychological wellbeing and skills training programmes
- gatekeeping programmes
- screening to identify those who might be at risk
- restriction of access to means used for self-harm and suicide
- improved media reporting and portrayal of suicidal behaviour
- encouragement of help-seeking behaviour
- public awareness campaigns
- help-lines
- internet sources of help
- reduction of stigma associated with mental health problems and help seeking.

Measures for at-Risk Populations

- psychosocial interventions for adolescents at risk of self-harm or suicide (eg, depressed adolescents, abused individuals, runaway children)
- screening of those at risk (eg young offenders)
- psychosocial interventions for adolescents who have self-harmed

- pharmacotherapeutic interventions for adolescents at risk of self-harm or suicide.

Whilst a number of recent reviews have provided a clearer picture of the epidemiology of self-harm in England, there remains a paucity of evidence regarding the effectiveness of preventative strategies, particularly primary prevention. More evidence is available regarding secondary prevention measures and this is reflected in a series of NICE guidance on self-harm which have been published over the last nine years.

Mental Health Interventions in Kent

This chapter will cover:

- mental health promotion
- psychological therapies
- 'secondary' services

7.1 Mental health promotion

Kent County Council is one of the few local authorities to have invested in mental health promotion and has developed its approach based on the Kent Live it Well Strategy. [xxxiv] The Strategy was developed and consulted on with people across Kent. All the Health and Wellbeing Boards in Kent recognise the importance of mental health and its impact on quality of life throughout the life course. Consequently the Joint Health and Wellbeing Strategies include mental health and promoting mental wellbeing, and support to people with specific mental health needs, as a priority[xxxv]. This needs assessment will contribute to the production of local mental health strategies and inform the priorities set out within Clinical Commissioning Groups and Local Authority commissioning plans and integrated health and social care plans.

7.1.1 National health promotion: Time to Change

Time to Change is a national campaign led by Mind and Rethink mental illness. Kent partners are supporting it through work with statutory and voluntary mental health organisations, service users and carers in Kent to:

a Improve understanding of and positive attitudes towards mental health.
b Reduce the stigma and discrimination experienced by people with a mental health problem, their family and/or carers (and encouraging people to talk about mental health).
c Increase the confidence and ability of people with mental health problems, their family and carers to address discrimination.

7.2. Psychological therapies

The Improving Access to Psychological Therapies (IAPT) services are commissioned by CCGs across Kent to provide a service for mild to moderate mental health problems. They use a stepped care model together with specialist employment support based on NICE guidelines for the management of: depression, anxiety, post-traumatic stress disorder (PTSD), obsessive compulsive disorder

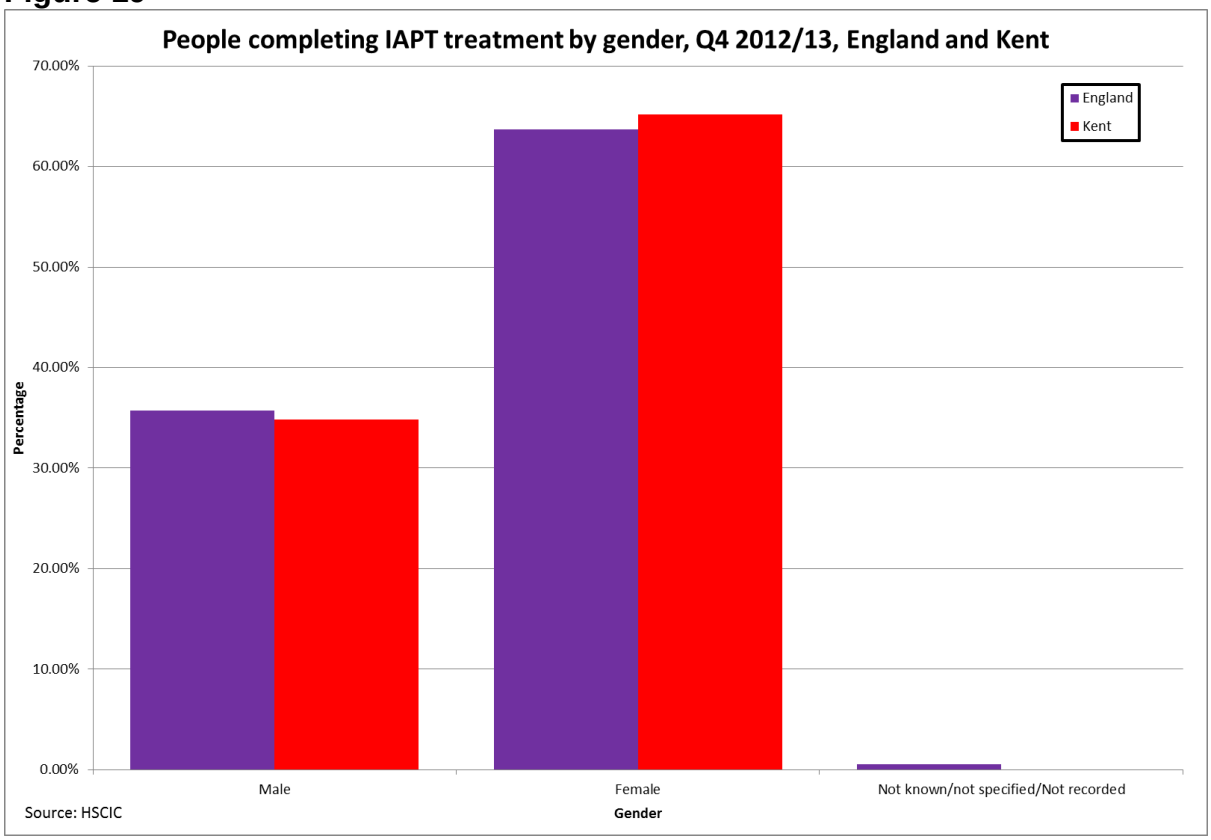
(OCD) and body dysmorphic disorder (BDD), Three of the principal aims of IAPT services are to:

a Support the effective management of activity and demand into secondary care, with earlier and more appropriate interventions and fewer episodes requiring secondary care.
b Recognise and work with the overlap between physical and mental health of long-term conditions and medically unexplained symptoms.
c Help people to have less time off work and retain/return to employment.

An estimated 81.9% of help-seekers with a common mental illness were referred to IAPT in 2013-14. Of these, 47.4% (14.1% of people with a common mental illness (CMI)) entered treatment, and a further 43.0% (12.8% of people with CMI) of help-seekers completed treatment.

In terms of addressing overall need in the Kent population the national ambition was 15% of the population to enter treatment; in Kent 14.1% entered treatment in 2013-14; up from 7% recorded in 2011. The Draft 2014 Health Equity Audit of IAPT services hoped to explore whether in some areas people were less likely to recover than others and what factors influence this outcome. The data collected to date, however, is not of sufficient quality to enable an assessment of postcodes for each CCG area. A recommendation from the HEA is that future audits should revisit this question.

Figure 19



Approximately two thirds of people entering treatment are women. Males of working age 18-64 are seen less in IAPT than women. Access by gender is in line with access for England (Figure 19).

7.3 "Secondary" services and service use models

The term 'secondary' services for mental health must be used advisedly as current pathways of care are changing. In general this category refers to people with or in need of a diagnosis of a serious (sometimes referred to as severe) mental health illness, notably psychosis, bipolar disorder, severe personality disorder and /or complex and psychotic depression. These are people who have disorders where the majority will have or need a care programme and thus be under the treatment of a psychiatric team.

The main provider of secondary mental health services in Kent is Kent and Medway Partnership Trust (KMPT). For effective service planning, investment needs to be made appropriately across the mental health care pathways to maximise overall levels of mental wellness within the population.

Like any person with a chronic illness, a person with a serious mental illness can be at any phase of their illness (either coping well, stable and managing symptoms, or in an acute phase, not coping or in need of urgent treatment).

This section explores the needs of people in Kent who are expected to be in this category and assesses the predicted numbers of these people against the number of people currently known to "secondary" services.

It is certain that the data presented here will raise more questions than provide answers. It will be up to all health and wellbeing boards (both locally and countywide) to ensure that the questions are both generated and answered. This is why it is important that this needs assessment is a living document that is updated regularly with accurate data.

7.4 Stepped care

As stated earlier in this needs assessment the vast proportion of mental illness need in the population of Kent (97%) is for common mental illness, however the 3% of severe mental illness (SMI) takes up the majority of health care expenditure.

The National Institute of Health Research (2010) and the current NICE Guidance advocates for a "stepped care" approach to treatment (sometimes known as a 'pathway' approach) (Goldberg and Huxley 1980). The "stepped care" model illustrates what proportions of people are likely to access which part of the service at any one time. This is important because it shows that not everyone who seeks help for mental health problems will need to go to hospital, some people can be effectively managed in primary care.

To answer the question about what proportion of patients need to be in which part of the mental health system, the numbers from a model by Goldberg and Huxley et al (1995) have been used here (Table 13). The following population estimates of expected numbers are made for Kent, based on this hierarchical schema of stepped

care and are provided only for guidance for commissioners. This is only a model and is not meant to be a literal predictor of need (due to the wide confidence intervals).

There are problems with the "stepped care" model and these are currently being dealt with by local commissioners. Any new models of care should be communicated clearly to all partners on the Health and Wellbeing Boards and local people; accurate data predicting, needs to be factored into these discussions. The model shows that a far smaller proportion of patients will be seen in the community/ inpatients compared to those seen in primary care (Table 13).

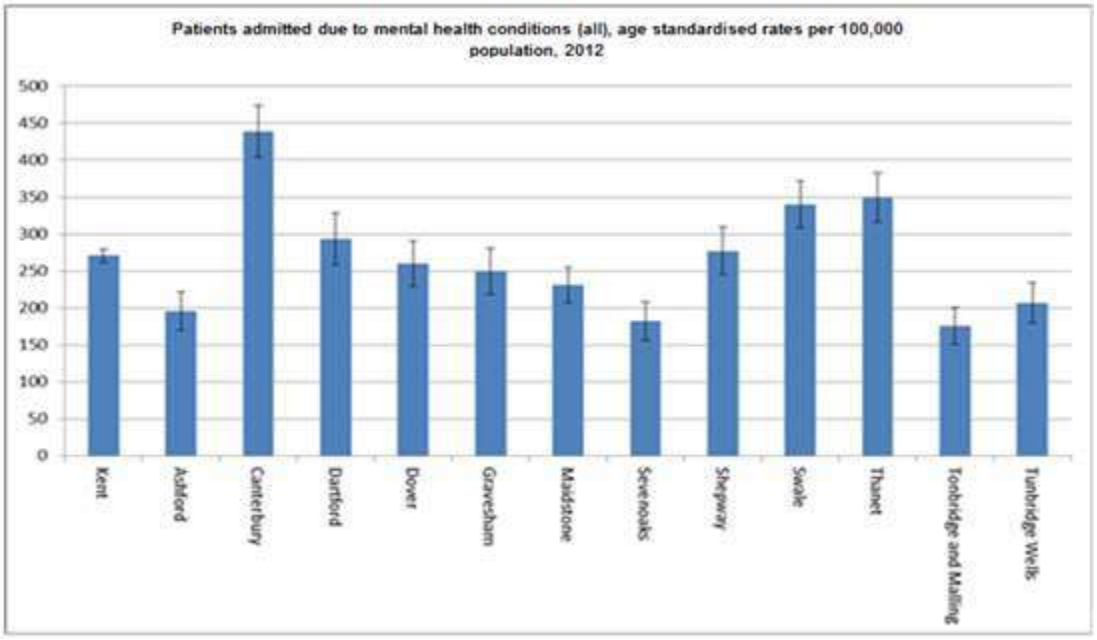
Table 13: Patient flows in Kent and CCG areas

	Number develop symptoms		Attend primary care	GP identifies disorders	GP refers to psychiatric services		Outpatients		Inpatients
	Lower estimate	Upper estimate			Lower estimate	Upper estimate	Lower estimate	Upper estimate	
Ashford	25754	30707	22783	22783	1981	2972	991	1981	495
Canterbury and Coastal	46218	55106	40885	40885	3555	5333	1778	3555	889
Dartford, Gravesham, and Swanley	51774	61731	45800	45800	3983	5974	1991	3983	996
South Kent Coast	42951	51210	37995	37995	3304	4956	1652	3304	826
Swale	22172	26436	19614	19614	1706	2558	853	1706	426
Thanet	29809	35542	26370	26370	2293	3440	1147	2293	573
West Kent	97095	115767	85891	85891	7469	11203	3734	7469	1867
Kent	320616	382273	283622	283622	24663	36994	12331	24663	6166

Source: Goldberg & Huxley, patient flows for adult mental ill-health in Stevens A, Raftery J, Mant J, et al. Health care needs assessment (third series) Radcliffe, 2007

The directly age standardised rate for hospital admissions in 2012 is 286.3 (95% CI; 277.4, 295.5) per 100,000 resident population in Kent. The distribution of the rate of admission for 'all mental health conditions' varies across districts. While Canterbury, Swale and Thanet had high rates of admissions, Tonbridge and Malling, Sevenoaks, and Ashford had rates that are lower than the Kent average (Figure 20).

Figure 20: Patients admitted due to mental health conditions (all), age standardised rates per 100,000 population 2012.



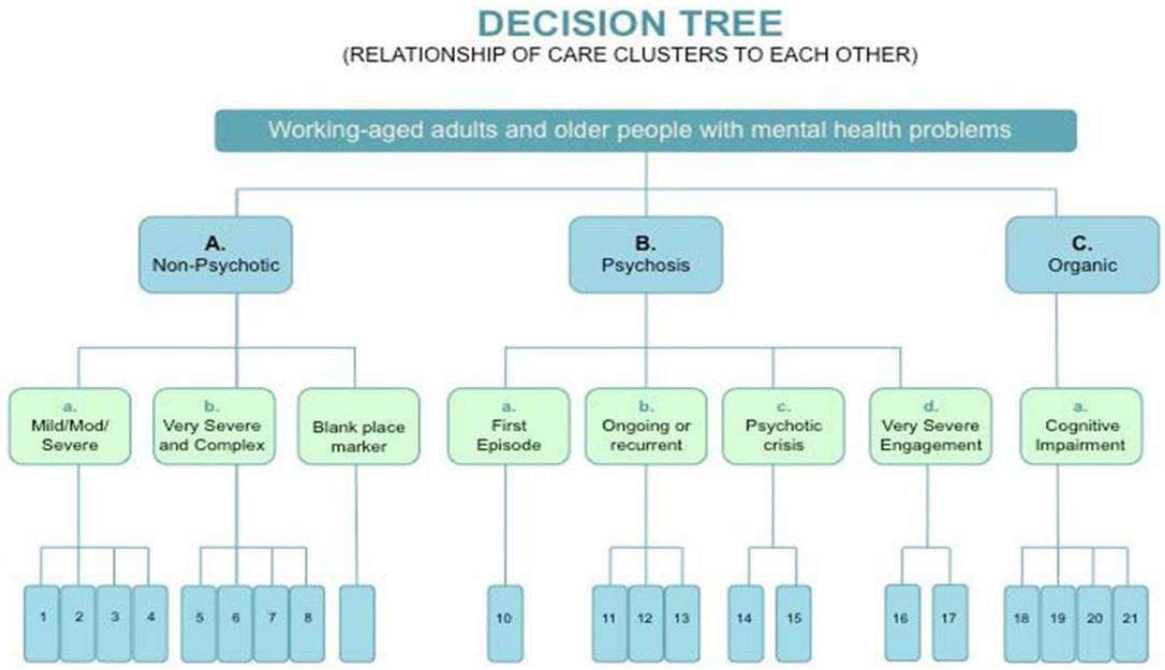
Source: KMPHO 2013

7.4. 'Clustering': a needs based payment system

Traditionally "secondary" MH services have been commissioned using a block contract model and services are commissioned for capacity (X number of teams with X number of staff). The system is changing to one which is focused on needs and outcomes. There is a new 'payment mechanism' for providers of mental health services and this is generically known as the Mental Health Tariff, where patients are organized in clusters according to their particular need for that service. Patients are assigned to super clusters A, B or C (Figure 21 below) on the basis of assessments (involving diagnosis) using a mental health clustering tool. In this context, cluster can be interpreted as a global description of a group of people with similar characteristics as identified from a holistic assessment and rated using the Mental Health Clustering Tool (MHCT).

The tool has 19 scales. Two things can happen upon referral – a person can be assessed to not need the services on offer or be appropriate for intervention and assigned to a treatment cluster.

Figure 21



Clustering (Figure 21), in practice, follows an initial assessment (typically within two contacts) and then the person is allocated to the most appropriate cluster. Each cluster represents a package of care for a defined period of time. At the end of the defined period the individual is reviewed and can be re-assigned to the same cluster (care package) or a new cluster depending on need. A review can also be instigated where there is significant change in planned care and additional services are deemed necessary (eg unplanned reviews, urgent admissions etc).

7.4.1 Service data and clustering: a few problems in assessing population need from payment data

Previously the only accurate data that was accessible from mental health systems was inpatient and outpatient data. The data available from community and specialist services – was nationally only collected on the ‘ activity’ basis, so it was hard to assess actual numbers of patients per area or how many patients had the majority of ‘contacts’. To improve this situation the nationally imposed ‘clustering tool’ will be - able to separate this out as providers now report numbers by clusters (care packages) see Figure 21 for the relationship between care clusters.

Traditionally clustering has not been the case both locally and nationally and, as a consequence, the data available to PH and commissioners has been poor. It is anticipated that in time the information from the assessments and number of care packages being offered will be more useful to public health and commissioners.

Future Demand, Unmet Needs and Service Gaps

Demand on mental health services over the next five years will be driven by changes in the number who need services. In other words, there will be more people who need services because the population is increasing, not because mental illness is itself becoming more common.

The King's Fund report 'Paying the Price' (2008) states that the 'increase in numbers simply reflects the increase in population. Prevalence rates for all mental disorders within all age groups are likely to remain broadly stable'. The number of people who meet the diagnostic criteria for mental disorder is greater than the numbers who use services. Future demand is therefore not as simple as a linear projection. If more services are available, more people can be treated. In mental health, better access, diagnosis or case-finding can increase demand on services, for example the following may lead to greater use of services: greater access to treatment for depression and anxiety, speedier response to crisis in severe mental illness, more accessible and acceptable services may discover cases of previously unmet demand eg from people with untreated serious mental illness.

However, more effective care pathways (such as management of serious mental illness in primary and community care) have the potential to manage demand by providing timely and preventative interventions.

The (2007) Adult Psychiatric Morbidity Survey (PMS) found that prevalence rates for most disorders were stable over the last eight years between surveys. The significant changes were:

- the number of people reporting self-harm increased
- the number of women reporting suicidal thoughts in the last year increased.
- the percentage of women aged between 16 and 64 years old with a common mental disorder rose from 19.1 per cent in 1993 to 21.5 per cent in 2007, with the highest rate in the age 45-54.

Evidence of what Works in Treating and Preventing Mental Health Problems

The following NICE guidance is relevant to identifying and treating mental illness and improving mental wellbeing:

Public Health guidance

Promoting mental wellbeing at work (PH22) (2009) focuses on interventions to promote mental wellbeing through productive and healthy working conditions, covering five areas (strategy, assessing opportunities for promoting mental wellbeing and managing risk, flexible working, the role of line managers, and supporting micro, small and medium-sized businesses).

Mental wellbeing and older people (PH16) (2008) focuses on the role of occupational therapy and physical activity interventions in the promotion of mental wellbeing for older people.

Clinical guidelines

Eating Disorders (CG9) (2004) recommends the core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and other related eating disorders.

Self-harm (CG16) (2004) outlines the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care.

Anxiety (CG22) (2007) provides recommendations for the identification and management of anxiety in adults in primary, secondary and community care.

Post-traumatic Stress Disorder (CG26) (2005) covers the care that people with PTSD can expect to receive from their GP or other healthcare professional, the information they can expect to receive about their condition and its treatment, what treatment they can expect (which may include psychological therapies and drug treatment) and the services that may help them with PTSD, including specialist mental health services.

Obsessive Compulsive Disorder (OCD) and Body Dismorphic Disorder (BDD) (CG31) (2005) covers the care people with OCD or BDD can expect to receive from their GP or other healthcare professional, what treatments may be offered, including psychological therapies and medication, the services that may help with OCD or BDD, including specialist mental health services and how families and carers may be able to support people with OCD and BDD, and how they can get support for themselves.

Bipolar disorder (CG38) (2006) covers what treatment people with bipolar disorder can expect to be offered, including medication and psychological therapies, advice on self-help, the services that may help people with bipolar disorder, including psychiatric or specialist mental health services and how families and carers may be able to support people with bipolar disorder, and get support for themselves.

Antenatal and Postnatal Mental Health (CG45) (2007) covers all mental disorders, including perinatal mental disorders with the aim of helping clinicians to balance the

risks of treating a mental disorder with the risks to the mother, her infant and other family members of not treating it.

Antisocial Personality Disorder (CG77) (2009) makes recommendations for the treatment, management and prevention of antisocial personality disorder in all levels of healthcare and across a wide range of other services.

Borderline Personality Disorder (CG78) (2009) makes recommendations for the treatment and management of borderline personality disorder in adults and young people in primary, secondary and tertiary care.

Schizophrenia (CG82) (2009) covers the care, treatment and support that adults (aged 18 and older) with schizophrenia should be offered, including people who develop schizophrenia before they are 60 and continue to require treatment after this age.

Depression in adults (CG90) (2009) makes recommendations on the identification, treatment and management of depression in adults aged 18 years and older, in primary and secondary care. It is published alongside Depression with a chronic physical health problem (CG91) (2009) which makes recommendations on the identification, treatment and management of depression in adults aged 18 years and older who also have a chronic physical health problem.

Suicide prevention: second annual report Department of Health (2015). The second annual report sets out what local areas can do to prevent suicide and save lives. The report calls on services to be more ambitious about suicide prevention, and challenge the assumption that suicide is inevitable and outlines how services can improve by adopting this new attitude and effective interventions.

The Suicide Prevention Strategy for England (2002) published by the Department of Health supported the Saving Lives: Our Healthier Nation target of reducing the death rate from suicide by at least 20% by 2010. The strategy is based on six goals: reducing risk in key high risk groups, promoting mental well-being in the wider population, reducing the availability and lethality of suicide methods, improving the reporting of suicidal behaviour in the media, promoting research on suicide and suicide prevention and improving monitoring of progress towards the Saving Lives: Our Healthier Nation target for reducing suicide.

New Horizons (2009) was published by the previous Government as the successor to the National Service Framework for Mental Health. It had the twin aims of improving the mental health and well-being of the population and improving the quality and accessibility of services for people with poor mental health. A number of documents were published, including Confident Communities, Brighter Futures which presented a framework for improving the mental health and wellbeing of the population as a whole, not just individuals experiencing mental illness. Whereas these documents will no longer be national policy, they contain a robust evidence-base that can be adapted for local strategies.

The aim of the Foresight report on Mental Capital and Wellbeing (2008) was to use the best available scientific and other evidence to develop a vision for reviewing the

opportunities and challenges facing the UK over the next 20 years and beyond and the implications for everyone's "mental capital" and "mental wellbeing", together with highlighting what all agencies will need to do to meet the challenges ahead, so that everyone can realize their potential and flourish in the future. The project also outlined the actions felt to be most important, and how available resources could be better allocated.

Research reviews on prevalence, detection and interventions in parental mental health and child welfare: summary report (Social Care Institute for Excellence Guide 30, July 2009) has identified a range of factors which inhibit good outcomes for parents and children where parental mental health issues are a feature of family life.

Service User Views

Service users and the public gave their views to the mental health commissioners for Kent and Medway when they were engaged in the creation of the Live It Well in Kent (Mental Health) Strategy.[xxxvi] Their views are summarised as follows:

Local

- services should fit in with where we live
- in the community as far as possible, rather than health locations
- in places where everyone else also uses resources to get on with life.

Personalised

- a single point of contact for service users
- alternatives to medication, increased access to talking treatments
- better signposting to resources and services so we can arrange support for ourselves with a personal budget.

Timely

- services should be when we want them (which is usually early on)
- better out of hours support with 24 hour support for people in crisis
- a proper procedure when police detain people with mental health problems.

Non-stigmatising

- service users should be empowered, not disempowered, by mental health services
- challenge stigma, not identifying service users as separate from the rest of society
- personalised relationships with people we know.

Recommendations

a Improve data input, data systems, data quality and evaluation of secondary mental health data.

a The vulnerable population in Kent is aging. Consider reviewing "'supporting people" and housing services and policies for vulnerable people in light of the population estimates in this needs assessment and link this with Integrated Care/Better Care funds.

b Improve data, pathways and quality of mental health services for people in the criminal justice system and mental health service users who come into contact with police.

c Use the progress made with “connected communities” to understand patterns of service use thereby improving access to psychological therapies and other wellbeing programmes.

d Build social capital through mapping the local assets for wellbeing and help publicise to the local population.

e Run targeted wellbeing campaigns using Kent Six Ways to Wellbeing

f Improve access to psychological therapies: particularly for people with a history of sexual abuse, relationship breakdown, substance misuse problems and for offenders and ex-military. Improve the social marketing of psychological counselling services.

g Improve the quality of the annual health check for people with severe mental illness.

h Ensure that the health and wellbeing of the migrant population is addressed by using “health trainers” and “community health champions” to publicise the services that are on offer and monitor and evaluate uptake of commissioned services accordingly.

i Empower local GPs with the skills and knowledge to refer to counselling services (particularly via primary care link workers).

j Ensure an equity audit on primary care mental health is undertaken.

k Align public health and social care services with NHS services particularly in areas of greatest deprivation.

l Ensure there is a local “deep dive” into the APMS survey to ensure that national estimates are accurate. This is underway for the 2015 survey and led by Public Health in Kent

m Develop bespoke training for police and GPs on mental health awareness and risk assessment/management techniques; this has started with health promotion support, Mental Health First Aid training for police and troubled families workers and the promotion of e-training for GPs.

n The mental health needs of black and Minority Ethnic communities and high-risk groups, such as offenders, migrants and asylum seekers/refugees need to be better understood to ensure appropriate service provision in Kent.

o Further needs analysis, assessment and targeting of older people (excluding dementia) are needed, particularly tackling social isolation and depression

p Of Kent’s population of adults with severe and enduring mental health problems, only 8% are in employment, improving the employment prospects of people with mental health problems is an important key priority.

q Having a clearer understanding of how ‘cluster’ data is used for planning and commissioning is important for CCGs.

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